



DELTA REGION
AIDS EDUCATION
& TRAINING CENTER

*Educating
health care providers
about HIV/AIDS*

HIV Clinician

formerly FACULTY NOTES

Spring 2001 • Vol. 13, No. 2

Gynecological considerations are more important now that HIV therapies have improved

Ronald Wilcox, MD

Between July 1998 and June 1999, women accounted for 32% of the adult cases of HIV infection and 23% of the adult cases of AIDS in the United States. Women are the most rapidly growing group with HIV infection in the US, especially in the African-American community. Because a larger percentage of their practices are HIV-infected females, health care providers must be familiar with many of the special concerns for women with HIV, especially in the area of gynecologic medicine.

In 1999, a study by Minkoff et al found that among 262 HIV-infected women, 46.9% had at least one incidence of a gynecologic condition upon serial assessments. With the improved therapies resulting in improved longevity and improved quality of life, the incidence of gynecologic problems is likely to become of more importance.

Cervical HPV

In 1993, the CDC expanded the case definition of AIDS to include invasive cervical cancer. In the HIV-infected female population, the incidence of abnormalities of the cells on a PAP smear ranges from 30-60%, with 15-40% having evidence of dysplasia. This is greatly increased when compared to the general population, being at least ten times more common in HIV-positive than in HIV-negative women. Human Papillomavirus has been shown to be the most common cause of cervical carcinoma; the spectrum of disease in this population ranges from subclinical disease to classic genital warts to lower genital tract intraepithelial neoplasia to

invasive cancers. HIV-infected women have been shown to have an increase in the prevalence of HPV, a greater prevalence of oncogenic subtypes, a higher likelihood of multiple subtypes, and a longer persistence of HPV infection. It was suggested by Sun et al that the presence of immunosuppression can shift the ratio of latent to clinically expressed HPV infection from 8:1 in the general population to 1:1 in HIV+ women with CD4 counts less than 200. When dysplasia is present in HIV-infected women, it is more likely to also involve other sites including the vagina, vulva, and perianal areas.

See Gynecological, next page

Inside

- 6 FDA Warning
- 7 Nutrition
- 8 Nursing
- 10 Mental Health
- 12 Journal Articles
- 12 CE Programs

Legal

Supreme Court rules in favor of states' rights instead of disabilities act

*Linton Carney and
Stacey LaFleur-Spawm*

No problem has proven as perplexing as the proper roles of the States and the federal government. Just think back to the 2000 Presidential election that ended in a showdown between the Florida Supreme Court and the United States Supreme Court. The Civil War, which still holds the top spot for US casualties and was probably the watershed of American history, was fought over the right of the States to permit slavery. The chief Constitutional basis for "States' Rights" is found in the Tenth Amendment: "The powers not

See ADA vs states' rights, page 4



Gynecological, from page 1

The outlook for HIV-infected women with cervical cancer is worse than that of their HIV-negative counterparts. They are more likely to have poorer responses to therapy, have more advanced disease at the time of diagnosis, have metastatic disease to rare places such as the clitoris or the psoas muscle, and have higher rates of recurrence or death.

Screening for cervical cancer is done by regular examination with PAP smears and bimanual examination. The PAP smear should be done initially every six months after diagnosis with HIV for three times; if these are all normal the PAP smear can then be done every year. If any abnormalities are seen, such as ASCUS (Atypical Squamous Cells of Undetermined Significance) or dysplasia, the patient should be referred for colposcopy and biopsy. The frequent repeat PAP smears are done because a single PAP smear has a false-negative rate of 10-25%; the repeat PAP smears greatly limit the false-negativity. Screening for sexually transmitted diseases should be done at the same time as the PAP smears. The frequency of PAP smears is increased if the client has ever had an abnormal PAP smear, treatment for cervical dysplasia, HPV infection, or in women with CD4 counts < 200. The American College of Obstetricians and Gynecologists does recommend PAP smears every 3-4 months during the first year after treatment for pre-invasive cervical lesions, followed by every six months after the first year.

Treatment or management of cervical lesions in HIV-infected women is a difficult task. Cryo-

therapy has the highest rate of recurrence. 5-fluorouracil (5-FU) cream can be applied 2 gm bi-weekly for six months and has been shown to decrease the rate of recurrence of high-grade lesions (31% vs. 8% observed vs. treated). HAART therapy has also been shown to decrease the recurrence rate, although studies have shown conflicting results in the effects of HAART on the incidence of abnormal PAP smears, the number of HPV subtypes, the amount of HPV present after 6-12 months of HAART therapy, or the acquisition or persistence of HPV.

Vaginal Discharge

Women with HIV have a higher incidence of presenting with vaginal discharges. The evaluation of vaginal discharge should include a thorough history, genital inspection, and bimanual examination. Laboratory work-up should include a saline wet mount, a KOH preparation, a vaginal pH determination, fungal culture if indicated by exam, and testing for gonorrhea and Chlamydia, either by ligase chain reactions of the urine or culture and ELISA respectively.

Vulvovaginal candidiasis is more frequent in the HIV-infected population. Recurrent vulvovaginal candidiasis is an indication for testing for HIV. Prevalence among HIV-infected women ranges from 3 to 15%, with an increasing incidence as the degree of immunosuppression increases. In HIV-infected women, the incidence of non-*albicans* candidal strains is increased to 26-27%, with the most common being *Candida glabrata*. Treatment can be done either with topical azoles, single dose oral fluconazole (150 mg), a Nystatin vaginal tablet (less effective), boric acid, or gentian violet.

Topical therapies are usually recommended for at least seven days. Consideration can be given to the use of a prophylactic oral azole either once weekly or when placed on antibiotics.

Recurrent candidiasis is defined as four or more symptomatic episodes per year. This should be thoroughly investigated, looking for other contributing factors such as douching, uncontrolled diabetes, steroid use, and pregnancy. Longer duration of standard treatment may be required and consideration can be made regarding weekly fluconazole or itraconazole or clotrimazole vaginal suppositories or the use daily of ketoconazole.

Genital Ulcer Disease

The most prevalent cause of genital ulcer disease in the United States is herpes simplex (HSV). The seroprevalence has increased since the 1970s by 30%, with a current prevalence of 21.9% of people aged 12 or older having detectable infection. In HIV disease, the presence of HSV ulcerations tends to be more prolonged and more frequent in outbreaks, rising as the CD4 cell count decreases. The lesions may be atypical in location or appearance and often are much more severe than those found in the HIV-negative population. The presence of the genital ulcer increases the transmissibility of HIV and the amount of shedding of HSV virus increases with furthering of immunosuppression, including asymptomatic periods. The change in incidence of resistance to the standard therapy of acyclovir is not known at this time; this may require the use of foscarnet or topical cidofovir.

