Transcript: Condom-Free Sex? Controversial Swiss Declaration

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At the 15th Conference on Retroviruses and Opportunistic Infections (CROI) in Boston, Regan Hofmann talks with Bernard Hirschel, MD, of the University Hospital, Geneva, Switzerland about a controversial Swiss position paper declaring that HIV-positive people with undetectable viral loads cannot transmit HIV. To see the video click here.

Regan Hofmann: Hi, this is Regan Hofmann, editor-in-chief of POZ magazine, and I'm here this morning with Professor Bernard Hirschel, from the University of Geneva, Switzerland. Thank you for being with us this morning.

Bernard Hirschel, MD: You're very welcome.

RH: We're here to talk about a statement that was issued recently by the Swiss Commission on HIV/AIDS. Dr. Hirschel was one of the co-authors; there were three other authors of the study, correct?

BH: That's right. Two other authors.

RH: Right. So there's been a lot of controversy. The basic premise, if I may, of the statement, which was based on an analysis of several studies over a long period of time, is that an HIV-infected person on Antiretroviral therapy, with a completely suppressed viral load for more than six months, is not technically sexually infectious. Is that true?

BH: That's right. No virus, no infection.

RH: No virus, no infection. That's a big, bold statement! And it's really rocked the community; there's a lot of discussion on both sides of it. Before we get into the specifics, can you tell use why the Swiss Commission decided to issue this statement now?

BH: There are several reasons. The first is, a series of trials in Switzerland where people were accused of endangering others through sexual relations—they were HIV-positive, the partner was HIV-negative. The defense said, "well, there was little or no danger because my client was treated and he had undetectable viremia." This defense was not admitted based on official statements saying that treatment had little influence on infectivity. And that's just plain wrong. So there needs to be some official statement to the contrary. The second reason revolves around couples who want to have children. If the man, for instance, is HIV-positive, the woman HIV-negative, some go to extraordinary lengths to avoid exposure to HIV by doing in vitro fertilization (fertilizing the egg outside the body, as in a test tube) and ovulatory stimulation, then have implantation of an

embryo and all that. Now that's all good and fine, but there are several problems. First of all, it's very expensive, secondly, not very efficacious, it's pregnancy rates are low, and thirdly, the ovarian stimulation causes multiple pregnancies and they are risky to the children, to the newborns. So you exchange a theoretical, probably inexistent risk of HIV infection against a very real risk of injury to the unborn child, and that's really a problem. You have to say something about that. Then there are other reasons; if you look at the general picture of prevention, you have condoms. That's it. You don't have vaccines, and we won't, and microbisides are way off in the future. Right? So what else can we do? I think we need to think about other means of prevention. Treatment is such a weapon against future HIV infection. And you cannot very well defend the point of view that we should treat additional people, not only for themselves, but also for prevention of additional infections while maintaining that treated people are still infectious. It's a real problem, the error of logic.

RH: Right. So you're saying, for example, I know I have—I'm HIV-positive myself, and in a serodiscordant relationship. One of my future hopes was PrEP (pre-exposure prophylaxis—taking anti-retroviral drugs to prevent getting infected with HIV) for my partner, potentially; for example, if I wanted to conceive naturally, then I would think about that down the road if PrEP was proven to be effective. But what this gives us is another option. So if I'm carefully monitored, perhaps, have no viral load for more than six months, then really, this could be as effective as PrEP, if PrEP was proven to be effective.

BH: Okay, that's true. But I mean, individual decisions have to be distinguished from public health recommendations. As an individual, you may really want to put all the chances on your side; you may want to have suspenders and a belt, and have PrEP plus undetectable viremia; that's a choice that you can make as an individual. But very probably, the risk to your partner in such a situation is nil, or negligibly small. And therefore, many couples so have children the usual way.

RH: And it's also, in a way, added insurance; for example, even if you are practicing safe sex, you use a condom, you're on treatment, your viral load's suppressed, and the condom breaks, this is also a situation where you might be able to feel a little bit better about not having potentially infected your partner.

BH: Of course. You get all of these people who are potentially exposed to HIV, who are panicking, who want post-exposure prophylaxis, or PEP (giving antiretrovirals to an HIV-negative person after they are exposed to HIV). Now the thing is, we do not give PEP if the exposing partner has undetectable viremia. I mean we do it if someone absolutely goes crazy if we don't, but anyway we don't recommend it because we don't think the risk is worth the expense and the potential side effects of PEP. If you multiply the probability of the infection by the cost and whatever, you get absolutely astronomical sums. I don't think it's a good expense of limited health care resources to do that.

RH: And that's the point today; when we talk about how many people, globally, are living with HIV and AIDS and may be soon to be infected or tested soon and find out, I mean, we're not only dealing with how do we control the virus and how do we treat those with the virus, but the sheer volume and the sheer cost of these treatments. So things like this, that would help reduce a double treatment or an unnecessary treatment would certainly be appealing. The practical question I've been asked a lot is—okay, so, how do I know my viral load is undetectable at any

given time? If I was at my doctor and had my regular lab work done, and say, several weeks ago or even three months ago, it was undetectable, and I choose to have unprotected sex in a serodiscordant partnership, is that safe? Do I need to go get a new viral load test ten minutes before every time I want to be with someone? How does it work?

