



November/December
1996

EUROPEAN AIDS TREATMENT NEWS

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plus: ...News, News, News

Information for readers

This newsletter is produced in British English. For Medical terms we use Stephan Dressler's 'Dictionary of Clinical Medicine' as standard. Examples for spelling for pharmaceutical compounds: *Aspirin*=tradename=capital first letters; acetylsalicylic acid=generic name=small letters; ASS or rHGH=abbreviations and codes=as given

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Statement of purpose

European AIDS Treatment News is a bimonthly publication issued by the European AIDS Treatment Group e.V. (EATG). The EATG is a group of activists from 15 European countries and a growing number of associates who participate in treatment activism, community-based research and treatment training programmes. EATG is governed by an annually elected board of directors (see "Members of EATG" in this issue). The contents of this newsletter follow the guidelines set by the general assembly.

EATN reflects the growing complexity and diversity of information and information needs by providing news on:

- Activities of the EATG and other activist groups
- New compounds and clinical research results
- European countries, drug companies and AIDS service organisations
- Conferences (reports and announcements)
- European drug regulation

EATN invites you to copy all or part of it and distribute it to interested others. Translations are an important tool in communicating treatment information. If you translate any part of *EATN*, please send a copy to the EATG secretariat (address see "Members of EATG") as we may then make use of it through our network.

Impressum

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Editorial

Dear readers,

For the first time in the 5 years of publication, *EATN* had an official presence at an international meeting. The 3rd International Congress on Drug Therapy in HIV Infection (in Birmingham, UK) gave us a welcome opportunity to meet many of you. More people at this conference recalled reading an issue of *EATN* than I would have expected. Some came by, briefly scanned the journal's contents and asked to be put on the mailing list. The most interesting conversations arose when explaining to passers by what the European AIDS Treatment Group is and what treatment activism is aiming at. Overall, however, the biggest return was the encouragement given by several of *EATN*'s long-term subscribers.

Looking back at 1996, it has been an astonishing year. For more than 10 months protease inhibitors have made positive news. They have stirred more hope than anything in a long time; and it has been hard to find rational and reserved comments in all the hype and positive thinking. Astonishingly, too, very little could be heard or read about treatment progress for opportunistic infections. The discovery of CKR5 and fusin - major advances in the understanding of HIV pathogenesis - also raise new interest, providing yet another target for therapy.

Currently access to protease inhibitors is a hotly debated topic. This is particularly true for countries with a large HIV population. Marketing and approval decisions in such countries - Spain for example - easily add up to a billion dollar issue. Not that most healthcare systems are fundamentally unable to pay for the new compounds. There is rising concern as to whether the additional expense is going to result in rationing rather than rationalization. Are we going to gain protease inhibitors but lose psychosocial services or medically 'soft' treatments (e.g. chiropody, massage)? Just one of a host of questions relating to the strategic use of HIV therapy, at a time when the HIV population in Europe is increasingly feeling the sting of economic constraints and methodological deficits.

Matthias Wienold

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News from EATG

Meeting with Hoffmann-LaRoche

On 20 November 1996, the Board of Directors met with Hoffmann-LaRoche representatives at Düsseldorf, Germany. At the meeting, ongoing studies with Roche products were presented. New clinical trials with saquinavir (*Invirase*) include a French study with the enhanced oral formulation (EOF) of this protease inhibitor in combination with d4T and ddC and studies in combination with other protease inhibitors. As announced on 6 November in a press release, a study has been planned for Belgium, France, Germany, the Netherlands, Switzerland and the UK investigating the combination of saquinavir and the non-nucleoside reverse transcriptase inhibitor (NNRTI) nelfinavir (*Viracept*). The plan is to enrol 150 patients across four treatment arms:

- saquinavir + nucleoside analogues (25 patients)
- nelfinavir + nucleoside analogues (25 patients)
- saquinavir + nelfinavir without nucleoside analogues (50 patients)
- saquinavir + nelfinavir + nucleoside analogues (one of which is new to the patient; 50 patients)

The enhanced oral formulation of saquinavir is also likely to enter combination trials with indinavir (*Crixivan*), which reportedly raises plasma saquinavir levels by 5-fold. The Hoffmann-LaRoche team assured EATG representatives that there will be no difference in development times for EOF saquinavir between Europe and the USA.

Arjen Broekhuizen expressed concern that saquinavir had been unavailable to several patients in Italy over a period of more than 10 days. Apparently, this shortage was not due to production problems, but to distribution problems with the Roche's Italian affiliate, which have subsequently been resolved.

EATG also discussed with Roche ways of involving patient representatives as early as possible in the development and execution of clinical trials. One option is setting up community advisory boards which enable an

ongoing, stable working relationship between community representatives and pharmaceutical companies. Roche representatives promised to raise this issue within the company and examine ways of establishing this type of co-operation with what they consider to be a 'target audience'. EATG must provide them with the names of people who are willing to work at this level. Suggestions should be made to Stefan Mauss, who is the EATG director with particular responsibility for Roche in his portfolio, or executive Arjen Broekhuizen.

Meeting with Ares-Serono

Ares-Serono, the Swiss company producing recombinant human growth hormone (rhGH) for the treatment of wasting, has established a working group with European treatment activists. Ares-Serono is seeking to co-operate with treatment activists in order to proceed smoothly with registration of their rhGH - trade name *Serostim* - and to exchange market-based knowledge. A number of issues of common interest have been identified, including European licensing by the EMEA, identification of national market peculiarities (compassionate use, pre-marketing, etc.) and communication and training of physicians and people living with HIV. Access problems will also be discussed by the working group, including pricing of *Serostim*. The group will meet again in the first quarter of 1997, and in the meantime the company will continue to work with national and local groups of treatment activists and the HIV community, consulting EATG on European issues.

Substances

CAESAR study

Results from the CAESAR study were presented at the 3rd International Congress on Drug Therapy in HIV Infection (Birmingham, UK, 3-7 November 1996). CAESAR was a double-blind, multicentre study comparing the efficacy and safety of 3TC (lamivudine, *EpiV*) + 3TC + zidovudine *versus* placebo when added to existing ZDV-based therapy in HIV-1 infection. A total of 1,892 patients - who had baseline CD4 cell counts of 25-250 cells/mm³ and Karnofsky (activity) scores ≥ 70 - were randomized in the ratio 1:2:1 to add placebo, 3TC or 3TC plus zidovudine (an NNRTI) to their concurrent therapy of ZDV (zidovudine, ZDV, *Retrovir*), ZDV +

ddI (didanosine, *Videx*) or ZDV + ddC (zalcitabine, *Hivid*).

According to an abstract by Christine Katlama on behalf of the CAESAR Co-ordinating Committee, results from a pre-planned interim analysis of data up to 5 July 1996 showed a 54% reduction in disease progression in the 3TC-containing arms. Progression rates in the overall population were: placebo 81/482 (17%); 3TC 80/935 (9%); 3TC + loviride 38/475 (8%). Mortality was also significantly reduced in the 3TC arms compared to placebo: placebo 22/482 (4.6%); 3TC 22/935 (2.4%); 3TC + loviride 13/475 (2.7%).

