



WOMEN & FAMILIES NETWORK

Welcome to the second issue of the Women and Families Network Newsletter.

The Network has really gotten off the ground in the past few months. We've got a new logo, organized a health retreat for over 50-positive women, started a web site and a listserve. To get more background information on the history of the Network, or if you are interested in signing up for the email-listserve, or coming to our next meeting check out our web site: <http://www.wfnetwork.org>.

You may have heard about the HIV Women's Health Retreat which took place on February 22-23rd, 2003. This conference was developed in response to a recent study on quality of care for HIV-positive Minnesotans. This study found that women's gynecological screening is either not documented well or is not being done according to clinical care guidelines. The main focus of the two-day retreat was gynecological issues for women with HIV, and learning how to talk with our providers, and each other, about these important issues. Although more than 80 women were interested in attending, space allowed only 50 to participate this year. Because of the level of interest, we hope to turn this into an annual retreat. We've also decided to focus this issue of the newsletter on gynecological care for women with HIV to make sure that many more women, beyond the 50 able to attend the retreat, get this important information.

On page 2 you will find an in-depth article from Project Inform on 'Gynecological Issues for Women with HIV'. This article will tell you everything you need to know to make sure you are getting the best possible gynecological care and to help you have informed conversations with your health care providers when gynecological complications occur.

On page 4 you will find some important information on lifetime limits on Minnesota Family Investment Plan (MFIP), or 'welfare' benefits and how you can prepare yourself if your five-year limit is approaching.

On page 5 you will find a listing of currently open and soon to open clinical trial opportunities with the AIDS Clinical Trials Unit (ACTU).

On page 10 you will find a list of novels, autobiographies and stories of women coping with HIV. Some of these books were written by women with HIV, others are about having a family member, loved one, or partner coping with HIV. Some are literary and sad, others hilarious. We're sure you'll find at least one good book from the list to curl up with this winter.

You can expect to receive the third issue of the Women and Families Network Newsletter in May 2003. That issue will be focus on pregnancy, parenting and HIV. We are currently looking for women who would like to write articles or share personal stories on this topic for this upcoming issue. Please contact us if you are interested.

Stay warm and see you again in May,

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The mission of the **Women and Families Network** is to address the needs of women and families affected by HIV through collaboration, advocacy, training and resource sharing.

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The Women and Families Network Newsletter is published with funds provided through Title II and Title IV of the Ryan White CARE Act, as well as financial assistance from the Midwest AIDS Training and Education Center through the Minority Community Training Partnership Program.

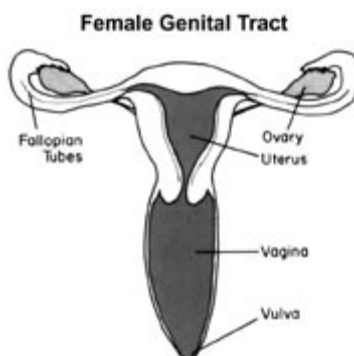
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Gynecological Issues for Women with HIV

All women, at some point in their lives, experience an unwanted gynecological (GYN) condition. For both women and doctors alike, common GYN conditions like yeast infections are usually no cause for alarm. Viewed as such, we learn not to be particularly concerned about them. When confronted with these conditions, we just want them to heal painlessly and quickly. And that's that.

But GYN conditions in women with HIV can sometimes take on a different, more troublesome, course. Gynecological conditions in HIV-positive women can become painful, recurrent and difficult to treat. They range from chronic, recurrent yeast infections to abnormal menstrual cycles (periods) and vaginal warts (caused by human papillomavirus, or HPV) to cervical cancer. For many women, recurrent GYN conditions are often the very first signs of HIV infection. Researchers have long known that the female genital tract (see diagram below) plays a significant role in acquiring or transmitting HIV and other infections. Yet, they are only just beginning to understand how HIV interacts with the genital tract and how this may give rise to a range of GYN conditions.

This article contains information on symptoms, tests and treatments for



common GYN conditions. It should serve as a tool to enable routine self-monitoring and care for GYN health and to facilitate informed conversations with health care providers when GYN complications occur.

Vaginal Candidiasis

Vaginal candidiasis, or vaginal yeast infections (sometimes called vaginitis), is a fungal infection of the vulva and/or vagina common in many women. It is the most common initial symptom of HIV in women and is also the most common reason that HIV-infected women first seek medical attention. Recurrent vaginal yeast infections and/or yeast infections that become less responsive to treatment are a sign of a weakening immune system.