In syphilis, HIV-infected patients may have abnormal



results of serologic testing, such as false negatives, delay in seroconversion, or very high titers. The rash of secondary syphilis can be unusual in the HIV+ population and consideration should be given to testing for syphilis with any skin condition in the HIV-infected host. If a painless ulcer is present that is suspicious for syphilis, but the serologic work-up is negative, consideration of biopsy or direct fluorescent antibody staining or dark field microscopy should be

The outlook for HIV+ women with cervical cancer is worse than that of their HIV- counterparts.

given. Treatment for primary or secondary syphilis or early latent disease can be with a single dose of benzathine penicillin G 2.4 million units IM, although some experts recommend three weekly doses of this in the HIV-positive population.

Chancroid, caused by *Haemophilus ducreyi*, causes a tender papule that becomes pustular, then ulcerates. There may be a decreased response to standard therapy, necessitating re-treatment or extended treatment regimens. Some experts recommend the use of erythromycin base 500 mg po QID for seven days in this population.

Other causes of genital ulcers in the HIV-positive host include Cytomegalovirus in the patient with low CD4 counts, lymphogranuloma venereum which may require prolongation of

therapy, granuloma inguinale (Donovanosis) which requires the addition of an aminoglycoside for therapy in this population, and tuberculosis.

Pelvic Inflammatory Disease (PID)

PID is usually polymicrobial, with the most common organisms being *Neisseria gonorrhoea* and *Chlamydia trachomatis*, along with organisms that cause bacterial vaginosis. Unusual causes can include CMV and tuberculosis. The minimum criteria for diagnosis include lower adnexal tenderness or adnexal tenderness or cervical motion tenderness. Additional criteria include elevated sedimentation rate or C-reactive protein, fever (oral) >38.3 C, abnormal vaginal or cervical discharge, or documented cervical chlamydial or gonorrhoea infection. Chronic endometritis was found to be twice as common in the HIV-infected 23% of the adult cases of AIDS at hysterectomy than in the HIV-negative controls. The clinical picture in the HIV-positive woman tends to have more severe abdominal pain, increased need for surgery with an increase in the incidence of tubo-ovarian abscesses, longer hospital stays. The CDC recommends that HIV-infected women with PID should be managed aggressively with parenteral antibiotic treatment, such as with cefotetan 2 gm IV q12 or cefoxitin 2 gm IV q6 plus doxycycline 100 mg IV, or clindamycin 900 mg IV q8 with an aminoglycoside. For milder cases, consideration can be given of an oral regimen with ofloxacin 400 mg po bid plus metronidazole 500 mg po bid for 14 days, or ceftriaxone 250 mg once, or cefoxitin 2 gm IM plus Probenecid 1 gm po once with

doxycycline 100 mg po bid for 14 days; oral treatment should only be given if close follow-up is likely. ❖

BIBLIOGRAPHY

- Abularach S and Anderson J. Gynecologic Problems (Chapter 6). A Guide to the Clinical Care of Women with HIV. 2000. Pp. 149-210.
- Adachi A et al. Women with Human Immunodeficiency Virus and Abnormal Papanicolaou Smears: A Prospective Study of Colposcopy and Clinical Outcome. *Obstet Gynecol* 81:372-7, 1993.
- Brown DR et al. Detection of Multiple Human Papillomavirus Types in Condyloma Acuminata from Immunosuppressed Patients. *J Infect Dis* 170:759-65, 1994.
- Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, Vol. 11, No. 1, Mid-year Edition, 1999.
- Cu-Uvin S et al. Prevalence of Lower Genital Tract Infections among Human Immunodeficiency Virus (HIV)-seropositive and High Risk HIV-seronegative Women. HIV Epidemiology Research Study Group. *Clin Infect Dis* 29:1145-50, 1999.
- Fleming DT et al. Herpes Simplex Virus Type 2 in the United States, 1976 to 1994. *N Engl J Med* 337:1105-11, 1997.
- Giannacopoulos KC et al. Genital Tuberculosis in a HIV-infected Woman: A Case Report. *Eur J Obstet Gynecol Reprod Biol* 80:227-9, 1998.
- Kerr-Layton JA et al. Chronic Plasma Cell Endometritis in Hysterectomy Specimens of HIV-infected Women: A Retrospective Analysis. *Infect Dis Obstet Gynecol* 6:186-90, 1998.
- Korn A et al. Pelvic Inflammatory Disease in Human Immunodeficiency Virus-infected Women. *Obstet Gynecol* 82:765-8, 1993.
- Maiman M. Management of Cervical Neoplasia in Human Immunodeficiency Virus-infected Women. *J Natl Cancer Inst Monogr* 23:43-9, 1998.
- Minkoff H et al. A Longitudinal Study of Human Papillomavirus Carriage in Human Immunodeficiency Virus-infected and Human Immunodeficiency Virus-uninfected Women. *Am J Obstet Gynecol* 178:982-6, 1998.
- Minkoff HL et al. Prevalence and Incidence of Gynecologic Disorders Among Women Infected with Human Immunodeficiency Virus. *Am J Obstet Gynecol* 180:824-36, 1999.
- Palefsky JM et al. Cervicovaginal Human Papillomavirus Infection in Human Immunodeficiency Virus-1 (HIV)-positive and High Risk HIV-negative Women. *J Natl Cancer Inst* 91:226-36, 1999.
- Petry KU et al. Human Papillomavirus Is Associated with the Frequent Detection of Warty and Basaloid High-Grade Neoplasia of the Vulva and Cervical Neoplasia Among Immunocompromised Women. *Gynecol Oncol* 60:30-4, 1996.
- Schuman P et al. Mucosal Candidal Colonization and Candidiasis in Women with or at Risk for Human Immunodeficiency Virus Infection. HIV Epidemiology Research Study (HERS). *Clin Infect Dis* 27:1161-7, 1998.
- Sun XW et al. Human Papillomavirus Infection in HIV-seropositive Women. *Obstet Gynecol* 85:680-6, 1995.
- Sun XW et al. Human Papillomavirus Infection in Women Infected with the Human Immunodeficiency Virus. *N Engl J Med* 337:1343-9, 1997.

