



CRIA UPDATE

COMMUNITY RESEARCH INITIATIVE ON AIDS

VOL. 9 No. 5

Quality of Life

The Winter 2000/2001 *CRIA Update* is devoted to quality of life issues in HIV research and care. While antiretroviral therapy has made a great difference in longevity for thousands of people in the United States, most people living with HIV must make major compromises in order to participate in recent medical advances. Many use challenging side effect management techniques in order to stay on treatment. Others continue to have seriously impaired and deteriorating immune systems even as they religiously adhere to their regimens. Still others, like our Board member, Gary Bonasorte, face diminished quality of life as a result of an impaired immune system, and tragically die much too young.

In light of these realities, we took a look at how researchers examine the effects of life-threatening disease and medical treatment on

quality of life. Bruce Rapkin, Ph.D. discusses the methods researchers use to measure quality of life and the challenges of creating and understanding such measurements given the highly subjective nature of the issue. Michael Shernoff, MSW describes some common quality of life concerns faced by people with HIV. We thought it particularly valuable to include personal perspectives; four incredibly courageous men and women describe the impact of HIV and current treatment on their daily lives.

We hope that you find this to be an interesting issue of *CRIA Update*. For us, it serves as a reminder that our work to improve treatment options for people living with HIV remains of critical importance.

J Daniel Stricker, Editor-in-Chief

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Gary Bonasorte - 1955–2000

It is with great sadness that CRIA announces the death of our Board member, Gary Bonasorte, from lymphoma on November 9th, 2000. He was just 45 years of age.

Gary was truly an exceptional human being and a constant champion of CRIA's mission. In 1991, he was one of the volunteers who helped to establish the agency. Few demonstrated as unwavering a commitment to CRIA and to the care we were providing to people who desperately needed access to clinical trials. Gary then became a paid staff member in charge of several important functions including volunteer recruitment, community treatment forums and office management. In 1999, Gary decided to devote his full efforts to playwriting and was recently successful in staging several productions. But he did not abandon CRIA in the process. He agreed to join our Board, and was actively involved in agency affairs up until his disease became unmanageable.

For all of us at CRIA, Gary was exemplary because he exhibited traits that are essential to the considerate care of people who live every day with life-threatening illness. He was always available to anyone in need, consistently compassionate, and a terrific listener. Our ability to help patients and clients has benefited immeasurably from his example.

CRIA extends its deepest condolences to his partner, Terrence McNally, and to his family in Pittsburgh.

Mail-in Quality of Life Survey Enclosed

WINTER 2000/01

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CRIA is an independent, non-profit, community-based AIDS research and treatment education organization dedicated to rapidly improving the length and quality of life for people living with HIV/AIDS. CRIA studies new treatments for HIV-related diseases through its clinical research and conducts a comprehensive treatment education program. Bulk copies of *CRIA Update* are available free to agencies that provide services to people living with HIV/AIDS. For more information call LaQuitia Moe at 212-924-3934 ext. 119.

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Study of 3 Different Drug Combinations in Drug-Naïve, HIV+ Individuals

CRIA is participating in 96-week study sponsored by Glaxo Wellcome. It will look at the effect of three different anti-HIV drug combinations on people infected with HIV. Some individuals with HIV experience changes in body shape as a result of fat redistribution. The primary purpose of this clinical trial is to study this effect. The study is for adults who are HIV-1+, have a CD4+ lymphocyte cell count greater than or equal to 50 cells/mm³, have a viral load greater than 1,000 copies/mL and less than 200,000 copies/mL, and have *NOT* received anti-HIV drugs in the past or have very limited use of certain anti-HIV drugs.

SAM-e for Depression in HIV+ Individuals

CRIA is currently conducting an 8-week open-label study of the efficacy and safety of using S-adenosylmethionine (SAM-e) to treat depression in HIV+ individuals. SAM-e is a naturally occurring compound that is sold as a food supplement in this country. 20 HIV-infected adults with diagnosed clinical depression have been enrolled in this study.

Directly Observed Antiretroviral Therapy (DART)

CRIA is currently conducting the pilot "Historical Prospective Study of Directly Observed Antiretroviral Therapy (DART)" with the CDC. Patient records from three types of settings providing antiretroviral therapy (AIDS residential health care facilities, day health centers, and ambulatory health clinics) are being compared to study the effect of DART on the clinical outcome of people living with AIDS. This research should generate data that will maximize the effectiveness of antiretroviral therapies and minimize the development of HIV resistance to these drugs.

Vigilance II Genotyping Study (Currently Enrolling)

The purpose of this study is to determine if an HIV-1 RNA genotype report is effective and safe to use for choosing therapy for HIV infection. We will be gathering data regarding an experimental test called genotyping, in this case the TruGene[®] HIV-1 Assay, developed by Visible Genetics Inc. Genotyping may allow doctors to see which drugs may or may not work against HIV infection. It may tell you if HIV may be resistant to certain drugs. Resistance means that the drugs given to you for your HIV may not work as well as thought. Genotyping is still being studied as an aid in treating HIV infection.

You may be eligible for this study if: 1. you are an HIV-1 infected person with a viral load of greater than or equal to 1,000copies/mL 2. you and your doctor have determined that a change in your anti-HIV therapy is indicated; or if no prior therapy has been given for HIV-1, then you and your doctor agree that therapy needs to be started.

You will come in for one blood draw specifically for the study. This blood will be used for the genotyping test. Your personal doctor will get the results of the genotyping test within 7-10 business days and use these results to help choose a drug regimen that may be beneficial to you. We will gather data about your progress (up to one year) from later blood draws by your personal doctor that are part of your regular care. You will be paid \$15 after enrolling into the study to cover transportation, lost time from work, or meals. Your insurance company or a state health insurance agency will be billed for the blood tests. If you do not have insurance or state coverage and if you cannot pay for the tests, your study doctor will try to enroll you in a special patient assistance program.

FOR MORE INFORMATION ON ANY OF THESE STUDIES, PLEASE CALL DR. IRENE CERGNUL OR DR. DOUGLAS MENDEZ AT (212) 924-3934, OR VISIT OUR WEB SITE (WWW.CRIMARY.ORG).

Editor's Notes

* All material in *CRIA Update* is presented for educational and informational purposes only, and is not intended as medical advice. All decisions regarding one's personal treatment and therapy choices should be made in consultation with a physician.

* *CRIA Update* refers to all drugs by both their commercial and scientific names upon their *first reference* in an article. Thereafter in the article, they will be identified with the name by which we feel they are most commonly known, either commercial or scientific.

Whose Life is it Anyway?

BY BRUCE D. RAPKIN, PhD

The Measurement and the Meaning of Health Related Quality of Life

My love-hate relationship with quality of life research started in 1975. I was a junior in college taking a seminar in environmental psychology. We were doing a class project that involved interviews with older nursing home residents. We could see for ourselves that the environment was dreary to say the least. Residents had little privacy, there was little to do, staff members were at times dismissive and even disrespectful of residents, there were few visitors, and the place smelled like urine and Lysol. I remember being stunned when we looked at residents' answers to the standard life satisfaction survey that we had included in our interviews. Many people's responses to items indicated that they were as happy as when they were younger, that these were the best days of their lives, and that they had gotten what they expected out of life.

These responses sparked considerable debate in our small class. Were these people really satisfied? How could they be satisfied in such dismal circumstances? Was this all that they expected out of life? Were they just telling us what they thought we wanted to hear? Our discussion turned to the question of intervention. If people were already satisfied, was there any reason to make changes in this nursing home environment? How do we know what would benefit these residents? I will never forget my professor's response: "Maybe our job should be to get them pissed off."

Over the past twenty-five years of research on quality of life, a lot has happened but, in some ways, little has changed. There has been a growing interest in measuring quality of life in health-related research. Quality of life studies are routinely conducted with people affected by every debilitating or life threatening illness, includ-

ing HIV/AIDS. This attention is a very positive trend. It reflects a growing awareness among health researchers and clinicians that the patient's perspective is important. Medical treatments may impact people in ways that cannot be understood in terms of biological responses. Indeed, some treatments may only benefit quality of life. Quality of life factors are weighed in treatment decisions and are a central concern in patient-provider communication.

"Medical treatments may impact people in ways that cannot be understood in terms of biological responses."

Despite this growing awareness, much of the technology for measuring quality of life remains similar to what it was twenty-five years ago. Widely used quality of life surveys focus exclusively on documenting satisfaction and well-being. We assume that no complaint means no problem, but is this always the case? What if people report good quality of life? When does high life satisfaction mean fulfillment and when does it mean complacency? How can findings of quality of life research guide support and care if we cannot be certain what people's answers mean? Perhaps most important, do these questions about meaning and personal fulfillment really matter in medical research?

