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Alcohol and HIV: a serious cocktail for transmission and medication adherence

A PEER-REVIEWED ARTICLE

Ronald D. Wilcox, MD, FAAP

Over the past year, many articles have been published or are soon to be published on the effects of alcohol use in the setting of HIV, especially regarding risky behavior and adherence to antiretroviral therapy. This article attempts to summarize some of the findings that should be of interest to HIV-treating medical personnel.

A study of 1,130 students performed at a large, urban, minority-serving university in Florida showed 14% reported risky sexual behavior (having more than one sexual partner in one year and not using

a condom the last time they had vaginal intercourse), and 11.9% reported consistent risky sexual behavior (having more than one partner in one year and not using condoms most or all of the time during the past 30 days). Alcohol use over the preceding month had the strongest independent association with both risky and consistent risky sexual behavior in multivariable analysis. This study demonstrated the need to address alcohol use when attempting prevention efforts for college-aged young adults.

Among male commercial sex workers in Kenya who had sex with other men, the use of alcohol three or more days a week

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Dentistry

We can secure the future for HIV oral health care

Alicia Rose Hathorn, DMD

As I fondly recall my days as a dental student, I am also reminded of the “protection” I was given when it came to patient selection. This protection was an outer shell harboring

“well” or nearly well people.

My job as a student was to focus on clinical skills, treatment planning and such. I do agree those were important priorities, but looking back, I

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Medicine

Alcohol associated with clinically-significant nonadherence

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increased the chance of having unprotected anal sex (OR 1.63; 95% CI, 1.05-2.54). Among African-American men who have sex with other men or both men and women but are not self-identified as gay or bisexual, alcohol use and drug transactions have been shown to foster same-sex sexual activities, allowing and rationalizing unprotected and same-sex activities.

A study in South Africa looked at the sexual behavior of men and women who were HIV-infected and who drank alcohol. For six weeks, sexual behavior and alcohol consumption were assessed daily by phone interviews. Fifty-eight HIV-positive women and 24 HIV-positive men reported drinking an average of 6.13 drinks when they drank; they also reported 4927 sex events, of which 80.17% were unprotected, with 58% of unprotected sex events occurring with HIV-negative or unknown HIV status partners. It was calculated that an estimated 2.95 incident HIV

infections occurred during the study. Drinking alcohol before sex by either or both partners increased the proportion and number of subsequent unprotected sex events when the quantity of alcohol consumed corresponded to moderate or higher drinking. Prevention efforts need to address reducing alcohol-involved unprotected sex among both HIV-negative and HIV-positive persons.

One intervention, also in Cape Town, South Africa, tried to decrease risky behaviors among persons who imbibe alcohol in an informal setting. The participants (117 men, 236 women) were randomized to attend either a one-hour HIV/alcohol information/education control group versus a three-hour theory-based behavioral HIV-alcohol risk-reduction intervention that focused on skills training for sexual negotiation and condom use. Among those who were light or moderate drinkers, the intervention showed a decrease in risky sexual behavior at three months but not six months after the intervention.

The relationship between alcohol intake and adherence to HIV medications has been studied extensively. A recent publication by Parsons et al analyzed the relationship between these two factors in 272 HIV-infected women and men with identified alcohol problems, evaluating the adherence to HIV medications over a fourteen day period. On days in which alcohol was consumed, there was almost nine times higher odds of medication nonadherence, with each drink increasing the odds by 20%. Individuals with strong and rigid beliefs about the importance of strict medication adherence were significantly more affected by each dose of alcohol with more complex regimens showing more effects of having one or more drinks. This study clearly demonstrates the need to assess for adherence issues in patients identified as having a problem with alcohol. An additional recent study by Applebaum et al did not show the same effect in men but only in women.

Braithwaite et al, in a study of over 3000 VA



patients in New England, evaluated the effects of quantity and frequency of alcohol intake and adherence to medications among groups of HIV-infected and HIV-negative patients over a 30-day period. Nonadherence was assessed as number of days with ≥ 1 dose missed or ≥ 2 hours tardiness in dosing; significant nonadherence was defined as $\geq 5\%$ absolute increase in proportion of days with missed nonadherence. Quantity-based categorization showed a 3.2-fold increase, self-reported impairment-based categorization a 3.6-fold increase, and quantity adjusted for mean daily consumption a 4.6-fold increase. They demonstrated that alcohol use was associated with clinically significant nonadherence at **two standard drinks for HIV-infected persons versus four standard drinks for HIV-negative participants.**

This study demonstrated the need to counsel HIV-positive patients that daily consumption of even two alcohol-based drinks may lead to an increase in in-adherence to their antiretroviral medication regimen.