Ron Wilcox is Assistant Professor of Clinical Medicine and Pediatrics, Section of Infectious Disease, LSUHSC, and Staff Physician, HIV Outpatient Program, Medical Center of Louisiana at New Orleans.



ADA vs states' rights, from page 1

delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States, respectively, or to the people." Deciding what these words mean has been a challenge since 1789, and even the Supreme Court has changed its mind on a number of occasions.

Recently the States' Rights movement has found a new source of attack on federal power in the Eleventh Amendment, which protects any State from being sued in federal court by a citizen of another State. (In 1890, the Supreme Court extended the Amendment to citizens of the same State, essentially insulating States from suits in federal court.¹) However, the Court has also decided that Congress can get around the Eleventh Amendment in some cases. The most recent shuttlecock in the badminton game was the Americans with Disabilities Act ("ADA").

A State can lose its Eleventh Amendment immunity either by an express waiver in its constitution or statutes, or if Congress abrogates (abolishes) the States' immunity.² Express waivers are rare, so a court generally must apply a two-step test to decide whether Congress has abrogated immunity. First, the court must find that Congress has "unequivocally expressed its intent to abrogate the immunity."³ Second, the court must conclude that "Congress has acted pursuant to a valid exercise of power."⁴ It is the second step that has tripped up Congress and the courts.

In the area of civil rights, Section Five of the Fourteenth Amendment gives Congress the right to abrogate the States' immunity to protect the substantive provisions of the Amendment.⁵ This authority lets Congress prohibit unconstitutional conduct, and even conduct which is not unconstitutional in itself but which still must be stopped to remedy or prevent unconstitutional conduct.⁶ Still, there are limits to Congress's power—the Supreme Court requires a "congruence and proportionality between the injury to be prevented or remedied and the means adopted to that end."⁷ In other words, don't go overboard.

In recent years, the Supreme Court has reined in Congress's authority under Section Five of the Fourteenth Amendment. The Religious Freedom Restoration Act (RFRA), enacted in 1994 to protect "persons whose religious exercise is substantially burdened by government,"⁸ was relied on by the Catholic Church to

sue a town's historic landmarks commission for denying a permit to enlarge a church.⁹ The Supreme Court focused on the hearings before Congress and decided that there had been no evidence of a widespread pattern of religious discrimination by the States. This made RFRA "so out of proportion to a supposed remedial or preventive object that it [could not] be understood as responsive to or designed to prevent unconstitutional behavior."¹⁰ Good-bye to RFRA.

In 1992 Congress amended the patent laws to make States subject to

*The majority said:
"Unconstitutional
discrimination against
the disabled has not
been shown."*

suit in federal court for patent infringements.¹¹ When a bank sued a Florida state agency for infringing on a patent it held, the Court again scrutinized the statute's legislative history to find the Fourteenth Amendment "evil" or "wrong" that Congress intended to remedy.¹² Since Congress had found no pattern of patent infringement by the States, and thus no history of "widespread and persisting deprivation of constitutional rights,"¹³ the act was unconstitutional.

Last year, in *Kimel v. Florida Board of Regents*,¹⁴ the Court insulated the States from suits under the Age Discrimination in Employment Act (ADEA). Looking once again to the legislative history of the ADEA, the Court found that there was substantial evidence of age discrimination in the private sector, but found no pattern of age discrimination by the States, particularly any discrimination "that rose to the level of constitutional violations."¹⁵

While these cases were making their way to the Supreme Court, States were making similar arguments about the ADA. Two Circuit Courts have agreed with the States' position,¹⁶ affecting State employees in Illinois, Wisconsin, Indiana, Pennsylvania, New Jersey and Delaware.¹⁷ On the other hand, the Eleventh Circuit in Atlanta,

covering Alabama, Georgia, and Florida, took the opposite view in *Garrett v. University of Alabama*.¹⁸

Garrett was a nurse at the university's medical school who took a leave of absence after she discovered that she had breast cancer. When she returned to work she had been demoted. After her complaints were unsuccessful, Garrett sued the university under the ADA, and the Court of Appeals rebuffed the State's argument that it had Eleventh Amendment immunity. The State appealed, and the Supreme Court heard the case in October 2000. In a companion case, *Milton Ash*, a security officer for the State, says his bosses refused to enforce their own anti-smoking policy to accommodate his severe asthma, and gave him a car to drive that leaked carbon monoxide into the passenger area.

The State of Alabama was supported in the appeal by several other States, including Arkansas, and other interest groups who filed friend of the court briefs. The States contended that there was no finding that they, rather than the private sector, had discriminated against disabled persons. In fact, the States claimed that during hearings and debate on the ADA, Congress specifically recognized that States were already making great strides toward integrating the handicapped into society. The States also pointed out that now all States have statutes that protect disabled persons from discrimination. Finally, the States argued that the remedy Congress provided, making them subject to suit for violations against the disabled, was not "congruent and proportional" because the remedy far outweighed the harm that Congress had identified.

For their part, Garrett and groups representing disabled persons (in addition to the Clinton Administration and former President Bush) disputed the State's position that they did not engage in a pattern of discrimination against handicapped people. In area after area, the Garrett brief and those filed by other interested parties detailed the States' dismal histories of segregating and demeaning persons with disabilities. State statutes that segregated the mentally retarded did so not only for their protection, but also to prevent "the passing on of mental deficiency from one generation to another, and the consequent propagation of criminals and paupers."¹⁹ "The welfare of the community"²⁰ was as much the issue as the welfare of the "feeble-minded," conveniently classified as idiots, imbeciles and morons in Arkansas, according to their perceived mental ability.²¹ Many States simply prohibited people with disabilities from entering their borders. Even today it is a crime in Mississippi to issue a marriage license to anyone who is an "imbecile."²²