Current Approaches to Quality of Life Measurement

There are several different approaches to quality of life assessment in use today. The

first might be viewed as a "molecular" approach. Just as objects are built up by assembling different molecules, this approach tries to determine a person's quality of life by putting together their answers to specific questions. Questions are related to many different topics and themes, which are referred to as different "dimensions" of quality of life. The molecular approach relies on standard self-report scales that ask about different aspects of life, including physical symptoms, pain and fatigue, ability to carry out chores and care for oneself, mental health, work performance, social activities, and general health and well-being. Some scales also ask about more existential concerns such as emotional well-being, sense of purpose in life, and spiritual fulfillment.

There has also been interest in developing "disease-specific" sub-scales that address particular quality of life concerns related to different diagnoses. For example, HIV-specific sub-scales might include HIV stigma, experiences with disclosure, living with complicated medication regimens, or satisfaction with sexual function and intimacy in light of HIV transmission precautions. There are many molecular quality of life scales that differ in terms of the number of dimensions that they include and the number of separate items (questions) used to measure each dimension. Responses to items are usually made on numeric rating scales, where numbers stand for the frequency or severity of a problem or how strongly one agrees with a given statement. (See box on page 4 for examples of items and dimensions from major quality of life measures used in studies of HIV/AIDS.)

Over the past ten years or so, a small industry has grown up around the molecu-

(Cont. on next page)

Whose Life is it Anyway?

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lar assessment of quality of life in health research. Several groups in the U.S. and Europe have grown out of academic circles to form small, private companies dedicated to quality of life assessment. These groups have focused on the development and promotion of standard multidimensional measures to assess quality of life. Measures developed by these groups have been administered to thousands of people, including people living with HIV/AIDS. They have been studied extensively in terms of “psychometric properties” such as “reliability” (the tendency to answer questions in a consistent manner) and “validity” (the tendency for peoples’ answers to correspond with their other known characteristics). Some measures have also established “norms” (average scores and scoring distributions) for people with different diagnoses and for non-patients.

Often, special attention has been given to translation of measures to different languages by ensuring cultural or linguistic “equivalence” (different translations of the items have similar norms and psychometric properties). These standardized molecular measures have emerged to fill an important niche. There are many instances when clinical researchers want a quality of life measure that can readily be compared across different people and groups, over time.

In contrast to molecular studies of building blocks, scientists refer to studies of an object’s overall properties as “molar” research. There has been a growing interest in looking at quality of life in molar terms, by using global assessments of life as a whole. Rather than asking about many different dimensions, these molar approaches ask people to put an overall value on their current life. One such approach, the Standard Reference Gamble, presents people with a range of bets, wagering time in their current health state

against time in perfect health. For example, most anyone would take the bet if the choice were one year in perfect health versus one year in current health. But, would you wager one year in current health to get eleven

months in perfect health? How about six months, or one month?

The assumption underlying this method is that quality of life is indicated by the
(Cont. on page 12)

WHAT DO QUALITY OF LIFE MEASURES MEASURE?

The most widely used measures of quality of life in clinical research involving people living with HIV/AIDS are derived from the Medical Outcomes Study (MOS), conducted during the 1980s by the Rand Corporation (REFs). Several versions have been derived from the MOS that differ somewhat in the number of items that they include and the aspects of quality of life that they assess.

In the early 1990s, researchers at Johns Hopkins created a version of the MOS measure specifically for HIV/AIDS research, the “MOS-HIV”. Other quality of life measures that have been adopted for HIV/AIDS studies include the Functional Assessment of HIV-Infection (FAHI) which was derived from a quality of life measure widely used in cancer research, and the HIV-AIDS Target Quality of Life measure (HAT-QOL) that includes areas of concern unique to AIDS.

QUALITY OF LIFE DIMENSIONS AND ITEMS:

General Health

- How would you rate your overall health? (Rated from “excellent” to “poor”)
- My health is excellent. (Rated from “definitely true” to “definitely false”)

Physical Functioning

- How much does your health limit the kinds or amounts of moderate activities you do, like moving a table or carrying groceries. (Rated “a lot,” “a little,” or “not at all”)
- I am forced to spend time in bed. (Rated from “not at all” to “very much”)

Cognitive Functioning

- How much of the time during the past four weeks did you have difficulty reasoning and solving problems? (Rated from “all of the time” to “none of the time”)

Emotional Well Being

- How much have you felt downhearted and blue? (Rated from “all of the time” to “none of the time”)
- How much have you been happy? (Rated from “all of the time” to “none of the time”)
- I worry about dying. (Rated from “not at all” to “very much”)

Social Support

- Family communication about my illness is poor. (Rated from “not at all” to “very much”)
- I get support from my friends and neighbors. (Rated from “not at all” to “very much”)

Other dimensions include Pain, Social Functioning, Financial Worries, Disclosure Issues, Sexual Function, and Feelings About Being Positive.

A Personal Perspective: Legs

BY JOHN HATCHETT

In July of 1996, at the XI International Conference on AIDS in Vancouver, triple combination therapy that included a protease inhibitor was all anyone seemed to be talking about. In fact, the entire conference almost felt like a giant pep rally for protease. And no one was cheering louder than I was.

I'd been diagnosed HIV+ in 1988 and started AZT in late '89, but stopped nine months later when I had to undergo chemotherapy for non-Hodgkin's lymphoma (NHL). For the next five years I resisted recommendations to re-start antiretroviral therapy, choosing to wait until either the data looked more promising or my health declined seriously, both of which finally came to pass in the winter of '95-'96. The stability I'd enjoyed for so long was shattered by a grueling six-month course of chemotherapy for a second bout of NHL (complete with episodes of bacterial meningitis and cryptosporidiosis), and I agreed to start a triple combination including indinavir (Crixivan). By the time I got to Vancouver, barely a month on therapy, I was feeling stronger with every passing day. Just four weeks after starting the combination, my viral load had dropped from 350,000 to undetectable (<400 copies at the time), and before long my CD4 count had climbed from a low of 52 to a whopping 250.

My health rebounded and by January of the following year I was heading back to work full time, struggling with food black-out periods (thank you, Crixivan) and clock watching like mad, lest I miss or mis-time one of those all-important doses. I had a constantly dry mouth, chapped lips and heartburn. Drinking what seemed like gallons of water every day to fend off kidney stones was certainly new to me, but all in all I was delighted – no, ecstatic – to be able to make the trade-off. Given what I'd been through with the chemo, these were very minor inconveniences indeed.

What I didn't notice right away was that the muscles in my thighs were not rebuilding after the chemo the way my other muscles were. For a long while I tried to ignore the problem, hoping the thighs would catch up with the rest of me. But then I began to fall. Nothing too dramatic, but all of a sudden my knees would buckle and give way beneath me. It first happened going down a flight of stairs into the subway, but I managed to grab onto the rail in time to avert a real catastrophe. When I went down on one knee in the middle of Sixth Avenue trying to beat the light against oncoming traffic, I started to get worried. I realized that I was incapable of running – *not* a comforting thought when

"I hate the way my legs look - knobby knees and toothpick quads over otherwise normal calves."

you live in New York City – and that I had no way to predict when I might go down.

It was slowly but definitely downhill from there. I had great numbers – viral load still undetectable (now <50 copies), CD4 counts in the mid-300's – and none of the adverse effects of therapy that many, if not most, of my friends were experiencing. In fact, for a long time I was the only person with HIV I knew who hadn't had to switch therapies at least once due to problems with tolerance or resistance. But I was losing the ability to rely on my own two legs to support me, in increasingly dangerous situations, and eventually I could see them beginning to waste away. I couldn't ignore it any longer.

When muscles are wasting away, the first suspect is often mitochondrial damage – destruction of those tiny engines that power our cells – resulting from adverse effects of

HAART. But this past spring a muscle biopsy determined that my mighty mitochondria were doing just fine, so my doctor and I decided not to change the drug combination I've been on now for 4½ years. Unfortunately, as is all too often the case when diagnosing HIV-related problems, the tests were great at determining what the problem *wasn't*, but fairly useless at determining what it *was*. There's definitely inflammation of the muscle fibers, but no one can say just what's causing it. So we're trying a variety of interventions to see what might help.