Changes in CD4 cell counts and HIV-1 RNA levels in a subset of 332 patients were 'consistent with the clinical results.' Dr Katlama states that the addition of 3TC and loviride did not result in additional clinical or laboratory toxicities to those seen in the control arm. In conclusion, the addition of 3TC to concurrent ZDV-containing regimens significantly reduced progression to AIDS or death and increased survival significantly.

[Good to know that there is more evidence for superiority of new nucleoside combination therapies. However, these data come in at a time when triple combination including a protease inhibitor has almost become a standard. Reality is moving faster than science. And still nobody knows what 'increased survival' really means in terms of months and years. St D.]

Source:

Katlama C. Clinical and survival benefit of 3TC in combination therapy with zidovudine-containing regimens in HIV-1 infection: Interim results of the CAESAR study. Glaxo Wellcome satellite symposium at the 3rd International Congress on Drug Therapy in HIV Infection, Birmingham, UK, 3-7 November 1996

Clinical trials with saquinavir

Protease inhibitor combinations:

Saquinavir (SQV) + ritonavir (RIT, *Norvir*)

Seroconverters/early disease/CD4 > 500

Study ID:

NV15375; USA; Markowitz

Treatment arms:

SQV-HGC* + RIT + 3TC + ZDV

Patient population:

N=24; 12 seroconverters, 12 with chronic infection

Special investigations:

Immunology; lymph node biopsy

Status:

Ongoing

CD4 < 500

Study ID:

EV15373; North America; Cameron, Cohen

Treatment arms:

SQV-HGC + RIT at doses of 400/400 bid; 400/600 bid; 400/400 tid; 600/600 bid

Patient population:

N=120; CD4 100-500; PI-naive

Status:

Ongoing

Study ID:

M61001; Switzerland; Battegay

Treatment arms:

SQV-HGC + RIT + d4T

Patient population:

N=70; CD4 \leq 250; RNA \geq 25,000; PI- and d4T- naive; RTI-naive or stable therapy for at least 2m

Special investigations:

Mutations/resistance; NSI/SI variants; QoL

Status:

Placed (start Oct 96)

Failures or insufficient response

Study ID:

USA; Thompson

Treatment arms:

SQV-HGC + RIT at doses of 600/200 bid to 600/400 bid

Patient population:

N=20; CD4 100-500

Special investigations:

Virology

Status:

Ongoing

**Saquinavir + indinavir (IND,
Crixivan)**

Study ID:

EV15372; USA

Treatment arms:

IND + ZDV + 3TC

Patient population:

N=12 HGC treated patients from EV14757

Status:

Ongoing

Study ID:

Australia; Workman

Treatment arms:

SQV-HGC + IND + RTIs

Patient population:

N=50

Status:

Ongoing

Saquinavir + nucleosides:

*Seroconverters/acute infection/early
disease/CD4 > 500*

Study ID:

Australia; Workman

Treatment arms:

7.2 g SQV-HGC + 3 RTIs

Patient population:

N=6 seroconverters

Special investigations:

Lymph node biopsy - if negative may withdraw
treatment

Status:

Ongoing

Study ID:

Germany; Stellbrink

Treatment arms:

7.2 g SQV-HGC + ddC + ZDV

Initial treatment for 3 months completed. Stop
therapy. If viral load rises patient switched to
3.6 g SQV-SGC** + ddC + ZDV

Patient population:

N=10; CD4 > 500; early HIV infection

Special investigations:

Lymph node biopsy; ultrasensitive HIV PCR

Status:

Ongoing

CD4 < 500

Study ID:

NV15107 (dose ranging SQV); USA

Treatment arms:

600 mg HGC; 400 mg SGC; 800 mg SGC;

1200 mg SGC

After 8 weeks all patients receive 1200 mg +

RTI(s)

Patient population:

N=88; CD4 100-500; RNA \geq 20,000; \geq 25%

treatment-naive

Special investigations:

Pharmacokinetics

Status:

Ongoing

Study ID:

NV15182 (SQV safety); USA

Treatment arms:

1200 mg SQV-SGC + treatment of choice (at
least one new nucleoside)

Patient population:

N=441; CD4 \geq 0; \geq 75% PI-naive

Status:

Ongoing

Study ID:

NV15355 (SQV activity); USA

Treatment arms:

1200 mg SQV-SGC + at least one new
nucleoside; 600 mg SQV-HGC + at least one
new nucleoside

Patient population:

N=140; CD4 \geq 0; RNA stratification >20,000
and <20,000

Status:

Ongoing

**Resistance/drug sequencing
studies:**

Study ID:

ACTG 333; USA

Treatment arms:

SQV switch to:

- Background + SQV-HGC (8 weeks) then
indinavir

- Background + SQV-SGC

- Background + IND

Patient population:

N=144; \geq 1 y HGC 600 mg (patients from
ACTG 229 and NV14256)

Special investigations:

Resistance

Status:

Ongoing

Other studies:

Study ID:

Netherlands; Hoetelmans, Beijns

Treatment arms:

SQV (bioanalysis, pharmacokinetics)

Patient population:

N=10 SQV pre-treated patients

Special investigations:

12 plasma and 9 saliva samples per patient

Status:

Ongoing (start Q2/96)

*HGC = hard gel capsule - the licensed form of SQV

**SGC = soft gel capsule - the enhanced oral formulation (EOF) - better bioavailability and hopefully greater efficacy?

[We also asked MSD and Abbott for a similar overview of ongoing clinical trials, but it did not reach us in time for this issue. Maybe, it will reach us in time for another issue. Maybe not. St D.]

Ateviridine

Ateviridine (U87201E; produced by Pharmacia & Upjohn) is a compound of the novel class of non-nucleoside reverse transcriptase inhibitors (NNRTIs). In a study of 10 patients with AIDS dementia complex (ADC), 4 of 5 patients who completed the study responded to atevirdine. An improvement of ADC was seen, as judged by quantified neurological and neuropsychological assessment. Ateviridine was administered at a dose of 1800 mg daily in three divided doses over a 12-week period. Side effects of atevirdine include rash, anxiety, intermittent diarrhoea and fatigue.

Source:

Brew BJ, *et al.* Pilot study of the efficacy of atevirdine in the treatment of AIDS dementia complex. *AIDS* 1996; 10:1357-1360

Nevirapine in children

ACTG 165 was a Phase I clinical trial of nevirapine (*Viramune* - Boehringer-Ingelheim's NNRTI) in 21 HIV-1 infected children. The study was terminated in 1995 and results have now been published, providing details on the pharmacokinetics, antiretroviral activity and safety of nevirapine in children. At dose levels above 240 mg/m²/day, five of ten children experienced durable suppression of plasma p24 antigen to below 50% of baseline values after 8

weeks of monotherapy. Rash, which occurred in one study participant, was the only toxicity regarded as nevirapine-related.

