OFFICE OF RESEARCH ON WOMEN'S HEALTH (ORWH)

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PINN POINT ON WOMEN'S HEALTH

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PODCAST 8:
HIV/AIDS IN GIRLS AND WOMEN

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I-N-T-E-R-V-I-E-W

ANNOUNCER: From the National Institutes of Health in Bethesda, Maryland, America's premier medical research agency, this is Pinn Point on Women's Health with Dr. Vivian Pinn, Director of the Office of Research on Women's Health. Now here's Dr. Pinn.

DR. PINN: Welcome to another episode of Pinn Point on Women's Health. Each month on this podcast we take a look at some of the latest developments in the area of women's health and the medical research that affects our lives.

For today's podcast, I'm so happy to welcome Dr. Victoria Cargill who is Director of Minority Research and Clinical Studies in the Office of AIDS Research in the Office of the Director here at the National Institutes of Health and we're going to talk about HIV/AIDS In Girls and Women.

But first, some hot flashes from the world of women's health research coming up in just 60 seconds when we continue with Pinn Point on Women's Health.

(Music played.)

ADULT: Come here and give Auntie a hug.

CHILD: Wow. You sure have lost some weight.

ADULT: How do you know that, Princess?

CHILD: Because now when I hug you, I can fit both of my arms around you and touch my fingertips. Are you on one of those diets that Mommy tries every month?

(Laughter.)

ADULT: No, sweetie. I'm just trying to eat healthy and move more so that I can spend more time with you.

CHILD: What do you mean?

ADULT: Well, diabetes runs our family and I'm trying to prevent it before I get it. There's a new program that has tips on more than 50 ways to prevent diabetes. So I'm doing it and getting results.

CHILD: So you mean you're doing this all for me?

ADULT: Well, something like that.

(Kiss.)

ANNOUNCER: Talk to your health care provider. Losing a small amount of weight by being active 30 minutes, 5 days a week and eating healthier can prevent Type 2 Diabetes. For more information and to get your free More Than 50 Ways brochure call 1-800-438-5383. This message is from the U.S. Department of Health and Human Services, National Diabetes Education Program.

(Music.)

DR. PINN: Welcome back to Pinn Point on Women's Health. As promised, again it's time to take a look at some of the hot flashes in the news regarding women's health research.

First, I want to bring to your attention some action that the Food and Drug Administration took recently. There's been a lot of interest in and a lot of questions about so-called bio-identical hormone replacement therapy or BHRT as some refer to these compounds. The Food and Drug Administration recently sent letters warning the pharmacies that make claims about the safety and effectiveness of these so-called

bio-identical hormone replacement therapies that their products are unsupported by medical evidence and [the claims] are considered false and misleading by the FDA.

The FDA is concerned that unfounded claims like these mislead women and health care professionals. There have been improper claims that these so-called bio-identical hormones are superior to FDA-approved menopausal hormone therapy drugs like estrogen or combined estrogen and progesterone, that they are superior to these and that they can prevent or treat serious diseases like Alzheimer's, stroke, various forms of cancer, or keep women feeling young and sexy. But the FDA is concerned about these claims because these compounded drugs are not reviewed for safety and effectiveness and there is nothing to ensure that they are any better or any safer for women.

I'd like to make sure that you're familiar with this recent action by the FDA, be concerned that no drug product containing Estreol has ever been approved by the Food and Drug Administration and there is no medical

information on the safety and effectiveness of this hormone. If you'd like more information about bio-identical hormones and the recent information from the Food and Drug Administration, go to the FDA Web site where they have consumer information for you.

Another hot flash is also related to menopausal hormone therapy. A study from the Fred Hutchinson Cancer Research Center in Seattle has suggested that women who take combination hormones for their menopausal symptoms are more likely to get lobular breast cancer, which is an uncommon type of breast cancer, but that women who take combination hormones are more apt to get this type of breast cancer earlier and, of course, the concern is that this type of cancer doesn't usually form a nodule in the breast or a lump in the breast So it may be harder to detect.

