DON'T FORGET
THE AIDS FOOD PANTRY:

************************

BRING DONATED FOOD TO THE NEXT COMMISSION MEETING

************************

THANK YOU!
There will be a cure for AIDS.
Talk with the people who are trying to find it.

Dr. Anthony S. Fauci
National Institute of Allergy and Infectious Diseases
Leader of the U.S. war on AIDS

Dr. Robert C. Gallo
National Cancer Institute
Authority on Molecular Biology of AIDS

Dr. Enrico Garaci
President
National Research Council of Italy

Dr. Michael S. Gottlieb
National Cancer Institute
Authority on AIDS

Dr. Robert R. Redfield
Chief of Behavioral Research
Walter Reed Army Medical Center

Carole Simpson, ABC News

Dr. Allan L. Goldstein
Scientific Director
Institute for Advanced Studies in Immunology & Aging

A Town Forum on AIDS.
Wednesday, June 2, 4:00-6:30pm, Lisner Auditorium
The George Washington University
730 21st Street NW, Washington DC (Foggy Bottom/GWU Metro)

This event will be telecast nationwide on C-SPAN Saturday, June 5th, 10:30pm EST.

Free—public welcome. Information: 202-339-1895

Sponsored by The Institute for Advanced Studies in Immunology & Aging, in collaboration with
American Red Cross, National Association of People with AIDS, National Minority AIDS Council and Whitman-Walker Clinic, with
AIDS/ARC PANTRY

DONATIONS NEEDED
OF HIGH PROTEIN, LOW SALT FOODS, CANNED
GOODS, SOUPS, PEANUT BUTTER, JELLY, TUNA,
CHICKEN, EASY-TO-FIX RICE AND PASTA PACKAGES,
TOOTHBRUSHES, TOOTHPASTE, SOAPS, ETC.

CHECKS ALSO ACCEPTED.
PLEASE MAKE PAYABLE TO
"COMMUNITY ACTION OF MARIN".

REMEMBER........
THIS IS AN ONGOING PROJECT
THROUGHOUT THE YEAR
California's Family has AIDS!

3rd Annual

AIDS BUDGET LOBBY DAY

Monday, May 10th
10:30 – 4:00
State Capitol, Sacramento

Come and speak out against California's continuing neglect of the AIDS epidemic. Meet with your elected officials to show that underfunding education/prevention, care and treatment services and cuts to entitlement programs affect all Californians!!

PROGRAM (tentative)

10:30  Briefing on state HIV/AIDS budget
11:30  Rally on Capitol steps
1:00 – 4:00  Appointments and/or drop-in visits with your legislators and legislative staff

It is essential that you pre-register as soon as possible so that we can schedule legislative appointments. The final deadline for registration is Friday, April 30th. In addition to carpools from various areas, limited seating will be available on a bus leaving from San Francisco.

AIDS Budget Lobby Day is organized by the AIDS Budget Coalition:

AIDS Project Los Angeles
AIDS Service Providers Association
California Association of AIDS Agencies
LIFE AIDS Lobby

Planned Parenthood Affiliates of California
Sacramento AIDS Foundation
San Francisco AIDS Foundation
San Francisco Interreligious Coalition on AIDS

To register, please mail in the form below or call 415/864-5855, x 2537
Commission announces Martin Luther King award winners

The Marin Human Rights Commission has announced the winners of Martin Luther King Jr. awards.

Each award comes with a $1,000 stipend to be donated to the winner's charity of choice.

The humanitarians of the year are:

- The Rev. Dr. Emmanuel O. Akognon, pastor of the Village Baptist Church in Marin City, for his efforts to feed the hungry, help the poor and found the Southern Marin Bible Institute and Scholarship Fund.
- Nesbit Crutchfield of Sausalito for his accomplishments in the struggle against apartheid. He was a delegate to the conference of the African National Congress, one of three at the July 1991 event.
- Dr. Milton Estes of Mill Valley, president of the Northern California branch of the American Civil Liberties Union, for his work for women's and minority rights.
- Lois Moore of Novato will be honored for her work for youth and community organizations, including Concerned Parents of Novato.
- Richard Payne of San Rafael for his courage and perseverance in raising consciousness about HIV. He co-founded the Marin AIDS Support Network.