Other studies have shown that viral resistance to nevirapine develops early in the course of monotherapy. In this trial, nevirapine-resistant viruses were isolated from all children during therapy, but the authors note that their isolation did not always predict loss of antiviral activity.

Source:

Luzuriaga K, *et al.* Pharmacokinetics, safety and activity of nevirapine in HIV type 1-infected children. *Journal of Infectious Disease* 1996; 174:713-721

Aztec

Aztec is a slow-release formulation of zidovudine, developed by Verex. In a telephone conference with EATG members, Dr A Hollister from Colorado University, principal investigator in six studies of *Aztec*, and Dr James Dunn and Mr Bannister from Verex, listed the advantages of *Aztec* as: maintenance of therapeutic blood levels of ZDV with a twice daily dose; and fewer drug-associated side effects and codon 215 mutations than *Retrovir*. Some of these data are in abstract We.B.3134 in the Vancouver ICA Abstract book. *[When I asked about publications in a peer-reviewed journal, I caused confusion. I gather that a paper has been submitted to either 'AIDS', or the 'Journal of AIDS and Human Retroviruses' - or possibly somewhere else. So much for the scientific side of our discussion. St D.]*

It is not clear whether *Aztec* really is superior to *Retrovir*, as Verex claims. Hugh McDade of Glaxo Wellcome said that *Aztec* would not provide any additional benefit to the 300 mg *Retrovir* tablet which is under development, and that there are no differences in side effect profiles of the two products. The clinical importance of the 215 codon mutation rate was questioned by Glaxo Wellcome. Glaxo Wellcome holds the patent for zidovudine, but will not use their patent rights to prevent Verex from continuing the development of *Aztec*.

ACTG 175

ACTG 175 was a double-blind study which evaluated treatment with either a single nucleoside or two nucleosides in HIV-infected adults with CD4 cell counts between 200 and 500. The trial showed that treatment with ZDV + ddI, ZDV + ddC, or ddI alone slows the progression of HIV disease and is superior to

ZDV monotherapy. Preliminary results were published in 1995 at both ICAAC and the European AIDS Conference in Copenhagen.

Plasma HIV RNA concentrations were determined in a subset of 366 study participants (of whom 175 had received previous antiretroviral therapy for more than 1 week). After 8 weeks, the mean decrease from baseline viral load was 0.26 log for patients receiving ZDV monotherapy, 0.65 for ddI monotherapy, 0.93 for ZDV + ddI and 0.89 for ZDV + ddC.

Sources:

Hammer SC, *et al.* A trial comparing nucleoside monotherapy with combination therapy in HIV-infected adults with CD4 cell counts from 200 to 500 per cubic millimeter. *New England Journal of Medicine* 1996; 335:1081-1090 (Oct 10)

Katzenstein DA, *et al.* The relation of virologic and immunologic markers to clinical outcomes after nucleoside therapy in HIV-infected adults with 200 to 500 CD4 cells per cubic millimeter. *New England Journal of Medicine* 1996; 335:1090-1098 (Oct 10)

New target for antiretroviral therapy?

Scientists from the National Cancer Institute in Bethesda, USA, report that they have found a gene mutation of HIV that seems to explain why some people at risk for infection do not get infected with HIV and also why others who are infected live for many years without progression to AIDS. HIV uses the chemokine receptor CKR5 of body cells for infection. Everybody inherits two copies of the gene which codes CKR5, one from each parent. Some people have mutations in the gene for CKR5.

In a group of 1,900 volunteers, people with two mutant copies of the gene for CKR5 were highly resistant to HIV infection. Those with one mutant copy progressed to AIDS more slowly than those without either mutation.

Sources:

O'Brien SJ, *et al.* Genetic restriction of HIV-1 infection and progression to AIDS by a deletion allele of the CKR5 structural gene *Science* 1996; 273(5283):1856-1862 (Sep 27)

New 'Journal of HIV Combination Therapy'

A new journal dedicated to antiretroviral combination therapy was launched in November 1996. The journal, currently published three times a year, is intended as a platform for the way forward in HIV therapy. Brian Gazzard (London), Anne Scoular (Glasgow) and Stefano Vella (Rome) are on the Editorial Board of the journal, which is published by Mediscript Limited (contact address: 1 Mountview Court, 310 Friern Barnet Lane, London N20 0LD, UK). The journal is supported by Glaxo Wellcome UK. *[A new edition of a journal which is also dedicated to antiretroviral combination therapy was launched in November 1996 at the Birmingham conference. EATN had a stand in the exhibition hall where conference delegates were encouraged to take up their free personal subscription. Some 400 delegates took advantage of this offer, bringing subscriptions to nearly 1,500 - so why should anyone create a new journal? St D.]*

Opportunistic Infections and other AIDS-Related Diseases

Cytomegalovirus (CMV) infection

CMV is still a major problem for HIV-infected persons who have experienced a marked decline in CD4 count to below 50-100 cells/mm³. A summary of an International Consensus Symposium on CMV has now been published. In this summary, intravenous ganciclovir or foscarnet are described as treatment options for newly diagnosed CMV retinitis. With regard to oral ganciclovir, the paper says that 'although clinical assessment of time-to-progression favoured intravenous ganciclovir, masked assessment of fundus photographs showed no statistically significant differences between intravenous and oral ganciclovir. Therefore, oral ganciclovir should be used only in patients who do not have sight-threatening retinitis for whom the risk of progression of retinitis is balanced by the benefit associated with avoiding daily intravenous infusions.' [*iv or oral ganciclovir / iv foscarnet - in any case this paper makes it clear, once again, that there are internationally recognized treatment options for CMV disease. Standard of care for CMV disease exists. In future trials, new anti-CMV drugs should only be tested in comparison to this standard of care and not against placebo! St D.*]

Source:

van der Meer JTM, *et al.* Summary of the International Consensus Symposium on Advances in the Diagnosis, Treatment and Prophylaxis of Cytomegalovirus Infection. *Antiviral Research* 1996; 32:119-140

Cidofovir warning

Cidofovir (HPMPC, *Vistide*) is a nucleotide analogue produced by Gilead Sciences. The drug was approved by the FDA in summer 1996 for the treatment of CMV retinitis.

Cidofovir should not be used at the same time as other drugs that are toxic to the kidneys or in patients with impaired kidney function. There have been cases in which the use of cidofovir was associated with severe kidney damage. To

prevent this from occurring, other kidney-toxic drugs should not be taken for at least a week before starting cidofovir. To protect the kidneys, probenecid must be taken according to a detailed schedule on the day of cidofovir infusion. In addition, intravenous hydration (infusion) must take place.