But this study also found out that usually this type of cancer in association with combination hormone therapy occurs only after taking these hormones for 3 to 5 years. Women who are taking combination therapy for their menopausal symptoms and adhere to the

recommendations that post-menopausal hormone therapy should be taken in the lowest dose for the shortest period of time should not have any concerns. This paper was published in the January issue of *Cancer Epidemiology, Biomarkers and Prevention.*

And one last hot flash and that is to bring to your attention the fact that while we've seen an increase in women taking folic acid supplements, recent data from the CDC, that is the Centers for Disease Control and Prevention of the Department of Health and Human Services, data suggests that while we've seen an increase in the number of women who are taking folic acid supplement—it is a B vitamin crucial to prevent some major birth defects—the number still remains too low according to the CDC and especially among women of child-bearing age where it is most important that folic acid supplements be taken to prevent birth defects if women do become pregnant and to protect the fetuses.

If you're looking for more information about folic acid supplements, speak to your physician, your nurse, your

clinic or go to the Department of Health and Human Services Web site to the CDC and look up folic acid.

With those few hot flashes, we'll have more for you in the next podcast. But I'm anxious to get to our interview today. Our guest today is Dr. Victoria Cargill who is Director of Minority Research and Clinical Studies in the Office of AIDS Research within the Office of the Director here at the National Institutes of Health.

Dr. Cargill is not only familiar with research related to HIV and AIDS, especially as it relates to women and minorities, but also is a practicing physician. So she has both the perspectives of a researcher, a policy maker, and that of a practicing physician in the community where she has become very familiar with the issues.

So, Dr. Cargill, welcome and thank you for joining us today.

DR. CARGILL: Thank you.

DR. PINN: Well, I could begin to spout some of the data, but you're the expert. Tell us what has been happening in recent

years as it relates to HIV/AIDS and women. Is this still considered a major issue for women in this country or around the world or have we taken care of the problem?

DR. CARGILL: Well, your question is multi-faceted. So let me start with one part and move forward.

First of all, HIV in women almost from the beginning of the epidemic has been a problem for women. It has been under-recognized though as an epidemic because the first five cases reported by Gotlieb and colleagues were all gay men and so unfortunately this led to a perspective that HIV and AIDS must be indeed a white, gay man's disease.

However, between 1990 and 1994, we saw a quick up-tick in the number of cases in women so that women actually went from something like 14 percent to 25 percent and now, where we are currently, women are a significant proportion of the cases and, more importantly, African American and Hispanic women are almost 80 percent of the AIDS cases reported in women.

If we think about what's happening locally, for example, in Washington D.C., we know that approximately one out of 20 women is HIV positive, which is almost staggering and if you think about HIV infection and AIDS and its consequences as recently as just 3 years ago it was still the third leading cause of death in African American women ages 25 to 34. So all of this continues to let us know that HIV infection is alive and well in women for a number of reasons from the basic science of how HIV is transmitted to the multiple social and economic and power dynamics in relationships that women often experience.

DR. PINN: When we think about or when I think about the fact that we've seen an increased recognition of how HIV affects women and that it does affect women from original thoughts that it was really just a condition that affected gay men and mostly gay, white men and we've certainly learned a lot more than that in recent years. But, you know, one of our focuses in women's health is to look at differences or similarities between men and women and, as I recall, the HIV syndrome, if

you will, is one that really helped bring attention to and point out why it's important to understand differences between men and women as we understand their conditions and how conditions may affect men and women differently.

Weren't there actually some changes made in criteria to diagnose AIDS after understanding that women may be affected somewhat differently than men that helped us to better make this diagnosis in women?

DR. CARGILL: What you're actually referring to is the 1993 change in the CDC case definition and the CDC case definition was actually changed because the original criteria we're using to diagnose AIDS really eliminate a large number of people, the bulk of which happen to be women. Unfortunately, it will also eliminate a fair number of people who were relatively early on in their infection or even if they were with advanced infection, particularly given their race and ethnicity, may be presenting differently.