While a variety of factors, including antibiotic use and oral contraceptives, can result in recurrent vaginal yeast infections, they generally are not the underlying causes in women with HIV. Rather, recurrent vaginal candidiasis in women with HIV is most often associated with a decline of CD4+ cell counts. When CD4+ cell counts fall below 200, the risk of recurrent vaginal and oral (in the mouth) yeast infections increase. As the immune system is further weakened and damaged, yeast infections occur more frequently, becoming more aggressive and less responsive to therapy. Therefore, intervening and treating candidiasis is important. Moreover, halting the damage of the immune system through the treatment of HIV disease, and allowing the immune system to rebuild itself so that it can control candidiasis is key to a long-term solution to the problem of recurrent yeast infections (see the table "More Tips Which May Help Prevent Recurrent Vaginal Yeast Infections" at right).

Symptoms of vaginal candidiasis include itching and swelling of the vulva, thick white-yellow or cheesy discharge and burning upon urination. With increased immune suppression, the primary location of the candida infection may shift from the vagina to the mouth or esophagus, the tube leading from the mouth to the stomach.

There are several effective forms of treatment for vaginal candidiasis, including creams and suppositories such as clotrimazole (GyneLotrimin) which are available over-the-counter and by prescription. If the candidiasis is unresponsive to local (i.e. at the site of the yeast infection) treatment, the antifungal drugs fluconazole (Diflucan) or ketoconazole (Nizoral) are usually effective. These are drugs taken orally, in a pill form, and treat fungal infections throughout the body (i.e. systemically). However, recent studies caution that women with very low CD4+ cell counts (less than 50) who have used fluconazole extensively are at increased risk of developing

fluconazole-resistant candidiasis. Many researchers advise the use of local treatments as the first choice in treating candidiasis, reserving systemic therapies, such as fluconazole, as a back-up. Dietary modifications such as decreasing sugar intake, addition of lactobacillus-containing yogurt (it will be on the label) or acidophilus capsules (available in health food stores), may also help prevent recurrences of candidiasis.

HIV and STDs

There is some concern that sexually transmitted diseases (STDs) might speed up the rate of HIV progression. This is based on observations that infections activate the body's immune system which in turn increases HIV replication. When HIV replication increases, there is an increase in damage to the immune defenses as the virus infects and destroys important immune cells.

An increase in the amount of HIV in genital secretions has been noted with several STDs. In some instances,

increases in HIV replication caused by STDs and other GYN infections may be restricted to the genital tract. This means that there might not be an increase in HIV in the blood, as measured during regular doctor visits, but there may be an increase in HIV in the genital tract, specifically. Increases in HIV replication may cause damage to the immune environment in the genital tract. Currently, it remains unknown what these increases in HIV in genital secretions mean over the long haul, but common sense suggests that damage to the immune environment in the genital tract will lead to increased GYN complications. Thus, more numerous STDs, or STDs left untreated, will probably contribute to increasing complications over time.

Untreated STDs assist the spread of HIV infection. For those who are HIV infected, an untreated STD increases the probability of passing HIV to their sex partners. An untreated STD also makes an HIV-negative person more susceptible to acquiring HIV from an HIV-positive sex partner. This relationship between HIV and STDs underlines the importance of early STD diagnosis and treatment.

Herpes Simplex Virus

Genital herpes is usually caused by herpes simplex virus 2 (HSV-2), but can also be caused by the same virus that causes cold sores (HSV-1). Once a person is infected with herpes, the infection remains present for life. Though it may be dormant for long periods, recurrent outbreaks of symptoms are also typically part of the disease. Several studies show that the sexually transmitted disease herpes simplex virus type II (HSV-2) may take an altered course in people with HIV-related immune suppression. For

More Tips Which May Help Prevent Recurrent Vaginal Yeast Infections

- **Don't douche!** Douching changes the vagina's natural acid level (called pH level) and causes inflammation, both of which may increase the risk of further infection, including STDs. Your body has a natural douching system—let it work!
- **Avoid the use of scented soap, bleach and fabric softeners when doing laundry.** Scented laundry soap contains chemicals which can aggravate a yeast infection. Residual bleach in your clothing may destroy healthy bacteria which help your body keep fungal infections at bay. Fabric softeners block moisture absorption, causing moist areas of the skin to stay damp, thus encouraging bacteria, etc.
- **Avoid tight fitting clothes.** Tight clothing blocks air flow and yeast infections grow best in moist environments. Thus, loose fitting clothing, which allows airflow, provides a drier environment.
- **Wear cotton underwear.** Unlike synthetic materials such as polyester, lycra and nylon, cotton breathes better, which means it lets air in and doesn't trap moisture.
- **Avoid washing the vaginal area with deodorant soaps and soaps which are heavily scented or perfumed.** Some women claim that when they stop using scented soaps in the shower or bath, yeast infections heal better and don't recur as often. This would include avoiding bubble baths.
- **Try a non-soap cleanser** like unscented Nutribiotic Non-soap with aloe vera to slightly moisturize the skin and promote healing. Soap can have a drying effect on the skin and can further aggravate the vaginal area affected by a yeast infection. Non-soap cleansers can be obtained at most health food stores and many supermarkets.

