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HIV Testing After 25 Years

ALARMING UNDERESTIMATION OF THE INCIDENTS OF HIV IN THE UNITED STATES

Our presidential election is only days away. Forty eight million people in America are uninsured and healthcare costs are rising 2 to 3 times faster than our nation's GDP. Where will America's Healthcare System be in 5 years? Welcome to ReachMD's monthly series Focus on Public Health Policy. This month, we explored many questions facing healthcare today.

After 25 years, does the HIV epidemic continue and to what extent? Welcome, you are listening to a special segment and Healthcare Policy on Reach MD XM157, the Channel for Medical Professionals. I am you host, Dr. Maurice Pickard, and joining you today is Dr. David Hardy. Dr. Hardy is Director of the Division of Infectious Disease at Cedars-Sinai Medical Center, an Associate Professor of Medicine in Residence at the David Geffen School of Medicine at UCLA.

DR. PICKARD:

Thank you very much Dr. Hardy for joining us.

DR. HARDY:

My pleasure, glad to be here.

DR. PICKARD:

To begin with, could you tell me what was the significance of the recent CDC statistics on HIV incidents?

DR. HARDY:

The main thing I think was most concerning about that was that it looked like that CDC had for lack of the best technology being used, had underestimated by about 40%. The number of new cases of Americans becoming infected with HIV and is more than just for the single year that they had gone through 2006, but actually back for probably about the last 8 or 9 years.

DR. PICKARD:

What were the numbers that they now report it?

DR. HARDY:

More specifically, the numbers had increased from an estimate of around 40,000 per year, which is what the CDC's have been telling us for the past 10 years. As far as number of new cases of Americans becoming infected with HIV, to an increase of over 56,000 cases per year, a full 40% increase over what they had previously been telling us.

DR. PICKARD:

What do they attribute this pretty significant statistical difference?

DR. HARDY:

The major increase was due to a technological improvement in the assay that they have been using. They are now using an assay at their multiple sentinel sites around the US, which they use to monitor the HIV epidemic and this new assay is actually able to discriminate between new cases of HIV, meaning those that occurred within the past 6 months and cases that occurred earlier than that time. So, this new assay was really able to assign a Y on the new cases of HIV infection.

DR. PICKARD:

Could you tell me what this new assay is, and what is the significance of a recent case and an older case?

DR. HARDY:

The assay is really not a new one, it's actually an older assay that has been somewhat tossed aside because it actually was too sensitive. It called a de-tuned ELISA. The de-tuned ELISA test is one that is overly sensitive. Errors in that site being perhaps creating false positives, but it also allows once the test case is, in fact, found to be confirmed, it can discriminate with great specificity whether that case occur within the past 6 months or later than that because of the fact that HIV antibodies, which it detects evolved overtime, so this test called the de-tuned ELISA is one that has been used in research studies to detect new cases of HIV for research studies, and in this way, it was being used for epidemiologic measures as well.

DR. PICKARD:

How quickly do the results come back with this test?

DR. HARDY:

This test is not a rapid test. It's a test that's done usually in batches in a laboratory in a standard sort of 96 well ELISA format, in which samples are taken from sites around the United States in which there is a suspicion of HIV infection in different populations. Initially with a batch <_____> use them, usually takes about at least 4 to 6 hours to run the test, but they are usually not done for diagnostic purposes. These tests are simply done for purposes of trying to attract the epidemic.

DR. PICKARD:

Then I must be confused. Isn't there a new test that takes minutes and actually even saliva as well as blood to determine it?

DR. HARDY:

There are some oral tests that are being used now for rapid personal patient identification, right. Those tests, which actually do not test saliva, but what they do is they run a wheel palate over the inside of someone's buccal mucosa or along the gingiva surfaces and actually pick up antibodies from those surfaces excreted in the mouth. So, those tests actually can be done as fast as 10 to 20 minutes in terms of results. Those are not the kind of tests that are being done for the CDC for these purposes. Those tests are done if someone wants to find out the positive rapidly. They are used particularly in Emergency Departments and also in situations where a woman is coming in to have a baby and has never had an HIV test and is tested at the time of delivery, so that the results can come back very rapidly and something can done to intervene in that delivery.

DR. PICKARD:

We'll come back to that, but while we are talking about this underestimation of the incidents, within that number, how did they break down as far as minority groups, genders. Was there anything else that caught your attention and other people, who are involved in the treatment of HIV/AIDS?

DR. HARDY:

There were some, I think, very concerning statistics in terms of the demographics of those persons, who are being diagnosed as newly HIV infected in the past 8 to 9 years, as has been the character of epidemic for the entirety of the past 27 years, the majority of these persons are male, 70% of them are male, 60% person them, in fact, classifies men, who have sex with men. The majority of the racial breakdown is, in fact, primarily African American followed by Latino Hispanic, and then followed by Caucasian, and then Pacific islanders, and native Americans, Alaska native as the smallest affected group, but the thing that was really the most concerning here was that the decrease is the trending down of new cases of AIDS that have been seen in many groups of individual, particularly high-risk heterosexual individuals, who can be infected by that route of transmission, injection drug users continues to go down. I think the most concerning is that since the mid 90s, there has been a significant increase in the number of new cases among men, who have sex with men, indicating that the prevention message has really not been getting out there. The other concerning statistic was that in terms of age groups, the majority, over 36% of the new cases are occurring among individuals between the ages of 13 and 29, adolescents, and young adults, individuals who have really not been getting the message about the problem with HIV epidemic and AIDS.