The briefs presented a litany of horror stories perpetrated by the States on the disabled. In the 1950s, the State of Massachusetts, in conjunction with MIT, used mentally retarded children as guinea pigs to test the effects of radiation; the isotopes were mixed into their morning oatmeal.²³ A decade later, Arkansas officials gave mentally disabled children iodine-131 for a thyroid study.²⁴ Newly arrived children at the Willowbrook State School in New York were routinely infected with hepatitis B until 1972.²⁵ As late as the 1980s more than a dozen States required mandatory sterilization for the “feeble-minded”; four States included epileptics.²⁶ Physically handicapped children were routinely segregated into special (and usually inferior) schools; over half the children with only orthopedic problems still go to special schools.²⁷ Bureaucrats denied jobs to physically handicapped people on the ground that the public would not want to see them. States enacted policies that kept the disabled from using public transit; one Connecticut transit official wondered why the disabled wouldn’t make it easier for his department by all living and working in the same place.²⁸ Even the ballot was not sacred: precinct officials were known to keep people from voting because their handwriting was shaky,²⁹ or to put the voting machines on a second floor with no elevator available and no paper ballots.³⁰

The Garrett side also discounted the importance of the States’ own laws that protect the disabled. Laws can be on the books but not enforced, and many of the State laws are not as broad in scope as the ADA. Garrett argued that the mere fact that States have laws on a particular subject does not automatically mean that Congress cannot legislate in the same area; when Title VII of the Civil Rights Act was passed, over 30 states had similar laws. In fact, the ADA was the culmination of years of federal laws targeted at ending State discrimination against people with disabilities: the Architectural Barriers Act of 1968; the Urban Mass Transportation Act of 1970; the Education for Handicapped Children Act (now IDEA); the Voting Accessibility for the Elderly and Handicapped Act of 1984; and the Rehabilitation Act of 1973.

On February 21, 2001 the Supreme Court held in favor of the States in a 5-4 opinion authored by Chief Justice Rehnquist and joined by the Court’s conservative wing, Justices Kennedy, O’Connor, Scalia and Thomas.³¹ The

majority concluded that Congress had failed to identify a history of unconstitutional employment discrimination by the States against the disabled. After first limiting the inquiry to employment discrimination, the Court then discounted evidence of discrimination by cities and counties since such local entities are not covered by the Eleventh Amendment. The majority concluded that the evidence adduced to Congress was often anecdotal, or showed only discrimination, not unconstitutional discrimination. Without a sufficient record to justify eliminating the States’ immunity, the ADA could not be applied against the State of Alabama to obtain a money judgment in favor of Garrett and Ash.

In a dissent, Justice Breyer, writing for Justices Ginsburg, Souter and Stevens, questioned not only the Court’s assessment of the Congressional record, but also the standard it had imposed on Congress in making a legislative record. Justice Breyer found at least 300 examples of discrimination by State governments in the record. He also questioned not looking at the history of discrimination by cities and counties, since local governments work with the State government, and generally local and State employees are in similar situations. The dissenters also ques-

The dissenting justices found at least 300 examples of discrimination in the record.

tioned the exacting standard the majority had placed on Congress. Requiring adequate evidentiary support in the record is far more rigorous than the standard used in previous cases, merely whether Congress acted reasonably.³² The dissent said the majority was setting a harder standard for Congress to prohibit discrimination than it imposes on laws that in fact discriminate against the disabled, which are upheld if they meet a “rational basis” test.³³

The majority pointed out that its decision was limited, affecting only State employees who sue for money damages.

Employees of “local” governments are not affected.³⁴ Title I of the ADA still set standards for the States, which the federal government can sue to enforce. Individuals can still seek injunctive relief to stop ongoing discrimination. Finally the Court noted that State statutes provide “independent avenues of redress.”

So what are these avenues for redress for State employees in Louisiana, Mississippi and Arkansas? The federal Rehabilitation Act of 1973³⁵ allows for the recovery of money damages against State entities that receive federal funds, but this statute is also being challenged as a violation of the Eleventh Amendment. State laws may prove the easiest, if not the best, avenue of redress.

All three States have laws that prohibit employment discrimination on the basis of disabilities. In 1997, Louisiana consolidated its employment discrimination statutes and devoted one section to disability based discrimination.³⁶ However, there are several limitations not found in the ADA. Employers have discretion not to consider as disabilities “chronic alcoholism or any other form of active drug addiction, any cosmetic disfigurement, or any anatomical loss of body systems.”³⁷ Private employers do not have to incur any additional cost in the hiring or promotion of a disabled person, and no employer has to spend more for architectural modifications “than that amount now allowed as a federal tax deduction.” Since Louisiana does not get a federal tax deduction,³⁸ arguably the State would never have to make architectural modifications. The law also requires employees to give a detailed account of the alleged discrimination to the employer at least 30 days before filing suit,³⁹ and the losing party can be forced to pay the other party’s attorney fees,⁴⁰ a provision that would deter many suits.

The Arkansas Civil Rights Act of 1993⁴¹ prohibits employment discrimination on the basis of disability. A person has “the right to obtain and hold employment without discrimination” based on disability, but, unlike the ADA, no reasonable accommodations have to be made by the employer for the employee to be able to perform the job.⁴² The statute does not cover alcoholism, current drug use, or psychoactive substance use disorders resulting from illegal use of drugs.⁴³ Employees are allowed to recover back pay, as well as compensatory and punitive damages, which are capped at \$300,000 for employers of more than 500 people. Moreover, because the statute expressly provides that Arkansas has not waived its sovereign immunity, State

See ADA vs states’ rights, page 6



ADA vs states' rights, from page 5

employees can not sue the State but can merely file grievances.⁴⁴

In Mississippi, no one seeking employment or already employed in State service is to be discriminated against on the basis of handicap.⁴⁵ The statute expressly applies only to disabled persons, not persons perceived to be disabled. In addition, not all State employees are covered; for example, persons employed at State institutions of higher learning are not covered, nor are part-time employees.⁴⁶

Besides the evident limitations of the State laws, disabled persons could face other obstacles. The Louisiana, Mississippi and Arkansas laws only rarely have been relied on by disabled people, so the State courts have had few opportunities to interpret them. On the other hand, lawyers for the disabled have the benefit of a decade of cases that have interpreted the ADA. There would also be a change in the agency that administers the law. Presently The Equal Employment Opportunities Commission oversees the ADA, with backup from the Disability Rights Section of the Department of Justice. There are no comparable agencies with the same degree of expertise in disability-based discrimination at the State level. Finally, disabled persons would lose the protection of the federal judges who are appointed for life, as opposed to State court judges in Mississippi, Louisiana and Arkansas, all of whom must face election and may not be so likely to protect the rights of unpopular minorities like disabled Americans. ♦