The award dinner will be at 5 p.m. Jan. 20 in the dining hall of the First Presbyterian Church of San Rafael, 1510 Fifth Ave. The cost is $20 a person. For reservations, call 499-6190 by Jan. 17.

Compiled from IJ staff reports

January 10, 1992
Streisand hails ‘time of healing’

Award honoree sounds note of hope and call to fight at APLA benefit Nov. 18

The following is the text of the speech delivered by Barbra Streisand at APLA’s Commitment to Life benefit on Nov. 18 at the Universal Amphitheatre. Streisand, David Geffen and L.A. Mayor Tom Bradley were each given APLA’s Commitment to Life award at the event.

Thank you Warren [Beatty], and thank you AIDS Project L.A. for the amazing work you’re doing and for giving me the opportunity to do my part tonight in the fight against AIDS. I deeply appreciate this award.

Few of us have responded with enough urgency to meet this crisis of catastrophic proportions, certainly not the last two presidents. I don’t mean to be partisan — because health, human rights and tolerance ought not to be partisan issues. But that’s what happened these last 12 years.

Bigotry was legitimized. Rules were made by and for white, Christian, heterosexual males. All the rest of us were left out. And a disease that has infected far more heterosexuals than homosexuals throughout the world, was dismissed as a gay disease with that official, homophobic wink — implying that those deaths didn’t really matter.

I will never forgive my fellow actor, Ronald Reagan, for the genocidal denial of the illness’ existence, for his refusal to even utter the word “AIDS” for seven years and for blocking adequate funding for research and education which could have saved hundreds of thousands of lives.

Then came George Bush, once the moderate, who in a Faustian bargain, allied himself with the same primitive, gay bashing immoral minority.

Like many of you, I sat and watched the Republican Convention in utter disbelief. How could the Pat Robertsons and the Pat Buchanans, presuming to be the spokespeople for God, spew such doctrines of divisiveness, intolerance and inhumanity? Who is that God?

A lot of us of different political outlook came together that night. The radical right linked the issues for us and reminded us of how much was at stake as they branded the concerns of women, gays, minorities and Democrats as un-American. How
dare they call us un-American!

When Pat Robertson stood up and warned of Clinton, and I quote: “He wants to repeal the ban on homosexuals in the military and appoint homosexuals to his administration,” I, and millions of other Americans, were even more convinced that Bill Clinton was our candidate.

When Pat Buchanan thundered, and I quote, “We stand with George Bush against the amoral idea that gay and lesbian couples should have the same standing in law as married men and women,” I wondered: who is Pat Buchanan to pronounce anybody’s love invalid? How can he deny the profound love felt by one human being for another—a love that all too often takes them to the bitter end, holding each other in hospices and hospitals all over this nation.

Well, George Bush didn’t say “no” to the Buchananians, but we said “no” to George Bush.

The far right finally went too far. They came out that night and the country looked straight into the face of hate and, thank God (the God I know), the majority of the people said “enough!” Enough racism, enough sexism, enough gay-bashing, name-calling and discrimination, enough extremism.

Isn’t it just fantastic that the American people came down on the right side, the side of human rights, clear and simple?

And we elected new leaders. We did it—you did it—I did it ... women, gays, Jews, people of color, working people, old people, young people, all of us who valued ourselves enough to demand that our voices be heard, all of us who cherish common decency and common sense revolted and out-organized, out-financed and out-thought those who despise what is best about this country; our cultural, racial and religious diversity.

I keep pinching myself. Finally, a president who is committed to finding a cure for AIDS.

Finally a president who acknowledges the patriotism of gays and lesbians willing to serve in the armed forces and who will remove the gag rule preventing medical workers from advising pregnant women as to their choices.

Finally we have a president that I think realizes that the most cost-effective thing to do is spend money on AIDS research and patient care with the same sense of urgency that has been devoted to the military budget or bailing out the failed S&Ls.

Now that the Cold War is over we have to redefine national security. I know I’ve paid a helluva lot of taxes for weapons they said would protect us if we were attacked by a foreign enemy.

It’s time to stop living with the paranoia of “what if” and start facing the reality of “what is.” “What is” is a real crisis in education, in health care, in the economy. “What is” the real national security, is the need for a nation to feel secure.

But how can we feel secure when our teen-agers are not being educated about AIDS — when, according to the World Health Organization, by the year 2000 most new HIV infections may be found in women. And they also estimate that, by then, the figures could reach a staggering 40 million people infected — 10 million of those will be orphans. These realities frighten me much more than the “what ifs” of being attacked by a foreign power.