I'm still a resounding success, antiretrovirally speaking, and without a doubt, I consider myself extremely lucky to have responded so well to therapy. But the thigh thing is definitely a down side. I *hate* the way my legs look – knobby knees and toothpick quads over otherwise normal calves – and it feels humiliating that I can't even stand up from a chair without using my hands to help. Five months of steroid injections, testosterone gel, low-dose prednisone, protein shakes, plant steroids, acetyl L-carnitine, creatine, going to the gym 3-4 times a week and physical therapy later, my missing muscles are starting to show signs of a possible reappearance, but there's still no guarantee. I'm making real progress – haven't fallen in over a month! – but it's slow and frustrating and a lot of hard work. Not knowing for sure what started all this, it's impossible to know if and/or when it might get worse again. I may eventually have to change cocktails, but for now I'm sticking with what's worked so far, watching for signs of any new developments and hoping for the best.

John Hatchett is Director of the PWHHA Leadership Training Institute, a New York State program that encourages skill development for people living with HIV/AIDS to participate in AIDS community policy and program work.

Evolving Realities of Quality of Life

By MICHAEL SHERNOFF, MSW

Being diagnosed with any chronic and potentially life-threatening illness can be a powerful motivation to examine your life and grapple with how to define what is meaningful. One of the most vague, and yet crucial, areas for such self-examination is determining how to increase your quality of life. As a long term HIV-positive non-progressor, this has certainly been true for me personally. Additionally, having worked with large numbers of psychotherapy clients who are living with HIV/AIDS, I routinely initiate discussions aimed at helping individuals determine what factors contribute to a satisfactory quality of life.

In the early days of the epidemic, the hopelessness of an AIDS diagnosis increased the urgency of the question: "How much am I willing to sacrifice quality of life just to extend my life?" Another question, though less urgent now than before, is: "What else do I want to accomplish before I die?"

Both personally and professionally, I have seen a radical change over the past 17 years in the way quality of life issues are framed. In September's *FOCUS: A Guide to AIDS Research and Counseling*, Robert Marks notes: "As combination treatment extends life, some people with HIV may exchange a threat to life for insults to the quality of life, as the debilitating but sustainable symptoms of antiviral therapy undermine feelings of health." He also wisely cautions that "both people living with HIV and providers may fail to recognize the fragility of improved spirit and may minimize, even yearn to minimize, the physical challenges of renewed health." Today, physical, emotional and interpersonal issues of renewed health form the core of quality of life concerns for all people with HIV, whether they are

treatment naive, benefiting from combination therapy, or being bypassed by the so called "protease miracle." Taking these medications is not simply a matter of popping a few pills a few times a day. Rather, these drug regimens have a radiating effect, which profoundly influences eating, sleeping, and work schedules as well as

"...quality of life is a balancing act, a matter of living fully in the moment while still planning for a future that is far from certain."

day-to-day interactions with other people. All of these factors have an important bearing on a person's sense of well-being and confidence.

A Balancing Act

Assessing your quality of life is complicated by its often puzzling and changing character. It results from a complex interaction of many personal realities, character traits, and convictions, notably disease progression, emotional state, the nature and extent of the personal and professional support you are receiving, spiritual beliefs, maintaining hope and the ability to tolerate and respond to uncertainty.

Martin, a long-term non-progressor, says he feels that he has been balancing a level of what clinicians call "supportive denial" about having a potentially life-threatening illness against the realities of medically managing the condition. He never stopped saving for his retirement or making long-term plans. To maintain his emotional equilibrium, he made signifi-

cant psychological accommodations, learning to live with the paradox of absolute uncertainty. "Most of the time I allow myself to really believe that I do have a chronic, yet manageable health condition," but one "that could be fatal." Even with new treatments, Martin feels both blessed by his undetectable viral loads and anxious about how long he will retain his health. For him, quality of life is a balancing act, a matter of living fully in the moment while still planning for a future that is far from certain.

Disability or Work

Individuals lucky enough to have had private disability insurance when the first antiviral drugs became available were faced with a major quality of life decision: whether or not to go on disability, retire early and give up a beloved career in order to spend their remaining time doing things other than working. In September's *FOCUS*, Lisa Capaldini, an HIV physician, researcher and long time activist, suggests that, when discussing quality of life, it is essential to remember that: "Different people have different priorities and these influence their quality of life concerns." The following two individuals made very different choices based on their personal priorities.

Barnaby was a brilliant attorney who loved practicing law. As he became progressively ill, his firm was supportive and made numerous accommodations in order for him to continue working. Following a hospitalization early in his illness, we explored his motivations for planning to continue to work as long as he could. We spent months discussing his feelings about retiring from the career that formed the core of his identity. He was unwilling to allow the illness to deprive him of work

he loved. In the end, he continued to work until the combination of blindness from CMV retinitis and uncontrollable diarrhea made it virtually impossible for him to get to the office. Near death, he explained to me that he was pleased to have been able to work for so long. Not being partnered or close to his family, he was already spending quality time with his friends. He had traveled a lot, and there was not much else he had wanted to do during his lifetime. He explained that having the ability to work was practically the only thing that gave him respite from the ravages of his illness.

Jim, a designer and executive at a cosmetics firm, was a long-term psychotherapy client. He entered treatment long after he knew he was HIV-positive, because he was unhappy not being partnered. He was a charming, attractive, sensitive man, and we worked on his dating skills. Jim met and fell in love with a wonderful man who had already lost a partner to AIDS. These two carved out a private life together around their demanding work lives. When Jim's condition worsened, he eventually decided to retire from work and become a full time househusband at their country residence, which was not far from where his sister, her lover, and their child lived. He died having spent the end of his life close to these people he loved most in the world, doing what made him happiest.

A New Lease on Life

The onset of combination therapies has greatly complicated the quality of life equation. So many seriously ill people with HIV disease have seen significant improvements that combination therapies are described as producing a "Lazarus Syndrome," named for the biblical story

about a man Jesus was said to have raised from the dead. HIV disease has now become a chronic and manageable illness for more than a small minority of those infected.

Many people responding positively to combination therapy say that their primary concern is financial security. While they could accept the prospect of living on a limited and fixed income so long as an early death seemed likely, this tolerance declined as their probable life spans lengthened. Cruelly, the fiscal resources of many long-term survivors have been depleted by their having previously opted to run their credit cards up to their limits, spend their life savings and viaticate their life insurance policies. These decisions, intended to improve their short-term quality of life, increase the fragility and vulnerability many long-term survivors and non-progressors now feel.

Perhaps the most noticeable change resulting from successful HIV treatment is a renewed capacity to participate fully in life. For some, this has meant a return to work, a change that has brought joy and fulfillment to many. For others, however, a range of psychosocial challenges, many of which can negatively impact a person's quality of life, lessens the excitement of returning to work. Some people find that a "clean slate" may be inspiring, but for most, having let go of the means and structure of a previous life becomes unsettling in the context of extended life. Adding to this confusion is the uncertainty about whether health recovered by combination therapy will be permanent, and by the understandable fear that working may mean that disability income will be lost forever. Trading off more free time for a work routine in order to earn more money can be a difficult emotional transition.

Community Forums

CRIA co-sponsors monthly educational forums on AIDS research and treatment issues. Upcoming forums:

Wednesday, January 10
**Entry & Integrase Inhibitors:
The Next Class of Drugs**

Wednesday, February 14
**Reports back from the 8th Conference on
Retrovirus and Opportunistic Infections**

Wednesday, March 7
Psychological Issues and HIV

The forums are held at 7PM in the Cronin Auditorium, 10th Floor of St. Vincent's Hospital at 11th Street and 7th Avenue, Manhattan. Forum summaries are available on CRIA's website: www.criany.org.

Additionally, people contemplating a return to work may experience a sense of failure and regret, a fear of having lagged too far behind to catch up, grief over lost dreams and opportunities, anger at themselves for not trying harder to overcome disability, and psychological paralysis. These feelings may be fed by the practical challenges of dealing with resumes that are no longer so impressive and professional skills that are no longer up-to-date. In addition, individuals re-entering the job market at the same level they had been at when they stopped working may now be competing for jobs with people who are younger than they are.

The case of Eric, completely blind at age 23 as a result of AIDS-related CMV, offers a poignant illustration of how a sense of well being is directly related to life expectancy. Successfully responding to combination therapy, he began once

(Cont. on page 17)

A Personal Perspective: Twenty Years and Counting

BY PAUL MULLER

I never expected to be around this long. I was there twenty years ago, when “life”—as opposed to “quality of life”—was the only thing on the agenda. I was admitted to the hospital in June of 1980 and told I had a compromised immune system, with pneumocystis carinii pneumonia (PCP), persistent generalized lymphadenopathy (PGL), non-A/non-B hepatitis, and exposure to tuberculosis. I survived. In 1985, when the antibody test became available, my HIV/AIDS status was confirmed.