So, for example, we recognize that bacterial pneumonia, certain types of

bacterial pneumonia that were recurrent, should increase the index of suspicion for provider to check for HIV infection. But for women and particularly women the issue of recurrent vaginal candidiasis was completely off of people's radar screens. And, so, there were anecdotal reports of women presenting to a physician with five, six, eight, ten yeast or candidal infections of the vagina in a year and never prompting a conversation on any of their sexual risk behavior or HIV testing.

In addition to that, we certainly appreciate now that women with HIV infection have for some time had a higher rate and risk of developing cervical pathology abnormalities including carcinoma in situ as well as the CIN lesions.

DR. PINN: Say what CIN is. We have a mixed audience. So I'm going to—because this is really wonderful information you're giving—ask you to back up just a little bit and say a little bit more about what candidal infection is and then what CIN is so that our entire audience will understand that.

DR. CARGILL: Sure. In terms of

candidal infections, women often refer to them as yeast infections or the “white itchies.” It’s a consequence of a lot of moisture in sexual practice. But the bottom line is it’s a recurrent yeast infection. Women are often given Monistat or you may have been given Fluconazole or Nizoral. But the bottom line is in a young woman who isn’t taking oral contraceptives, doesn’t have diabetes, doesn’t have an immune disorder other than HIV, to have six, eight, ten yeast infections like this in a year, someone needs to be very suspicious that this is a marker for the immune system failing and it’s failing in being able to control what is a normal inhabitant of the female vagina, yeast, and it is overgrowing and causing infection.

Now the other comment I made was about CIN, cervical intraepithelial neoplasia and that is a very important early, but precancerous, warning lesion that is found in PAP smears. One of the findings that has been consistent over the duration of the epidemic is over 90 percent of women with HIV infection also have Human Papillomavirus infection and

we now appreciate the role of Human Papillomavirus, particularly certain types, and we number them by type so we can keep them straight, are associated with cervical cancer.

So now you have an individual who already has an immune deficit. The immune deficit affects those cells which are responsible for watching the body cells for abnormalities or cancer cells and now we also have a virus that's known to drive cancer in a certain organ, i.e., the cervix, and you can see it's not surprising that women with HIV infection have more cervical pathology and ultimately have higher rates of developing cervical cancer and having that cervical cancer progress quickly.

DR. PINN: You just happened to mention something about cells and often I'll hear from people I know who are being followed for HIV or AIDS about their cell counts. For those who don't understand that, could you say a little bit about cell counts and why physicians and others look to their patients and help them monitor their T cells or other cell counts?

DR. CARGILL: Sure. Cells are very important in HIV. I think, first of all, it's important to understand that the virus attacks us by latching on to several cells and, while we focus on T cells, there are a number of cells that HIV attach itself to including monocytes and macrophages. Those are white cells which live in our skin and other portions of our body and in the layers in between our organ cells that very often are called out whenever there's an immune challenge.

But the cells we ask that our patients who have HIV infection know and follow are called their CD4 or T cells and, in the immune system, we can really think of it as a seesaw. T cells are the killer or the fighters. They're the ones that come out and sniff over every cell of our body and decide whether or not it should be there or not and, if it's abnormal, it's sort of like the police officer on the corner that can blow the whistle and all the recruits come, whether it's humoral sources like proteins or other cells and the cell is destroyed.

On the other hand, we have these wonderful cells. I tell my patients to think of them as sort of the lazy, hang-out cells called the CD8 cells and they're suppressors. They're the ones that say, "Go back. There's not a big stir here. False alarm." In normal balance, the seesaw should be perfectly level. CD4s and CD8s should be in a ratio so that it's one to one or 1.5 or two, meaning we have more of our CD4s or killers than we have our CD8s around.

But, unfortunately, when you become infected with HIV, it's like walking around with a huge bucket of sand with a tiny hole in the bottom and it's not until you've walked a couple of miles that all of a sudden you realize that half the bucket is empty. Where did it go? And it's the same thing with HIV. Very quietly while people go on living their lives, feeling relatively normally, maybe a little nausea here, a little sweating there, they wander into a physician's practice because they don't feel well and lo and behold the cells are not right and these cells are T cells and, as I mention, these are cells that

fight cancer, these are cells that fight fungus, these are cells that fight yeast, these are cells that fight tuberculosis and so all the complications that come with the epidemic make sense when you understand the cells that are destroyed.