The moral immune system of this country has been weakened and attacked and the AIDS virus is a perfect metaphor for it.

The malignant neglect of the past 12 years has led to the breakdown of our country’s immune system: environmentally, culturally, politically, spiritually and physically. I keep asking myself: Why was our immune system not stronger? Why did we not have better resistance to that deadly virus of hatred?

I feel that we are how entering a time of healing. We are grateful that our new president is committed to life—that he has put before us an agenda which is compassionate, caring and as he has said: “AIDS policy can now be made based on sound scientific and public health principles—not on panic, politics and prejudice.”

We will be there to support him every step of the way. Our hopes are high and so are our expectations.

But lest we be lulled into a false sense of security, the struggle goes on. Just look at the vote for hate in Colorado where voters rescinded any protection for gays in employment or housing.

There are plenty of us who love the mountains and rivers of that truly beautiful state, but we must now clearly that the moral climate there is no longer acceptable, and if we’re asked to, we must refuse to play where they discriminate.

Many of us in this community worked very hard to get this president and many members of Congress elected. We didn’t do so in order to be invited to formal state dinners at the White House. We supported these candidates because they promised us profound change. And we want them to know—we will be listening, watching and waiting.

In 1986 I saw a play by Larry Kramer called “The Normal Heart” which affected me deeply and I plan to make it into a movie. Set against the beginning of the AIDS epidemic, it’s about everybody’s right to love.

The main character, Ned Weeks, founded the Gay Men’s Health Crisis only to be thrown out because he was too loud, too aggressive, too accusatory, too angry.

Months later, discouraged, disheartened—sick of fighting his friends as well as his enemies, sick of the stupidity—worn down, he now faces his lover who’s dying of AIDS. And his lover looks up at him and says: “Please learn to fight again. Don’t lose that anger. Just have a little patience and forgiveness—for yourself as well.” After his lover dies, Ned cries out: “Why didn’t I fight harder? Why didn’t I picket the White House all by myself if nobody would come?”

We’re filled with hope right now that some day, some how, we will see an end to this human tragedy. But let us vow, if need be, to picket the White House all by ourselves—until somebody comes.

Thank you.
Apartments getting scarce in Marin

By Nancy Isles Nation
IJ home editor

SUSAN AND Francisco Granen have been renters at a large San Rafael apartment complex for four years. The parents of two daughters, Anita, 9, and Marina, 3, have no intention of buying a house in Marin.

"We don't want to buy a house, all of our effort is going into our business," Susan Granen, 36, says.

Before moving to their apartment, the Granens owned a house in Terra Linda but sold it to put their energy and finances into their importing business.

"When it was raining the kids' room got flooded and I just called the management," Granen says. "For busy working parents there's no time on the weekend to do the garden and maintain the house."

She also doesn't like the cost of houses in Marin. "For $500,000 I could buy a ranch somewhere else. It's to our advantage not to buy here."

When the Granens rented their apartment there was little to choose from in their price range, but they loved the one that they found because it backs up to a huge open-space back yard where the girls can play. If they were looking today, they would have a harder time. With one of the lowest vacancy rates in the Bay Area, Marin has a scarce supply of rental properties.

According to a report on the Bay Area rental market by Ann Roulac and Co. of Tiburon, the average vacancy rate for the nine-county area is 3.3 percent. In Marin, just 2.9 percent of all apartments are without tenants on average. The report tracks commercial rental complexes and does not include private rentals.

The reason for the shortage, Ann Roulac says, is few rental properties have been constructed since 1986. And few will be. "There's nothing in the planning process and there is very little financing available today," Roulac says.

The only sites that have been proposed for large rental projects in Marin are the Hamilton Field site in Novato and the Marin City USA development in Marin City. Marin City USA has received approval from the county Board of Supervisors but is being held up by financial and other complications. The Hamilton project is

Renters

From page D1 under consideration by the Novato Planning Commission.

The scarcity of apartments means that rents are high. The average for a studio in an apartment complex in Marin is $575, while a one-bedroom unit typically would cost $925 a month. A two-bedroom apartment averages $1,075, according to Roulac's report.

