ABBOTT

Diagnostics Division

Abbott Laboratories
Abbott Park, Illinois 60064

June 27, 1988

Constance B. Wofsy, MD
Associate Clinical Professor of Medicine
Co-Director, AIDS Activities
Assistant Chief, Infectious Diseases
University of California
San Francisco General Hospital
San Francisco, CA 94110

Dear Conny:

Thank you again for your superb presentation in the Abbott Centennial Symposium on AIDS. It was a great success.

As already mentioned to you during the meeting, we intend to publish the proceedings and to distribute it primarily to Abbott's customers. The enclosed manuscript is an extended summary of your presentation for your review. Could you please make all necessary corrections and send it to me within two weeks.

We intend to have this piece published in August in order not to be out of date when things go so fast.

If you have any questions, please contact me.

Best regards
Yours sincerely,

Jean-Pierre Allain, MD
Manager Medical Research

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JPA:dc

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SCHOOL OF MEDICINE

July 12, 1988

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

Jean-Pierre Allain, M.D.
Manager
Medical Research
Abbott Laboratories
Diagnostics Division
Abbott Park, IL. 60064

Dear Dr. Allain:

I have corrected the annotated manuscript from my talk given to the group at the Abbott Centennial Symposium and hope that my changes are reasonably legible. You will, I'm sure, pass it on to the appropriate editorial staff. One important piece relates to Figure 2. The xerox shows a slide I presented of HIV encephalopathy; in actual fact, the point that Figure 2 should illustrate is the rapid clearing of toxoplasmosis with therapy and I presented two slides which look very similar - they are CT scans, one showing a fairly large lesion and the second two weeks later showing virtual resolution of the lesion. The copies of slides that I have are now incorporated into other talks so I can't relate to you where they are in the sequence. Someone will have to go back through and make the appropriate substitution.

I enjoyed the Abbott Symposium very much. I also enjoyed the other speakers and must say I was most gratified at the warm reception my talk received and at the opportunity to present some clinical materials succinctly to individuals who may have very little exposure to the clinical aspects of HIV-related diseases.

After the completion of the monograph, my understanding is that the slides will be returned. It gets tedious to see one's slides all over the place and I had indicated that I didn't wish them to be generally disseminated. A few of the slides were other people's data which they gave me the permission to show even though the data per se is unpublished.

I am sure this monograph is providing a bit of work on your part, but the transcription was in general very good and quite workable for me. If you would like me to review a further draft, by all means send it back and I will take a quick look.

Have a fruitful and relaxing summer.

Sincerely,

Connie Wofsy

Thanks!

Constance B. Wofsy, M.D.
Co-Director
AIDS Activities Division
Assistant Chief
Infectious Diseases
San Francisco General Hospital

CW:sb

[Possible deletions]

C. Wofsy.

CLINICAL ASPECTS OF AIDS AND RELATED DISORDERS

Because 75% of new AIDS cases in the next five years are expected to be diagnosed in cities outside the metropolitan areas now most affected by the disease, more widespread knowledge of currently optimal clinical care for AIDS patients is essential, Dr. Constance B. Wofsy asserted.

"I doubt there will ever be a true AIDS specialty, although some experts in infectious and pulmonary diseases, oncology, and immunology have become quasi-AIDS experts," ~~she said. "The majority of HIV-positive individuals will--and should be--cared for by routine means of primary care."~~ as part of

Primary care physicians can manage the common infections in AIDS patients, such as Pneumocystis carinii pneumonia (PCP), and certain consultations for other AIDS-related problems. Dedicated AIDS clinics and inpatient units ~~will be necessary in some areas~~ are appropriate in areas with a large number of infected people, but internists, and some family physicians subspecialists will ~~also be~~ provide much of the treatment for ~~treating~~ AIDS patients.

DIAGNOSTIC ISSUES

[Asymptomatic HIV-positive individuals make relatively little use of medical resources, but their use of health care services escalates as the severity of the disease increases.]

Evaluation of the early stages of disease generally falls to the primary care physician, who ~~is most likely to be~~ will increasingly employ diagnostic tests that have prognostic implications (table). to aid in counselling and decisions about antiviral treatment, and life plan issues.