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Lifetime Limits on MFIP Have Arrived: *Are You Prepared?*

Short history of welfare reform

The original purpose of welfare, as it was conceived of during the depression, was to provide a safety net for vulnerable people. In 1996, under a Republican congress, President Clinton signed a sweeping welfare reform law that eroded the safety net and basically transformed welfare into a job placement program. Supporters of welfare reform highlight the decreasing caseloads and increased numbers of people employed as a sign of its success. However, critics point out that much of the increased level of employment had little to do with welfare reform and was mostly due to the thriving economy of the mid-1990s.

The clock is ticking

In Minnesota, the new welfare law was the Minnesota Family Investment Plan (MFIP). MFIP includes a five-year (60-month) lifetime limit on the amount of welfare money a person can receive. Every month that a family receives cash benefits through MFIP, it gets a month closer to its 60-month limit. When a parent goes off MFIP, the clock stops, and then it starts if the parent starts receiving cash grants again. The clock ticks even if a parent cannot work because of a short-term disability. For example, if a parent with HIV is hospitalized and goes on short-term disability and cannot follow through with his or her work plan, the months that they receive cash benefits are counted towards their 60-month total.

MFIP families affected by HIV

The median income of women living with HIV in Minnesota is \$789 a

month, and many receive MFIP benefits to try and make ends meet. The strict work requirements and sanctions imposed on women who for one reason or another do not or cannot comply with all the MFIP requirements have a direct impact on women with HIV. The effort needed to keep up with all the paperwork and bureaucracy of MFIP can be a full-time job in and of itself. For those who suffer from periodic bouts of serious illness or the side effects of HIV medications, staying in compliance with MFIP rules is extremely difficult and tiring.

At the same time, these are the very same families for whom a safety net is an absolute necessity. People suffering from a disability or illness that prevents them from working will not be subject to time limits. However, many people with HIV might not be eligible for this exemption if they are not disabled. Other states hit their time limits earlier than Minnesota and have defined disability in a variety of ways. In New York, for example, everyone with HIV receives welfare cash benefits without time limits.

What you can do if your five-year limit is approaching

If your time limit is approaching, don't panic. About 60 percent of all people approaching their lifetime limits are eligible for extensions. You may be eligible for an exemption or extension on your lifetime limit if you fall into one of the following categories.

1. If you are physically or mentally ill or disabled

The first step you should take is to get

your doctor to write a letter that says you have an illness or disability that prevents you from working. A medical doctor, psychiatrist or psychologist can write the letter for you. This letter must state that your illness or disability will last longer than 30 days and stops you from getting or keeping a job. It is not yet clear whether all people with HIV are given exemptions from the lifetime limits, but you should begin talking to your doctor and your financial worker if you are approaching the five-year mark.

It is understandable that you may be uncomfortable disclosing your HIV status to your financial worker. However, disclosing your HIV status might help you get your benefits extended. If you are in this situation and unsure what to do contact the Legal Aid Society of Minneapolis at 612-334-5970 or the Minnesota AIDS Project women and families systems advocate, Ribka Berhanu, at 612-373-9175 for advice on how to proceed.

2. If you are a caregiver for an ill or disabled family member

You must get a letter from your family member's doctor that says that you are needed in the home to care for family, and that the illness or disability is expected to last for more than 30 days.

3. If you are a victim of domestic violence and have worked out an alternative employment plan

MFIP recipients can "stop the clock" if they are in situations of domestic violence. However, only 0.5 percent of people eligible for the exemption are using it. If you are a victim of domestic violence, you should talk to

your job counselor about developing an alternative employment plan.

4. If you are working, and...

- a. Are a single parent, have complied with MFIP regulations for at least 10 of the past 12 months, and have been participating in employment activities at least 25 hours per week, you should look into an exemption.
- b. Are in a two-parent family, have complied with MFIP regulations for at least 10 of the past 12 months, and you and your partner participate in employment activities at least 45 hours a week, you should look into an exemption.

And most importantly, how to appeal an unfair decision:

If your benefits are delayed, denied, lowered or cut-off or if you feel that you have been unfairly sanctioned, there are resources available to help you appeal those decisions. You can contact the Legal Aid Society of Minneapolis at 612-334-5970 or Ribka Berhanu, MAP women and families systems advocate, at 612-373-9175, for information on how to appeal an unfair MFIP decision, or if you have any further questions on the 60-month time limit.

Information in this article is based on pamphlets from the Legal Aid Society of Minneapolis.

For further information, contact Ribka Berhanu, MAP women and families systems advocate, at 612-373-9175 or rberhanu@mnaidsproject.org

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Currently Open and Coming Soon Studies at the AIDS Clinical Trials Unit

Currently Open

Study 1 - A5082 The Lipodystrophy study: People who have lipodystrophy (loss of fat in arms/legs with increase in fat in neck/abdomen) and have a high fasting insulin level will be randomized to Metformin (Glucophage) and/or Rosiglitazone (Avandia) to see if it improves the insulin level and fat redistribution syndrome.