During those early years, I was an observer, fiercely maintaining a sense of denial. It didn't hit home until I lost a sister and a cousin to the virus in the early '90s. I slowly began to accept the fact that I was positive and took steps to deal with it. Unfortunately, I had a lot to overcome internally when it came to getting medical care. I harbored the same fears as many other people in my community about the medications and a well-founded distrust of many in the medical community. Overcoming my reservations, I started on a regimen of AZT and Videx (ddI) in 1993, which resulted in serious side effects—unmanageable pancreatitis and peripheral neuropathy. So I stopped medications.

Life didn't seem worth living if I had no control over it. I fell into a very depressed state and was forced to confront another taboo, seeing a psychiatrist. Thankfully, I overcame that taboo. During this time, some people from the People with AIDS Coalition (PWAC) convinced me to become a volunteer. That's when things started to change for the better. I allowed myself to become involved with AIDS issues, focusing on the medications and managing drug side effects.

I also restarted antivirals (Zerit [d4T] and Epivir [3TC]) because of a decline in my CD4 count. I was able to deal with the medications a little better this time, but now I began to experience feelings of guilt. I wondered why I was still here while family members and friends were not. I continue to address these issues as life goes on for me.

In 1996, with the introduction of protease inhibitors and the advent of triple combination therapy, things started to look a little better for those of us living with HIV/AIDS. In 1997 I added

"Major problems with diarrhea interfered with my lifestyle and destroyed my image of being in control."

Viracept (nelfinavir) to my regimen. Major problems with diarrhea interfered with my lifestyle and destroyed my image of being in control. My lipid levels became dangerously high, and I never attained the undetectable viral load that some others had achieved on HAART. Life was still here, but not the way I wanted to live it, with barely any control over my bodily functions and risking a possible stroke. I didn't revert back to “woe is me” but continued to strive on.

An experience I went through at that time defines what quality of life means to me. I had promised to help with a seminar for people who are HIV+. When I awoke the morning of the seminar, my diarrhea was uncontrollable, and I could have canceled. Being a very active person, I decided to go anyway. The diar-

rhea wasn't going to stop me. I took along some Depends, diapers for adult incontinence. I learned many valuable lessons that day, not the least of which was that Depends hold up pretty well. But you have to change them quite often when you have diarrhea, so that you don't feel so soiled.

Today I am on Kaletra (lopinavir), the most recently approved protease inhibitor, and have finally achieved an undetectable viral load. This should make me happy, but I continue to contend with increasing lipid levels, and I had a stroke last year. I'm weighing whether or not to stay on the protease inhibitor, whether or not having an undetectable viral load is worth the possible downside. I do all I can medically and holistically to control my lipids without increasing my lipid-controlling medications.

I continue to go out into various communities to talk about HIV prevention, testing and treatment. I don't need Depends any more, but there are plenty of other complications going on. I love this work, and it makes a major contribution to my quality of life. It's something I look forward to on a daily basis.

So twenty years and counting—counting on twenty more.

Paul Muller is currently volunteering with the AIDS Training Center at St. Vincent's Hospital in New York City.

A Personal Perspective: Shit Happens and then you go on Meds

By SUSAN RODRIGUEZ

When I was first diagnosed HIV+ in 1995, I had to take a crash course in learning about HIV as well as having to deal with the emotional and mental issues surrounding my status. At that time, there were a limited number of antiretrovirals available. Through my reading and speaking with healthcare providers and treatment activists, I decided to hold off on taking any of these medications. Instead, I emphasized strengthening my immune system by eating better and using vitamin and mineral supplements. My physical health and blood work remained stable with this regimen for about three and a half years.

It was important to me not to feel like I was sick. For me, taking medication was representative of being sick. I had a wonderful doctor who listened to my concerns and respected my decision not to start therapy. As the protease inhibitors came onto the scene and guidelines for initiating combination therapy became available, he and I discussed them. I felt that there was not enough long-term data, especially in women, to know what the effects of these drugs might be. I was feeling okay physically, and I did not want to have to deal with possible side effects. My hectic lifestyle—running around as a mother of three kids and a lot of activism and advocacy—the strictness of the drug regimens, and the potential side effects played into my decision not to take anything. I knew that if and when I started therapy, it would be a well thought out, informed decision made with my doctor.

Quality of life for me meant that I was feeling physically well, taking care of myself holistically and not being reminded about the virus by taking medication. Problems arose when I forgot to take care of me—missed medical appointments, not eating right, forgetting to take vitamins, smoking, not exercising, and being involved in stressful

"While my current lab reports reflect an intact and improved immune system, I gauge my quality of life on how I feel."

situations. My physical fitness slowly declined—I was tired more, suffered from frequent respiratory problems, and wasn't feeling right physically or mentally. My lab results reflected this decline—CD4 count down to 188, a CD4 percentage of 10%, and viral load at an all-time high of 150,000. I was ready to commit to a regimen, one that my doctor and I felt would suit me in terms of optimal viral suppression while also being relatively easy to take with minimal side effects.

Fortunately, the therapy I started did not cause serious side effects, except for diarrhea in the morning and skin rashes, both of which subsided after a few weeks' time. I was prepared to deal with the possibility of these side effects and didn't let them interfere with my desire to obtain maximum health benefits from the meds.

I have been on the same regimen for a year and a half now, and I can honestly say that it has not impacted my life detrimentally the way that I thought it would when I wasn't ready to be on medication. Yes, I have some of the longer-term side effects such as peripheral wasting and high cholesterol, but these have only prompted me to start taking better care of myself—exercising regularly, eating properly and integrating complementary therapies into my health plan. While my current lab reports reflect an intact and improved immune system, I gauge my quality of life on how I feel. And I feel pretty good—less tired and less frequent upper respiratory ailments.

I made an educated and informed decision about my treatment, one that I was ready to commit to because I was mentally, physically and emotionally comfortable with it. Since I was able to do that, I feel I can deal with any problems that may arise.

Susan Rodriguez is a woman living with HIV, breast cancer survivor and mother of three children. She is President & Executive Director of Sisterhood Mobilized for AIDS/HIV Research & Treatment (SMART). She is also currently working on obtaining recycled pediatric medications for children living with HIV/AIDS in Latin America through Aid for AIDS' Kids Project.

New Drugs in Development

BY TIM HORN

FUSION INHIBITORS

New protease inhibitors? Sure. Novel reverse transcriptase inhibitors? Interesting.

There's a lot to be said for new protease and reverse transcriptase inhibitors coming down the pike. But it's also clear that we need new *classes* of drugs—treatments that are effective for people with multi-drug-resistant HIV, that have fewer side effects, and that are easier to take. Fusion inhibitors may be just what the doctor will need to order, and if all goes according to plan, the first in this class may arrive on pharmacy shelves next year.

Fusion Confusion

Protease inhibitors prevent HIV's protease enzyme from working. Reverse transcriptase inhibitors, which include nucleoside and non-nucleoside analogues, are active against HIV's reverse transcriptase enzyme. Yet these drugs interfere with HIV's ability to replicate relatively late in the infection game—they go to work after the virus has already entered a cell and prepared itself to go about its ugly business.

As their name implies, fusion inhibitors act much earlier in the HIV infection cycle by preventing the virus from attaching—or fusing—itsself to the outer membrane of healthy T-cells. Fusion actually has many steps; thus pharmaceutical companies are currently developing several different types of

fusion inhibitors, some of which are now in clinical trials.

The first step in HIV's lifecycle is to gain access to a healthy T-cell's interior. To do so, HIV's outer coating—its envelope—must dock with proteins called receptors on the T-cell's surface. Once the virus grabs hold of these receptors, it can manipulate the membrane of the cell and gain entry.

The process begins with HIV's gp120 protein binding to a T-cell's CD4 receptor. From there, HIV's gp41 protein must bind to a second T-cell receptor—either CXCR4 or CCR5. Think of it like this: HIV is trying to gain access to a locked room. It must use its hand (gp120) to grab the doorknob (CD4) and a key (gp41) to unlock the door (CCR5/CXCR4).

Here's a look at the various fusion inhibitors currently being studied in laboratories and clinical trials:

gp41 binders

Pentafuside (T-20)

The fusion inhibitor foremost in everyone's mind is pentafuside (T-20), a drug being developed by Trimeris and Hoffmann-LaRoche. Pentafuside binds to HIV's gp41 protein and, as discussed above, prevents the virus from docking with a T-cell's CCR5 and CXCR4 receptors.

Most of the experience with pentafuside has been in patients who have taken—and often failed—other antiretrovirals. One study involved 78 patients who had tried, on average, eleven anti-HIV drugs in the past. When they were given pentafuside, 55-60% had at least a 1-log decrease

in viral load, and one-third saw their viral load decrease to undetectable levels after four months of therapy. While it is true that patients in this study received other antiretroviral drugs that may have contributed to these positive results, many researchers argue that such a benefit would not have occurred if it weren't for pentafuside.