Source:

GMHC *Treatment Issues* October 1996 10(10):9

1263W94

New compounds from Glaxo Wellcome seem to come without a name. This is the case with the nucleoside analogue 1592, and it is (still) the case with this one, which is a potent inhibitor of CMV in laboratory studies. The compound has now entered Phase I trials to evaluate its safety and pharmacokinetics. In healthy volunteers 1263W94 was well tolerated. A frequently reported adverse event was a bitter or stale taste in the mouth. Further developments may be expected.

Source:

Biron K, *et al.* 1263W94 - a novel, potent, orally bioavailable compound for the treatment of CMV. Glaxo Wellcome satellite symposium at the 3rd International Congress on Drug Therapy in HIV Infection, Birmingham, UK, 3-7 November 1996

Regulatory Affairs

Since the last issue of *EATN* was published, several protease inhibitors have received approval by the EMEA - the London-based European agency for evaluation of medical substances. The protease inhibitors are: ritonavir (trade name *Norvir*, produced by Abbott Laboratories), saquinavir (trade name *Invirase*, produced by Hoffmann-LaRoche) and indinavir (trade name *Crixivan*, produced Merck/MSD).

Approval by the EMEA does not necessarily mean that all these new compounds will immediately be available in all EU-member states. National regulatory authorities still have to confirm the EMEA decision (which may take additional time) and reimbursement issues need to be clarified. [*Please, also see the article on page 118 - 'Use of Protease Inhibitors in Europe'. MW*]

Drug Companies

Invirase launch meeting

At the European launch meeting for *Invirase* (saquinavir), held at Montreux on 28 September 1996, we had the opportunity to speak with Dr Clive Spiegler, who is currently based at Hoffmann-LaRoche's facility in Nutley, New Jersey, USA. Dr Spiegler, who has a background in chemistry and pharmacology, is project manager of Hoffmann-LaRoche's International Project Team for *Invirase*. This team is comprised of individuals from Switzerland, UK and the USA and has managed the development of saquinavir from its discovery in Roche's laboratories in Welwyn Garden City, UK, through pre-clinical and clinical development, to global registration.

EATN: *Saquinavir is associated with a problem of low bioavailability. A possible solution to the problem could be the enhanced oral formulation of saquinavir. When will this formulation enter clinical trials in Europe?*

Dr Spiegler: It is anticipated that trials with the enhanced oral formulation will begin in Europe before the end of 1996. The first trial is likely to be a proof-of-concept study, looking at the combination of the enhanced oral formulation of saquinavir with nelfinavir. The study will begin as soon as the results from the pharmacokinetic interaction study with the two drugs (enhanced oral formulation of saquinavir and nelfinavir) are available.

EATN: *Hoffmann-LaRoche is an international pharmaceutical company with global activities. Will Hoffmann-LaRoche Europe be the leader of future clinical development of saquinavir in Europe?*

Dr Spiegler: The *Invirase* Project Team has a global development strategy and registration programme which includes studies in Europe. In addition to that, there will be smaller studies on a country level. These studies are designed and implemented locally by the national Hoffmann-LaRoche affiliate.

EATN: *Which combination therapies with saquinavir will be explored in the near future?*

Dr Spiegler: We feel that protease inhibitor combinations (PI-PI combinations) with saquinavir have a strong potential, based on the preliminary results of the ongoing saquinavir/ritonavir combination study. The *Invirase* Project Team is pursuing combination therapy studies with ritonavir and nelfinavir. In addition,

pharmacokinetic studies are either planned or ongoing with indinavir or the Vertex/Glaxo Wellcome protease inhibitor, 141W (VX-478).

EATN: *Will Hoffmann-LaRoche look into the combination of antiretroviral therapies with immunomodulatory therapies?*

Dr Spiegler: The possibility of looking into these options is currently under discussion.

[We can talk frankly about our defects only to those who recognize our qualities. Andre Maurois]

Crixivan European symposium

On 4-5 October 1996, MSD (Merck) invited about 550 physicians, researchers and journalists to a symposium in Geneva, Switzerland, to mark the occasion of the European launch of *Invirase*, their protease inhibitor. Scientific presentations included, once again, the well-known slide which indicated the benefits of indinavir over 44, 48 and (now) possibly even 52 or more weeks. Clinical endpoint data were not shown (and were not shown 6 weeks later at Birmingham either, a fact that raised some criticism among the Birmingham audience since Merck has gained approval for *Crixivan* based on these data).

On 4 October 1996, media representatives were informed that the European wholesale price for *Crixivan* in EU-member states will be 9.64 ECU a day (roughly equivalent to the US price in June 1996, when the positive opinion of the CPMP came through in Europe). Major publications with outstanding economic expertise such as *Wall Street Journal* and *Financial Times* covered the pricing issue, and pointed to the fact that this unitarian wholesale price will lead to major differences in the price which has to be paid by the individual consumers in different European countries. The price differences are due to different taxes and pharmacy shares in different countries. Thus, *Crixivan* will cost the equivalent of UK £7,000 a year in Spain, while the final price in Britain will be around £4,000. *[MSD does not seem to have understood the consequences resulting from these differing retail prices. Some economies will be unwilling or unable to pay for all the drugs that are needed unless companies come to terms with pricing issues. Economically, it is also questionable whether a drug needs to be priced similarly across differing markets. MW]*

The pricing in ECU (the EU's future currency) must be understood as an attempt by MSD to prevent cheaper re-imports from Southern Europe to Central Europe - an issue that has prompted concern in all international drug companies. *[If other companies follow this example in the future, they will be following a bad example. St D.]*

In Europe, MSD has no programme for reimbursement, compassionate use or expanded access. At the MSD press conference, when I asked about reimbursement programmes for countries where *Crixivan* is not immediately available, Dr Jeffrey Sturchio from MSD told me in reply that the company had given the drug away for free in clinical trials. *[What an answer! The Helsinki declaration on bioethics obliges sponsors of a trial to provide the drug for free! St D.]*

MSD seems to regard the post-approval access problem as a problem exclusively for governments and governmental agencies to handle. This opinion was even backed by Dr Joep Lange, who said, 'We must not always point at the companies,' thus indicating that it is the governments' turn.

[Most pharmaceutical companies have provided - at least limited - reimbursement programmes or expanded access programmes, which continued over a certain period of time even after approval of a new compound. These programmes are essential for people with HIV who are living in countries where local authorities need weeks, if not months, to straighten up reimbursement issues with health insurance providers and other parties. MSD and Joep Lange are right when they say that this problem should be solved on the governmental side - but: as long as it has not been solved, people with AIDS depend on the help of pharmaceutical companies, at least for an interim period of time. MSD did not help in Spain, Italy or Belgium, but they lowered the price of Crixivan in Germany. Thanks! St D.]

MSD drugs for free - but not against HIV

The US drug company Merck has established a donation programme for *Mectizan*, a drug against the tropical disease onchocercosis (river blindness). Recently, Glaxo Wellcome announced it will also give away free supplies of its new malaria medicine, *Malarone*, to developing countries. The treatment regimen for *Malarone* involves taking four tablets for 3 days.