Active depression has also been shown in innumerable studies to be a

strong predictor of in-adherence to HIV therapy. Sullivan *et al* showed recently that heavy alcohol use and alcohol dependence were associated with a higher score on the Center for Epidemiologic Studies Depression Scale (CES-D), indicating increased incidence of depression. Upon further in-depth analysis, this association between

Alcohol use may actually influence the effects of HIV disease directly.

alcohol use and depression incidence continued to be demonstrated primarily in the alcohol dependence group and less so in the heavy alcohol use group. By increasing the incidence of depression, alcohol dependence will affect the patient's ability to adhere to his/her HIV regimen, leading to advancement of disease and development of a resistant strain of HIV.

Alcohol use may actually influence the effects of HIV disease directly. In a study by Marcondes *et al*

involving SIV and rhesus macaques, chronic alcohol ingestion by the monkeys resulted in a reduction in the number of circulating CD4+ T-cells, as well as an increase in monocytes expressing the CCR5 co-receptor. Samet *et al*, in a study involving 595 HIV-infected humans prospectively over a seven year period, assessed the effects of alcohol consumption on CD4 cell counts and HIV viral loads. The study controlled for factors such as depressive symptoms and adherence, as well as stratified patients based on antiretroviral therapy (ART) use. This study showed an average decrease of 48.6 cells/mL for HIV-infected patients who drank alcohol heavily but who were not on ART as compared to those who did not have heavy alcohol consumption, though the same association was not found in the group of patients who were on ART. No effect on HIV viral loads were seen in either group.

In summation, prevention programs for both HIV-negative and HIV-positive populations need to address the role alcohol use plays in increasing risky behaviors for HIV exposure,

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especially in the heavy using and alcohol dependent clients. All members of the multi-disciplinary teams that care for HIV-infected clients need to assess alcohol use on a regular basis, using screening techniques such as the CAGE questions, and patients need to be counseled when beginning or changing medications on the association of heavy alcohol use and poor adherence to HIV therapy, as well as the effects alcohol can potentially have on CD4 counts, especially

in those who are not on HAART therapy. ❖

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Clinicians: please share your HIV experiences with students

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didn't learn true patient management of medically compromised patients. Of course there were many lectures focused on this topic in several classes I thoroughly enjoyed, but what we don't use, we sometimes lose. Mind you, the baker's dozen of patients I was given who had elevated medical compli-

cations (diabetes, hypertension, psychiatric needs, etc.) definitely helped my confidence in treating those patients.

During my clinic years, I treated very few known HIV and hepatitis C infected patients, though my rotations at the emergency clinic did provide a kaleidoscope of people with broader medical issues and dental needs.

It wasn't until the residency year that my eyes were opened to the world of medically compromised patients, the vastness of a realm I barely knew. The egg I had been living in broke and I became aware of a family of people with so much need, especially the need for compassion, understanding and love. As my confidence grew, I thought I could become



someone who could help meet the need for these patients.

I finished that year and went to work in a public health dental clinic with the idea of using this opportunity to become what I knew I was supposed to be: provider, educator, supporter, friend. I was asked to consult with HIV patients experiencing dental pain and oral manifestations. They quickly became regulars and my heart grew.

After a couple of years, I had the opportunity to become the director of a new clinic that would treat PLWH (people living with HIV). The administrative duties were new, but everything has a learning curve. We opened our doors and the rest is history. My grinch moment had come and my heart had grown exponentially with what I felt for my patients. I knew I was in the realm I was meant to inhabit and that I had become an adoptive member of a loving family.

I wanted others to know what I felt, how rewarding my dental life had become. I knew the way to bring others into my realm was

to begin with students; *after all, they are the future.*

My lectures gave way to students wanting to spend time at my clinic treating patients. They were *learning* about HIV disease, oral manifestations, how they could share their abilities and knowledge with others. They were *unlearning*

That's when I
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the stigmas they carried in their hearts. They were also molding their confidence into a double helix of human spirit, belonging, treating, loving. By sharing their experiences with fellow students, they also encouraged new interest.

With successes at our local dental school and dental hygiene programs, I began looking at our state programs. What could I do to bring my world to the students and faculty of

other dental programs? Did they have the same misconceptions that a majority of people have about HIV? Would they want to hear what I had to say?

I have been welcomed with open arms. Students are thirsting for knowledge, experience, great stories of success...of life. Students gravitate toward the opportunity. Not all respond, of course, but our touching and sharing with as many as we can means that as health care providers, we will sustain our family.