As the virus progresses, the T cells drop and use T cells as a marker just like you use your gas gauge. When they're full, meaning 1,000 or better, life is good. We have to monitor you. When you have a half of tank of gas or about 500, that's when we really need to start paying attention and watching you more closely. When you're at about two-thirds of a tank or maybe a little less than that, maybe about one-third and you're about 350, it's time to get busy and talk about medication. When you're operating at a quarter or less which means T cells around 200, we need to protect you against some of the infections that are very common like we hear AIDS pneumonia or a big word, Pneumocystis carinii, and we get down to an eighth of a tank, that's when if we don't get help soon we're not going to make it to the

gas station. That means we have to protect against viruses and infections that people ordinarily wouldn't even think about being bothered with but now they're going to come out in full force because the immune system is staggering and that's really why we ask our patients to watch their T cells.

DR. PINN: I think that was a great explanation. I like the way you explained that and what has been impressive to me is how people who have HIV are really very familiar with and really understand that issue about cells and monitoring and I think that's some progress that the AIDS community has made and that hopefully the medical community has contributed to, which leads me to another question I want to ask you and then I'll come back to maybe some more current questions.

But when this condition first became recognized, we know there was great concern because there was phobia in the community of health care professionals about taking care of or wanting to even make that diagnosis. Have we seen great improvements in that area, especially for women, but in

general?

DR. CARGILL: It's really a mixed bag. You know, stigma is alive and well and I like to think of stigma as the something you have that I don't have that lets me feel better than you are and it's an unfortunate aspect of human nature, but there it is. In the beginning, we had a great deal of stigma because the disease was characterized based on its epidemiology and still is by people engaging in behaviors that most of us would not go out and put on a billboard in our front yard, sex with multiple sexual partners, intravenous drug use, sharing needles, perhaps using crack cocaine and sharing pipes, anal intercourse whether you're a male or a female and that's very important because all too often we stress gay men. Well, why is it gay men? It's not because they're gay. It's because of anal intercourse and it's important for our audience to understand and remember that there are many women whether they admit it or not who engage in anal intercourse for a number of reasons and, particularly, young girls which is a high-risk behavior for HIV

transmission.

So in that time period, it was very easy to stigmatize people and the words we would often hear as code was a physician calling in and saying, ”I have one of those people in my office I would like to talk to you about” and I always like to tweak people and say, “What is ”one of those people? Is there someone with a unique syndrome of cancer or something? I don’t understand what “one of those” means.” And people would clear their throats and become uncomfortable.

I think in that way that’s changed. We certainly see women engaging in care. I wish we would see more women access care quickly so we didn’t have to have women come in with advanced disease.

But now we have different types of stigma. We have women now facing that not every provider they see understands that she has options if she chooses to want to bear children. We see women who have chosen to bear children and have HIV-negative children and have done according to protocol to reduce and minimize the risk of their partner still

being referred to in less than polite terms about their choices. We have women who are afraid understandably because of intimate partner violence to discuss their HIV status with a partner and therefore may choose to either go without partners or may lie and unfortunately place their partners at risk.

So stigma is not gone. Stigma has just changed how it appears. It's the ultimate chameleon I think.

DR. PINN: What options do women with HIV have if they want to become pregnant?

DR. CARGILL: That's an excellent question and, first, I would like to say that women who are HIV positive have the right to consider and decide whether or not they wish to have children. They do not have the right to engage in a behavior to have children that would place someone else at risk. So I want to be very clear before we proceed down that road that I'm saying that any woman who wants to have a baby and who is HIV positive just go ahead and take care of that and not worry about risk. That's not true. But every woman has the right to make that decision.