Such simple dosing should make it feasible to run a large donation programme.

Source:

Green D. Glaxo may give malaria drug to developing world. *Financial Times* 20 November 1996, p16

Countries

France

Sidaction 96, a fundraising campaign which took place in France in April this year, has raised FF64 million (approximately US \$14.2 million). The majority of donations was collected in Ile-de-France and Paris and in the Southern Province of Provence-Alpes and Cote d'Azur. In 1994, Sidaction attracted donations of FF300 million. The significant drop in donations was discussed extensively by representatives from Ensemble contre le SIDA, who admit that management mistakes may have partially contributed to the decrease. In addition, the changing public image of HIV infection which is now (wrongly) perceived as a manageable disease may have caused a drop in public awareness of Sidaction.

Source:

Follea L. Ensemble contre le sida révèle l'ampleur de l'échec du Sidaction 96. *Le Monde* 20 November 1996, p9

Germany

Post-exposure prophylaxis against HIV infection after accidental needlestick injury has been discussed by a working group at the Robert Koch-Institute, the German federal agency for infectious diseases. Results from this discussion have now been published. From this discussion, it is apparent that post-exposure prophylaxis with ZDV in some cases was successfully used in the past in preventing HIV infection.

Three pharmaceutical compounds are currently recommended for prophylaxis: ZDV (*Retrovir*), 3TC (*EpiVir*, lamivudine) and indinavir (*Crixivan*). After cleaning and disinfection of the wound with water and detergent, post-exposure prophylaxis should be considered in all cases with high risk of HIV infection (e.g. needlestick injury with a needle that was previously used in an infected patient). The drugs should be administered as early as possible for a period of 4 weeks.

Source:

Überlegungen zur medikamentösen
Postexposition prophylaxe nach beruflicher HIV-
Exposition. *Epidemiologisches Bulletin* 43/96:293-295

The Netherlands

NATEC, the Dutch agency for the evaluation of medicines against HIV and AIDS which is directed by Joep Lange, is planning a combination trial in 402 treatment-naive patients with CD4 cells below 500 and HIV RNA levels above 10,000 copies/ml or HIV-associated symptoms. The combinations to be tested include saquinavir + ZDV + 3TC versus ritonavir + ZDV + 3TC versus indinavir + ZDV + 3TC versus saquinavir + d4T + ddI versus ritonavir + d4T + ddI versus indinavir + d4T + ddI. *[This clinical trial is either a result of all the satellite symposia featuring Joep Lange, or it will result in more such satellites... St D.]*

Romania

The Romanian parliament has voted with an overwhelming majority for new legal restrictions against homosexual men and women. With 165 against 20 votes (and 11 abstentions), the parliament has passed a law which permits up to 5 years imprisonment of homosexuals who offend so-called good taste. *[The recently elected president, Constantinescu, is aiming at full EU membership for Romania as soon as possible. Case for harmonization of laws on homosexuality: All laws concerning sexual discrimination should be abolished! Prior to entry in the EU and within the EU... St D.]*

Source:

Totok W. Rumäniens Homos droht der Knast. *Die tageszeitung* 12 September 1996: p8

Switzerland

The Swiss AIDS Treatment Group (SATG) published the first edition of *Swiss Aids Treatment News* in September 1996. The launch issue of this new newsletter deals with Vancouver results and recent developments in antiretroviral therapies. *Swiss Aids Treatment News* is published bi-monthly and is available through SATG, c/o Aids-Hilfe Schweiz, Konradstrasse 20, CH 8005, Zürich. Tel: +41 1 273 4242; Fax: +41 1 273 4262.

Source:

AIDS INFOTHEK 1996 8(5)

Use of Protease Inhibitors in Europe

by Matthias Wienold

Major developments in the complexity of drug therapy for HIV infection have given rise to concerns regarding inequalities in access to novel compounds across and within European countries. A workshop at the 6th AIDS & Medication conference in Helsinki, 6-9 September 1996, recommended that an overview of currently available antiretroviral therapies be developed. The following report on the situation in individual countries is based on information submitted by EATG members across 16 European countries. In general the information relates to the situation in late September 1996. Figures given for average survival time after AIDS diagnosis are generally based on data before the introduction of protease inhibitors.

Austria

While the official estimate for cumulative HIV incidence in Austria is 6,000 cases, unofficially it is estimated that some 12-15,000 people with HIV (PHIV) are living in Austria. A total of 1,608 AIDS cases were reported by the end of August 1996, the number of AIDS-related deaths is given as 1,079. The average survival time for people living with an AIDS diagnosis (PWA) is estimated to be 2-3 years. Criticism of the official figures is mainly directed at an underestimation of the recent resurgence of infections amongst the gay and bisexual male population.

The use of protease inhibitors (PI) in Austria is reported to be minimal. Currently some 200 individuals are being treated with a combination therapy that includes a PI. Of these, about 100 PHIV are on indinavir (IND), 50 are on saquinavir (SQV) and 50 are on ritonavir (RIT). While all these individuals are currently accessing the compounds through clinical trials, future cost recovery for patients under insurance coverage is currently a matter under discussion in the insurance system. A price range between US \$8-10,000 is reported for IND. There is no common standard regimen for combination therapy. Major concern has arisen in terms of foreseeable compliance problems with triple combinations.

Belgium

The official estimate for cumulative HIV incidence in Belgium is 17,000 cases, with 10,132 confirmed cases of a positive HIV antibody test result. A total of 2,101 AIDS cases were reported by end of August 1996, and the number of AIDS-related deaths is given as 1,090. The average survival time for PWA is estimated to be 2-2.5 years.

The use of PIs in Belgium is reported to be limited. Currently some 450 individuals are being treated with a combination therapy that includes a PI. Some 220 PHIV are on IND, with roughly 120 on SQV and RIT, respectively. Availability of PIs is limited to trial participants and PWA with < 50 CD4 cells/mm³. The latter have access to RIT and IND through a government-sponsored programme. A price range between US \$4,700-6,700 is reported for RIT and SQV. At the time of report, Merck was not willing to supply the relevant information to EATG members. The current standard for combination therapy is two reverse transcriptase inhibitors (RTIs). The population is currently treated with: ZDV - 1,400 cases; 3TC - 700; ddI - 600; and d4T - 150. Hoffmann-LaRoche refused to provide data on the use of ddC and oral ganciclovir. Cidofovir is not available in Belgium.

Denmark

The official estimate for cumulative HIV incidence in Denmark is 5-7,000 cases. A total of 1,914 AIDS cases were reported by the end of August 1996; the number of AIDS-related deaths is given as 1,526. The average survival time for PWA is estimated to be 15-18 months.

A triple combination therapy including a PI is standard therapy for PWA with < 100 CD4/mm³. Dual combination is standard for PWA with < 200 CD4/mm³. Access is granted for free through government funding. A price range between US \$4,000-6,700 is reported for PIs.