REFERENCES

¹ Hans v. Louisiana, 134 US 1 (1890).
² Atascadero State Hosp. v. Scanlon, 473 U.S. 234, 240-241, 105 S.Ct. 3142, 87 L.Ed.2d 171 (1985).
³ Atascadero, 473 U.S. at 242
⁴ Id.
⁵ Kimel v. Florida Board of Regents, 528 U.S. 62, 120 S.Ct. 631, 644, 145 L.Ed.2d 522 (2000); Florida Prepaid v. College Savings Bank, 527 U.S. 627, 639, 119 S.Ct. 2199 (1999).
⁶ Kimel, 120 S.Ct. at 644.
⁷ City of Borne v. Flores, 521 U.S. 507, 520, 117 S.Ct. 2157 (1997).
⁸ 42 U.S.C. §2000 bb(a).
⁹ Borne, 521 U.S. at 512.
¹⁰ 521 U.S. at 531-532.
¹¹ Florida Prepaid, 527 U.S. at 632.
¹² Id at 639-640 (citing Borne at 525).
¹³ Id at 640 and 645.
¹⁴ 528 U.S. 62, 120 S.Ct. 631 (2000).
¹⁵ 120 S.Ct. at 649. Additionally, the Court stated that through the ADEA's "broad restriction on the use of age as a discriminating factor, prohibits substantially more state employment decisions and practices than would likely be held unconstitutional under the applicable

equal protection, rational basis standard." 120 S.Ct. at 647. These issues, the appropriate standard of review for disability-based discrimination, and whether Congress can prohibit only State action that the Court itself would declare unconstitutional, are not discussed in this article.

¹⁶ Lavia v. Commonwealth of Pennsylvania, 224 F3d 190 (3d Cir. 2000); Stevens v. Illinois Dept. Of Trans., 210 F3d 732 (7th Cir. 2000).

¹⁷ Three Circuit Courts have considered whether ADA regulations can forbid the States from charging for disabled license plates. The Fourth Circuit, covering Maryland, Virginia, West Virginia, and North and South Carolina, and the Fifth Circuit, which covers Texas, Louisiana and Mississippi, have upheld State immunity, *Neinast v. Texas*, 217 F3d 275 (5th Cir. 2000); *Brown v. North Carolina Div. of Motor Vehicles*, 166 F3d 698 (4th Cir. 1999). The Ninth Circuit, covering Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon and Washington, ruled against State immunity, *Dare v. California*, 191 F3d 1167 (9th Cir. 1999).

¹⁸ 193 F3d 1214 (11th Cir. 1999).

¹⁹ 1920 Miss. Laws 288, ch. 210.

²⁰ 1918 La. Acts No. 141.

²¹ 1917 Ark. Acts 942.

²² Miss. Code Ann. 93-15-5 (f) (2000).

²³ U.S. Dep't of Energy, Report of the Advisory Comm. On Human Radiation Experiments (1995), ch 7.

²⁴ Government Used 16,000 in Radiation Tests, AP (Aug. 18, 1995).

²⁵ U.S. Dept. of Energy, Report of the Advisory Comm. on Human radiation Experiments (1995), ch 7.

²⁶ U.S. Civil Rights Comm., Accommodating the Spectrum of Individual Abilities, 37 (1983).

²⁷ U.S. Dept. Of Educ., Twenty-First Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act (1999)

²⁸ 2 Leg. Hist. 1085 (Jade Category).

²⁹ 2 Leg Hist. 1219 (Nancy Husted-Jensen).

³⁰ Equal Access to Voting for Elderly and Disabled Persons: Hearings Before the Task Force on Elections of the House Comm. on House Admin., 98 th Cong., 1st Sess. (1984), 45.

³¹ 531 U.S. (2001).

³² E.g. *Katzenbach v. Morgan*, 384 U.S. 641, 652-656. (1966)

³³ *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432 (1985).

³⁴ *Moor v. County of Alameda*, 411 U.S. 693 (1973); *Lincoln County v. Luning*, 133 U.S. 529 (1890).

³⁵ 29 U.S.C. 701 et seq.

³⁶ La. R.S. 23:321 et seq. (Supp. 2000).

³⁷ La. R.S. 23:322 (6). Note that active drug use is not covered under the ADA.

³⁸ Id. at (9).

³⁹ La. R.S. 23:325.

⁴⁰ Id.

⁴¹ A.C.R.C. § 16-123-101.

⁴² A.C.R.C. § 16-123-107.

⁴³ A.C.R.C. § 16-123-102.

⁴⁴ The only way for a State employee to obtain compensation is through the State Claims Commission, a non-legal entity that is funded by the Arkansas state legislature.

⁴⁵ Miss. Code Ann. Section 25-9-149.

⁴⁶ Miss. Code Ann. Section 25-9-107. Note, however that in the latest amendment to Section 25-9-107, the legislature stated: "It is the intent of the legislature that

...ve physical or
o
ce
b
ed
pe
al
fu
se

L
a
A
T
C

Caution issued for HIV combination therapy with Zerit and Videx in pregnant women

FDA and Bristol Myers Squibb are warning health care professionals that pregnant women may be at increased risk of fatal lactic acidosis when prescribed the combination of the HIV drugs stavudine (Zerit) and didanosine (Videx or Videx EC) with other antiretroviral agents.

The new warning follows three reported cases of fatal lactic acidosis, with or without pancreatitis, that occurred in pregnant women taking Zerit and Videx in combination with other drugs used to treat HIV. Two of the cases were reported from ongoing clinical trials of an investigational HIV drug, and one was identified through worldwide post marketing surveillance. In addition FDA has received several nonfatal reports of lactic acidosis, with and without pancreatitis, occurring in pregnant women receiving only Videx and Zerit. Although data have suggested that women may be at increased risk for the development of lactic acidosis and liver toxicity, it is unclear whether pregnancy potentiates these known side effects.

The complete FDA Talk Paper can be accessed at <http://www.hivatis.org/atisnew.html>.

Source: HIV/AIDS Treatment Information Service (HIVATIS) broadcast email.



Nutrition

HIV providers need to know about food assistance programs

Ginger Bouvier, MEd, LDN, RD

Food. It is a basic physiological necessity that most Americans have readily available. Nearly 90 percent of U.S. households have assured access at all times to enough food for healthy, active lives. At the same time, 10 percent of U.S. households experience hunger and inadequate food availability.¹ Government surveys show that the nutritional adequacy of a household's diet goes down as income goes down, making hunger a condition of poverty. There is also at least some association between HIV disease and poverty². Therefore, many HIV-infected individuals are at risk for experiencing inadequate access to food.