Study 2 - A5030 CMV-Valgancyclovir study: People who have CD4 less than 100, HIV viral load greater than 400 and have been exposed to cytomegalovirus (CMV) at some-time in their life (most of us have) will be followed every eight weeks to see if CMV virus is growing in the bloodstream. If it is, they will be randomized to Valgancyclovir or a placebo to see if the medication prevents people from becoming sick with CMV (CMV can cause blindness, or problems in the stomach and bowels, etc.) People will be paid \$20 for each study visit.

Study 3 - Naltrexone study: Study designed by Minneapolis doctors based on "bench science" information that Naltrexone seems to increase the actions of two anti-retroviral medications in the test tube. People will be randomized to take very small doses to see if it increases the activity of their anti-retroviral medications. Payment will be made for each study visit (\$15) and for completing longer study monitoring days (\$50).

Study 4 - A5110 The Fat-wasting Study: People with lipoatrophy (fat wasting in the arms, legs and/or face) will switch medications to

remove the antiretroviral medications (nucleoside analogues-NRTI's) that are believed to cause this condition from their regimens. All other medications they are taking will remain the same. Close monitoring will be done on viral load counts throughout the study.

Study 5 - A5148 Niacin for High Cholesterol Study: Niacin will be tested in people taking antiretroviral medications who have high cholesterol and triglyceride levels. This medication is used in people who do not have HIV and we will be looking to see if it is safe and effective for those with HIV who are on antiretroviral's. People will follow a fat-lowering diet and complete an activity diary while on the study.

Study 6 - A5165 DAPD Salvage Study: Testing the new nucleoside antiretroviral medication DADP for its safety and effectiveness. The drug mycophenolate will also be studied to see if it can increase the antiviral action of DAPD. This study is for people who have taken many different HIV medications before and are not responding well to their current treatment. Payment will be made for each study visit.

Opening Soon

Study 1 - A5142 Comparing 5 Initial Regimens Study: 5 different antiretroviral regimens will be tested to determine who one is best as a first therapy for people with HIV. Researchers will be looking for the regimen which best decreases the HIV viral load while causing the

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instance, the painful sores in and around the genitals and/or anus caused by herpes tend to be more frequent, persistent and require higher doses of treatment. The most common sites of recurrent herpes infection in women are the labia majora (the outer vaginal lips), the labia minora (the vagina's "inner lips") and the buttocks.

It is important to remember that symptoms of herpes correlate with the severity of HIV-related immune deficiency. For example, HSV ulcers persisting for over one month are associated with severe immunosuppression and are considered an AIDS-defining illness.

Oral acyclovir (Zovirax) and famciclovir (Famvir) are used to treat herpes. For women with frequent HSV outbreaks, daily acyclovir therapy may be helpful in the prevention of outbreaks. If herpes stops responding to acyclovir (e.g. sores

don't go away within two weeks after starting acyclovir therapy), a number of other therapies are available to treat acyclovir-resistant herpes. These include: intravenous foscarnet (Foscavir) and topical cidofovir (Vistide).

Syphilis

Syphilis is a progressive bacterial infection that is usually sexually transmitted. It is important to recognize and treat syphilis promptly because the disease may progress more rapidly due to immune suppression associated with HIV. Progression occurs in three stages: primary syphilis, characterized by painless ulcers or lesions; secondary syphilis, indicated by widespread lesions and swollen lymph glands; and tertiary syphilis, most often characterized by lesions in organs and tissues (sometimes called neurosyphilis as it often affects the central nervous system).

Standard treatment for syphilis is oral penicillin or ceftriaxone (Rocephin). Several studies report that treatment for primary staged syphilis—a single dose of penicillin G benzathine (Bicillin)—may fail in HIV-infected persons. Therefore, like herpes, it may be necessary to treat HIV-positive people with syphilis using higher doses of standard antibiotic therapy or longer courses of treatment.

Other Common STDs

Diseases such as chlamydia, gonorrhea, trichomonas and bacterial vaginosis commonly occur among women with HIV. Currently, standard treatment regimens are used to treat these conditions. These include antibiotics such as azithromycin (Zithromax), ceftriaxone or doxycycline (Vibramycin) to treat chlamydia and penicillin and/or tetracycline (Achromycin) to treat gonorrhea. Both bacterial vaginosis and trichomonas are treated with metronidazole (MetroGel, Flagyl).

When these diseases occur, the vaginal acid level (pH level) changes, making the GYN environment more welcoming to other infections (including HIV infection). Furthermore, untreated GYN complications, particularly chlamydia and gonorrhea, are the common cause of pelvic inflammatory disease (sometimes called "PID") and cervicitis (tenderness and swelling of cervix). Thus, it is important to treat these common STDs in order to prevent further complications.