Unfortunately, resistance to pentafuside does occur. Because the drug targets a protein HIV—and because we know HIV rapidly mutates to resist anti-HIV drugs—pentafuside will definitely need to be used in combination with other drugs and may not work indefinitely.

Pentafuside will be the first anti-HIV drug that will require twice-daily injections. Because of the drug's fragile structure, it cannot be absorbed through the stomach, so an oral formulation isn't possible. Many people who have received the drug in clinical trials say that injections aren't nearly as bad as one would think and that, aside from itching and slight pain near the injection site, side effects are minimal. Phase III trials of pentafuside are ongoing.

T-1249

Because Trimeris, the developers of pentafuside, have seen resistance in patients using this drug, they're developing a second fusion inhibitor called T-1249. Like pentafuside, the drug binds to gp41. However, Trimeris hopes that it will be harder for HIV to develop resistance to T-1249, due to its more complex structure. The drug

New Drugs in Development

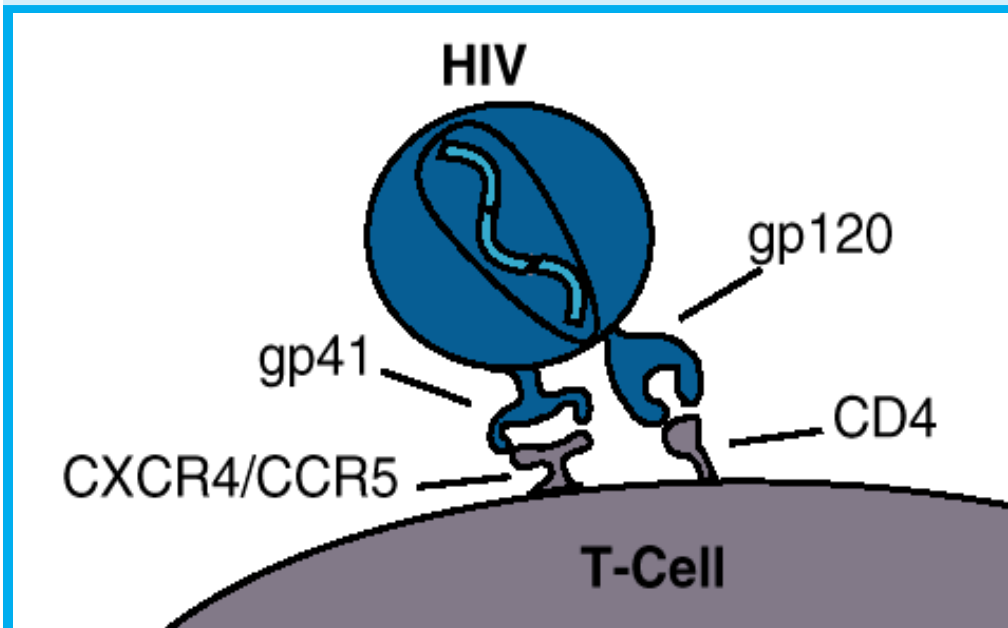


illustration by David Pieribone

is now entering clinical trials and will require daily injections.

gp120 binders

PRO 542

PRO 542, being developed by Progenics Pharmaceuticals, contains segments of the CD4 protein and key sections of immunoglobulin O, an important antibody. The drug targets gp120, the protein on HIV's outer membrane that docks with CD4. Single injections of PRO 542 have been safely given to six people at one of four doses. At the highest dose, decreases in viral load were seen, with few side effects. Results from future studies of this unique drug are eagerly awaited.

CXCR4 inhibitors

AMD-3100

There have been some concerns about using drugs to target CXCR4. Heart and artery problems in laboratory animals

that have been bred so that CXCR4 is missing from their cells, heart and artery problems have been reported. Thus, some researchers are worried that a drug designed to alter the function of CXCR4 may cause serious side effects.

Luckily, this hasn't been the case in early studies of a drug called AMD-3100, which has been in development for quite a while by the Canadian company, AnorMed. This fusion inhibitor binds to CXCR4 and has been shown to reduce HIV reproduction in test tube studies. It has also been shown to be safe in animals and in a small study of HIV-negative volunteers.

The first study of AMD-3100 in HIV-infected patients is going on now in some U.S. cities. No information has been reported yet about the drug's effectiveness or safety. Like all of the fusion inhibitors discussed here, AMD-3100 and other CXCR4 drugs, including T-22 and ALX40C, will require once- or twice-daily injections.

CCR5 inhibitors

Over the past few years, researchers have discovered that people with missing or mutated CCR5 receptors may be resistant to HIV infection, an understanding that suggests enormous therapeutic possibilities. While there are a handful of inhibitors of CCR5 on the radar screen, they are all in the very early stages of development. These include AOP-RANTES (Gryphon Sciences) and TAK-779 (Takeda Chemical Industries).

As with CXCR4 inhibitors, there have been some concerns regarding the use of drugs that target CCR5. It is believed that HIV may use CCR5 to gain access to cells during the first several years of therapy and then switch to CXCR4 as disease progresses. Some researchers suggest that this switch allows for the virus to become even more powerful and speeds up the rate of immune system decline. In turn, a drug that blocks CCR5 may unknowingly send the virus on a hunt for CXCR4, a situation that may hurt the immune system even more.

Whether or not this theory is true has yet to be determined. But it underscores the fact that, even though new classes of drugs offer a whole lot of promise, they will need to be studied very carefully and viewed with caution.

Tim Horn is executive editor of The PRN Notebook, published by Physicians' Research Network in New York.

point where people are no longer willing to take the bet. People who would gamble for one month of perfect health presumably value their current lives less than those who would not risk a month or a day.

Other molar methods include scaling tasks where people read brief descriptions and rate their preferences for different health states (including their own), single item ratings, and other time trade off scenarios similar to the Standard Reference Gamble. Compared to molecular measures, less work has been done to establish reliability, validity and norms for these molar measures. However, some researchers prefer molar approaches because quality of life is boiled down to a single number.

Quality of Life Assessment in Clinical Research

Quality of life measurement enters into clinical research and practice in many different ways. The earliest uses of quality of life measures in health research were as part of natural history studies, documenting the problems and challenges faced by people living with arthritis and other chronic, debilitating diseases. Quality of life considerations began to enter into the treatment of AIDS during the late 1980s and early 1990s, as AZT and treatments for opportunistic infections came into use and length of survival after diagnosis began to increase.

As a general trend, it is probably reasonable to say that quality of life tends to decline with advancing illness. However, the picture is not quite so simple. Some sub-dimensions of quality of life, like physical symptoms or the ability to care for oneself, tend to decline with physical health status. However, these measures all show a wide range of responses. Some of the sickest patients can report the fewest symptoms or the greatest ability to care for themselves. Other dimensions, like social satisfaction, emo-

tional well-being, or spiritual fulfillment, are not highly associated with physical health.

Quality of life concerns also enter into decision-making at the end of life. As such, quality of life assessment has always been a major feature in research on advanced directives and palliative care. Indeed, until recently, clinicians tended to offer care for “quality of life”, only after options to cure or control disease had been exhausted. However, modern specialists in palliative care

"The study of quality of life places the focus on the whole person, not just on viral load, CD4 count or number of lesions."

have made a compelling case that concerns for *quality* of life and *quantity* of life are complementary, and should not be seen as opposite. Despite its importance, there are inherent difficulties involved in conducting quality of life assessment at the end of life. Standard measures may be burdensome and potentially upsetting to patients who are very sick. Efforts to assess quality of life by asking a caregiver or clinician are often unsatisfying because these proxy measures may not reflect the patients' concerns.

Often, studies make special accommodations to assist patients in completing measures or to allow them to complete questions over several occasions. Studies that have been conducted during the months, weeks and even days before death tend to show considerable variation in quality of life. Problems and concerns differ from person to person, and symptoms such as pain, fatigue and depressed mood may

change from day to day. Studies to help ease suffering and provide support at the end of life often measure change in quality of life to determine benefits to patients.

In recent years, quality of life considerations have entered into clinical trials that test new medical treatments. Traditionally, such studies have relied on “biological endpoints” such as differences in disease progression or mortality to demonstrate the effectiveness of treatments. However, new methods have become available to factor in quality of life considerations. For example, rather than simply comparing treatment in terms of length of survival, investigators now speak about “quality-adjusted life years” or QALYs. These studies essentially use measures of quality of life to value or weigh survival time. Thus, someone who survives three years after treatment without any symptoms or health problems may actually have a higher QALY score than someone who survives five years with poor quality of life.