There are multiple options available to women, but I think, first and foremost, we have to start at the beginning. Any woman who finds herself in the situation of being HIV positive must seek care because it is much easier to get a woman into the best immune shape and overall general health shape possible before she conceives rather than trying to catch up afterwards.

You know, one of hot flashes had to do with folic acid and trying to prevent neurotube deficit. You can imagine that we have even more difficulties if we're trying to make sure the immune system is right, we don't have transmission to the fetus and that we have a mom who is healthy afterwards because there's no point in having a baby who doesn't have a mom.

That being said, there are several options. One of the options that patients will choose is they will choose often to have an in vitro fertilization, meaning they will have their eggs harvested. We have excellent techniques now to having sperm washed. So that there's sperm wash and that can be done

and then literally sperm and egg are introduced and then the sperm are -- the egg is then implanted. One of the difficulties with sperm washing is it can be quite expensive and so for individuals who do not have the resources available to them, that's difficult.

The other option and this is something that it's one of the those things where my patients tell me and I say, "I'm glad that you decided to do this and I'm also glad I necessarily didn't know ahead of time" is something that's known by its lay term of turkey basting and that is individuals whose partners will ejaculate outside of themselves into a container and they will literally use one of those basters to introduce the semen into the vagina at the base of the cervix during the time of fertility.

Obviously, this requires that women be very familiar with their menstrual cycle, with what their time of fertility is, and that is why I think it's best we have women who are in care because the other piece of this is the guidelines for treating women with HIV

infection are different if you have a woman who is pregnant. The same viral load triggers that we use to initiate therapy or the same T cell triggers, they're not the same in women who are going to bear children.

And there is very good reason for this. We have been able to successfully reduce the transmission of HIV infection from mother to child to being almost unheard of in this country. That is not true all over the globe. So this is why we particularly stress that we need to make sure they get into care so that they can have the best care options available and because they and their partners can make informed decisions.

DR. PINN: I think that's very good news especially for women of child-bearing age who have been exposed to the HIV virus and who still wish to have families and for their spouses or their significant others.

But we've been talking about women of child-bearing age. What about older women?

DR. CARGILL: That is also an excellent question. It's the other side of the coin and I actually was just reading again

yesterday some additional information about older women.

You know, many women especially if they've passed the age of menopause or children are grown, they feel like this is it. I don't have to worry about being pregnant. I don't have to worry about someone walking in on us. We can just basically have a good time and that's true and that's not true. Women, unfortunately, who are older and particularly perimenopausal and post menopausal bear some unfortunate similarities to their adolescent counterparts and that is that their risk of acquiring HIV infection through unprotected intercourse is greater and we should explore why.

When women are post and perimenopausal vaginal lubrication is not as prompt and prominent as it in women of child-bearing age. Therefore, it increases the likelihood that there's going to be micro and maybe even in some ways macro trauma to the vagina and we're talking about a virus that already finds it way in through a number of different outlets. So it doesn't need a

highway like 95 opened up to jump straight into the immune system and then on into blood dissemination.

The second reason why women who are peri- and post menopausal are at risk is the vaginal layers are much thinner and, in addition to that, a lot less forgiving of the sort of trauma that can happen, that is, normal part of trauma with sexual intercourse. So it's important for women to be careful about that.

And, third, and this is one that you touched on, many women are taking hormone replacements and these hormone replacements can change the junction. There's a place where in the cervix if women still have a cervix where the endocervix or portion of the cervix and the other outer part of the cervix meet and if that creeps up too much onto the surface that area is very easily traumatized and will bleed. Well, now if you have a blood opening and a person who has semen inside of them and that is released is HIV infected it's now opening up a vascular highway back into the system.

So for all of these reasons, women who are peri- and post menopausal or older thinking, ”I can’t get pregnant, I don’t have to worry about this,” yes, you do. And they have to worry about it not only because of their own physiology but because men are living longer. They’re living healthier. Thanks to many medications on the market, such as Viagra and Cialis, they are much more interested in being sexually active and these men are often being sexually active with individuals with whom they are not having a monogamous relationship and are placed at risk.