As a health care provider and an invaluable resource to your patients, it is essential for you to know what food assistance services exist in your community. Federal, state, and local agencies provide several programs designed to help meet nutritional needs of low-income individuals and families. In addition, there are food assistance programs, such as Food For Friends in New Orleans, specifically for low-income individuals with AIDS.

Food Stamps

Food stamp applications are available at any Social Security office. To get food stamps, household members must meet certain conditions:

- everyone in the household must have or apply for a Social Security number
- most *able-bodied* people age 18-60 years must register for work, and may be required to participate in an employment and training program
- the household can't have more than \$2000 in resources (cash, bank accounts, and property), but if the household includes a person age 60 or older the limit is \$3000; the house and the lot it is on do not count as resources, but vehicles may count
- households also must meet an income limit after certain deductions are made; income limits vary by household size and change each year

Food Stamps and Homelessness

A person is considered homeless if he/she doesn't have a fixed regular nighttime residence, or the primary nighttime residence is a temporary accommodation in:

- a supervised shelter
- a halfway house
- a place not designed for regular sleeping (hallway, bus station, lobby, etc.)

There are special provisions to help homeless people receive food stamps:

- a homeless person's claim is given priority handling
- eligibility is based solely on the circumstances
- food stamps may be used at approved eating facilities such as some "soup kitchens"

For more information about the federal Food Stamp Program, call 1-800-221-5689.

The Emergency Food Assistance Program (TEFAP)

This program helps supplement the diets of low-income Americans by providing them with emergency food assistance at no cost. Under TEFAP, commodity foods are made available by the U.S. Department of Agriculture to the States. Each State gives the food to local agencies, usually food banks, which then distribute the food to "soup kitchens" and food pantries that serve low-income people. Each State sets the household income criteria for determining eligibility to receive food for home consumption. There are a number of shelters and "soup kitchens" in most major cities, which provide prepared meals for homeless and needy individuals.

Women, Infants, and Children (WIC)

The WIC program provides nutritious foods that supplement the diets of eligible pregnant women, infants, and children less than five years of age. Eligibility is based on income and nutritional risk as determined by a health professional. HIV disease qualifies as a nutritional risk. The state or local health department can provide more information about the WIC program.

The Nutrition Program for the Elderly (NPE)

NPE is a food program designed to assist people age 60 years or older. Age is the only eligibility factor. No income limits have to be met in order to participate in the program. Neighborhood centers for the elderly serve well-balanced meals at least once a day, five days a week. Home-delivered meals, usually called "meals on wheels," are provided to the elderly who are homebound. For more information on this program, contact the local office on aging or the Social Security office.❖

Ginger Bouvier is Nutrition Specialist in the HIV Outpatient Program of the Medical Center of Louisiana at New Orleans.

REFERENCES

1. <http://www.centeronhunger.org/fsifacts.html>
2. Gillies, P., Tolley, K., & Wolstenholme, J. (1996). Is AIDS a disease of poverty? *AIDS Care*, 8, 353-363.

Clinical Consultation for Health Care Providers

Delta Region health care providers can consult with HIV experts at university medical centers:

- Louisiana 504-568-3855
- Mississippi 601-984-6105
- Arkansas 501-686-5585

National Consultation Lines:

- National Warmline
800-933-3413
- National PEPLINE
888-448-4911



Nursing

Nurse's "Lifeline" parallels ups and downs of HIV epidemic

Marsha J. Bennett, RN, DNS

A common technique to use in group or individual psychotherapy is called a "Lifeline."

This involves taking a piece of paper and drawing a line with a positive or negative slant, representing positive and negative experiences in your life. The line meanders up and down, depending on your perception of the event as positive or negative. Imposing this line on a graph adds a sort of valence aspect, but the positive and negative events and memories are the focus of this activity.

As an example, I recently constructed a Lifeline for my work life. What emerged was a line chronologically depicting my history entwined with the history of HIV/AIDS. See Figure 1 for what it looked like.

I marked the initial line entry in 1981, when the medical/scientific community first recognized that something was going on in young people dying of KS and PCP. Then in 1983, we identified the agent thought to be causing HTLV-III or LAV (now called HIV). So I felt more positive, more hopeful now that we finally had a name (ah, the power of naming) and an organism attached to this disease. Then in 1985, scientists discovered that you could indirectly detect the presence of this virus by antibody testing. So my own hopeline climbed a bit higher, waiting for the day we could actually quantify the testing process. In 1987, the very first antiretroviral drug, zidovudine, was approved. That

felt truly remarkable, and in the next few years a number of antiretrovirals were approved in rapid succession. Our patients and their health care providers rushed to try each one as they emerged, individually, from the FDA approval process. Perhaps relief was in sight.

Then there was a lull in the early 1990s. Nothing new appeared on the horizon. Yes, new drugs were in development (we kept hearing about the protease inhibitors), but people were already failing the approved antiretrovirals, and there was little else to offer. Our patients also continued to experience side effects that necessitated their stopping their antiretrovirals. We had little or nothing to offer as alternative medications. So 1993 felt bleak.

The International AIDS Conference in Yokohama (1994) championed the effects of the protease inhibitors and combination therapies were realized. The Conference also released additional information on the long-awaited viral load testing, soon to be available. The nonnucleoside reverse transcriptase inhibitors were also being tested and marketed. All in all, 1995 felt very promising, and those HIV-infected persons taking the new combinations were doing quite well. For the first time in years, death rates and rates to progression to AIDS began a decline.

The CDC recognized and published data about this decline in 1997; we saw it in the clinic where I work as well. Our deaths

each month dropped from 18-20 down to 8-10.

What we also saw beginning in 1997, although we are still realizing the consequences and aftereffects, was the phenomenon of resistance. The legacy of all of the accelerated approved antiretrovirals used as monotherapy in the late 1980s and well into the 1990s, probably contributed to resistance to the medications. Patients who were not able to take their medications as prescribed, who were unable to comply, or simply did not adhere to their prescribed regimens, also contributed to resistance. In 1997 and 1998, compliance and adherence became paramount. My own hopeline wavered, but never plummeted. I believed, as I do now, that we can continue to educate our patients about taking their medications, and offer them all avenues of support to do so.

A resurgence of hope in the new millennium? I do have hope for the future. I believe in the indomitable nature of the human spirit. I believe in the creativity and problem solving skills of our species.