"This is a strong rental market because people love living in Marin County," she says. Marin's high-end rental complexes, such as Lincoln Village Apartments and Larkspur Court both at Larkspur Landing and the Highlands of Marin in San Rafael, have few vacancies.

But the rental market has not been unscathed by the nationwide recession. At the Channing Crest Apartments in San Rafael, manager Karen Danti says that while the complex is 99 percent full now, last summer things were slow.

"I think people were being cautious about moving because of the economy," Danti says. Like several other complexes, the 254-apartment Channing Crest used incentives to draw new residents.

Channing Crest currently is offering $200 off the first month's rent to anyone who signs a 12-month lease. However, as strained state and local budgets force cities to increase fees, renters may find themselves paying even more for rent. This week San Anselmo raised business fees for apartment building owners from $6 per unit to $50 per unit annually. The increase will very likely be passed along to tenants. If other cities in Marin follow San Anselmo's example, average rents across the county will climb.

See Renters, page D4

Median rent prices

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Source: Association of Bay Area Government

11 chart/Bob
THE YOUNG MAN, diagnosed HIV-positive, sat on his living-room floor, surrounded by brochures he had collected from visits to the San Francisco AIDS Foundation and to San Francisco General Hospital's AIDS ward.

Slowly, he arranged them into piles — 12 piles, to be exact. Each was devoted to a different topic, from acupuncture to hospice care, offered by a different agency.

"It's almost overwhelming. There is so much information out there, I couldn't believe it," he said. "I know people who are feeling sick or tired and don't have the ambition or the functional strength to figure it out in an organized way."

AIDS organizers agree that in this city, so rich with AIDS resources, it is still possible for people to die without getting the help they needed.

With no clearinghouse of information, no designated "case manager" to assist patients through the course of the disease, it is easy for them to get lost in the maze. After the stunning news of a positive HIV test, all but the most sophisticated people are unsure of the next steps.

For example, a typical HIV or AIDS patient may not anticipate the many bus trips he'll be making to get medical care — and isn't aware of Muni's discount passes. Or he doesn't realize that it takes nine months for the Social Security office to process each application for benefits — and that if he waits too long to file, he may be dead before the first check arrives.

"I've walked a lot of people through this," said Charles Caulfield, a former Dallas social worker who himself has AIDS. "It can be demeaning and confusing."

"You don't know what your priorities should be, you don't know what you're going to need. How would you? A lot of people learn of services after their need has subsided. There's no way to learn, except by trial and error."

Cleve Jones, founder of The Names Project and a man with HIV, explains: "Most people have a very long struggle with HIV. At first, you have issues related to your job or apartment. As time goes by, as circumstances change and worsen, you start dealing with different AIDS agencies. You get bounced around so much. There is little continuity. The services don't mesh. As a result, people aren't getting the benefits they qualify for — they're not getting the services they need."

"In addition to a centralized case-management system, patients suggest creating a computerized record of each person's illness that would match him to the appropriate service group each step of the way. Patients could also benefit by a single bulletin-board system that would post services and tell how to gain entry."

A computerized data base listing all services in The City could announce an opening that could be automatically filled by the next person on the waiting list.

"San Francisco's services are great. They couldn't be better," said Caulfield. "Anyone who doesn't believe that should go to Tulsa, Okla., for a couple weeks. We are extremely fortunate here."

"It's not a matter of creating more services. It's a matter of better using what we have — creating a bridge between the services and the population they are targeted to reach."
Orient Yourself With UCSF's Herbal Study

by Dennis Conkin

Quan Yin Healing Arts Center and the University of California San Francisco have announced a controlled study to determine how effectively Chinese herbs may relieve symptoms of HIV infection.

The 12-week study, which will be conducted at San Francisco General Hospital, is the first to apply Western scientific methods in tracking the efficacy of Chinese medicine in treating HIV disease, according to Jeffrey Burack, M.D., clinical instructor of medicine at UCSF.

"Many of our patients continue to experience severe symptoms even with the best available medical care," Burack said in a press statement. "Some, whether we like it or not, seek alternative therapies. I think it's time we subjected these alternative therapies to the same kind of rigorous scrutiny we give to mainstream drugs."

The use of herbs is a critical element in the 5,000-year-old practice of Chinese medicine, along with other methods of treatment such as acupuncture and massage.

Patients selected for the study will be randomly assigned to receive either the herbal preparation or an identical-looking but inactive placebo for 12 weeks. At the conclusion of the study, all the patients who received a placebo will receive a free 12-week supply of the herbs.