Physical examination of the head and neck is one of the best methods for identifying early signs of HIV infection. Among the ~~prognostic~~ diagnostic? signs are generalized lymphadenopathy (~~a~~ large posterior cervical node~~s~~ ~~is~~ are ~~a~~ frequent ~~feature~~ encountered); ~~pseudomembranous~~ thrush ~~on the soft palate~~; hairy leukoplakia seen particularly along the side of the tongue (a marker that does not respond to antifungal therapy); and Kaposi's sarcoma (although usually present on the skin or conjunctiva, it may also appear in the mouth, particularly on the upper gingival fold).

Characteristics of opportunistic infections in patients with AIDS may differ from those of the same infections in other immunocompromised groups. Almost all the opportunistic infections that constitute an AIDS diagnosis are infections to which most individuals have been exposed in the past. ~~PCP~~ Diagnostic infections include: Pneumocystis pneumonia (PCP), toxoplasmosis, cryptococcal meningitis, candida esophagitis, disseminated mycobacterium avium intracellulare, cytomegalovirus, cryptosporidiosis, isosporiasis, chronic mucocutaneous herpes simplex, recurrent ~~s~~almonell~~osis~~ sepsis, extrapulmonary tuberculosis, and disseminated histoplasmosis. Multiple simultaneous infections can occur.

Diseases in HIV-infected individuals may present themselves ~~occur~~ differently than previously seen in other populations. PCP is typically seen as a diffuse bilateral interstitial infiltrate in the perihilar region, but in AIDS patients and pleural effusion is seldom seen with PCP (although it may signal Kaposi's sarcoma), ~~and~~ atypical infiltrates can mimic

the fibronodular changes seen in tuberculosis (although dual infection ~~is not infrequent~~ may occur). Figure 1 shows the now-accepted sequence of events for evaluating AIDS patients with PCP.

In therapeutic trials of various agents against these infections, the toxicities encountered were more frequent, unexpected, and unusual than those seen with the same therapies for these diseases in other populations. In HIV-positive individuals, more lengthy therapy is required, for example, three weeks for PCP. Experimental therapy ~~is~~, such as inhaled pentamidine ~~may~~ become standard therapy.

for PCP prophylaxis and ganciclovir for cytomegalovirus infection

have, in many instances

PCP THERAPY

Inpatient PCP therapy involves parenteral treatment with trimethoprim sulfamethoxazole ~~and~~ or pentamidine, but almost half the patients have such severe toxic reactions that they cannot take the full course of treatment because of neutropenia, hepatitis, or elevated creatinine. Unique to AIDS patients treated with trimethoprim/sulfamethoxazole are nausea and vomiting. Fastly Life-threatening hypoglycemia and occasional arrhythmias are among the risks of ~~outpatient~~ treatment with pentamidine. unique limiting its routine use for outpatient therapy.

Outpatient therapy is appropriate for post-PCP patients who have a good respiratory rate, satisfactory oxygen levels, and an established health care provider. Oral dapsone (100 mg once a day) plus trimethoprim (10-20 mg/kg/day divided into four doses) ~~are~~ is the first choice of therapy in these cases. However, a G6PD determination is essential because dapsone can induce hemolysis in G6PD-deficient patients.

Therapeutic alternatives may be oral trimethoprim with sulfamethoxazole or aerosol pentamidine (now investigational). If the patient does not respond to therapy, the antibiotic should be changed. ~~or a steroid tried.~~ The value of steroids for patients with severe disease is not established. Anecdotal reports suggest benefit in some cases.

~~For patients not receiving AZT,~~ the relapse rate at nine months is ~~46%~~ about 50% thus secondary prophylaxis for Pneumocystis PCP is widely accepted. Aerosol pentamidine, which requires ~~a~~ The patients consent ~~form~~ because it is ~~an~~ investigational ~~drug,~~ appears to be the least toxic, but the optimal dose has not been established.

Part of caring for PCP patients involves obtaining information about their wishes in case of cardiac arrest, giving appropriately worded information about the likelihood of survival, and working with ~~the patient~~ in making life decisions, ~~since patients may be estranged from family.~~ Durable power of attorney ~~may be needed in a crisis.~~ Identifying a friend or lover as such can be very important especially especially since patients may be estranged from family.