Clearly, calculation of QALYs depends upon the importance relegated to different quality of life concerns. Early studies using QALYs used a single set of weights for all people, so a problem like “itching” might be seen as less detrimental to quality of life than “incontinence”. However, recognition that the quality of life impact of these problems may differ from person to person has led some investigators to recommend that patients assign their own subjective weights to determine QALYs, often using one of the global techniques described previously to assess quality of life.

Quality of life may also factor into studies of the treatment process. For example, in HIV/AIDS, quality of life may enter into treatment adherence. Medications may reduce quality of life for some patients, by creating many side effects, by interfer-

ing with preferred routines, or by intruding upon desired activities and relationships. These quality of life factors may determine whether or not an individual is able to remain on medications for an extended period. Quality of life may also enter into the process of patient-provider communication. Good communication requires dialogue and problem solving around quality of life factors. Clearly, patients with the poorest quality of life often have the greatest need for assistance from providers, and are therefore most likely to experience the most serious barriers to care.

Quality of life concerns provide a bridge between hi-tech western medicine and alternative ways of healing. As noted previously, a number of quality of life measures include scales that address spiritual concerns and a sense of meaning in life. These existential aspects of quality of life enter into psychotherapy, peer or “buddy” programs, mutual help groups and other supportive interventions. Studies of meditation and other techniques to reduce stress and help people cope also emphasize improvement in multiple quality of life dimensions.

The Quality of Life Research Paradox

As this overview highlights, health-related quality of life is playing an increasingly important role in respect to every aspect of the treatment and care of people living with HIV/AIDS. There is an acceptance in many quarters that patients must have a voice in their care. The ultimate effectiveness of all treatment depends upon the ability to respond to the patient’s quality of life concerns. The study of quality of life places the focus on the whole person, not just on viral load, CD4 count or number of lesions. These are very positive trends.

So what’s the problem? My love-hate relationship with this whole area of research is driven by one central concern:

Quality of Life Survey

As part of this issue of *CRIA Update*, we thought it would be interesting to learn something about the quality of life of our readers. The questions included on the enclosed survey represent two different approaches to measuring quality of life - a standard scale where people rate items provided by researchers, and an open-ended scale where people rate themselves on their own dimensions. We have also included background questions to help us better understand the quality of life concerns of different members of our audience.

Please take a few minutes to complete this survey, fold it so that our address shows, staple and mail it back to us. This is an *anonymous* survey, so don’t write your name anywhere on the form.

We will present a summary of the results in a future issue of *CRIA Update*.

We want to hear from as many of you as possible. Thanks for participating!

that our research methods are not up to the task at hand. Widely accepted ways of measuring quality of life are simply unable to help us truly understand the respondents’ perspective. For example, although we may identify many people willing to gamble for six months of perfect health, the *implications* of this devaluation of current quality of life are not at all clear. Different people may decide to take this bet based upon very different concerns. Even more descriptive, molecular measures may be misleading. People may have very different things in mind when they rate work performance, social satisfaction or overall health. Similarly, ratings of pain or performance difficulty depend upon the standards of comparison being invoked. Is an individual’s answer based on their own past performance, their perception of others, or an internal stereotype of what it means to be “an AIDS patient?”

In short, current methods for measuring quality of life provide a numerical rating of quality of life, but offer no insight or

information into how people arrive at their ratings. This has serious implications for our ability to interpret quality of life research. Neither molecular nor molar quality of life measures are helpful in understanding the following types of research findings:

- People respond to the same treatment in opposite ways—quality of life is improved for some but diminished for others.
 - In some studies, people who are “sicker” according to objective clinical indicators rate their quality of life as good or better than objectively “healthier” respondents.
 - People tend to place relatively higher values on “health states” (based on descriptions of symptoms and problems) that are similar to their own.
 - An individual reports improvement in quality of life despite declines in health status.
 - Different experiences and situations seem to influence quality of life among diverse groups of patients, de-
- (Cont. on page 15)

WHAT DOES QUALITY OF LIFE MEAN TO YOU?

In most quality of life studies, researchers assume that “one size fits all.” Everyone answers the same standard set of questions supplied by investigators. However, a growing number of researchers are interested in understanding what quality of life means to different people. The things that may be most important to one group or one person may not matter at all to another. Psychologists refer to this as “idiographic” assessment, which literally means that individuals are prompted to “write” the measures that apply to them. Idiographic measures are not widely used in clinical trials or other health outcomes research because they are far more difficult to administer, score and interpret. Even so, it may be very valuable to use measures such as these in conjunction with standard approaches, to take into account the ways that illness and treatment can change a person’s outlook on quality of life.

The following techniques have been used to better understand patients’ perspectives on quality of life.

PERSONAL GOALS ASSESSMENT

This approach sheds light on the priorities and concerns that are most important to an individual’s satisfaction and quality of life.

First, please answer the following questions to help us identify your personal goals. Be as specific as you can. List as few or as many goals as you need to include the different things that matter to you at this time in your life:

In order to have the most satisfying life possible...

1. What different things do you want to accomplish?
2. What situations do you want to prevent or avoid?
3. What problems do you want to solve?
4. What things do you want to keep the way they are now?
5. What circumstances do you want to be able to accept?
6. What responsibilities or roles do you want to let go?

Now look back over your list, and consider how close you are to reaching these goals. Please rate each goal on a scale from 0 (Very Close – Goal Attained) to 10 (Very Far).

This measure of quality of life is scored by summarizing the numerical goal attainment scores and by describing the areas of concern reflected in a person’s goals (family, mood, living with HIV, etc.).

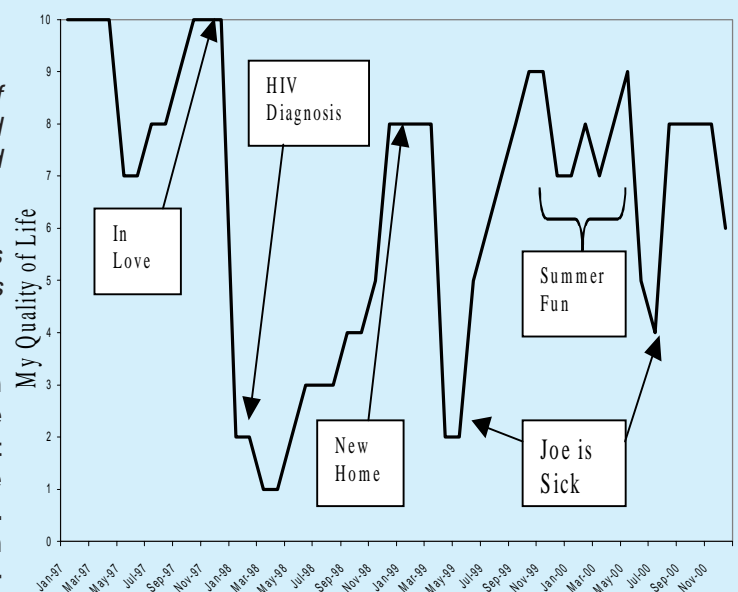
LIFE GRAPHING

This technique emphasizes changes in quality of life over time.

On this graph, we are interested in learning how your quality of life has changed over time. Draw a line that shows the ups and downs in your quality of life from the year before you received your HIV diagnosis, up until today.

Now let’s look back over the graph to find out what was happening at different times. What explains the ups and downs that you’ve had?

This graphing technique is very flexible. The timeline can focus on any period of time, from a few days to an entire lifetime. The ups and downs on the graph can represent overall quality of life, satisfaction with care, symptoms like pain or fatigue, or any other aspect of quality of life. Concepts identified on the graph may differ greatly from person to person, depending upon personal history, circumstances and values.



pending upon characteristics like gender, ethnicity or socioeconomic status.

In short, we are left with the same paradox that confronted me as an undergraduate. Although a great deal of time and technology is devoted to understanding people's quality of life, researchers cannot truly understand what their answers mean. The danger is that we are left unable to distinguish between fulfillment and complacency. We don't know whether to celebrate success or foment rebellion. When are we helping people to truly feel better and when are we communicating that whatever they're handed is as good as it gets?

This problem is particularly troubling in respect to research with people affected by HIV/AIDS. People who have experienced a lifetime of discrimination or poverty may start with low expectations when it comes to standards of support and care. People who have inter-

nalized AIDS stigma may feel that they do not deserve good quality of life. It is incumbent upon those of us who conduct quality of life research to be sensitive to these possibilities in interpreting our findings.