The herbs are given in easy to swallow pill form, according to Misha Cohen, L.Ac., OMD, who developed the preparations known as "Essence" and "Clear Heat."

"It's an herbal study, not acupuncture," Cohen told the Bay Area Reporter, "in some ways they work well together. In some ways they work differently. Acupuncture deals with energetics and helps in stress reduction."

Cohen said the herbs chosen for the study are well known anti-retrovirals in the Chinese medical pharmacopoeia, including honeysuckle, oldenlandia, viola, and isatis.

The preparations have already been used by Cohen in treating HIV patients with no significant adverse reactions.

The study is open to men and women 18 years old or older, who have a T-cell count between 500 and 200 and who are HIV-symptomatic.

"We have room for 30 people in the study," Cohen told the B.A.R. "In order for it to be significant, we need to study between 150-180 people. But we need someone to provide the funding."

For more information about participating in the study contact Mary Payne, R.N., at 415 476-9296, extension 84602.
The ‘other’ drug problem

Older Americans paying price for taking too many drugs at high doses

By Judy Foreman

Boston Globe

They call it America’s “other” drug problem. It’s not about kids shooting up in alleys, or the street drugs that caused 165,000 emergency room visits last year. But in some ways, it’s even more insidious. And it’s clearly bigger.

It’s the 243,000 people aged 60 or over who wind up in the hospital every year because of adverse reactions to prescription and over-the-counter drugs, as one study found. It’s the estimated 61,000 people over 60 with drug-induced Parkinson’s disease caused by vastly overprescribed antipsychotic drugs such as Haldol, Thorazine, Mellaril, Stelazine and Prolixin.

It’s the estimated 32,000 people who break their hips every year because of drug-induced falls.

And the 163,000 whose memory loss is caused or made worse by sleeping pills, tranquilizers, blood pressure medications or antipsychotic drugs, according to estimates by Dr. Sidney M. Wolfe, head of Public Citizen Health Research Group in Washington, D.C.

It is, in other words, Mom or Dad sitting at home popping too many drugs at too-high doses prescribed by too many doctors who don’t talk to each other—and, all too often, winding up depressed, fatigued, forgetful, incontinent or unable to walk.

At which point, another doctor visits, another diagnosis and yet another prescription is the usual “cure,” the assumption being that depression, fatigue, incontinence and the like are normal parts of aging.

They are not, insists Dr. Jerry Avorn, a Brigham and Women’s Hospital geriatrician in Boston, who has led a campaign to “un-advertise” and “de-market” the most overprescribed drugs.

Since 1980, as part of several research projects, Avorn has sent pharmacists to doctors’ offices with the real story about many drugs, to counteract what often constitutes the only drug “education” doctors otherwise get: visits by salespeople from pharmaceutical companies.

Most medical and nursing schools offer only short courses in pharmacology, and even less training in geriatrics. And most drugs are tested in younger people—often men—but used primarily in older people, the majority of whom are women.

Avorn’s experiments on about 500 doctors in five states has paid off handsomely. The doctors educated by his pharmacists reduced inappropriate drug prescribing by 15 percent. And by reducing prescriptions, the doctors saved Medicaid twice as much as Avorn’s program cost.

“The overwhelming proportion of drug-induced illness in older people stems from doctors’ prescribing the wrong dose or the wrong drug, sometimes when no drug at all is needed,” Avorn says. “It happens in nursing homes, too, where half of residents take mind-altering drugs, often to make them more manageable.”

Adds Wolfe, author of “Worst Pills/Best Pills,” drug problems among older Americans constitute the nation’s “biggest” drug problem “in terms of the numbers of people involved and the seriousness of the consequences.”

In the right doses and under the right supervision, of course, many drugs are life-saving or life-enhancing.

But millions of older Americans, with doctors’ unintentional collusion, wind up as messed up by drugs as younger people.

Avorn’s experiments on about 500 doctors in five states has paid off handsomely. The doctors educated by his pharmacists reduced inappropriate drug prescribing by 15 percent. And by reducing prescriptions, the doctors saved Medicaid twice as much as Avorn’s program cost.

The root problem, says Avorn, “is again, the belief that old people are inherently weak of mind and have trouble with their urine, that they are no longer interested in sex, that they get mixed up.