My request to physicians, nurse practitioners, nurses, dentists, social workers, all of us who give ourselves to others, is that we share our experiences with these students. Most of us probably do what we feel is enough. Maybe it is, but let us also aid in the education and completion of a ripe mind, let us do with it what can be done. Let us help to open it with the brightness of humanity.❖

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Legal

When are advance medical directives needed in Delta states?

Stacy LaFleur, JD, and Jonathan Uhl

Advance medical directives—Medical Powers of Attorney and Living Wills—are often sought after by people living with HIV/AIDS. Some desire these documents for peace of mind, others out of necessity. This article hopes to clarify some misperceptions and misunderstandings about these very important documents.

Medical Power of Attorney

A Medical Power of Attorney, or Power of Attorney for Health Care, allows someone to name a person or persons to make medical decisions if he or she becomes too ill to make decisions or to communicate with his or her health care provider.

Arkansas

If an individual does not have a Power of Attorney for Health Care, Arkansas law designates those who are authorized to consent to surgical or medical treatment on behalf of another, including:

- a parent of a minor child
- a parent of an adult child of unsound mind
- an adult for his or her minor sibling or adult sibling of unsound mind
- maternal or paternal grandparents, in the absence of a parent who is authorized
- a married person, for a spouse of an unsound mind
- an adult child, for one's mother or father of unsound mind.¹

An agent appointed through a durable power of attorney for health care has priority decision-making authority, even over others who may be permitted by law to consent to surgical or medical treatment.² Therefore, if an individual is uncomfortable with any of the statutorily designated individuals making those decisions, or wishes for someone else to make those decisions, then it would be prudent for that individual to execute a Durable Power of Attorney for Health Care.

Louisiana

Similarly, in situations where a client is unable to handle his/her medical

affairs, Louisiana law gives the next-of-kin the right to make those decisions. The next-of-kin is the first available person on the following list: spouse, adult child, parent, sibling, then more remote relatives.³ If clients feel comfortable with next-of-kin handling their affairs and believe that they know and respect their wishes, then a Medical Power of Attorney may not be needed. However, if a client does not trust the next-of-kin to carry out his or her wishes, believes the next-of-kin will be unavailable or unwilling to make decisions, or wishes to have someone other than the next-of-kin make those decisions, then the client should execute a Medical Power of Attorney.

Mississippi

Mississippi combines a Power of Attorney for Health Care form and an Advance Health-Care Directive form in a single document.⁴ If a patient's primary physician determines that the patient lacks capacity to make decisions and no agent or guardian has been appointed or is reasonably available, then a surrogate may make health



decisions for the patient.⁵ A patient may designate anyone to act as a surrogate by personally informing the health care provider. If no designation was made, then a spouse, adult child, parent, or adult sibling (in descending order) may act as a surrogate.⁶ If none of these people are available, then an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available, may act as a surrogate.⁷ This last designation is more helpful for those who would rather have a friend or significant other make medical decisions. However, because it comes into play only after other surrogate designees have been eliminated, it is still prudent for that person to execute a Power of Attorney for Health Care.

Living Will

A living will places limitations on the type and extent of medical treatment that a person wishes to receive at the end of a fatal illness.

In Arkansas, adults (over 18) who are of sound mind may execute advance directives governing the with-

holding or withdrawal of life-sustaining treatment should they become terminally ill⁸ or permanently unconscious.⁹ The advance directive becomes operative when it is communicated to the attending physician and when the attending physician and another physician, in consultation, determine that the patient is in a terminal condition and no longer able to make decisions regarding the administration of life-sustaining treatment or is permanently unconscious.¹⁰ If an incapacitated patient has not made a valid declaration nor designated an agent for health care decisions, then the statute designates statutory decision-makers who may execute a declaration on the patient's behalf.¹¹ Therefore, if a patient has not made a decision regarding end-of-life care or is comfortable letting the next-of-kin make those decisions, then a living will is not necessary. However, if that patient does have specific end-of-life wishes, a living will should be executed.

Under Louisiana law, only a very close relative, such as a spouse, a parent, or an adult child, has the legal authority to have

life-support withheld from someone.¹² If someone has a next-of-kin who is trusted to make those decisions and that relative is comfortable with the responsibility, then that person does not need a living will. However, if someone has made a decision regarding end-of-life medical care, a living will is needed under the following situations: 1) the next-of-kin is not a close relative; 2) the next-of-kin is unavailable or unwilling to make those decisions; 3) the client does not trust the next-of-kin to respect his or her wishes; or 4) the client does not want to burden someone else with the responsibility of making those decisions.