Pelvic Inflammatory Disease (PID)

Pelvic inflammatory disease (PID) represents a range of inflammatory disorders of the upper genital tract, including the fallopian tubes, the uterus, ovaries and, in advanced stages, the abdominal lining. Common

HIV in the Female Genital Tract

Inflammation of the vagina caused by unhealthy bacteria or physical trauma due to penetration, douching or other factors, can increase the risk of contracting HIV. When the vagina is inflamed, there are small breaks in the vaginal membranes, exposed blood cells and an increase in the vaginal acid level (called pH level). All of these factors can decrease the vagina's ability to defend against HIV and other STDs.

The role of HIV in the genital tract and how it promotes or worsens GYN conditions is only beginning to be understood. Some studies have shown that high levels of HIV in genital secretions (also called cervicovaginal secretions or CVS) correlate with high levels of HIV in the blood and/or GYN infections, swelling and tenderness. HIV interacts with other viral infections, such as herpes simplex virus (HSV) and human papilloma virus (HPV), the virus that causes genital warts. HIV and related immune suppression may also increase susceptibility to other infections, particularly vaginal candidiasis (yeast infections) and chlamydia. Finally, data from a recent study also show that, compared to HIV negative women, positive women have more chronic inflammation (including pain, itching and discharge) around the vagina and cervix without a causative STD.

symptoms of PID include chronic, moderate-to-severe pain; tenderness in the abdomen; irregular menstrual cycles; non-menstrual bleeding and painful and frequent urination. Like other gynecological conditions, PID appears to be more prevalent, severe and resistant to treatment among women with HIV and especially women with AIDS. Indeed, the Centers for Disease Control and Prevention (CDC) recommend hospitalization and intravenous (directly into the vein) antibiotics for treating PID in women with HIV. Studies indicate that relapse of PID occurs more often in women with suppressed immunity.

Cervicitis

Inflammation of the cervix, known as cervicitis, is another symptom of PID. A number of conditions can lead to cervicitis. Chlamydia and gonorrhea infections can result in swelling of the cervix. Cervicitis may also result from untreated trichomonas or bacterial vaginosis. Cytomegalovirus (CMV), a virus in the herpes family which is also the leading cause of blindness among people with AIDS, can also be a GYN complication and may cause cervicitis as well. Cervicitis is often present without symptoms. When symptoms do occur, they include non-menstrual bleeding, bleeding after penetrative intercourse, painful urination and lower back pain. The treatment for cervicitis depends on the identified cause of the condition.

Human Papilloma Virus and Cervical Disease

Human papilloma virus (HPV) is a sexually transmitted disease and the cause of genital warts. HPV primarily affects the cervix and plays a primary role in the development of cervical

Abnormal GYN Screening Terms	
Atypia	These cells show minimal changes. May be "atypical" due to the presence of a vaginal infection, the use of oral contraceptives or because the person doing the Pap smear may have not handled the cells properly.
Dysplasia	Means "abnormal development." Dysplasia is a pre-cancerous condition. Dysplasia is categorized as mild to severe by using CIN 1-3 and CIS to represent the extent of the problem.
SIL	Squamous Intraepithelial Lesions. SIL is another way to describe dysplasia by identifying lesions in the thin cellular layers of the vaginal tract. Again, SIL suggests a pre-cancerous condition.
CIN 1	Cervical Intraepithelial Neoplasia. CIN means abnormal growth or tumor in the tissue covering or surrounding the cervix. CIN 1 means that one-third of the sample has dysplasia or pre-cancer. It is mild dysplasia.
CIN 2	CIN 2 means 2/3 of the sample has dysplasia. It is moderate dysplasia.
CIN 3	CIN 3 means the entire sample shows cells with dysplasia. It is severe dysplasia.
CIS	Carcinoma-In-Situ. On a Pap smear, this report means the same thing as CIN 3, the entire sample shows dysplasia. However, the sample shows no sign of invasive cancer.

dysplasia (abnormal cells) and cervical cancer. Recent studies have demonstrated that women with HIV, particularly those with low CD4+ counts, have an increased frequency and severity of HPV-related cervical dysplasia. The outcome for HIV-positive women with cervical cancer-the most severe form of cervical dysplasia and an AIDS-defining illness-is much graver than for women without HIV. However, if detected early, less severe grades of dysplasia (CIN I or II) are fairly easily treated which stresses the need for regular and timely GYN screening to catch pre-cancerous conditions before they become severe.

Women with HIV have high recurrence rates of cervical dysplasia after standard treatment (39-87 percent among HIV-positive women vs. 0-18 percent among HIV-negative women). A study of the AIDS Clinical Trial Group (ACTG 200) suggests that 5-Fluorouracil (5-FU) is safe and effective for preventing recurrent cervical dysplasia (CIN). Study participants who

received one 2-gram application intravaginally at bedtime every two weeks for six months had reduced recurrent cervical dysplasia with minimal side effects.