Part of the trouble lies in sheer numbers.

Americans over 60 are 17 percent of the population but consume 40 percent of prescription drugs and 70 percent of over-the-counter medications, according to the National Council on the Aging, Inc., a nonprofit, private group in Washington.

“They take, on average, anywhere from 2.3 drugs, as a 1992 study showed, to five, six or more drugs concurrently if they have multiple diseases. And half of those prescribed drugs, other studies show, are never taken as directed.”

Part of the problem, too, is that “older people are systematically avoided in many drug trials,” says Avorn, who adds that age bias in drug tests is greater than gender bias.

And because doctors get almost no systematic training in geriatrics, they tend to prescribe doses that are safe for young people but potentially dangerous for older people, whose livers and kidneys process drugs more slowly, leaving drugs in the system longer.

Beyond that, many of the drugs taken by older people have unintended mind-altering effects, among them beta-blockers such as Inderal, which is prescribed for high blood pressure and angina but can cause depression. Tranquilizers such as Valium or Librium and sleeping pills can also cause depression.

Other drugs are simply too strong for the problem at hand, such as Haldol, an anti-psychotic drug developed to fight schizophrenia that is widely used to sedate older people.

An older person with Alzheimer’s disease who is babbling and asking for his mother, forgetting she has died, is different from a young schizophrenic who believes the KGB put electrodes in his brain,” says Avorn. “These are different conditions, and it’s often not appropriate to use the same drug for them.”

Even ibuprofen, an over-the-counter pain-killer, can be dangerous for older people, who are more likely than younger people to suffer fatal gastrointestinal hemorrhage on the drug.

Because much of the problem stems from patients going to too many doctors who don’t communicate, one obvious solution is to pick one doctor to be in charge and review all your drugs.

Or talk to a nurse. Compared to doctors, nurses take better medical histories, ask more questions and are less likely to overprescribe drugs, according to a study published in April 1991 in the Archives of Internal Medicine.

If you conclude that you’re taking too many drugs, a caveat is in order: Never stop or change a drug without medical supervision. Going cold turkey on Inderal, for instance, can trigger a heart attack.

But if, under supervision, you taper off a drug, and your depression or incontinence goes away within a few days or weeks, your symptoms were probably drug-induced.

And if you’re really stuck, there’s always the “brown bag” approach recommended by Dr. Stanley Slater, deputy associate director of geriatrics at the National Institute on Aging.

Just dump your medicine cabinet into a bag and take it to all one doctor “who understands the elderly,” says Slater, especially if you have consulted several specialists or are still taking medications prescribed years ago.

“The basic rule,” says Slater, “is if you are taking a lot of medications and feel woozy or confused, don’t assume it’s you. It could be the medications.”
Free ddC Available to Those Who Qualify

by ARTURO JACKSON III

The Hoffmann-La Roche pharmaceutical company announced that it would distribute ddC free of charge to those who qualify for two new expanded drug access programs. One new program, which will be instituted within the next two weeks, will distribute ddC nationwide to individuals who are HIV-positive, who have HIV-related symptoms and less than 300 T-helper (CD4) cells; or individuals who have remained asymptomatic but have less than 200 T-helper cells.

The second program, which is still in the planning stages, will distribute ddC to HIV persons with T-helper cells in the 300 to 500 range. The new Hoffman-La Roche ddC distribution program was announced February 21 in response to a recent FDA investigation surrounding the quality of underground versions of ddC available at local buyer’s clubs. Numerous “buyer’s clubs” around the country market alternative HIV treatments to the HIV-positive consumer.

FDA officials investigated underground ddC after consumer inquiries prompted the agency’s attention. After testing samples of ddC from two different batches obtained from buyer’s clubs in New York and San Francisco, FDA investigators reported that some of the capsules contained no active ingredient, while others contained potentially dangerous amounts of the drug. After analysis of the drug samples, the FDA “strongly urged” the immediate halt of all underground sales of ddC, effectively cutting off the supply of the drug to an estimated 4,000 to 15,000 people with HIV across the country who had been obtaining the drug from various buyer’s clubs. Preliminary research results have previously indicated that a combination treatment regimen utilizing AZT with ddC appears to have a greater anti-viral affect than either drug alone.