DR. PINN: I guess that means we have to really try to get the message out not just to young women whom we think of as being the most sexually active, but to more mature women, to our mothers and our grandmothers, so that they can recognize that they too are maybe vulnerable to this condition and to take those necessary precautions or have those concerns.

But you said they’re often like adolescents. What do we see with young girls

in relationship to the statistics and to susceptibility to the virus?

DR. CARGILL: Adolescent girls clearly are a large part of the epidemic, particularly in racial and ethnic minority populations and even more disconcerting is if you take a look at where this happens geographically. It's very clear that this is not uniformly distributed either. In the very same places that you find high rates of sexually transmitted infections, teen pregnancy, you also see adolescent girls very much being impacted by HIV and this would be in the South, especially the deep South, and the Northeast. This is a concern.

There are many markers of young girls being at risk for HIV infection and they are all the ones that we would already think about for other diseases and for, particularly, pregnancy, young girls who have low self-esteem, young girls who come from environments where they had been physically, sexually, emotionally, or all the above, abused.

Very often we see that this is part

of peer pressure and it's a reflection of the type of relationship the young girl has with someone she can speak to whether it be an older woman who is her mother or someone in her extended family or even a mentor. Because the very same things that put them at risk, you can take the flip side and find that these are protective. Investigators around the country have demonstrated that if you take a look at young girls who are either in a peer group where pregnancy and early sexual activity is not the norm or they have an ongoing dialogue with very clear normative discussions around sexual health, sexual being, including HIV, as opposed to making HIV the sole topic are at much less risk of acquiring HIV infection.

It is very sad to see our adolescents coming in with HIV infection because very often this is the first shot across the bough, if you will, that tells them what they need to do has to change. I mean, they may have gotten an episode of gonorrhea, syphilis or herpes and said, "Okay. Fine." But, basically, it's not the same as when

someone has to sit you down and say, "You have HIV infection."

That being said, I worry very much about our late adolescents because we are now increasingly seeing studies that college students are beginning to view HIV disease as being no different than having diabetes and I would say there's a huge difference between having diabetes. The similarity ends with them being both chronic diseases. But I've never heard of anybody catching diabetes from someone because of sex or impeding their ability to have children to quite the same extent that we're talking about HIV infection and so it means that we have a lot of educating to do.

DR. PINN: What do you think we need to do to get not just young girls but older women and young and older men to really understand the seriousness of an HIV infection?

DR. CARGILL: I think it has to start with education. But it cannot be just basic education, this business as usual. You know when I think about how I was taught about

sexually transmitted infections. I feel I was fortunate because I lived in a household where you just said what you had to say at the dinner table no matter how old you were.

But in many cases, it was this diseased, dirty person, vamp model, that's presented to us and what happens to people? They say the flip side is if you look good and you have a nice income and you come from a nice background you couldn't possibly have any of these. Well, with over a million cases and another 250,000 who don't even know that they're infected, I would say that's probably not true.

So what we need to do is realize that every single person is at risk for having HIV infection. Your risk may be low. It may be medium. Or it may be high. But you're at risk.

I have two adolescent children. Neither of my boys are sexually active yet, but I have spoken to them from the time they were two about their body so that my young children knew when they were two they had a penis. They didn't have a wee-wee or, you

know, whatever else people want to use. They need to know the name for it. I wouldn't tell them their arm was a stick. Why would I tell them something else?

Do I consider them at risk for HIV infection? Absolutely. They're black males and I tell them that. Just because you're not sexually active doesn't mean your risk is zero because your mind is your biggest sexual organ and at some point unless I co-oped your mind to help you understand that there are steps you need to take to protect yourself until you can trust the other person to have unprotected sexual intercourse, you're at risk. Because if your mind isn't co-oped, your body is going to follow your mind.

And I think this is part of the message we need to be aggressive in terms of social marketing. We need to talk about sexually transmitted infections as a reality. It's not HIV to the left, gonorrhea to the right, syphilis to the front and herpes in the back.