So how do you know if your patients need these documents? The most important indicator is family situation: Are they married? Do they have other family members who are close whom they trust? Or are they estranged from their families or live far away from relatives? Are they in non-marital relationships and wish to have their significant others make medical decisions on their behalf? Secondly, if patients feel strongly about their medical care and/

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or end-of-life decisions, it would be best to have advance directives executed. Patients can be directed to contact their attorney, or if they cannot afford an attorney, they can be directed to one of the legal services providers who often assist clients in executing advance directives. ❖

Stacey LaFleur is Executive Director, AIDS Law of Louisiana. Tulane law student Jonathan Uhl contributed to this article.

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Nursing

NP mentors Nepal HIV clinics in clinical decision making

*Deborah Konkle-Parker,
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In May–June 2008, I went to Nepal for six weeks to provide clinical mentoring in HIV clinics, through the International Center for Equal Health Care Access (ICEHA). ICEHA is a global non-profit organization sending Western HIV healthcare workers to rapidly transfer their clinical expertise to colleagues in resource-poor settings. These volunteer healthcare workers become clinical mentors, transferring practical expertise on how to provide the best HIV care possible within existing resource limitations. One of the main limitations in the third world is not just funding for HIV medications, but also the expertise to safely and effectively use the medications that are available through global HIV programs. This program affects this latter limitation.

ICEHA has been involved in the countries of Burundi, Cambodia, Ethiopia, Kiribati, Lesotho, Nepal, Rwanda, Seychelles, South Africa, Sudan, Suri-

name, and Vietnam, with many additional countries to follow. ICEHA doesn't become involved with a country unless the country requests the help, and the developing country is willing to support the costs for the mentor (airfare, local room and board, and daily stipend). Once local colleagues provide the best care possible within the existing resource limitations in their setting, ICEHA's involvement will cease, and the local clinic will have been set up to stand on its own as a local resource.

HIV in Nepal is, in part, a different epidemic than we see in the US. Epidemiologists discovered that a high number of infections were arising in the very rural undeveloped hill country in the Far West of the country. Exploration uncovered the fact that most of those infected had been migrant workers in Mumbai, India, or were wives or children of migrant workers. Further exploration revealed that about 25% of all migrant workers reported that they visited female sex workers in Mumbai, and a large percentage of

those individuals were infected with HIV. This concentrated epidemic among migrant worker families allowed Nepal to apply to UN AIDS Fund for money to address this epidemic through prevention and treatment.

The government of Nepal intends to provide HIV care to its citizens, but to speed the process to prevent HIV from entering into the general population, multiple non-governmental organizations (NGOs) began the process through grants they received from USAID. Family Health International (FHI) has been the main provider of HIV care, as it developed a system of decentralized antiviral therapy (ART) distribution clinics scattered across the country, and focused in the Far West. Because of the lack of knowledge of management of HIV disease, the need for ART in a very poor country, and the need for widespread distribution among the rural illiterate poor, a complicated system of care was needed. The system includes about 25 clin-

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Nursing

Volunteers assist with chronic disease management process

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ics distributed around the country staffed specifically for HIV care, most providing free ART distribution; community home-based care (CHBC) workers in 12 of the country's 70 districts who could provide outreach, education, assessment, and transportation in the rural communities; and transitional housing specifically for HIV-positive individuals when attending clinic appointments. These houses provide food, shelter, and care for those who are unable to get home after a clinic appointment, for those who are just starting on ART and need education and assessment, and for those waiting for the results of CD4 tests and CBCs in order to direct their care. As individuals sometimes walk or ride for hours to attend clinic appointments, this transitional housing is critical. As ART regimens available for initial treatment are, practically speaking, restricted to combinations of AZT/3TC/NVP due to the cost, and there is a high rate of AZT-induced

anemia, it is critical for patients to be observed for two weeks after starting initial treatment to assess for side effects and anemia. Only when profound AZT-induced anemia is diagnosed are they able to switch to d4T/3TC/NVP. Because free ART could only be obtained at FHI clinics (which will be transitioned to government clinics at some point in the near future), patients are required to go to the ART clinic every month, despite very long trips from the rural hills to these clinics scattered throughout the country. Exceptions to this rule could be made for those who were cut off from the clinic by monsoon rains, or who had other severe difficulties with travel, and they might be given two to three months of medicines at a time.