OTHER DISORDERS

Neurologic disorders can also complicate AIDS infection. Toxoplasmosis and cryptococcus are the most common and the most treatable. Diagnosis should begin with a computed tomographic (CT) scan. If that does not reveal HIV encephalopathy, it should be followed by a lumbar puncture for cryptococcal antigen, a VDRL, and a routine culture. If the CT scan shows multiple lesions in an HIV-positive patient, the cause is probably toxoplasmosis. If empiric therapy does not lead to improvement within two weeks, a magnetic resonance imaging scan ~~can help in diagnosis~~ may further elucidate the picture and a biopsy should be considered. Toxoplasmosis usually responds readily to therapy. (Insert A next page)

a space occupying lesion suggesting toxoplasmosis or

For a single brain lesion ~~that is likely to be an ordinary brain abscess,~~ the differential diagnosis is more difficult. ~~serology is less helpful. Although a positive IgG implies latent infection,~~

A single toxoplasmosis lesion may mimic an ordinary pyogenic brain abscess. Unfortunately toxoplasma serologic testing is not helpful. Insert B next page

(B)

half the population has IgG to toxoplasmosis. ~~Others~~ A few patients with biopsy-proven toxoplasmosis had no serologic markers for toxoplasmosis. Figure 2 shows the rapid improvement of a brain lesion in an AIDS patient following treatment with pyrimethamine, sulfadiazine, and folinic acid. Insert (A)

Fig. 2

AU: DOES HALF THE ENTIRE POPULATION HAVE IgG TO TOXOPLASMOSIS? yes.

Cryptococcal meningitis requires prolonged intravenous therapy with amphotericin. Because it must be administered through a central venous line, a surgeon must insert the line and may experience reluctance. ~~Failed~~ Unless an outpatient infusion program is in place ~~provide access, which may~~ be impossible in an outpatient setting. Amphotericin therapy may

Neurosyphilis in HIV infected patients ~~has been noted~~ ~~CNS relapse can occur~~ after adequate treatment of primary and secondary syphilis. Because meningovascular syphilis may have various presentations, Dr. Wofsy recommended a lumbar puncture and careful evaluation of persons with unexplained neurologic symptoms which could be syphilitic in origin.

~~Mycobacterium tuberculosis infection in AIDS patients is serious~~ has particular public health issues because of communicability. Virtually all other non venereal opportunistic infections in AIDS are not passed from person to person. The Centers for Disease Control recommend isoniazid in HIV infected persons who are PPD positive prophylaxis with isonicotinoylhydrazine. Treatment for extrapulmonary tuberculosis, which ~~often~~ may constitutes an AIDS diagnosis, is the same as for ~~any case of tuberculosis.~~ non AIDS patients with similar tuberculosis infection

Cytomegalovirus retinitis may respond to gancyclovir ~~DHPG~~ prophylactically called DHPG, however, gancyclovir is not licensed by the FDA and thus requires informed consent from the patient.

AU: PLEASE SPELL OUT "DHPG" not needed

HEALTH CARE WORKERS

Although the risk of ~~contracting~~ HIV infection after a needle-stick exposure ~~approaches~~ is about 0.4% ~~compared with about 20% for~~ in contrast to an approximate 20% of needle-stick exposure ~~to hepatitis B~~, risk of aquiring hepatitis B after a

The seriousness of the disease makes optimal

for an issue of paramount importance

infection control ~~of HIV has become an important issue~~ in hospitals and among health care workers. Since it is impossible to know who is infected, particularly in emergency situations, San Francisco General Hospital, like many other institutions, has adopted universal blood and body fluid precautions for all patients. ~~These~~ Such precautions require considerable changes in procedures ~~for many people~~ and require intensive retraining however, approximately 40% of needle-stick injuries are preventable. These efforts are well worth the protection to health care workers.

Although primary care of AIDS patients is difficult, support groups are can and care providers must care for themselves

be helpful in avoiding burnout of personnel, Dr. Wofsy concluded.

but more people involved in care ~~and comfortable~~ with ~~HIV related~~ diseases and care allowing turnover and repletion of care providers is mandatory if we are to keep provision of ~~provide~~ care for AIDS patients at a high standard.