In addition to cervical dysplasia, if symptoms of HPV infection occur, they often include multiple small warts on the vagina or around the anus. Many types of treatment are available when symptoms of HPV occur including surgical removal, electro-cautery (removal by electric current), chemical removal, laser removal and the topical cream imiquimod (Aldara). Unfortunately, treatment can be painful and HPV-related warts commonly reoccur. Recent studies caution against the use a common treatment option called cryotherapy, which involves freezing off the wart or abnormal cells. Cryotherapy can cause normal tissue to heal over deeper areas of dysplasia, causing future genital screenings to appear normal while abnormal tissue grows undetected beneath the surface.

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Also, many women report that the aftermath of cryotherapy can be very painful.

Menstrual Irregularities

Changes in periods (menstrual cycles) are common, regardless of HIV status. Many of the changes reported by positive women include irregular periods, heavier or lighter periods, a worsening of symptoms associated with premenstrual syndrome (PMS) and a darkening of menstrual blood. Another common menstrual disorder among HIV-positive women is the absence of menstruation altogether. This condition is called amenorrhea and it is defined as a history of no menstrual periods for more than 90 days. In some studies, amenorrhea has been more frequent among women with lower CD4+ counts (less than 50).

It is not known exactly how HIV disease affects the reproductive system and the menstrual cycle or how female hormones—estrogen and progesterone—interact with the immune system. Studies have shown that substance abuse, chronic illness and significant weight loss can lead to a dysregulation of the hypothalamus, the part of the brain that regulates sex hormone secretion and can affect menstruation. It is presumed that problems with the immune system due to HIV cause changes in female hormones and result in menstrual irregularities.

HIV-infected women with abnormal or changed menstrual bleeding should seek medical attention to determine the cause of the abnormality. Heavy bleeding or painful periods are associated with pelvic inflammatory disease, discussed above. They may also be explained by low platelets (the

component of the blood involved in clotting and immune response) associated with HIV infection. A low platelet count is determined by a blood test called a complete blood count (CBC). If your platelet count is low (under 50,000), be sure to review your medications with your doctor because some of them (including aspirin and ibuprofen) may affect the body's blood clotting process. Several treatments are available for platelet counts below 20,000, including the anti-HIV drug zidovudine (AZT, Retrovir), corticosteroids, intravenous gamma globulins and platelet transfusions. In addition, alcohol should be avoided because it may block platelet production and interfere with normal blood clotting processes.

Heavy and/or frequent menstrual bleeding (dysmenorrhea) can cause anemia, or low red blood cells, which can also lead to amenorrhea. While the symptoms of dysmenorrhea and amenorrhea are opposing, they may both be caused by anemia. Anemia is also a common condition among HIV-positive women and can cause fatigue. When severe, anemia can also lead to amenorrhea.

It is important to investigate all potential causes of amenorrhea. Aside from anemia, these may include pregnancy, ovarian cysts, opportunistic infections, menopause or other GYN conditions. Other factors may include the use of antiviral therapy and other medications (such as megestrol), street drugs

Menstrual Irregularity Co-Factors Chart

Factor	Comments
Age	Younger and older age are both associated with menstrual irregularities. Young women often have irregularities when first beginning to menstruate, sometimes lasting through puberty. Older women, especially those going through menopause, also commonly have irregularities. On either end of this age spectrum, hormone therapy (e.g. progesterone/estrogen) may help to regulate menstrual cycles. However, it is not known if trying to regulate these natural changes is helpful.
Body Mass Index	Women who are very thin, malnourished, or who generally have extremely low levels of body fat often have menstrual irregularities, particularly increased time between menstruation and/or very light bleeding during periods. For women who are thin because of malnutrition and unwanted weight loss issues, attention to treating unwanted weight loss can help to regulate the cycle.
Drug Use (substance use/abuse)	Injection drug and other substance use are associated with changes in menstrual cycles.
Illnesses & Infections	Some illnesses, and side effects from drugs used to treat them, can influence menstrual cycles. Inflammatory and infectious conditions (e.g. vaginitis and pelvic inflammatory disease) can also affect regularity.
Dysplasia	Dysplasia (e.g. vulvar, vaginal, cervical and ovarian) is associated with changes in menstrual cycles.
Race	While this particular study only looked at whites, Latinas and African Americans, there did appear to be more menstrual irregularities among African Americans compared to the other groups. It may be, in this particular study, that other factors confounded the ability to truly isolate any differences caused by race difference. However, even this hint of a racial differential warrants further study.

(particularly heroin and/or marijuana use) and poor nutrition. Finally, body weight changes, stress and too much exercise can cause a defect in the secretion of a hormone necessary for normal menstruation to occur (called gonadotropin-releasing hormone or GnRH).