Using the WHO guidelines, ART is prescribed based on CD4 counts if there is a testing facility available, or on clinical symptoms that show significant immune compromise, such as wasting or an opportunistic infection (OI). When the CD4 is

under 200, or they meet the clinical criteria, ART can be started, though not before. In some facilities where CD4 testing was not available during my stay, negotiations were taking place for a weekly CD4 testing day at a distant clinic where blood would be drawn and transported within a few hours drive. Plans were in place for patients to stay in close proximity to the clinic until test results were back (one to two days) so that they could start or change ART if needed, rather than having to make the long trip, usually walking for hours through the hills, to get their test results. Viral loads were not available at all, but the WHO guidelines provide criteria for changing medications, which are based on a significant CD4 decrease, worsening clinical status, or a new OI.

There are different WHO CD4 and clinical criteria for ART initiation in children, and these include a delay in developmental milestones. This was a type of care that very rural clinics did not feel comfortable with, and families with HIV-positive children often had to travel



even farther than adult patients to reach the few pediatric HIV clinics in the country. Orphaned children are particularly a problem, when both parents have succumbed to AIDS.

Besides mentoring about the clinical decision-making process, ICEHA volunteers assist clinics in the process of chronic disease management, which is not a well-known model of care in the third world. For the most part, people come to the doctor only when there is a problem that they can't solve by home remedies, rather than proactively managing chronic disease. Clinic processes are very critical to management of HIV disease, especially as the numbers needing treatment grow rapidly. These processes include those that support doing CD4 counts on a large number of patients in a single day (because of limited availability of lab personnel), that support a large number of patients needing assessment and medications each day but are not necessarily acutely ill, that provide multidisciplinary support and teaching, and that utilize the valuable input of the CHBC workers. My fellow mentor and I were able to contribute to the health-

care process as we introduced and facilitated the adoption of a nursing assessment process, in order to relieve the burden on the doctor; by facilitating the start of a CD4 program and a pediatric HIV clinic in a district hospital that was very distant from any other ART sites; and by suggesting an approach to track patients who do not attend clinic when due for refills, rather than focusing only on those who actually arrive in the clinic, and focusing only on those on ART as opposed to those who are pre-ART. We were also able to speak to the head of HIV treatment in the country to suggest starting ART earlier than a CD4 of 200, and to discuss an idea of using other medications as first-line treatment in certain patients, as AZT-induced anemia was very widespread.

In conclusion, I was surprised to find that the decentralized HIV health care structure in Nepal was enviable, as compared to the structure we have here in Mississippi. Unfortunately, when the government takes over the healthcare from the NGOs, this may dissolve, and the struggling care and management of HIV disease will

suffer significantly. There are multiple burdens on the healthcare system in Nepal, not the least being the poverty and lack of education of the patients and the difficult geography of the country, with an inadequate infrastructure for transportation. FHI and ICEHA have been able to make a huge difference in the lives of people infected with HIV, and have begun significant programs to prevent the further spread of the disease. The future of the programs will be interesting to watch, as the care is shifted to the government for sustainable programs.

For further information, go to www.iceha.org or email volunteer@iceha.org. Trainings take place regularly in New York City and London for those interested in mentoring. Volunteers include physicians, nurse practitioners, nurses, pharmacists, lab technicians, social workers, health educators, and others with professional HIV experience. ❖

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NEW ORLEANS, LOUISIANA

Clinical preceptorship for physicians, nurse practitioners, physician assistants: Care and Management of the Patient with HIV Disease—March 9-10, 2009. 15.5 CMEs. Contact Danielle Pierce, 504-903-0788 or dpierce@lsuhsc.edu.

Clinical preceptorship for nurses and clinical service providers: Comprehensive Management of the Patient with HIV Disease—May 4-5, 2009. 11 contact hours. Contact Danielle Pierce, 504-903-0788 or dpierce@lsuhsc.edu.

Clinical preceptorship for dentists and dental professionals: Oral Health Management for the HIV/AIDS Patient—October 12, 2009. Up to 6.7 CDEs. Contact Danielle Pierce, 504-903-0788 or dpierce@lsuhsc.edu.

JACKSON, MISSISSIPPI

Course for physicians, physician assistants, nurse practitioners, nurses, pharmacists, case managers, social workers: Care and Management Overview of HIV Infection—February 19-20, 2009. Discipline-specific CE. Contact Nona Mills, 601-984-5542 or nmills@medicine.unmsmed.edu.

PINE BLUFF/LITTLE ROCK, ARKANSAS

Clinical preceptorships for primary care providers—ongoing by request. To arrange, contact Derrick Newby, 870-535-3062 or dnewby700@aol.com.

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