TABLE. Tests with potential prognostic implications for infection with human immunodeficiency virus type 1.

↓ white blood cell count	↑ erythrocyte sedimentation rate
↓ hematocrit	↑ B2 microglobulin
↓ ~~CD4~~ T4 cells	persistent p24 antigen
↓ albumin	

FIGURE 1

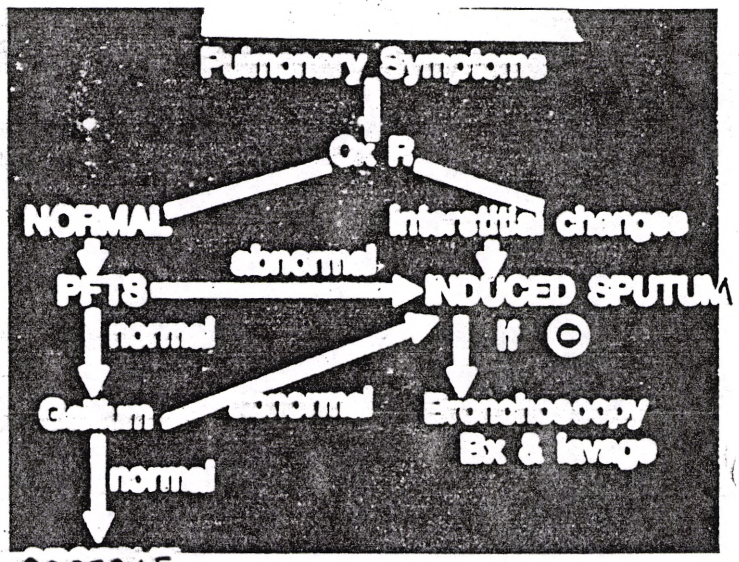
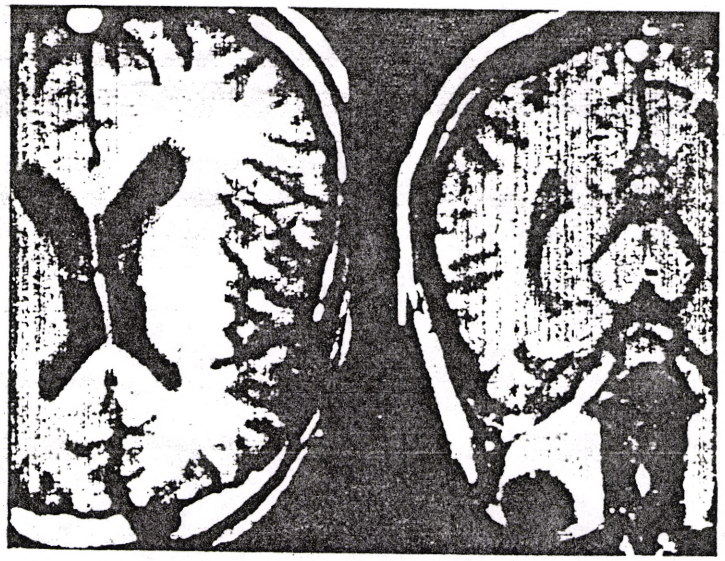

Pulmonary Symptoms
Cx R
NORMAL
Interstitial changes
abnormal
PFTS
INDUCED SPUTUM
normal
If ⊖
Gallium
abnormal
Bronchoscopy
Bx & lavage
normal
OBSERVE

FIGURE 2



wrong slide

This is a slide of HIV encephalopathy. The toxoplasmosis slides are two CT scans. They must be shown as a. + b. to make the point.

FIGURE LEGENDS

FIGURE 1. Diagnostic decision tree for pulmonary symptoms in patients at risk for acquired immune deficiency syndrome. Cx R = chest x-ray film; PFTS = ?.

Pulmonary function tests

AU: PLEASE SPELL OUT "PFTS"

FIGURE 2. Computed tomographic scan showing resolution of brain lesion in patient with acquired immune deficiency syndrome following treatment.

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Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

June 3, 1988

Janet Bickel
Association of American Medical Colleges
1 Dupont Circle
Washington, D.C. 20036

Dear Janet:

Thank you for all of your telephone help. I am enclosing assorted brief materials on APEX and women's related issues for your information. I will send the other manuscript at a later time.