There are several ways to alleviate many of the GYN symptoms that accompany common menstrual problems. Premenstrual and menstrual cramping usually responds to over-the-counter medications including aspirin, ibuprofen (Motrin or Advil) or naproxen (Aleve). Some women experiencing menopausal symptoms choose to treat with hormone replacement therapy or herbal and nutritional therapies. Birth control pills, which mimic normal menstrual cycles, are also used to treat amenorrhea. Finally, stress reduction, vitamin supplementation (such as a regular one-a-day vitamin), regular exercise and nutrition should always be incorporated into any treatment plan.

Screening

Since women with HIV have high rates and generally more severe cases of GYN complications, it is important to screen frequently and regularly (see below for GYN Screening Guidelines). GYN screening is normally done with one of two diagnostic tools, the Pap smear and/or colposcopy.

Pap Smear

A Pap smear is a test used to detect cervical cancer and is a standard part of the routine gynecological examination. It involves inserting a long cotton swab into the vagina and "swabbing" cells from the cervix, which are then examined under the microscope. While the Pap smear is relatively non-invasive, often only causing a sensation that feels like pressure on the cervix, the usefulness of the test is

beginning to be called into question—especially when it is being used as a screening tool for cervical cancer in women with HIV. (NOTE: When there is tenderness or swelling, even a Pap smear, which is generally not painful, can cause discomfort).

The problem with Pap smears as a useful diagnosis procedure lies in the fact that 15-30 percent of Pap smears results that come back as "normal" are, upon subsequent colposcopy and biopsy, abnormal (called "false negative" results). In other words, abnormal pre-cancerous cell growth that may require further examination or immediate treatment pass undetected during the Pap test. The problem of false-negative Pap smears has led some health care providers to suggest colposcopy as a more accurate screening procedure, particularly among HIV-positive women where early detection is most critical.

Colposcopy involves the examination of the cervix for signs of cancerous growth by means of a flexible magnifying tube (called a colposcope) which is inserted in the vagina. While insertion of the colposcope into the vagina may cause discomfort, the actual procedure usually isn't painful. Still, colposcopy has its own drawbacks. Not only does it require management by a specialist but, coupled with biopsy, it can be a painful experience with some risk of infection and bleeding. At this point, it is difficult to say whether or not colposcopy screening is a necessary procedure for HIV-positive women without signs of an abnormal Pap smear.

Pap Plus Speculoscopy

A promising new screening tool called Pap Plus Speculoscopy (PPS) has recently gained FDA approval. It is almost as sensitive as a colposcopy plus biopsy, is less invasive and painful, and does not require a

specialist to perform the procedure. PPS involves a standard Pap smear and the lighting of the cervix with a chemical light called a Speculite after the vinegar wash. The Speculite whitens abnormal tissues so a clinician may detect potential disease. This procedure feels like a regular Pap plus a tingly, sometimes stingy sensation due to the vinegar wash. The new test is becoming more widely available in STD, Planned Parenthood and other GYN health providing clinics.

Conclusion

Many of the GYN complications HIV-positive women experience also affect women who are not living with HIV. However, the same conditions tend to be more frequent and are more serious and difficult to treat in women with a compromised immune system. At the same time, GYN complications further compromise the immune system. Consequently, it is very important that GYN complications be diagnosed, monitored and treated under the guidance of a health care provider.

Since many of these complications lack obvious symptoms and can persist undetected, regular exams are crucial, even when feeling well. Like breast exams, Pap smears, colposcopies and PPS are designed to detect early, pre-cancerous conditions. Detection and treatment at these early stages is a critical step in preventing a GYN condition from progressing, as is monitoring your own GYN health and advocating for your own best behalf.

The information for this article was taken from WISE Words, a newsletter of Project Inform devoted to treatment issues concerning women with HIV. These materials, as well as information on many other topics, are available free of charge to all those who need them. For more information, contact the Project Inform National HIV/AIDS Treatment Hotline (1-800-822-7422) or visit their website <http://www.projectinform.org> ■

Curl Up with a Good Book This Winter

Locating books that feature the stories of women coping with HIV can be difficult. That's why we've created this list of novels and autobiographies for you. Better yet, they are all free! Free because we've made sure all these books are available in Minnesota libraries. Call your local library and find out if they have a copy, if they don't they can order it from another library that does.

To get a free library card stop by your local library and bring with you identification that verifies who you are and your address. If you don't have your current address on your ID, bring something else that verifies your address such as a checkbook, piece of mail with a recent postmark, a utility bill or rent agreement.

... So as the winter chill descends, plan to curl up in bed with one of these great books!



What Looks Like Crazy On An Ordinary Day

Author: Pearl Cleage (1999)
Oprah Book Club, Selection, September 1998.