The added benefit of the combination therapy, according to the preliminary research data, is that lesser amounts of both AZT and ddC are required for anti-viral effectiveness and, consequently, the likelihood of toxic drug reactions is also greatly reduced. “The drug ddC has been used successfully by many HIV-infected persons who acquired the drug through a buyer’s club,” stated Mitchell Katz, M.D., chief of the Research Branch, San Francisco Department of Public Health AIDS Office.

Individuals who would like to initiate an AZT/ddC combination treatment regimen can obtain the drug through their primary physician. The paperwork involved with the first phase of the ddC distribution program is being streamlined, so that the drug will reach individuals demonstrating an urgent need for ddC and subsequent combination anti-viral therapy. Some HIV advocates have expressed concern that the anticipated required paperwork for the second phase of the ddC distribution program, which will make the drug available to HIV individuals with 300 to 500 T-helper cells, may discourage physicians from participating in the program.

“Once the study protocol is designed, we can only hope that the paperwork involved to get ddC will not be too complicated,” stated Richard Copeland of the Healing Alternatives Foundation, a local alternative treatment buyer’s club.

We feel that this is a dramatic and necessary step to address the needs of the AIDS community at this time,” stated Paul Oestreicher, spokesperson for Hoffmann-La Roche. “Roche is committed to helping people in the AIDS community,” the spokesperson added. Local AIDS activist organizations, including ACT UP/Golden Gate and Project Inform, have been actively involved in negotiations to make the drug available. ACT UP/Golden Gate has been urging the FDA to review preliminary data from ACTG 114, a trial involving 1,000 study participants, which has been monitoring the effects of AZT/ddC combination therapy, whose preliminary data, it is hoped, will expedite federal approval of the drug. “The decision of Hoffmann-La Roche is a victory for AIDS activists and HIV-infected persons,” Katz added. “It’s a step in the right direction,” stated Larry Tate, Project Inform’s hotline manager. It will depend on how much more widely ddC becomes available,” Tate emphasized. Physicians can contact Hoffmann-La Roche’s ddC coordinating center at 1-800-ddC-21-HIV (1-800-332-2144) for complete program enrollment information.
ON THE MATTER OF SURVIVAL

Donald I. Abrams, MD

"Why should we keep loading up people with HIV infection with all these various treatments that are certainly not without toxicities and very likely to interact with each other in the body if they have no impact on the ultimate goal—the prolongation of life?"

A lot of paradigms have shifted, as they say, over our first decade of fighting HIV. The movement to reject survival as an endpoint gained momentum back in 1986 upon the early termination of the placebo-controlled AZT trial in patients with AIDS and advanced AIDS-related complex (ARC). In this landmark study, patients receiving AZT benefitted in all possible parameters. Weight and performance status improved, CD4 lymphocyte [T-helper cell] counts rose, even skin test anergy went in the right direction. To top it off, opportunistic infections were significantly reduced in the AZT recipients. The clincher, of course, was the lopsided "body count." Nineteen placebo recipients died prior to study termination compared to only one patient receiving AZT. With all of the other clues that the drug was beneficial, how could any ethical investigator wait for such an imbalance in mortality to stop the trial and make the drug available to all? And yet, this is the study which demonstrated that AZT prolonged survival, and it is cited in all subsequent literature as the one trial to conclusively demonstrate that advantage.

The authors (Fischl, et. al.) of that pivotal study remarked that "these data demonstrate that AZT administration can decrease mortality and the frequency of opportunistic infections in a selected group of subjects with AIDS or AIDS-related complex, at least over the 8 to 24 weeks of observation in this study" (my emphasis). Does a decrease in mortality automatically translate into the prolonged survival that the trial has been credited with demonstrating? The population of patients with AIDS enrolled in the study had experienced a first episode of Pneumocystis carinii pneumonia within the previous 120 days. Only 10% of those enrolled completed the intended 24 week trial; the mean duration of participation was 120 days. Therefore, the AIDS patients enrolled had received initial diagnoses of PCP only 4-8 months prior to the end of the study. Eighteen more patients in the AZT-treated cohort reached this landmark, compared to the placebo group. In 1986, the average life span of a patient in San Francisco after PCP diagnosis was 13.2 months, making it a bit premature to truly claim survival prolongation on the basis of this study alone. Decreased mortality, yes, during the 8 to 24 weeks of observation—but prolonged survival? At least to me, that still remained to be proven. Following termination of the placebo-controlled part of this milestone study, numerous updates on how the cohort was faring, as well as reports on the aggregate experience...
of patients on the treatment IND, seemed to support improved survival—but the gold standard of the controlled clinical trial as the yardstick was absent.