I hope to meet you one day. Thanks!

Sincerely,

Constance Wofsy (Connie)

Constance B. Wofsy, M.D.
Co-Director
AIDS Activities Division
Assistant Chief
Infectious Diseases
San Francisco General Hospital

CW:sb

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Please address reply to undersigned at
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1001 Potrero Avenue
San Francisco, CA 94110

June 8, 1988

Theresa Burns
New Market Press
18 East 48th St., #1501
New York, NY. 10017

Dear Ms. Burns:

Here is the draft. I like each paragraph but the "sequence" is off. The ideas need bridges. Any ideas from you and Lynda?

I'm capable of reworking it but with Stockholm 24 hours away I had better send you this and let you fuss with it..

Sincerely,

Con Blosy

Constance B. Wofsy, M.D.
Co-Director
AIDS Activities Division
Assistant Chief
Infectious Diseases
San Francisco General Hospital

CW:sb

Enclosure

cc: Lynda Madaras

DRAFT

June 8, 1988

Preface to Lynda Madaras Book

Since 1981, I have been actively involved in every aspect of the medical, social, and ethical policy issues surrounding the AIDS epidemic. The cumulative number of AIDS cases in San Francisco has reached 4800 by April30, 1988. During this time, I have cared for and counseled untold numbers of patients, given hundreds of talks, and worked with other AIDS researchers and policymakers at a local, city, state, and national level for many years. While this epidemic has been in progress, our two children, a daughter now ten and a son now fourteen, have spent the last five years hearing of AIDS at the dinner table, seeing their mother on television and discussing AIDS in a variety of classroom activities in San Francisco where AIDS is constantly in the headlines.

In conjunction with rearing my own family and a growing awareness of the need for good preteen education in reproductive biology and sexuality, I received and was impressed by two other publications by Lynda Madaras, What's Happening to my Body? A Growing Up Guide for Mothers and Daughters and What's Happening to my Body Book for Boys. When I was asked to provide a preface for this current book, I was delighted at the prospect of having available a book about AIDS targeted at teens which used the same clear language and no nonsense terminology as the other publications.

The book has met its goal. The medical information is up to date and meticulously researched. The author has managed to take the wealth of information about this very complicated social, medical and ethical disease and keep the tone simple but accurate. The style is matter of fact. There is no whining. No asking "why did AIDS have to happen"; No Apology; no fingerpointing, no blame. The message is, "Okay, Now we have

AIDS to deal with; here's how we can do it." The book is full of vignettes of personal experiences, some tragic, some funny, some pearls of good advice and all useful in getting important messages across.

It is the translation of complicated facts into everyday life and everyday language that make the book so valuable. Kids can read this book by themselves or with their parents. Parents would be well-advised to read it themselves.

Despite all the AIDS-related publications available, none are targeted at teens, few of whom are infected yet. However, the teen years are years of experimenting, with approaches to sexuality, drugs, peers, ethics, morals, and years spent practicing being the adults that they are going to become. Teens are a potential next risk group. If teens heed the practical wisdom in this book, the existing low teen infection rate may well be maintained.

Most kids do not have such a direct source of information available and many parents have their own questions about AIDS and unresolved dilemmas. Kids get tired of hearing about AIDS. The grown-ups who are making the policies and deciding what is "safe" didn't live through their own exhilarating, tortured, self-conscious exploring teen years with the spectre of AIDS hanging over them. They were not exposed to carefree sex on the television at 8:00 p.m. followed by an AIDS documentary at 9:00 p.m., and a school report on AIDS due the next day.

June 28, 1988

To: Craig Wolf

From: Sam Broyles SB

Re: Moving matters

1. Please ensure that the room next to Dr. Wofsy's office is available to AWARE TODAY for storage of their materials, i.e., remove everything in the room with the exception of the marked materials and clean the floor.

2. Please ensure that the boxes currently in my office area are removed and my new desk and return are placed there.

3. As we discussed yesterday, I will list the items to be moved from my office and from Dr. Wofsy's and contact Delancey Street Movers at which time I will discuss box rental with them.

4. As of our discussion yesterday, I am under the impression that Dr. Wofsy and I will be moving to Ward 95 during the week of 7/4-8/88.