Estonia

While the official estimate for cumulative HIV incidence in Estonia 62 cases (52 living in Estonia), unofficially it is estimated that some 2-300 people with HIV (PHIV) are living in Estonia. A total of 9 AIDS cases were reported by end of August 1996; the number of AIDS-related deaths is given as 5. The average survival time for PWA is estimated to be 9 months.

Monotherapy with ZDV and TMP/SMX for PCP are the only treatments available free of charge to PHIV in Estonia through government funding. 10 PHIV receive ZDV monotherapy and 2 receive ddI. Two patients are on the dual combination of ZDV + ddI. If PIs were priced at US \$50 per year, an estimated 15-20 additional PHIV would be eligible for triple combination therapy.

Finland

The official figure for cumulative HIV incidence in Finland is 774 cases, while the estimate is 950-1,000. A total of 250 AIDS cases were reported by the end of August 1996; the number of AIDS-related deaths is given as 191. Average survival time after AIDS diagnosis is three years.

Combination therapy is recommended and available through a government-sponsored programme for PHIV with a viral load $> 10^3$ -30,000. The decision between dual or triple combination depends on CD4 count and physical status as additional indicators. Access also depends on availability of funds at local hospitals, as budgets are regionalized. The number of individuals reported to be on antiretroviral therapy are: ZDV - 120; ddC - 80; ddI - 60; d4T - 30; 3TC - 50. At the time of this report (end of November 1996), 80 PHIV were being treated with SQV, 20 with IND and 15 with RIT. Prices for PIs range from US \$13,300-17,000. Oral ganciclovir is being made available to five patients. Cidofovir is expected to become available in January 1997.

France

Cumulative HIV incidence in France is estimated to be 150-200,000 cases. A total of 44,015 AIDS cases were reported by end of June 1996; the number of AIDS-related deaths is given as 26,339. The median survival time for PWA was 2 years (before the introduction of PIs).

PIs in France have been available free of charge to PHIV through a government-funded programme since spring 1996. Currently some 17,400 individuals are being treated with a combination therapy that includes a PI. Some 10,000 PHIV are on IND, 3,200 on SQV and 4,200 on RIT (November 1996). Recently the increase of patients treated with SQV and RIT has come to a halt, while IND prescriptions are still rising. The current situation regarding treated PHIV and PWA, as described by official figures (June 1996), is 15% on monotherapy,

67% on dual combination and 18% on triple combination. Cidofovir is currently used by about 150 patients in France.

Germany

15,308 cases of AIDS diagnosis and 9,961 AIDS-related deaths were reported in Germany (as at 30 September 1996). Estimates from official sources put the real figures at 18,000 AIDS cases and 13,000 deaths. Official estimates for cumulative HIV incidence are at 50-60,000. The median survival time after an AIDS diagnosis was 14 months; the mean survival time was at 18.7 months (1995).

Access to PIs has been possible free of charge to PHIV, since approval in the USA, through insurance companies. There is only a nominal co-payment for prescriptions. While no data are available for the use of IND, more than 2,000 PHIV currently receive therapy with SQV and RIT (more than 1,000 each). The price for PI varies from US \$5,600-11,200. Dual or triple combination therapy is the current standard of care.

Hungary

While the official estimate for cumulative HIV incidence in Hungary is 3,500-4,000 cases, there are only 600 confirmed cases of positive HIV-antibody test results. A total of 225 AIDS cases were reported by end of June 1996; the number of AIDS-related deaths is given as 140. The average survival time for PWA is 19.2 months.

The use of PIs in Hungary is reported to be limited to drug supplied through clinical trials - 20 individuals are on SQV and 15 on RIT. IND was not available at the time of evaluation. Drug-related costs are covered by health insurance. Currently some 40 individuals are being treated with a combination therapy that includes a PI. As NASBA viral load measurement has only just become available, treatments can only now be measured in terms of effects on viral replication. The population is currently treated with: ZDV - 150 cases; 3TC - 15; ddI - 60; and ddC - 75. Delavirdine is applied to 20 patients (in triple combination). Three individuals receive oral ganciclovir.

Italy

The official estimate for cumulative HIV incidence in Italy is 150,000 cases. An estimate by the EATG member submitting this report puts the figure at 200,000. A total of 37,000

AIDS cases were reported by end of June 1996; the number of AIDS-related deaths is given as 23,052. The average survival for people living with an AIDS diagnosis (PWA) is 15 months.

Monotherapy is still widely used, while dual combination with two RTIs or RTI + PI seem to be on the rise. Triple combination is only available to a very limited number of patients. At the time of reporting 1,900 individuals were receiving a PI as part of their treatment regimen. This number is judged to be completely insufficient. PIs are only available to PWA with $< 50 \text{ CD4/mm}^3$ through government sponsored programmes. Prices at time of reporting were US \$6,000 for RIT and IND. SQV was only available through expanded access.

Latvia

While the official cumulative HIV incidence in Latvia is 55 cases, the estimate is at about 200. A total of 16 AIDS cases were reported by October 1996; the number of AIDS-related deaths is given as 4. The median survival time for PWA is 16 months.

SQV is provided to all who require the treatment through government funding. Currently three patients are in this category and the cost is US \$5,500 per year. Other therapies available include: ZDV - 6 cases; ddC - 5; 3TC - 3; oral ganciclovir - 4.

Luxembourg

In May Luxembourg reported 108 AIDS cases. Since 1981, 60 AIDS-related deaths have occurred. The official estimate for the number of HIV infections is at 240; a local EATG member estimates it at 340.

All three PIs are accessible through social security-funded programmes and triple combination has been the standard of care since May 1996. RIT is most commonly used; IND is increasingly prescribed and little use is made of SQV. Overall some 100 individuals receive triple combination. IND and RIT are reported to cost US \$6,500 and SQV costs 'a little less'. The breakdown of RTI use is: ZDV - 95 cases; ddC - 40; ddI - 30; 3TC - 30 (and rising); d4T - 5. Oral ganciclovir is available to two patients through clinical trials and will be available for general use in December 1996. Cidofovir is not available.

The Netherlands

As of January 1996 3,840 PWA have been registered in the Netherlands in total. The official estimate of a cumulative incidence of 8,000 PHIV is considered to be too low by the EATG member reporting.

The standard recommendation for therapy with antiretroviral compounds is triple combination for PHIV and PWA with $< 500 \text{ CD4/mm}^3$ or viral load $> 10,000$ copies. Treatments are available free of charge to patients: government funding provides for 3TC, and the PIs, ZDV, ddI, ddC and d4T are paid for by insurance companies. The figures for PI use are RIT - 600; SQV - 500; IND - 100-150. Other compounds are used with the following frequency: ZDV - 1,200-1,500; 3TC - 8-900; ddC - 400; d4T - 3-350; ddI - 175-300. Some 100 PWA currently receive oral ganciclovir. Cidofovir is not available.

