Table 1

Risk of developing AIDS in 6 years (%)

HIV viral load (copies/mL)	*CD4 T lymphocyte count (cells/microlitre)*		
	CD4 < 350	*CD4 350-500*	*CD4 > 500*
> 55 000	93	79	67
20–55 000	73	57	50
7–20 000	42	40	26
< 7000	19	22	15

Treatment is recommended when the risk of developing AIDS is greater than 50%.

and co-receptor antagonists) have been developed. These are variously available through trials and special access schemes. Modifications to existing drugs have sought to improve dosing schedules, with once-daily treatments and the combination of up to three drugs in a single tablet. Attention has been focused on the need to improve and maintain compliance to maximise the impact and duration of whatever treatment regimen is adopted. Consequently, there is a need to tailor treatment to suit each individual and the lifestyle they lead.

From the late 1990s to the present time, HIV treatments have come under increasing scrutiny. Long-term treatment with HAART is clearly not straightforward or without consequences. Developing alternative regimens for those in whom treatment has failed, simplifying regimens to improve compliance and managing the wide range of adverse effects is a challenge.

HIV treatment has become increasingly complex and clinicians must confront numerous issues and dilemmas, without a clear consensus on the best treatment strategy to adopt.

Awareness of the complications and adverse effects related to antiretroviral therapy has made many clinicians more cautious about advocating early treatment, in contrast to the 'hit hard and early' approach initially adopted with HAART. The current Australian, American and British guidelines for starting antiretroviral therapy are much more conservative than those released in 1997. Protease inhibitors are now used less frequently in early treatment regimens than they were when HAART first came into vogue and nearly every drug combination included at least one protease inhibitor.

Treatment of symptomatic HIV infection or AIDS extends life and most clinicians would offer therapy in these situations. However, in asymptomatic patients, current recommendations suggest that treatment does not start until the CD4 T cell count falls below 350/microlitre or the HIV load exceeds 50 000 copies/mL. These recommendations are based on the risk of developing AIDS within six years without treatment (Table 1).[4]

In just over 20 years AIDS has grown from a cluster of cases into a substantial global health problem. In the Western world, the disease has changed from being predictably fatal to a chronic manageable condition, for those in whom the drugs work well. In the world's poorest nations, however, little has changed and effective therapy is almost completely unattainable. The epidemic continues to rage out of control and the main concerns are more basic; prevention, diagnosis, access to health care and palliation.

REFERENCES

1. Sepkowitz KA. AIDS – the first 20 years. N Eng J Med 2001;344:1764-72.
2. Bartlett JG. The Johns Hopkins Hospital 2002 guide to medical care of patients with HIV infection. 10th ed. Baltimore: Lippincott Williams & Wilkins; 2002.
3. National Centre in HIV Epidemiology and Clinical Research. Australian HIV Surveillance Report 2002;18:9,10. Sydney: Communicable Diseases Surveillance Unit, Communicable Diseases Branch, NSW Health; 2002.
4. Kelly M. The state of play: HIV treatment. HIV Australia 2002;1:13-5.

FURTHER READING

AIDSinfo: HIV/AIDS Medical Practice Guidelines. US Department of Health and Human Services.
http://www.aidsinfo.nih.gov/guidelines

Conflict of interest: none declared

Self-test questions

The following statements are either true or false (answers on page 71)

5. The best combination of drugs for the treatment of HIV infection is unknown.
6. HIV has not developed a resistance to protease inhibitors.

Patient support organisations

National Association of People living With HIV/AIDS (NAPWA)

and

State and Territory AIDS Councils (see page 67)

The National Association of People living With HIV/AIDS (NAPWA) is Australia's peak non-government advocacy organisation representing people living with HIV/AIDS community-based groups from each of Australia's states and territories.

Contacts

National Association of People living With HIV/AIDS (NAPWA)

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Newtown NSW 2042
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Web site: www.napwa.org.au
E-mail: admin@napwa.org.au

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The story of one complaint

John S. Dowden, Editor

Shortly after a review of tegaserod[1] was prepared for *Australian Prescriber*, one of the editorial staff noticed an advertisement for the drug in a medical newspaper. The advertisement appeared to show a young man and a young woman complaining about their symptoms of irritable bowel syndrome. Unfortunately, the young man would not be able to get relief from tegaserod as it was only approved for women. Without studying the product information, health professionals may not have been aware of this restriction from the advertisement.

I wrote to the Code of Conduct Committee to say the advertisement could be misinterpreted. I did not specify which section of the Code might have been breached, but the Australian Pharmaceutical Manufacturers Association (APMA, now Medicines Australia) identified three possible breaches.

On the day the APMA informed me the complaint would be considered, I was surprised to receive a telephone call from the manufacturer of tegaserod. Obviously the APMA had promptly informed the company of the source of the complaint.

The head of marketing politely discussed the issues I had identified. I was reassured that there had been no intention to misinform health professionals. The manager suggested that as any breach of the Code of Conduct would be a minor technicality it may be appropriate to withdraw my complaint. He also pointed out that the Code of Conduct Committee has a big workload and it would be helpful if the Committee did not have to consider inadvertent breaches.

The manager followed up his telephone call with a civil electronic mail message asking me to consider withdrawing the complaint. If other companies take this very persuasive approach it may help to explain why relatively few complaints from health professionals reach the Code of Conduct Committee.

I was on the verge of withdrawing the complaint when tegaserod started appearing in the general media. The stories hailed tegaserod as a breakthrough treatment and featured Kirstie Marshall (Olympic skier, now turned Victorian MP) as the celebrity sufferer. Unfortunately, the message that tegaserod was only approved for women with a less common form of irritable bowel syndrome was not clear. Perhaps the marketing materials did need clarification? I decided not to withdraw the complaint.

The Code of Conduct Committee found the advertisement had breached all three sections of the Code. In keeping with APMA policy[2], I was asked to keep the verdict confidential in case the company appealed the decision. I heard nothing more about the complaint until it was published in the annual report of the Code of Conduct Committee.[3]

REFERENCES

1. Tegaserod. Aust Prescr 2002;25:74-5.
2. Marley J. Complaints: a personal view. Aust Prescr 1999;22:80.
3. Medicines Australia. Code of Conduct Annual Report 2002. Canberra: Medicines Australia; 2002.

Patient Support Organisations

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State and Territory AIDS Councils

AIDS Council of NSW
9 Commonwealth Street
Surry Hills NSW 1300
Phone: (02) 9206 2000
Web site: www.acon.org.au

Northern Territory AIDS Council
46 Woods Street
Darwin NT 0800
Phone: (08) 8941 1711
Web site: www.octa4.net.au/ntac

AIDS Action Council of the ACT
16 Gordon Street
Acton ACT 2601
Phone: (02) 6257 2855
Web site: www.aidsaction.org.au

West Australian AIDS Council
664 Murray Street
West Perth WA 6872
Phone: (08) 9482 0000
Web site: www.waaids.com

AIDS Council of South Australia
64 Fullarton Rd
Norwood SA 5067
Phone: (08) 8362 1611
Web site: www.aidscouncil.org.au

Victorian AIDS Council
6 Claremont Street
South Yarra VIC 3141
Phone: (03) 9865 6700
Web site: www.vicaids.asn.au

Tasmanian Council on AIDS and Related Diseases
319 Liverpool St
Hobart TAS 7000
Phone: (03) 6234 1242
Web site: www.tascahrd.org.au

Queensland AIDS Council (QuAC)
32 Peel Street
South Brisbane QLD 4101
Phone: (07) 3017 1777
Web site: www.quac.org.au