BH: Well there are some complicated logistics involved, I guess. I think what we will do in the next month, we will try to give some guidance as to how safe is safe. I can tell you that we have looked in—there is this large cohort in Switzerland, the Swiss HIV Court, with regular follow up. So we have viral loads, and we can ask the question, if somebody has two viral loads that are undetectable, how likely is it that the next will be undetectable? We don't have the data yet, but it looks like the reliability has improved considerably since HAART was first introduced. So in 1998 or so, the probability that the next viral load had a detectable result was something like five percent, and that has come down considerably. The second impression from just looking at the data is that those who do have a detectable viral load after an undetectable one are those people who have a lot of resistance, a long treatment history, and many, many changes in treatment history, a second line therapy, all that. Of course, compliance is certainly a factor. Those who miss doses are of course more likely to have a detectable viral load. So I think we can give some guidelines, but the absolute certainty is a goal that you cannot acquire.

RH: Well let's talk about when your viral load might spontaneously come up, or what might cause a blip or for it to rise; vaccinations, drug resistance. What is a safe interval for people to be tested—let's say a common recommendation is if you're not sick, you haven't presented any other symptoms, your compliance is quite good; twice a year, most people have their lab work done, sometimes four times a year. Is there any reason to think that you should have your blood work done more frequently, so that you can track your viral load more carefully if you were going to apply the implications of this statement?

BH: Well I'm not sure that there are implications that way. But so far, data have been analyzed in regard to decrease the interval from the customary four times a year to two times a year or something. There's a poster here from the EuroSIDA cohort that you can safely go to twice yearly, that the chances to have, in that interval, a high viral load are really low. So I would say that this is really the lower limit, twice year—at least for right now, that's what we do in our practice. We usually have a routine of every three months, and if patients have very reliably undetectable viral loads and no problems with their meds, we go to twice yearly, every six months.

RH: You all were looking at studies primarily conducted in, maybe even exclusively conducted in heterosexual couples engaging in vaginal sex. What about gay couples and what about anyone engaging in anal sex? Is that going to change this recommendation?

BH: Well, there are no data. You'd have to admit that it's speculative. Of course, one can logically assume that it would be similar because the risk of transmission by anal sex, if you take out the more traumatic practices that at times are associated with anal sex, are probably similar between anal and vaginal sex. So you would expect that the effect of treatment would be similar. But this is speculation; we don't have really good data on that.

RH: Is anyone planning to study that?

BH: I think there are some studies, but I can't really quote you any such studies. So far it has been

sort of a taboo subject. The idea was you recommend a condom for everybody and everything and if something happens, it's their fault; that's more or less… so it has been difficult. Of course, unprotected sex in patients who have undetectable viral load is largely practiced in the homosexual community, and I hope that this sort of statement will stimulate some studies that will give some quantitative answers.

RH: Have you received any criticism for issuing this statement?

BH: Yes. There are two criticisms; the first is [that] the evidence is incomplete. It's true. The problem is that it will never be complete. The absence of a risk can never really be proven. You can quantify the risk, you can say it's small and you can put some zeros before the one, but how people view the residual risk is very different. I think it's different in general, not only with HIV—if you think of the risk of nuclear power plants, some people can't sleep because of that and political movements are founded on that fear, and others don't care at all. Or the mad cow scare in Europe or the Bird Flu. So there are these differences, they are to be expected, and they're hard to resolve; there's no right way or wrong way. The second type of critique goes this way: "Well yes, we have known that, we tell it to patients and when we talk to patients we counsel them that way. But we shouldn't really talk about it in public because it will be misunderstood." That's another philosophical question; do you have truth for the masses and another truth for the initiated? As a whole, I'm not quite in favor of this because in the long run, it doesn't work—information circulates, it's confusing. I think that a good public health message has, first of all, to be precise. And the information that treatment does not influence transmission risk is not true, and you cannot base your public information on that.

RH: Do you think that people will misinterpret this study and become unnecessarily infected? Is there a concern being voiced about that?

BH: Personally I don't think so, because I see that we are lagging behind what's already in the community. The serosorting (choosing to have unprotected sex only with people of the same confirmed HIV statues), and

RH: Barebacking, all that.

BH: Yes, many people do care about stratifying their risks. And of course, the vast majority, practically all infections are transmitted by people who are not treated.

RH: Or aware of their status.

BH: Or aware their status, right. Therefore, I think that you should look at the shrub and forget the forest. I don't think that will have much influence.

RH: It's interesting, it's almost an impetus for people to know their status, to get on treatment when it's right for them, to maintain good adherence so that they can suppress their viral load. It gives them another option. I mean, as someone who never thought about having unprotected sex again in my lifetime because I'm HIV-positive, it's a very interesting and refreshing thought to consider. So I appreciate you talking with us today very much, and for clarifying this really interesting issue. Is there anything else you'd like to say on the matter?

BH: Well along the lines of what you just mentioned, the reaction we get from many people, and

especially those that are most disenfranchised and discriminated against, for instance the African women in Geneva who are really the poorest of the poor and often in difficult legal circumstances, very heavily discriminated against in their own community, this sort of encouragement is really felt to be very positive by them. I mean, part of the reason that we said something publicly was also for them; I think it reinforces their motivation to get treated. That's at least what they tell us and I think that's a good result.

RH: Great. Well thank you very much, it was a pleasure to have you here.

BH: Thank you.

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