Norway

Norway has 534 reported AIDS cases and 442 AIDS-related deaths. The official cumulative incidence of PHIV is 1,625.

Treatments are available free of charge provided by the government. The standard treatment recommendation is triple combination.

Portugal

A total of 3,337 AIDS cases had been reported by the end of June 1996 in Portugal. There were 2,062 known AIDS-related deaths. The number of PHIV is estimated to be above 30,000. Average survival time for PWA is 2 years.

Drugs are difficult to get even after registration. The major problem rests with hospital administrators who require each individual case to be justified - and this process is slow. So, even though protease inhibitors are available free to PHIV (either through compassionate use, or company or government sponsorship), the numbers are low. A total of 110 patients are taking protease inhibitors (SQV - 40; IND - 40; RIT - 30). 1800 mg of SQV per day gives an annual cost of US \$5,760. 800 mg IND per day costs US \$4,380 per year. The standard treatment recommendation is ZDV + ddC or ZDV + ddI. While Glaxo Wellcome estimates that some 2,000 individuals are receiving ZDV, only 44 were receiving 3TC (as at August 1996). d4T will only become available in January 1997. Oral ganciclovir is not available.

Spain

Cumulative HIV incidence in Spain is officially estimated to be 125,000 cases. As reported earlier, this figure is considered to be an underestimate. EATG members estimate the total HIV+ figure at 400,000. A total of 45,000 AIDS cases were reported by the end of June 1996; the number of AIDS-related deaths is given as 22,500.

The government covers the cost of therapy for 1,000 individuals on SQV and 200 individuals on RIT. 660 participants also gain access to PIs through clinical trials. The current standard treatment recommendation is either monotherapy with ZDV or dual combination with ZDV + ddI or ZDV + ddC. 1900 PHIV receive 3TC through clinical trials and on a named patient basis. d4T is only accessible to a small number of individuals in clinical trials.

Switzerland

5,316 AIDS diagnoses and 3,886 AIDS-related deaths were reported in Switzerland. Official figures for cumulative HIV incidence are at 21,925 with an estimate of some 25,000 cases. Median survival time after AIDS diagnosis was 3.2 years.

The standard recommendation for therapy with antiretroviral compounds is dual (ZDV + 3TC or ZDV + ddI or ZDV + ddC) and triple combination (ZDV + 3TC + IND or ZDV + ddI + RIT). Monotherapy has become obsolete. Individuals pay 10% of costs, the remaining 90% being covered by the federal office of social insurance. The figures for PI use are RIT - 4-700; SAQ - 500; IND - 500. Costs are US \$6,307 for RIT and SQV, and US \$6,000 for IND. Other compounds are used with the following frequency: ZDV - 1,800; 3TC - 1,300; ddC - 165. Bristol-Myers Squibb Switzerland did not give exact figures. Some 65 PWA currently receive oral ganciclovir. Cidofovir is not available.

Summary

Country	Cumulative HIV incidence	Total number using PIs
A	6-10,000	200
B	17,000	450
DK	5-7,000	?
EE	2-300	nil
SF	950-1,000	115
F	150-200,000	17,400
D	50-60,000	>2,000
H	3,500-4,000	35
I	150-200,000	1,900
LV	200	3
LUX	250-350	100
NL	>8,000	1,250
N	1,700	?
PT	>30,000	110
E	125-400,000	1,860
CH	25,000	1,700

Access to PIs varies widely across the 16 European countries included in this report. These variations cannot be accounted for by just one of the variables suggested. They reflect difficulties and peculiarities at different levels of each individual country's health system. Figures for PI use as a percentage of the estimated HIV population are, however, lowest in countries with financial restrictions on access (e.g. Estonia, Italy and Spain). Lack of a common standard recommendation of including a PI in triple combination regimens may account for differences in countries where the drugs are widely available (e.g. Germany as compared to Switzerland). Standardized care seems to have the largest impact in countries with a low incidence (e.g. Luxembourg, the Netherlands). Bureaucratic thresholds account for the situation in Portugal. In France, PI use seems to have stabilized at about 10% of the HIV population. Prices for PIs vary from US \$4,000 (Denmark) to US \$13,000 (Finland) for one year's treatment. The variation in prices within countries is much more limited.

Access to RTIs also seems to vary widely. Figures are incomplete but are generally not disproportionately exceeding the use of PIs where both classes of compounds are available. This points to a (historical?) reluctance to initiate therapy. This issue requires more research to evaluate the variables influencing drug use in

general. d4T is the only RTI not widely used due to restrictions in availability.

Access to oral ganciclovir and cidofovir is still limited by regulatory and market availability problems.

Survival for PWA after diagnosis varies from 9 months in Estonia to 3 years in Finland. As these data are widely based on deaths occurring before the availability of PIs, no effect of PIs on survival can be demonstrated. Figures indicating any drug-related survival benefit are expected to be available in the first quarter of 1997 (for Germany, where PIs have been used since mid-1995).

Conference Announcements

● = new entry

● **4th Conference on Retroviruses and Opportunistic Infections**
Washington DC, USA. 22-26 January 1997.

Information:

Jennifer Manise, IDSA
11 Canal Center Plaza, Suite 104
Alexandria, VA 22134, USA
Tel.: +1 703 299 0200
Fax: +1 703 299 0204

● **Community Programs for Clinical Research on AIDS (CPCRA)**
Washington DC, USA. 6-7 February 1997.

Information:

Elaine Allison, CPCRA Operations Office
Tel.: +1 301 230 9670
Fax: +1 301 230 7190
e-mail: eallison@cpcra.niaid.nih.gov

IX Symposium de Sidénologie: "De la virologie... .. la thérapeutique"
Toulon, France. 7-8 March 1997.

Information:

Albine Conseil
5 boulevard de Courbevoie, bât. B, Ile de la Jatte
92523 Neuilly-sur-Seine Cedex
France
Tel: +33 47 47 57 37
Fax: +33 46 40 70 36

International Conference on HIV and Iron

Brugge, Belgium. 14-15 March 1997.

Information:

Dr Johan R. Boelaert
Algemeen Ziekenhuis St.-Jan
Ruddershove 10
B 8000 Brugge
Belgium
Fax: +32 50 45 22 99

Topics will include: iron, oxidative stress and HIV transcription; nitric oxide and HIV; iron, cell-mediated immunity and HIV; iron deprivation against AIDS opportunists; etc.

Kuwait Fifth International Conference on AIDS

Hawalli, Kuwait. 17-19 March 1997.

Information:

Organizing Committee
P.O. Box 7886
Code 32099 Hawalli
Kuwait
Tel: +965 5339519
Fax: +965 5339518

Covers epidemiology; pathogenesis; immunology & development of vaccines; clinical management & therapy of AIDS; ethical issues; and public sessions in Arabic.

IV Congreso Nacional Sobre El SIDA Valencia, Spain. 1-3 April 1997.