DR. PICKARD:

Well, it's interesting that the people, who practice high-risk heterosexual activity as well as drug users are going down. Are they getting the message? Before we go onto the people who aren't getting the message, does it have something to do with needle exchanges, which has certainly been controversial in Unites States.

DR. HARDY:

That's a good question. I think the concern here is that the messages being put out by our major Steadily Funded Prevention Organization, the centers for disease control and prevention, CDC for short at Atlanta has been really somewhat limited in the kind of information that we have been able to put out there. They have been following a protocol, primarily the ABCs, meaning abstinence from sex, be faithful – meaning monogamous to their partners or single partner, and condoms as a third and tertiary way of actually preventing HIV. For individuals who are heterosexual and are concerned about procreation, pregnancy, that in fact can make some sense because that's another added thing of about having safe sex. For individuals who are not concerned about procreation, particularly men who have sex with men, that kind of approach really doesn't hit home and doesn't make sense, and in large part, its good news that the persons who became infected through injection and drug use, perhaps through some needle exchange programs in sentinel areas around the country and heterosexuals have been alerted to this. Its very good news, I am glad to see those cases are actually starting to come down. The bad news is that the program that the CDC has been putting out, really hasn't been targeting the individuals who are probably at the highest risk for this and that is young men, primarily African American and Hispanic, who are having sex with other men and not lacking in the way that our program has been working there.

DR. PICKARD:

The present administration has gotten a lot of credit because a PEPFAR, the US Presidential Emergency Plan for AIDS Relief, which is our global attempt to bring this epidemic under control. The ABCs that you have mentioned are supposedly being loosened. Should we say that the emphasis on abstention is being toned down or more money is going into prevention in the global approach, we see that happen in United States.

DR. HARDY:

That's a great question. You know that prior to this program for AIDS relief in Africa and other parts of the world is a wonderful program and is something that certainly all of us want to continue to support because of the huge problems this endemic has had around the world. I think some of the problem, especially after new CDC statistics tell us, is that we need a national PEPFAR. We need something to actually focus some of those energies on what's going on here in United States. One of the saddest statistics I have heard at the recent internationalized conference was that if the African American community affected with HIV United States was piled up as an individual nation that group of people would be qualified as a PEPFAR nation right here in Unites States. Something that I find really concerning because of the fact that while our present administration has seemed fit to send money away from our United States to combat AIDS, they have done very little in terms of putting money right here at home, where the problem is actually much more dramatically increasing than what we thought before.

DR. PICKARD:

Yeah, as a part of that same conference I was struck that if you look at African Americans in the United States, there are more African Americans suffering with AIDS than 7 out of the 15 countries are that is part of PEPFAR.

DR. HARDY:

That's very true. Even our nation's capital, Washington DC, has one of the highest prevalence rates of HIV infection per capita than many countries that are getting PEPFAR in Africa. Again, a real estimate to the fact that we have been looking away in terms of

epidemic, in terms of its funding for prevention than looking towards own backyard.

DR. PICKARD:

The other statistic that came from that conference was that 4% of the 23 billion dollars we spent this year are on prevention, and if you factor an inflation prevention is only 5% more in 2006 than it was in 1990, and I think again, this just means that we need PEPFAR in United States.

DR. HARDY:

Well, I think we need something in the same lines that are PEPFAR, but probably the better way to call would be a national HIV/AIDS strategy or plan. Since the beginning of this epidemic in 1981, since the CDC has been tracked at, there has never been a federally sponsored national HIV/AIDS plan or strategy, how to handle this epidemic. Unlike countries like Brazil, United Kingdom, Canada, Mexico, all those countries have put together a national AIDS strategy, and in doing so, have really been able to bring down the numbers of HIV in their countries. The United States has just not done that and it is a real lacking.

DR. PICKARD:

Well, why do you think African Americans, who only make a 12% of our population, actually represent 45% of new cases?

DR. HARDY:

You know that is a very complex question for which there is no, I think, one simple answer. As many people always talk about a medicine is multifactorial, meaning that there are probably several socioeconomic factors, the fact that perhaps there is a greater concentration of African American in certain urban areas or perhaps injection drug use or perhaps interactions in the law and prison time where HIV transmission is also very high. This is something that is not really clear. There is a hypothesis <_____> called here that there may be a genetic hypersusceptibility among Africans or persons of African descent to HIV. It's called the Duffy antigen. A British researcher hypothesized this and it may say that an antigen that protects you from malaria and helps you survive that disease may actually make them more susceptible to HIV. Whether this is really true or not, is yet to be fully worked out, but I think it's probably socioeconomic, I think it's probably cultural, I think it may even be generic, who knows.

DR. PICKARD:

Today, we have been talking about the very alarming underestimation of the incidents of HIV in the United States. There are multiple reasons, there is certainly minority groups that are being affected way out of proportion to the general population. I want to thank Dr. David Hardy, who is Director of the Division of Infectious Disease at Cedars-Sinai Medical Center and also an Associate Professor of Medicine at Geffen School of Medicine at UCLA. I want to thank you all for listening to this special segment on Healthcare Policy.

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