Television coverage of AIDS and transmission of the AIDS virus

The introduction of the government framework “The national strategy for sexual health and HIV” is necessary for attempts to prevent sexual causes of premature death and ill health, at a time when transmission of HIV is at a record level and heterosexual intercourse is the most commonly reported mode of transmission. However, policy formation alone will not be effective in the fight against AIDS in the United Kingdom. Commentators have noted television coverage of AIDS has declined as the progression of the AIDS epidemic has fallen from media interest. While television coverage raises AIDS awareness and encourages safer sex, it is unclear if it has an impact on infection rates. I have studied the association between television coverage and HIV transmission.

Television programmes with an AIDS specific content broadcast in the United Kingdom between 1981 and 2000 were identified. Criteria for inclusion were UK-wide terrestrial television programmes promoting AIDS awareness and encouraging the practice of safer sex; documenting the life of a person with AIDS; or a dramatisation featuring an AIDS storyline. Televised public education campaigns were excluded from the search, having been reported elsewhere. Television listings data were collected from a Scottish national newspaper (Daily Record) providing UK-wide television listings. Hand searching was conducted on the 1st, 15th, and 28th days of the months of February, May, August, and November; from 1981–2000: a 3.3% sample of available coverage. The sample was augmented by additional sources. A search for programmes shown as part of a one-off media campaign (as reported in the literature); between 27 February and 6 March 1987 to promote AIDS awareness and encourage safer sex was conducted. Supplementary programmes were obtained ad hoc from reviewing The Guardian CD Rom (from 1989–2000) and The End of Innocence: Britain in the time of AIDS.

Thirty-seven UK terrestrial programmes covering HIV/AIDS were identified, the earliest in 1983, most recent in 2000, and a peak of programmes in the late 1980s. Between 1996 and 1999 no programmes covering HIV/AIDS were found. Twelve programmes about AIDS were shown during the media campaign of 1987. The decline in television coverage of AIDS contrasts with the steady increase in transmission of HIV (see fig 1 and table on STI website).

The findings of my study are tentative, but hint that television coverage of AIDS has declined as transmission of HIV continues. This complements Nicoll and colleagues’ argument that AIDS campaigns (often televised) are likely to have reduced HIV transmission in the 1980s. Television is a rich source of information about AIDS, offering a powerful while unevaluated medium for promoting AIDS awareness and safer sex to the general public. Given the current low level of media interest and the ceaseless increase of HIV transmission, it may be beneficial to formally evaluate a national media campaign on this important public health issue using quasi-experimental methods.

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A table of television coverage of AIDS 1981–2000 is on the STI website www.stijournal.com/supplemental

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2 Jackson T. No news is bad news. BMJ 2000;321:1419

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High frequency of antibodies to syphilis and HIV in hepatitis C virus positive blood donors may reflect its sexual transmission in this region

Hepatitis C virus (HCV) infection is a great cause of concern because of the risk of chronicity and other sequelae. Studies on the prevalence behaviour pattern and sexual transmission of HCV infection among the population are required for formulating strategies to control spread of HCV. The aim of this study was to evaluate the occurrence of HCV in voluntary blood donors as they are known to be a high risk population for transmission of these infectious agents. Comparison was made between the presence of syphilis, HBV, and HIV infection in HCV negative and positive blood donors to confirm these as markers or predictors of HIV infection in a high risk population which may reflect the transmission of HCV by a sexual route.

Voluntary blood donors (n = 3905) from New Delhi, India, were randomly recruited between August 2001 to March 2002 and were unpaid. These donors were screened for antibodies to VDRL, hepatitis B surface antigen (HBsAg), hepatitis C virus (HCV), and HIV using previously validated second generation ELISA kits. Data were analysed using the χ² test. Odds ratio (OR) was used to measure strength of an association.