And then finally we have to address something that's been very difficult for us in

this country. We have to address the fact that we don't have any problems using sex to sell what we want to get people to buy. But we have a huge problem talking about it and until we can narrow that gap, we're going to be selling a lot of things to people who are going to be dying and that's unfortunate.

DR. PINN: Before we conclude this interview, I have just a couple of more questions. One, several times we've alluded to the fact that HIV/AIDS seems to be more common in some populations of women of color. Could you comment on that? Is that true or is it because it's reported more or recognized more and, if it is more common, why?

DR. CARGILL: There is actually no question if we look at the testing site data that there is a huge disparity when we talk about HIV infection in women. Any time you can look at an infection rate and compare African American women to their Latino counterparts to Asian Pacific Islander women to Native women and to white females and see rates that start at eight to ten times higher and then work their way down, there's a clear

disproportion.

And I think there are a number of reasons why. I don't think it's an accident that HIV is over represented in communities of color, particularly if you're talking African American, Hispanic. We certainly know for Native women, even though their numbers are small, they are clearly heavily and disproportionately impacted. These are all communities who have been ravaged by a lot of common problems, poverty, alcoholism, substance abuse.

In addition to that, if you look at African American women, one-third of African American men at some point have been incarcerated. Incarceration and prisons as far as I'm concerned are really a huge amplification center because despite what we would like to believe we certainly know by some of the Congressional actions and by those who have been in and come out and tell us rape and drug use is alive and well in prison and those are vectors for transmitting infection and then these men come out and they resume their lives.

In addition to that, you're looking at populations all of which have unequal access to health care, maybe mistrustful of health care systems, and finally, you're looking at populations that have more than one problem to deal with in terms of physical health. It is not uncommon to find people with multiple medical problems and often, and unfortunately, multiple sexually transmitted infections. There is one thing HIV loves. It's a revved up immune system because all the cells that it likes to infect are at the party and it's like a gigantic welcome home.

DR. PINN: We've talked about some progress and we've talked about some areas that still need to be addressed. But what can we expect from research that's underway and what is the message of hope, hopefully, that we can give to our audience about HIV/AIDS?

DR. CARGILL: The thing I think we should leave people with is a couple of take-home points. First of all, this is not 1984 and 1982. I was a resident and a fellow during those days and it was very bad times. People showed up when they were sick in July

and they were dead by December. I mean we have patients. I have some patients now that tease me and say, ”You know, 15 years ago we were talking about planning my funeral and now all I’m talking about is going on a diet.” I mean, there is good news in that we’ve been able to really help people in terms of the quality and quantity of their lives.

The second is that we have newer agents all the time. Whoever thought we would have an injection that allows us to block uptake of virus and now looking at blocking, integrating, it into ourselves. So I think that’s hopeful.

The third is that we press on for a microbicide. This has not been a good year in terms of the prevention news for either microbicides or vaccines. That doesn’t mean it’s impossible. I’m fortunate that I trained in a place where the individual who is responsible for the pneumonia vaccine failed countless times and finally we got it right and we succeeded. Now we all take it for granted. So while I think our work is cut out for us, I think microbicides on the horizon

will be good news for men and women who wish to protect themselves.

I think that our newer agents will hopefully continue to eliminate virus from the genital compartment or lower it and I think hopefully we'll take a look at one day soon what are all the options we have right now. So if we didn't get another thing, in what combination or what sequence do we need to use them so that we could actually drop this multiplication rate and replication rate below one? Because if we can do that, we've won the ball game.

DR. PINN: Are there other things you'd like to tell our audience related to the whole issue of girls and women and more mature women who may have or may be exposed to or may be living with HIV/AIDS?

DR. CARGILL: Sure. I'd like to close with a story because it's one I remember and whenever I feel a little bit down about what I'm doing or how we do this, it brings a smile to my face. But it reminds me that we all have assumptions that allow us to inadvertently help continue the epidemic.

One of my patients was a delightful 82 year old woman and she was asking about getting a hip replacement. But her concern about getting a hip replacement is it would limit her hip mobility and I mistakenly made the assumption she was talking about walking and doing her errands because she was quite active. And I assured her that that would not be the case.