Information:

SEISIDA
Apartado de Correos 42.137
E 28080 Madrid
Spain
Tel: +34 91 314 24 61
Fax: +34 91 314 35 96

Spanish-language national conference on AIDS.

● **3rd Annual Meeting of the British HIV Association**

Warwick, UK. 12-13 April 1997.

Information:

BHIVA Organizing Secretariat
Mediscript Limited
1 Mountview Court
310 Friern Barnet Lane
London N20 0LD, UK
Tel.: +44 181 446 8898
Fax: +44 181 446 9194

2nd International Conference on Nutrition and HIV Infection

Cannes, France. 23-25 April 1997.

Information:

Agence LSO International
23 Bd. Général Vautrin
F 06400 Cannes
France
Tel: +33 93 94 16 00
Fax: +33 93 43 40 02

State-of-the-art presentations on epidemiology of malnutrition in HIV disease, endocrinology, metabolic aspects, alimentary behaviour, psychological determinants of alimentation, etc. Educational programmes on nutritional evaluation, enteral support, oral supplementation, home-based nutritional support. Workshop on paediatric aspects. Abstract deadline 9 December 1996.

● **Congress of Molecular Medicine Berlin, Germany. 3-5 May 1997.**

Information:

Springer-Verlag Congress Office
Heidelberger Platz 3
D 14197 Berlin, FR Germany
Tel.: +49 30 82787 206
Fax: +49 30 82787 465
e-mail: grossman@springerkongress.de

Sessions include a section on molecular basis of infectious diseases, for which David Ho from the recently renovated and extended Aaron Diamond Center is an invited speaker, and on immunological disease. Basic Science.

● **3rd International Conference on Home and Community Care for Persons Living with HIV**

Amsterdam, The Netherlands. 21-24 May 1997.

Information:

Ms Mariska Timmers
Bureau PAOG
Tafelbergweg 25

NL 1105 BC Amsterdam
Tel.: +31 20 566 4801
Fax: +31 20 696 3228
e-mail: F.Wolters@inter.nl.net

8th European Congress of Clinical Microbiology and Infectious Diseases Lausanne, Switzerland. 25-28 May 1997.

Information:

Administrative Secretariat
c/o AKM Congress Service
Clarastrasse 57
CH-4005 Basel
Switzerland
Tel: +41 61 691 51 11
Fax: +41 61 691 81 89

AIDS Impact: Biopsychosocial aspects of HIV infection - 3rd International Conference

Melbourne, Australia. 22-25 June 1997.

Information:

Conference Secretariat AIDS Impact
The Meeting Planners
108 Church Street
Hawthorn Victoria
Australia 3122
Tel: +61 3 9819 3700
Fax: +61 3 9819 5978
E-mail: meeting@iaccess.com.au

Conference topics include: culture, community, care; developing and sustaining prevention; HIV/AIDS and mental health; social and ethical dimensions of drug and vaccine trials; euthanasia; the internationalization of AIDS responses; discourses in the clinic; politics and HIV; and others. Deadline for abstracts 17 January 1997.

● **The Footman James Retrofestival Birmingham, UK. 9-10 August 1997.**

Information:

Mike Kennington
Tel.: +44 121 767 3536
Fax: +44 121 767 3535

The event for veteran vintage and historic enthusiasts.

6th European Conference on Clinical Aspects and Treatment of HIV Infection Hamburg, Germany. 11-15 October 1997.

Information:

Prof Dr M Dietrich
Bernhard-Nocht-Institut for Tropical Medicine
Bernhard-Nocht-Str. 74
D-20359 Hamburg
Germany

Tel: +49 40 311 82 390
Fax: +49 40 311 82 394

Organized by the European AIDS Clinical Society (EACS). A programme similar to the Copenhagen conference in September 1995 can be expected, including basic research on new therapeutic approaches as well as presentation of results of new clinical trials. A medically dominated conference. The EACS was formed in 1988 and is a forum for clinical investigators who are 'interested in the management of HIV-infected persons'.

12th World AIDS Conference (International Conference on AIDS) Geneva, Switzerland. 28 June-3 July 1998.

Information:

12th World AIDS Conference Geneva
c/o Congrex (Sweden) AB
Box 5619
S-114 86 Stockholm
Sweden
Tel: +46 8 612 69 00
Fax: +46 8 612 62 92
E-mail: aids98@congrex.se
Internet: <http://www.aids98.ch>

Just another international conference...

● **4th International Congress on Drug Therapy in HIV Infection Glasgow, UK. 8-12 November 1998.**

Information:

Gardiner-Caldwell Communications Ltd
The Old Ribbon Mill
Pitt Street, Macclesfield
Cheshire SK11 7PT
UK
Tel: +44 1625 61 53 25/6
Fax: +44 1625 61 65 63

A programme similar to the Birmingham conference in November 1996 can be expected, with a major focus on antiretroviral therapies. Medical conference mostly dominated by pharmaceutical companies - a huge satellite with many smaller satellites.

Miscellaneous

George was in an indinavir monotherapy trial and initially had great success reversing a sudden crash in CD4 count (it went from 250 to 70 and eventually to over 600). His viral load became undetectable (under 200 copies/ml) and stayed that way for 18 months. Now, even though he has also been taking d4T/3TC for nearly a year, HIV is again at 20,000.

Darryl, conversely, had been stable on d4T/3TC when he added indinavir. His viral load went from 50,000 to below 1,000 for 6 months, while his CD4 count leapt from 250 to 450. Then, suddenly, his viral load went up to 180,000, close to the figure in the days before d4T/3TC.

Michael was diagnosed with AIDS in 1989 but had been a long-term ZDV success story. In the last few years, though, he has not done so well. He has had PCP, two cases of MAC and finally cryptococcal meningitis. Michael switched nucleoside analogues several times along the way with at most marginal improvement. Last winter he tried adding saquinavir - it provided no evident benefit and caused frequent vomiting. He went on indinavir more recently, but too late to do much good given how ravaged his body had become. Michael died in August of bacterial pneumonia.

'I'm seeing treatment failures most commonly in patients with very high baseline viral loads - over 100,000 - and low CD4 counts. Those with low viral load and high CD4 counts in general are not crashing or failing,' said Gabriel Torres MD, Treatment Issues' medical consultant, reporting on what he has encountered so far with the new antiviral combinations.

Source:

Gilden D. When HAART is not enough. *GMHC Treatment Issues* October 1996; 10(10):1

'In less than a decade, AIDS has evolved from a fulminant, rapidly fatal illness into a chronic, albeit incurable, disease.'

Source:

Selwyn PA. HIV therapy in the real world. *AIDS* 1996; 10(13):1591-1593

Members of EATG

The European AIDS Treatment Group is keen to have input from you and welcomes any information you want to share.

You are invited to get in touch with the secretariat or any individual member. The secretariat will also supply you with information, leaflets and other publications of the European AIDS Treatment Group.

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D-10967 Berlin

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The list of addresses of EATG is currently being revised. If you want to reach a member in your country, please contact the secretariat.