Figure 1 Television of HIV/AIDS incidence and incidence of HIV transmission in the UK, 1981–2001.
The antibodies to HCV were detected in 61 (15.6%), HbsAg in 109 (2.79%), VDRL in 132 (3.38%), and HIV in 40 (1.02%) donors. In HCV negative blood donors, VDRL was detected in 129 (3.35%), HbsAg in 106 (2.75%) and HIV in 31 (0.8%) donors and in HCV positive blood donors HCV positivity increased significantly to nine (14.75%) OR (21.2) and VDRL and HbsAg reactivity was found 21.2, 1.48, and 1.82 times more often respectively in HCV positive blood donors (table 1).

In conclusion, the high frequency of antibodies to syphilis and HIV in HCV positive blood donors confirm this as a marker or predictor of HIV infection in a high risk population and may also reflect the risk of transmission of HCV by the sexual route, which seems to vary with the population studied.

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References

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Self obtained samples for genitourinary infections

We assessed the concept of self sampling, as part of screening for sexually transmitted diseases, first in the early 1990s in a pilot study. The aim was to assess the validity and acceptability of the procedure as an alternative for the sex industry workers (or as a supplement to the sex industry workers) of ensuring that everyone has better access to information on sexual health and to make services more available and accessible to all those who require them at all ages. The strategy also has specific aims of reducing acquisition, transmission, and the prevalence of undiagnosed HIV and STIs. Specific targets to increase the uptake of HIV testing in hepatitis B vaccination have also been set.

The issue of case management guidelines was not detailed in the strategy since this has been specifically tackled by the specialty of genitourinary medicine. A clinical effectiveness group was set up between the Association of Genitourinary Medicine and the Royal Free and University College Medical School for the Study of Venereal Diseases in 1997, with the specific remit of producing evidence based national guidelines and standards for those working in the specialty of genitourinary medicine. These were published in STI in 1999 and updated in 2002. I hope these observations will help to update the survey with particular reference to England.

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Polymorphic immune restoration syndrome after effective HAART

HAART is able to suppress HIV replication and restore specific immune responses. We and others have demonstrated that previously

5 Gorovit SC, Smith DW, Harnett GB. The diagnosis of chlamydia, gonorrhoea, and trichomonas infections by self obtained low vaginal swabs, in remote northern Australian clinical practice. Sex Transm Infect 2002;78:278-81
untreatable progressive multifocal leukoen-
cephalopathy (PML) may improve and has
very rarely been reported following HAART.
However, CD4+ increase is also associated
with inflammatory reactions to previously
silent infectious agents, as well as aberrant
immune phenomena.1

Case report
A 27 year old HIV/HCV (hepatitis C virus) patient
was observed in 1997 with a CD4+ count of 357 cells x10^3/l and HIV-RNA
>1 000 000 copies/ml. HAART was started
and maintained until 1999 when it was
stopped at the patient’s request. On October
2001 he returned asymptomatic, with a CD4+
cell count of 34 x10^3/l and HIV-RNA 130 000
copies/ml. Stavudine + lamivudine + nevi-
rapine were then started, together with
trimethoprim-sulfamethoxazole. He experi-
cenced an optimal response (CD4+ count 159
x10^3/l, HIV-RNA <50 copies/ml on March
2002). One month later, the patient was
admitted because of mental slowness, apha-
sia, ataxia, impairment of fine movements of
the right arm, and hypostenia of the right leg.
He was afebrile and laboratory tests showed
WBC 5300 x10^9/l, RBC 4550 x10^6/l, Hb 16.1
g/dl, PLT: 259 x10^3/l, eosinophils 8.3%, AST
369 IU/l, ALT 1446 IU/l, γ-GT 599 IU/l, PT 84%,
and raised total plasma IgE 330 IU/ml.
Toxoplasma serology, HBsAg, HBsAb, and
HAV-IgM were negative; HBc-IgG and HAV-
2
-IgG were positive; and HCV-RNA was 172 x10^6
copies/ml (baseline 13 x10^6 copies as at
October 2001, before HAART). HAART was
stopped and liver biopsy performed, showing
chronic hepatitis with cholestasis, marked
erosinophilia, parenchymal and periportal in-
filtrates of predominant lymphocytes, and
plasma cells suggestive of allergic disease.
Cranial magnetic resonance imaging scans
revealed subcortical white matter lesions in
both frontal lobes and internal capsule with
faint peripheral enhancement after gadolin-
ium contrast. Cerebrospinal fluid analysis was
normal, fungal and bacterial cultures, crypto-
cocal antigen, and polymerase chain reaction
for HSV-1,2, varicella zoster virus, Epstein-
Barr virus, cytomegalovirus, Mycobacterium
spp were negative, while JCV-DNA was
positive; a cidofovir standard dose was initi-
ated. Subsequently, progressive improvement
was observed (fig 1) and PML stabilised.