Several studies have started to address the inherent ambiguity in existing molecular and molar measures by developing ways to get at the *meaning* of quality of life. See opposite page and below for examples of ways we have used in our work to help determine what quality of life means to different individuals living with HIV/AIDS. These measures are not standard and I do not expect that they will be widely used in clinical research. However, they do help us to understand the different ways that people can think about their quality of life. Other investigators are conducting similar work in a number of different patient populations.

Ultimately, this line of research may lead to measures that can distinguish people who have different ways of thinking about quality of life. This will allow us to take into account diverse patients' perspectives and values regarding quality of life. Ultimately, we need to determine how experiences of illness and treatment can change what matters in people's lives and lead them to understand quality of life in new ways.

Bruce D. Rapkin, Ph.D. is an associate professor of psychology in the Department of Psychiatry and Behavioral Sciences, Memorial Sloan-Kettering Cancer Center. Dr. Rapkin is the principal investigator on several studies of access to care and quality of life among people living with HIV/AIDS and their families.

REFERENCE GROUPS AND STANDARDS OF COMPARISON

This assessment method focuses on standards of social comparison that people use to determine their quality of life.

This picture represents a ladder with 10 rungs. The very top of the ladder represents the best possible life you can imagine, while the bottom stands for the worst possible life you can imagine.

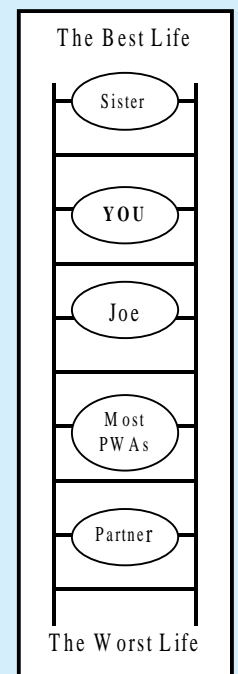
First, where are you on this ladder? Place yourself on the rung that best shows how you feel about your life at this time.

Next, please identify someone that you would place on each of the other rungs of the ladder. It can be someone you know now or in the past. It can also be a character from a book, a movie or TV.

Now, start at your position and go up one rung at a time. How are you different from the people on higher rungs? What does it take to go up each level?

Finally, do the same thing going down the ladder. How are you different from the people on lower rungs? What would bring you down each level?

People can differ greatly in terms of the comparisons they that associate with quality of life. Several approaches can be used to compare people along the ladder, such as the method of *triads*. Groups of three names are selected at random; respondents state one way that any two of these people are alike and different from the third. Over enough comparisons, the respondents' standards for quality of life emerge.



A Personal Perspective: Inside Job BY LILLIAN THIEMANN

Growing up, I never gave much thought to “quality of life.” Nor did I make decisions with any thought as to how they might impact it. Kids are like that. As an adult drug addict, I continued in the same vein (no pun intended), hoping that life would just get better. But I was still somewhat directionless - and definitely powerless - about getting my thoughts, and more importantly my actions, in sync with living.

My first step toward making self-supportive, quality of life decisions was realizing that I was miserable and that my drug taking was a big part of it. My quality of life definitely improved after a short while off drugs. I could think more clearly, and I wasn't broke all the time. But this didn't mean I knew what to do with my life, and I felt a fair amount of confusion when I even tried to think about it. That's where therapy came in. Although at times it was and still is painful, taking an up close and personal look at myself with a therapist helped me to feel steady, more real and in control. Diving into a 12-Step recovery group was the most important thing I've done to maintain an emotional quality of life over time.

But what about living with HIV, Hepatitis C and cirrhosis? When I look back at my reactions to these diagnoses, I see that over the course of the first few months an interesting process kicked in, a process that I half-jokingly call the *AIDS Advantage*. To get the “advantage” I had to sort through some feelings and put them together in a way that would support my health: 1) the feeling that my time on earth could be drastically reduced by diseases; 2) an understanding that stress

and depression would kill me; and 3) the recognition that doing things that excite and interest me feels good. These simple thoughts, and a willingness to try, gave me a major advantage in living. They inspired me to cut out many of the negative influences in my life and stimulated me to do the things I always wanted to do but had put off for fear of failure. I discovered a tenacity for living and an inner strength I didn't know I had.

"We can get used to almost anything and incorporate the most extraordinary things into our lives."

In 1989, my doctor charted my life expectancy to be two years, but by going through this process I believed I could go to school, work, become an athlete, create art and do any number of things. People would say, “Why are you working so hard? Is this the way you want to spend your time - on things you'll never get to finish?” My answer was, “Yes, what else should I be doing?”

My quality of life remained great until my T-cells got down to 5 and my viral load skyrocketed. *I didn't feel sick*, but the numbers said I was an accident waiting to happen. I started on HIV antiviral treatment in 1995 in one of the earliest Crixivan trials (ACTG 035), taking it with AZT/3TC. For the first three months, my physical quality of life plummeted. I had to take drugs with inconvenient eating restrictions three times a day. Side effects impacted on every area of my life, and

my search for ways to lessen them became a mission. While the side effects were at their worst, I wondered if I could continue to perform well in the life that was giving me so much emotional benefit. The process I described above kicked in again, and I hung in there.

It's weird how adaptable humans are. We can get used to almost anything and incorporate the most extraordinary things into our lives. When facial wasting and truncal obesity entered my life, I was devastated but determined to do everything I could to stay on treatment. I am still in the 035 study and still have an undetectable viral load after five years. I feel as if I've traded some quality of physical life for a larger quantity of actual living.

As long as I am alive there is hope that one day my quality of life will be great in every area. Until then, I use the fortitude I've learned over the years to stay in the game, make the best of the life I have today, and help others know that quality of life is, for many, an inside job.

Lillian Thiemann is an HIV educator and a member of the NYC Women's HIV Collaborative, an organization that is currently formulating advocacy agendas and action to benefit HIV positive women.

Evolving Realities

CONTINUED FROM PAGE 7

again to make plans, learning to walk independently with a seeing eye dog, joining a gym to regain weight, beginning a new relationship, and joining a support group for the visually impaired, where he became a role model for other group members. Despite these improvements, Eric stressed that his motivation to rebuild his life hinged on the thought that his time was limited. He has not made peace with the prospect of growing old as a blind man, feeling that this would entail an unacceptable quality of life.

The Impact of Side Effects

People with HIV/AIDS routinely have to make important decisions about treatment - whether or not to begin combination therapy, when to do so, whether to change treatments in response to an increase in viral load or intolerable side effects, and, in some cases, whether or not to stop combination therapy altogether. It might seem ridiculous for an individual to even consider not initiating combination therapy, given its life-extending potential. But there is plenty of reason for uncertainty, especially for individuals who are treatment naive since there is considerable disagreement about the best time to begin therapy.

If an individual decides to begin combination therapy, he or she must determine which combination will be right for them. It is helpful at this point to make a list of life priorities and how these might be affected by various medications. For example, if spontaneous socializing around meals is something you cherish, you may not want to take drugs that require precise scheduling of medication and meals. Juggling medication schedules and meal times

can make a person feel trapped. If you are very athletic or travel a lot for business, you may opt not to try medications that may cause diarrhea. You need to consider the possible negatives, such as the potential indignity of soiling yourself, of needing to stay close to a bathroom, or the need to take anti-diarrheal medication. If you work at home with ready access to a bathroom, diarrhea may not be as big a concern.

"People living with a potentially terminal illness often feel burdened by the societal construct that the extension of life - at any cost - is the only or best option."

Individuals facing choices about beginning treatment need to speak with or read accounts by other people who have been on the drug or regimen in order to hear real-life reactions. For many people, side effects may be perceived as the primary effects of the medications—and in the short term they may seem more serious than HIV infection. They can be a valid reason to alter the course of a medication regimen. Side effects are significant when they limit mobility or otherwise prevent people from going about their normal routines. Even relatively minor side effects, such as flatulence or excessively dry skin and scalp caused by Crixivan or loss of body hair sometimes caused by Epivir (3TC), impact how a person feels about himself by possibly impairing self-esteem and self-image. This must be factored into the emotional cost of taking various drugs.

Both treatment success and failure have raised the bar regarding quality of life expectations for people with HIV/AIDS. Capaldini writes, "Four years ago when people with HIV were relieved not to be dying or hospitalized, medication side effects were a welcome exchange for longer lives. Now as they extend over the long term, side effects have become less tolerable. Many people with HIV have unexpectedly tasted the possibility of normal lives, and are reacting to the limitations imposed upon them by diarrhea, peripheral neuropathy and fatigue."