She asked if I would be present while I made the referral to an orthopedic surgeon which I did and I will never forget when she made us both promise that we would not discuss this or leave our notes lying around which, of course, we never would but it’s because her 40-plus-year-old daughter was in charge of the cleaning service that cleaned our office suites. And when she had us both in the room, she made it very clear to us that her concern about having her hip done was that she had five or six sexual partners whose average age was 62. Now remember she’s 80. And she was not going to have this interfere with her sexual activity and you could not share with my daughter because obviously

doesn't know what's going on.

In the meantime, the evening after we both picked our mouths off the floor, I saw her daughter coming into our cleaning suite and she pulled me aside and wanted to know if there was something I could do to help her talk to her 22-year-old daughter because she would never want her mother to know this because her mother couldn't understand this new generation picking lots of partners, but could I talk to her about condoms.

Well, when I saw the daughter who came in to see me, the daughter didn't want me to know that she was talking about her mother whose husband had walked out and she was starting to see these men and could you talk to her about HIV.

So the point is we had three generations right there. Nobody talked to each other about sex, but everybody came to the doctor because everybody felt the other person needed an education and the point is we all need an education and I'll leave it there.

DR. PINN: That's right, including doctors and nurses and health care providers

and I think the information you've given will help all of us.

Thank you, Dr. Cargill. And coming up next, a few final thoughts for this month when Pinn Point on Women's Health continues.

(Music.)

ANNOUNCER: The National Institutes of Health invites HIV-positive volunteers who are off anti-HIV medications to participate in a clinical study. Men and women age 18 through 65 with CD4 counts of 350 or greater and without Hepatitis B or C are asked to call 866-999-1116 or visit cc.nih.gov. All study-related tests and medications are provided at no cost. Compensation provided. Travel assistance may be available. The NIH is a nonprofit government agency and part of the Department of Health and Human Services.

(Music.)

DR. PINN: And now a few final thoughts. We have heard lots of very interesting, very important, and very up-to-date information from Dr. Victoria Cargill, Director of Minority Research and Clinical Studies in the Office of AIDS Research in the

Office of the Director at the National Institutes of Health here in Bethesda, Maryland.

She has really pointed out how we made progress, but there are still areas that we need to learn more about. That is, we think about the impact of HIV/AIDS on our communities, on girls and women and more mature women, that we've seen progress, but we still have a need for more education and more research, both to know about what we're dealing with and for research to help us understand how to better utilize the agents and preventive strategies we have to have them be more effective as well as hopefully to come up with something that may provide a cure for this condition.

You've heard from her a very important point that this is not just a condition when we look at the community of females that affects those of child-bearing age, but we need to look at early adolescents, those who may be just learning about sexual behavior without knowing about it and probably more importantly those of the mature age group

meaning in the 60s and 70s and 80s who are still, may still be sexually active, and not realize that they also may be susceptible to this virus where we've not even thought about it before because we don't think of these communities of women in this age group in terms of perhaps sexual activity or being in positions to be exposed to the virus.

I think the message has been one of hope. The message has been one of progress. But the message has also been one that we as women and you as men understanding about these issues in women and that those who are in health care professions, we all need to be more vigilant, more understanding, more concerned and more knowledgeable about this condition of HIV/AIDS if we're going to make a difference.

In a moment, the announcer will tell you where to send your comments and your suggestions for future episodes. But for now, I'm Dr. Vivian Pinn, Director of the Office of Research on Women's Health at the National Institutes of Health in Bethesda, Maryland.

Thank you for listening.

ANNOUNCER: You can e-mail your comments and suggestions concerning this podcast to Marsha Love at lovem@od.nih.gov. Pinn Point on Women's Health comes from the Office of Research on Women's Health and is a production of the NIH Radio News Service, News Media Branch, Office of Communications and Public Liaison at the Office of the Director, National Institutes of Health, Bethesda, Maryland, an agency of the U.S. Department of Health and Human Services.

(Whereupon, the above-entitled matter was concluded.)