Moving clinical trials into patients in earlier stage(s) of disease helped to take the heat off the survival endpoint issue. When ACTG 016 and ACTG 019 evaluated populations with mildly symptomatic ARC or totally asymptomatic disease, evidence of activity of drug compared to placebo was apparent way before any significant number of deaths occurred. Benefits with regard to CD4 cell increases and decreased disease progression were significant in ACTG 016 after a mean duration of 9 months of treatment; only 2 of the 711 patients enrolled had died. The same benefits were appreciated in the 1,434 asymptomatic patients with CD4 cell counts <500/mm^3 enrolled in ACTG 019 after a mean of 55 weeks of follow-up. The authors (Volberding, et al.) cautioned, however: “it is possible that even if AZT persistently delays the onset of AIDS, it may not have an ultimate effect on survival.” To many that would seem counterintuitive. How could disease progression be forestalled without prolongation in survival?

The concept of disease-free survival is well known to the oncologist. In October 1991, I spent a week at an oncology review course at Harvard. Although I am a certified cancer specialist, I spend most of my time being an AIDSologist, so I figured a little brushing up on what was new in the world of cancer medicine couldn’t hurt. That’s when I had a revelation. For 5 days, 8 hours a day, I sat in an auditorium hearing lecture after lecture about treatment of every different type of cancer—lung, stomach, colon, breast—all of them. In each case, there are many different therapies available—either single modality or combinations of chemotherapy, radiation and/or surgery. And day after day, slide after slide of survival curves were flashed on the screen. Many treatment options were shown to be able to shrink the tumor—for a time, that is. But, if these new therapies did nothing when compared to the old therapy, or to no therapy, to prolong overall survival, they are most often cast aside, and felt to be of little therapeutic value. As a medical specialty, oncology is a new field. Although still in its infancy, oncology has made great strides in curing some malignancies and in significantly prolonging survival in others. Much of this progress has come at the cost of relinquishing treatments that are not impacting overall survival.

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The much maligned study of early versus late antiretroviral therapy conducted by the Veterans Administration further confuses the survival issue in patients with HIV disease. This study in patients with symptomatic ARC followed 338 patients for just over 2 years. Those assigned to early treatment received AZT immediately, while the late treatment group received placebo until their CD4 count dropped below 200/mm^3 or until they developed an AIDS-defining event. Once again, although disease progression was halved in the early treatment group, overall survival was the same. Patients on the early treatment arm tended to develop more AIDS-related events in a shorter time than those who were in the late treatment group. Granted, many would prefer to have a longer period of disease-free survival to enjoy and, hopefully, to suffer less once an AIDS-defining event has occurred, but it still seems disappointing that benefits in CD4 count increases and disease progression decreases are not translating into prolonged survival. Are these laboratory and clinical markers accurate substitutes? Can they serve as surrogates for survival in studies of therapies for HIV infection?

Obviously, these are difficult questions that will not be answered here and now. But it is worth noting, as more and more antiviral agents are approved early in their development, that it will take some time for us to determine what they really do and when best to use them. The more we use currently available treatments in wider populations and the more we try to correlate the emergence of viral resistance to clinical outcome, the more unclear we become about appropriate treatment strategies. In a recent review entitled “Zidovudine [AZT]: Five Years Later,” the authors (McLeod and Hammer) remind us that “the effects of early therapy on survival and the optimal time to initiate therapy remain controversial” even for “the cornerstone of antiretroviral therapy.”

It is certainly difficult, and a bit unsettling, to face the uncertainties that still remain in the field of treatment of HIV infection. Most of us would feel much more comfortable if there were more absolutes and fewer questions. Progress has been made, and will continue to be made in the upcoming years. But we really must face the critical issue and not pooh-pooh survival in favor of modest transient increases in CD4 counts, or even significantly decreased short-term disease progression. The ultimate progression of HIV disease, unfortunately, continues to be towards death as an endpoint. At a recent meeting, I discovered a number of people wearing lapel buttons extolling, “All I Want Is The Cure And My Friends Back.” Wouldn’t we all! But with just a little more reality testing, we should be demanding treatments that will prolong survival. I, for one, don’t think we should settle for less.

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