PEP Rally

Post-exposure prophylaxis just might reduce the risk of infection, but counseling is crucial.

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A moment of passion, a broken condom, a shared needle, a rape—if the other person either has or might have HIV, each traumatic incident raises the question: Can I stop the virus from taking hold? Post-exposure prophylaxis (PEP)— starting two or three antiretroviral drugs (usually AZT and 3TC, sometimes plus a protease inhibitor) within 72 hours of exposure and continuing them for one month—is aimed at just that. Erroneously called the "morning-after pill," PEP is actually more like "the month of hundreds of pills after," says David Ostrow, MD, a psychiatrist and longtime AIDS specialist at Loyola University Medical School in Chicago. And while indirect evidence of PEP's effectiveness is slowly mounting, Ostrow is one of many prevention researchers who worry that providing it as an isolated service may encourage unsafe sex or needle sharing.

The idea for "sex/injection PEP" came from findings that health workers exposed to HIV through needle sticks had an 81 percent reduced risk of seroconverting if they used AZT for four weeks. As for those exposed through sex or drug use, several hundred people have now been followed post-PEP, and none have seroconverted (although almost two-thirds have reported temporary drug side effects). But these studies don't prove that PEP works: Because the risk of transmission per exposure is quite low, larger numbers of people would need to be followed in controlled studies before that could be determined.

"For ethical and feasibility reasons, we will probably never know if PEP is effective," says Michelle Roland, MD, manager of San Francisco General Hospital's PEP Project. "Some health care workers who took three AIDS meds within hours of a needle-stick accident still got infected." Nonetheless, Roland says, the evidence is "pointing in the right direction." The CDC says that PEP is "unproven" for nonoccupational exposures and should only be offered on a case-by-case basis—for example, where risk is assessed to be highest (such as anal receptive sex or shared syringes).

Interestingly, in the few studies of those exposed via sex or drug use, treatment completion rates were much higher than among health workers. "Our study had support and adherence counseling," Roland explains. "That's very different from a health care worker being handed a bottle of pills and told, 'Good luck!'"

Both Roland and Ostrow say that counseling on how to avoid future exposure is the most important part of PEP for those at risk through sex or drugs. "The point is not to give medication,

but to help people not to get exposed again," says Roland, who is studying whether varying levels of counseling accompanying PEP can reduce high-risk behavior. Otherwise, Roland says, PEP could wind up increasing HIV rates by offering false assurance that infection can be prevented despite continuing unsafe behavior.

Ostrow adds, "My experience is that most internists or nonspecialists in prevention just say, 'Don't do it again,' but you need to look at the exposure circumstances in a detailed, nonjudgmental way, and use the visits related to PEP to do education and counseling."

Because there is no national PEP hotline, Roland advises those who are sexually active or who inject drugs to develop a plan for a worst-case scenario. "This does not mean planning to take your partner's medication," she says. "You need access to a physician who knows how to prescribe antiretrovirals properly, within several hours of exposure—the sooner, the better. You should also find out about counseling resources before any incident occurs."

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