Transcript: Women & HIV Treatment

February 29, 2008

At the 15th Conference on Retroviruses and Opportunistic Infections (CROI) in Boston, Regan Hofmann talks with Judith Currier, MD, about treatment and research advances in women living with HIV, and learns that many women are doing quite well. Click here to watch the video.

Regan Hofmann: Hi, this is Regan Hofmann. I'm here with Judith Currier, director of the clinical trials unit for the Center for Clinical AIDS Research and Education at the UCLA Medical Center. Today, Dr. Currier and I are going to talk about HIV in women. My first question, Dr. Currier, is, can you fill us in on any significant advances that have happened recently in studying HIV in women?

Judith Currier, MD: Well I think there's been an increasing awareness and interest in understanding how treatment affects women compared to men. Studies that are evaluating antiretroviral treatment are trying to enroll larger numbers of women so that we can make comparisons. Some of the data being presented at this conference is looked at in different studies of drugs, whether there are difference between women and men. And while there's not an extensive amount of new information, it's reassuring to see that, in general, women respond as well as men to treatment, when they actually take it and have access to it and are able to be on it.

RH: Are there any factors that affect women in particular that don't affect men, in terms of being barriers to care?

JC: Well I think that barriers to care exist for both men and women. We heard during a plenary session yesterday that one of the largest reasons people die of AIDS in places where treatment is available is that they don't get the treatment. And even though it's available through different programs, they don't get it because they don't know they have HIV. And they don't know they have HIV because they haven't been tested. So the reasons that women might not be tested are different from men. Fortunately, pregnancy is a time when women are pretty much universally tested, are often picked up. But women who haven't been pregnant may not recognize that they've been at risk for HIV. The CDC is advocating for much more widespread testing for HIV so that we can find the people who are HIV positive and unaware of their diagnosis because they don't have any symptoms.

RH: You know I've heard a lot of anecdotal stories that women who ask for HIV tests from their doctors (who are not infectious disease specialists) will talk them out of it; including some older women—some of my mother's friends, who I asked to do me a favor and ask their doctors for HIV tests. And a lot of the doctors said, "Oh, you don't need one." Is that a common reality?

JC: Well I think that that was previously a common response; earlier in the epidemic, people really

tried to identify high-risk groups. But for women, that was harder to do. And now that's really changed-- the approach is much more generally recommending HIV testing to anybody who's sexually active. And that's become something that's really being recommended. How well it's being followed through on is another issue, and I think it's the kind of thing where people need to take responsibility for themselves and for their doctor. I would be concerned if a health care provider tried to talk somebody out of having an HIV test. I think now that would be much less common.

RH: That's an excellent point; women need to advocate for themselves, and know about this and make sure that they're tested. In terms of treatment, there's a study recently that was recently reported on that said that about forty-seven percent of women are not on recommended regimens, regimens that are recommended by federal guidelines. Why might that be true for women?

JC: There may be a number of reasons. One of the factors that's been found to associated with what kind of treatment people are on is where they're getting their care. So if women are more likely to be uninsured or getting care from providers who are less experienced with HIV, then that might contribute to them being on regimens that weren't considered the standard regimen of care. I think that that is improving over time. Another reason may be that, potentially due to intolerance of a regimen, they may stop; I'm not exactly sure what study you're talking about so I don't know the data specifically. But I think it may have more to do with, potentially, where they were getting treated, and the time frame, when the study was conducted.

RH: Right. We're hearing a little bit more these days about concerns for people aging with HIV; some having been on treatment a long time, and also some who have just lived with the virus for a long time. Are there special concerns for women who are aging with HIV?

JC: Well first of all, I think it's important to reflect on the fact that people are worrying about aging. Because we expect that people who get treated for HIV are going to live, hopefully, a normal life span. And they're going to have to face the challenges that everybody else faces as they age. But whether they're different in the setting of HIV has become a much more interesting topic, and there's a whole session devoted to that at the conference tomorrow. So we worry about whether there are differences in the onset of menopause in women with HIV; does it come earlier? Is it associated with more symptoms? It's clear that, for men and women with HIV, something about HIV infection increases their risk of developing diminished bone density or osteoporosis, osteopenia—which is already a more common problem among women. So I think trying to understand how that might differ, what are the appropriate things to do for treatment or prevention. Another big issue is cardiovascular disease, which appears to be increased in people with HIV. Is there a differential increase in women compared to men? Well to date, studies really haven't shown that. But I think that we still need to get more information to try to see. There's some suggestion that the excess risk could be different in women than it is in men. Whether that's due to differences in hormonal changes, we just don't know. But I think these things are reasons why people need to be in care longitudinally, and be in care where they're dealing with care beyond their HIV: getting their cholesterol and blood pressure checked, getting screened for diabetes if that's appropriate. So these are all long-term issues that we now focus on, as we're able to control HIV better.

RH: As a woman, I've lived with HIV for eleven years. And my doctor often jokes, he says, "LOok, in some ways, you're more aware of your health overall, because of your HIV. And because you're paying attention, have paid attention to things like your cholesterol levels and your blood sugar levels, you can almost hope to have a longer, healthier life down the road." I should point out, though, that a lot of people who are "aging with HIV" today have also had the disease for, some of them, twenty years, some of them contracted the disease at an older age. So there's so much we don't know about how this disease will manifest in people, and again, especially in women. There's a historical study going on right now, the GRACE Study, which has involved only women. I think it's the largest of its kind looking at the effects on certain treatments women with HIV. That's very unique, isn't it?

JC: The GRACE study, (Grace stands for "Gender, Race, and Antiretroviral Experience) is a study to evaluate the safety and tolerability or one of the newer drugs, a protease inhibitor. It's actually enrolling women and men, but what's unique about it is that it enrolled seventy percent women and thirty percent men—most of the time it's the other way around. And the study was developed to get more information about this new drug in women, so women could make decisions about using it and know what the side effect profiles were. Data should be coming out from that study in the next year. And I think it's also provided in many of the sites around the country that have participated; that the sponsors of the study went to sites where women were getting care, and put the study there, and put resources for enrollment and recruitment. And they found that if you do that, you can enroll women into studies; they want to be participants. So I really look forward to being able to talk about the results of that when they're available.

RH: So that's probably a precedent-setting study then, in what we've learned from taking the study to the women. I know that there are some unique challenges that women have in terms of childcare and accessing the centers where they're going to participate in the study. Do you think others will follow because of this study?

JC: Well I think that there have been ongoing efforts to involve more women in research, and they have met with varying levels of success. I think it's really important that, people sometimes say, "Well, we don't know anything about how treatment works in women," and I would actually argue that we do know a lot about it. And you don't hear as much about it when there's not difference. You only hear when there's clearly a difference in a type of a side effect. And it's really the women who also have some responsibility to advocate for themselves, to get involved in this if it's appropriate for them, in research into evaluating drugs, looking at other side effects. And that's how we'll learn what we need to know. So there is definitely a lot more interest worldwide; over fifty percent of HIV infections occur in women world wide. So we really need to know what the optimal treatments are that can be taken and tolerated for many, many years.

RH: So the news looks as good today for women as it does for men?

JC: I think it does. Absolutely.

RH: That's great. Well thank you so much for being with us.

JC: You're welcome.

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