And furthermore, I have some rather concrete proof. Hanging on my wall is a piece of art by Eric Avery, MD, of UTMB-Galveston. He is a practicing psychiatrist and artist. The title of this particular piece by Dr. Avery is called "Blue Smallpox—The Print of Hope." *It is a portrait of the last human on earth to have been diagnosed with smallpox in 1977. Anytime you feel the*



need to refresh your sense of hope, please stop by my office and look at the symbol of hope.

I am inserting a copy of a blank hope scale for your own use and reflection (Figure 2). I never assigned any numerical

value to the y-axis, and all of the data points are purely anecdotal. ♦

Marsha Bennett is Research Coordinator in the HIV Division of LSU Health Sciences Center.

Figure 1 HOPE: A Personal History

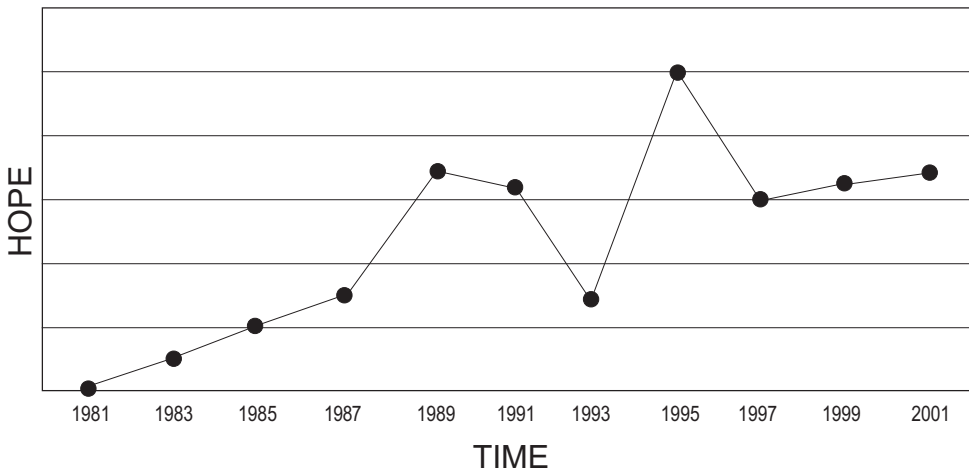
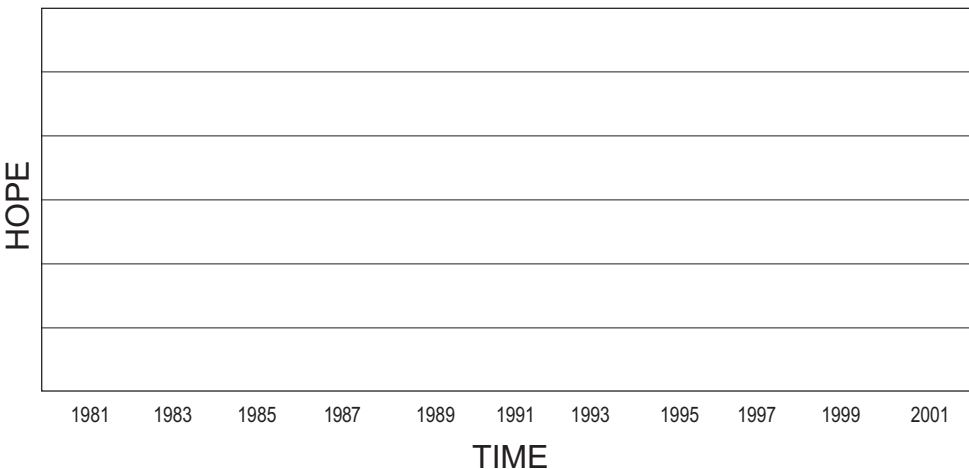


Figure 2 HOPE: A Personal History



Items of interest from the CDC's Division of HIV/AIDS Prevention

The website of the CDC's Division of HIV/AIDS Prevention has recently posted four new items of interest to HIV care providers:

▲ "Characteristics of Persons Living With AIDS at the End of 1999." Find it at this website address: www.cdc.gov/hiv/stats/hasrsupp71.htm

▲ "Surveillance of Health Care Workers with HIV/AIDS" is located at this URL: www.cdc.gov/hiv/pubs/facts/hcwsurv.htm

▲ "Replicating Effective [prevention] Programs" at www.cdc.gov/hiv/projects/rep/default.htm

▲ In addition, the MMWR (February 23, 2001/Vol. 50/No. 7) contains a report on the syphilis outbreak in Southern California last year. This report discusses the relationship between syphilis and risk for transmission of HIV. Find it at www.cdc.gov/mmwr/preview/mmwrhtml/mm5007a2.htm

Source: AETC National Resource Center broadcast email

HIV/AIDS treatment guidelines...
www.hivatis.org



Mental Health

Coalition needed to address lack of resources for dually diagnosed

Penelope W. Dralle, PhD

Over the years my work has often revolved around clients who were dually or multiply diagnosed with mental and physical diseases. They often experience significant social and environmental stressors and frequently have genetic predispositions for major illnesses and also developmental delays.

Recently, a convergence of issues around decreasing resources for the treatment and prevention of substance abuse and dependency has brought me to the conclusion that those of us working in the areas of mental health, HIV prevention and treatment, public health, and public hospitals such as the Medical Center of Louisiana at New Orleans, need to join together to address the problem. Generalized examples of problems that appear to be increasing are described below. Similar cases have been addressed in the professional literature and in the news media.

In many mental health services departments, the number of clients who have a diagnosis of substance abuse or dependence in addition to their diagnosis of mental disease is over 50 percent. In order to be served in the public mental health sector, they must have a primary mental disorder. As you might suspect, this creates a dilemma of the magnitude of "which came first, the chicken or the egg?" With decreasing resources allocated by the state to the Louisiana Department of Health and Hospi-

tals, which covers both mental health services and substance abuse services, both sections are struggling to maintain mandated services. The service to clients with dual diagnoses, who require extra resources and can push workers to their limits, often is not rewarding especially in light of their perceived high recidivism and relapse rates.