When wrestling with these decisions, it can be helpful for a medical and/or mental health professional to acknowledge that treatment dilemmas often pose trade-offs. There should also be frank acknowledgment of the difficulty of achieving a viral load below the level of detection. Each individual needs to examine his or her feelings about what they might have to put up with in order to try to achieve this goal. Capaldini urges medical providers to "attend to a person's symptoms and side effects even when, after applying quantitative criteria, treatment seems to be successful. The easiest mistake a medical caregiver may make in the new era of HIV treatment is to falsely assume that improving viral load and CD4 cell readings translate into feelings of day-to-day well being."

Recently there has been much discussion of the therapeutic effects of "structured treatment interruptions." Although still under study, this new approach is welcome news for people on antiviral drug regimens, holding out the prospect of periodic relief from potentially debilitating side effects. These

(Cont. on next page)

Evolving Realities

medically supervised “drug holidays” have also greatly improved people’s emotional states even while creating an additional potent anxiety related to all of the medical uncertainties.

Living Long or Living Well

People living with a potentially terminal illness often feel burdened by the societal construct that the extension of life—at any cost—is the only or best option. Medical and mental health professionals can help people who question this belief by providing support for alternative views, including those that center on the life priorities and capacities of the individual. Such conversations can help people assert control over their lives, turning the burden of decision making into a life-affirming and empowering challenge.

People with HIV often experience anxiety when they are awaiting the results of blood work. Downplaying the importance of the numbers can have a positive psychological effect. People on combination therapy should steer away from an either/or view of what constitutes treatment success or failure. Instead, try to think in terms of a spectrum extending from the achievement of a level of viral replication that is beneath the detectable level, including symptom reduction but incomplete viral suppression, to a high level of viral activity and continued CD4+ cell depletion. Such an approach speaks to the reality that a number of people with HIV have not only survived, but thrived, on combination therapy for more than three years, requiring re-evaluation of the old HIV disease model of “infection —latency —sickness —death.”

CONTINUED FROM PREVIOUS PAGE

Thomas, a 50-year-old living in Manhattan, illustrates this point. “Combination therapy has not made my viral load undetectable, but it has still been a godsend, and I am not complaining, despite the side effects. The few KS legions I used to have are now gone, and my CMV retinitis has not gotten any worse. Prior to beginning these drugs I would also become confused at times, which my physician assumed was a neuropsychiatric complication of HIV. This symptom is also a thing of the past. I feel like I have regained my life. My first year on combination therapy was focused on regaining my health. The second year was about allowing myself to slowly develop a cautious optimism that these treatments were going to benefit me on a long-term basis. This third year has been about the challenges of improving my quality of life in terms of resuming my career and attempting to regain some kind of financial stability for the rest of my life, no matter how long that will be.”

In the end, it is each individual who sets their own quality of life agenda, always in light of the existing medical and psychosocial options. For anyone to reach informed decisions about treatment, each person will need help in the form of treatment education and information. Some people are comfortable evaluating the existing medical options and their subsequent physical and emotional consequences on their own or through conversations with friends, family members or peers. Others benefit from professional counseling to sort through all the information and accompanying feelings. However, only after an individual has ac-

cepted his or her own responsibility for their role in the decision-making process, can health-care professionals provide them with the necessary guidance. This way, each person living with HIV and the members of his or her health care team can strive together towards insuring that quality of life goals are always a priority.

Michael Shernoff, MSW is a psychotherapist in private practice in Manhattan who has written extensively on mental health issues of people with HIV/AIDS and of gay men. His most recent books are HIV Treatment: Mental Health Aspects of Antiviral Therapy and AIDS and Mental Health Practice: Clinical and Policy Issues.

CRIA’s Treatment Education brochures are currently available free to AIDS service organizations and people living with HIV/AIDS

Clinical Trials Explained

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Understanding Your Lab Results

To order, contact LaQuitia Moe at 212-924-3934 ext.119, or by mail to Treatment Education, 230 West 38th St. 17th Fl., New York, NY 10018 or email us at treatmented@criany.org.

Westchester Forums

CRINA is very pleased to announce a new contract with the Westchester County Department of Health to conduct community forums on resistance testing in several areas north of New York City. As CRINA's other treatment education services, the upcoming events will be designed primarily for people living with AIDS (PLWAs) and non-medical care provider audiences. CRINA will be working cooperatively on this project with the largest HIV service provider in the targeted communities – AIDS Related Community Services (ARCS). Our role will be to develop a curriculum for these events as well as written materials which participants can use to reinforce the subject matter discussed. We will also be responsible for securing expert speakers who can explain issues surrounding resistance testing in ways that are accessible to a lay audience. ARCS will provide outreach for participants as well as manage several key logistical functions. Call CRINA's Treatment Education Department for additional information on this new project.

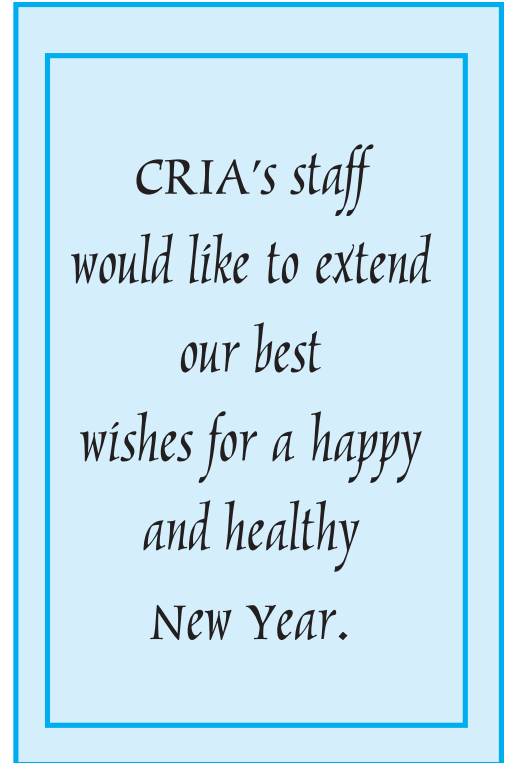
Abstract to be presented at Retrovirus Conference.

CRINA's researchers will be presenting results of our recent pilot independent trial of topical Acetylsalicylic Acid (aspirin) combined with Diethyl Ether in the treatment of peripheral neuropathy at February's Eighth Conference on Retroviruses and Opportunistic Infections in Chicago. CRINA Board Member Jill Cadman proposed the study to our Research Advisory Committee because so many of our patients suffer with this pain-

ful condition on a daily basis. No effective treatment has been developed to address either the root causes of peripheral neuropathy or to alleviate its symptoms. It was hoped that the topical application of aspirin would at least offer more effective relief than aspirin taken orally or other alternative existing therapies. Fortunately, the results of our trial were positive. We are naturally excited to publicize these findings to the national HIV scientific community in the hopes that care providers will begin to consider use of topical aspirin as a way to alleviate pain for many thousands of individuals who suffer with peripheral neuropathy. Look for a copy of the abstract following its presentation at the February conference to be included in the next *CRINA Update* as well as on our web site.

CRINA Begins New Study of Genotypic Testing

CRINA has begun working with Visible Genetics to conduct a new study of their genotypic testing product. This is our first foray into examining the potential benefits of the relatively new diagnostic tests. CRINA's protocol, called Vigilance II, has two goals. First, it will look at whether treatment outcomes for patients whose physicians use results of genotypic tests to help determine which antiretroviral drugs to prescribe differ from patients whose physicians do not utilize this information. Second, the study will allow us to develop a database that quantifies the prevalence of different HIV strains within the New York City area. Such information can possibly help physicians to prescribe regimens that are more likely to be effective from the start at



suppressing HIV. Our new database would also be valuable for HIV researchers in designing innovative trials. CRINA's goal is to enroll 1,000 patients into Vigilance II over the next 12-months. Call our research department if you have any questions about this study.

CRINA Board Elections

CRINA is pleased to announce the re-election of Board Members Marisa Cardinale, Bob Colacello, Douglas Dieterich, MD, Tiffany Dubin and Renaldo Herrera at our September 20th Annual Meeting. Also, after four years on the Board, Brian Hayman decided to resign his position. CRINA's staff would like to thank all of these individuals for the commitment they have shown to our work over the past several years and the direction they will provide to us in the years to come.

GENEROUS CONTRIBUTORS

The following persons, corporations and organizations made major donations between September 16 and December 15, 2000 to support CRIA's research and education efforts:

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Thoughtful donations in memory of the following remind us of what is at stake in the fight against AIDS:

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Contributions in support of CRIA's vital research initiatives were made in honor of the following individuals:

Maria Abelardo
The Marriage of Tom Caldwell & Andy Reynold
Jerome Ernst, MD
Terrence McNally
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