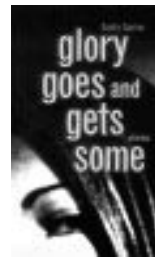
Ava has spent the last 10 years living in Atlanta. When she discovers she's infected with HIV, she sells her hair-dressing business and heads back to her childhood home of Idlewild, Michigan, to spend the summer with her recently widowed sister before moving on to San Francisco. As the trials and tribulations pile on, the experiences of Cleage's characters prove to be universal: death, love, second chances. Ava's acerbic, smart-mouthed narrative keeps the story buoyant; by the time this endearingly imperfect heroine and her cohorts have negotiated the rocky road to a happy ending, readers will be sorry to see her go, even as they wish her well. (Fiction)



Butterscotch Blues

Author: Margaret Johnson-Hodge (2000)

This is the poignant story of a 34-year-old woman finding the love of her life and then having her faith in the relationship tested when he becomes HIV-positive. (Fiction)



Glory Goes and Gets Some: Stories

Author: Emily Carter (2000)

In 'Glory Goes and Gets Some', Minneapolis-based author Emily Carter gives us a streetwise and sardonic look at sex, HIV, addiction, and recovery. From her patrician childhood on the Upper East Side, to her chemical addictions downtown, to her unlikely, tenuous yet rewarding, alliances with the full range of treatment mavens in Minnesota, Glory gives us an uncensored and irreverent account of her experiences in twelve-step recovery - a process that, for all its faults, ultimately works for her. (Fiction)



Penitent, With Roses: An HIV+ Mother Reflects

Author: Paula Peterson (2001)

This beautifully written account won the 2000 Bakeless Literary Publication Prize for Nonfiction. It is an autobiography of a young white, middle-class, heterosexual Jewish mother who is diagnosed with AIDS when her son is 11 months old. (Autobiography)



Some Sunday

Author: Margaret Johnson-Hodge (2001)

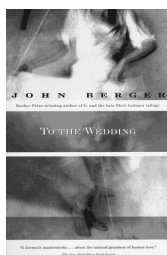
In this Sequel to 'Butterscotch Blues' Margaret Johnson-Hodge explores sisterhood, skin color, self-esteem and sex. Set in New York City, the novel begins as a grieving wife struggles to recover from the loss of her handsome young Trinidadian husband to AIDS. Adrian was the love of Sandy Hutchinson's life, and she's not sure if she can go on without him. The story follows Sandy's recovery and search for love. (Fiction)



In Search of Serenity: A Black Family's Struggle With the Threat Of AIDS

Author: Patti Renee, Rose (1993)

In Search Of Serenity is Rose's account of her family's odyssey that begins with her mother's diagnosis in Harlem as HIV-positive and extends to Nairobi, Kenya, in hopes of a solution in Kemron. Rose challenges African Americans to recognize AIDS as one of the most serious problems facing Blacks worldwide and to respond with a concrete, community-based plan of action. (Autobiography)



To The Wedding: A Novel

Author: John Berger (1996)

Ninon, a beautiful and vivacious young woman engaged to be married, is HIV-positive. Berger proceeds to tell her first joyful, then sorrowful story. When Ninon learns of her catastrophic illness, she tells her fiancée she can't marry him, but he insists, declaring that they'll live what years they have together. (Fiction)



Traveling Light

Author: Katrina Kittle (2000)

Summer's is a life of lives cut short—her life as a dancer terminated by injury, and her life with Nicholas truncated by indecision as her beloved older brother's life is decimated by HIV when AIDS slowly and inexorably ravages his body. Called home to help care for Todd, she teaches in the high school she once attended and moves in with her brother and his lover, Jacob. Together with Arnicia, their live-in home health

aide, and Nicholas on weekends, time passes. Summer must come to terms with joys and sorrows in this wonderfully moving book on love in all its variations. Kittle's novel is hard to put down, and harder still to forget. (Fiction)

My Name Is Mary: A Memoir

Author: Mary Fisher (1996)

Those who think of Fisher as "the Republican poster girl for AIDS" may find themselves surprised by this sensitive and frank description of her life, her weaknesses, and her disease. She is particularly insistent that she not be regarded as a heroine, and those who have praised her and her book range from President Ford to Larry Kramer. (Autobiography)

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fewest side effects. This study is for people who will be taking HIV medications for the first time.

Study 2 - A5146 Therapeutic Drug Monitoring Study: A new method of dosing HIV medications will be tested in this study. Therapeutic Drug Monitoring works to individualize the dosing of antiretroviral medications and along with resistance testing, should result in getting the best medication response possible for the participants. This study is for people who have taken many antiretrovirals before, including protease inhibitors, and may not be doing well on their current medications.

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Remember that the MNACTU will provide a \$50 stipend for each study visit for people living outside of the 7-county metropolitan area (Hennepin, Ramsey, Carver, Scott, Dakota, Anoka and Washington) to help offset their travel costs. Please contact the MN ACTU for more information.

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