Comment
We report a complex polymorphic immune
restoration syndrome of PML (demonstrated
also by JCV-PCR in contrast with previous
reports1) combined with the first case of liver
damage related to delayed immune mediated
hypersensitivity reaction to nevirapine.
Several facts support an immunopatho-
genetic role of aberrant immune recovery in this
case: (i) these phenomena occurred together
in concomitance with raising CD4+ T cell
count under effective HAART; (ii) PML during
HAART is exceptional; (iii) both PML during
HAART and nevirapine hypersensitivity2
occurred during the first weeks of therapy in
the case series reported so far; (iv) nevirapine
hypersensitivity is frequent in conditions of
pathogenetic mechanisms and immuno-
logical factors associated with immune resto-
ration diseases may be diverse and unex-
pected. Moreover, nevirapine hypersensitivity
is immediate while this case of liver damage
occurred after a substantial period on nevi-
rapine and with concomitant elevation of
γ-GT enzyme and increase in HCV replication.
Therefore, it would have been very difficult to
make the correct differential diagnosis with
either late onset metabolic idiosyncrasy to
nevirapine or relapsing HIV hepatitis without
liver histology. Thus, avoiding liver biopsy in
such cases may lead to an underestimation of
the causative role of nevirapine.

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1 Cinque P, Casari S, Bertelli D. Progressive
multifocal leukoencephalopathy, HIV, and
highly active antiretroviral therapy. N Engl J Med
2 Mayo J, Collazo J, Martinez E. Progressive
multifocal leukoencephalopathy following
initiation of highly active antiretroviral

NOTICES

International Herpes Alliance and International Herpes
Management Forum
The International Herpes Alliance has intro-
duced a web site (www.herpesalliance.org) where
patient information leaflets can be downloaded. Its sister organisation the Inter-
national Herpes Management Forum (web site:
www.IHMF.org) has launched new
guidelines on the management of herpesvirus
infections in pregnancy at the 9th Inter-
national Congress on Infectious Disease
(ICID) in Buenos Aires.

Pan-American Health
Organization, regional office of
the World Health Organization
A catalogue of publications is available online
(www.paho.org). The monthly journal of
PAHO, the Pan American Journal of Public
Health, is also available (subscriptions:
pubsvc@psp.sheridan.com).

XIX International Congress
of the Society of The Fetus as a
Patient
1–4 May 2003, Gran Hotel Sitges, Barcelona-
Sitges, Spain.
Further details: (fax: +34 93 418 7832; email:
bcn2003@iudex.us.es).

Australasian Sexual Health
Conference: Tango down
South—2003!
4–7 June 2003, Christchurch Convention
Centre, New Zealand.
Further details: Dart Associates (tel: +02
9418 9396/97; email: dartcon@mpx.com.au;

NSC Dermatology Update 2003
Further details: Mrs Alice Chew, National
Skin Centre, 1 Mandalay Road, Singapore
308205 (tel: +65 6350 8405; fax: +65 6253
3225; email: training@nsc.gov.sg).
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http://sti.bmj.com/content/79/2/170.1

These include:

**Supplementary Material**
Supplementary material can be found at:
http://sti.bmj.com/content/suppl/2003/04/14/79.2.170.DC1

**References**
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