As public funds for medical care for indigent and low income populations become more restricted and must stretch further, the question of allocation of medical resources for uninsured and publicly-covered clients reaches all levels of health care professionals: surgeons and other physicians, case managers, nurses, hospital administrators, etc. Topics for the Annual Continuing Medical Ethics Workshop, sponsored by the Ethics Committee of the Medical Center of Louisiana, are selected based on the types of calls answered by the ethics acute response team and by issues brought before the committee. For the 2001 workshop, issues to be addressed include 1) the reuse of single use instruments, 2) the limiting of surgeries (such as heart valve replacements) and other high cost procedures (such as complex, expensive medical regimes) for those who are nonadherent with recommended follow up, 3) outlining principles, issues, and legal aspects surrounding decisions on resources use, 4) urban versus rural health care services, and 5) how the health care community can or

should access the larger group of shareholders in the allocation decision making process. Often substance dependency is a major underlying factor in decisions regarding resource allocation.

In recent discussions with Dr. Howard Wetsman, Director of Psychiatry at the HIV Outpatient Program (HOP) Clinic in New Orleans, he highlighted the goodness of fit between his training as an addictionologist and his role at the clinic. Drug use is a notable high risk behavior for contracting HIV and also has a significant impact on disease progression. Dr. Wetsman notes that both HIV and substance dependency are chronic life-long incurable diseases which require daily treatment to maintain and prolong life. If the addiction and the underlying mindset are not treated, there is little chance that the patient will be able to adhere to complex medical regimes. It is necessary to combat the denial and cognitive processes that support addiction in order for the patient to gain access to the emotional memory that reminds them that they will die if they do not take care of themselves daily. (For a recent review, see Basso, M. and Bornstein, R., *Neuro-behavioural Consequences of Substance Abuse and HIV Infection*. J. of Psychopharmacology, Vol.14(3), England, Sage Pub. Ltd. 2000, 228-237.)

Different perspectives on substance abuse treatment approaches often lead to splitting and conflicts within treatment teams regarding the most effica-



rious interventions. Particularly pointed are differences related to harm-reduction ideologies about substance abuse and total abstinence advocates. Counselor burn out, particularly in regard to feelings of personal accomplishment, has been related to having more clients with dual diagnoses. (Shoptaw, S. et al, *Burnout in substance abuse counselors: Impact of environment, attitudes, and clients with HIV*. J of Substance Abuse, Vol 19(2), Sept 200, 117-126.) The numbers of patients that continue to engage in HIV-risk behavior is discouragingly high. One study reports that up to 66% continue high risk behaviors in a population of drug-using HIV-seropositive individuals in a methadone program. (Avantis, S. et al, *Continuation of high-risk behavior by HIV-positive drug users: treatment implications*. J of Substance Abuse Treatment, Vol 19(1), Jul 200, 15-22.) Some factors associated with nonadherence to treatment and prevention recommendations include ongoing illicit drug injections, (Stein, M. et al, *Adherence to antiretroviral therapy among HIV-infected methadone patients*. Amer J of Drug & Alcohol Abuse, Vol 26(2), May 2000, 195-205) and psychiatric severity and poor behavioral skills (Avantis, S. et al, 2000).

Although there is little correlation between knowledge and behavioral change, most studies reviewed do show reduction in risk behaviors in groups of persons who receive drug abuse treatment. Broome et al report reduction of sex and needle risks in both outpatient methadone treatment and outpatient drug-

free modalities (Broome, K. et al. *HIV risk reduction in outpatient drug abuse treatment: Individual and geographic differences*. AIDS Edu & Prev, Vol 11(4), Aug 1999, 293-306) To access NIDA's information on Principles of Drug Addiction Treatment FAQs online, go to www.nida.nih.gov/nidahome.html and choose Treatment Research.

Recommendations for improvements at the national level were developed by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). They held public hearings in 1999 which focused on improving treatment services and determining who should pay for services. They concluded with a plan that calls for "investing for results to close the treatment gap; a commitment to quality treatment; 'no wrong door' for entering treatment; changing attitudes that stigmatize those in recovery; and building partnerships so that research can be translated into practice in the field" (www.samhsa.gov/centers/csat/content/ntpfact.htm).

My concern is translating these recommendations into action steps at the local and state level. *In an effort to begin taking concrete steps toward the development of an action plan, I would be interested in hearing from health care providers and others who are interested in advocating at the local and state level.* Please contact me at pdrall@lsuhsc.edu. ♦

Penelope Dralle is Associate Professor, Department of Psychiatry, LSU School of Medicine.

Serious Adverse Events Attributed to Nevirapine Regimens for Post-exposure Prophylaxis After HIV Exposures—Worldwide, '97-'00

In September 2000, two instances of life-threatening hepatotoxicity were reported in health-care workers taking nevirapine (NVP) for postexposure prophylaxis (PEP) after occupational human immunodeficiency virus (HIV) exposure. In one case, a 43-year-old female health-care worker required liver transplantation after developing fulminant hepatitis and end-stage hepatic failure while taking NVP, zidovudine, and lamivudine as PEP following a needlestick injury. In the second case, a 38-year-old male physician was hospitalized with life-threatening fulminant hepatitis while taking NVP, zidovudine, and lamivudine as PEP following a mucous membrane exposure.

To characterize NVP-associated PEP toxicity, CDC and the Food and Drug Administration (FDA) reviewed MedWatch reports of serious adverse events in persons taking NVP for PEP received by FDA. The report summarizes the results of that analysis and indicates that healthy persons taking abbreviated 4-week NVP regimens for PEP are at risk for serious adverse events. Clinicians should use recommended PEP guidelines and dosing instructions to reduce the risk for serious adverse events. The complete CDC MMWR report can be accessed at <http://www.hivatis.org/atisnew.html>.

For information about the treatment of HIV and AIDS-related illnesses, contact our ATIS Health Information Specialists at 1-800-448-0440 or at atis@hivatis.org.

Source: HIV/AIDS Treatment Information Service (HIVATIS) broadcast email



Stay current with the latest HIV/AIDS journal articles

▲ Adverse Effects of Antiretroviral Therapy [Carr A, et al. Lancet 2000;356:1423]

▲ Test Failed to Support Claims for Origin of AIDS in Polio Vaccine [Dickson D, et al. Nature 2000;407:117]

▲ Sonographic Assessment of Regional Fat in HIV-1-Infected People [Martinez E, et al. Lancet 2000;356:1412]

▲ Meta-analysis of Hepatitis C and HIV Co-infection Hepatitis C in Patients with Human Immunodeficiency Virus Infection: Diagnosis, Natural History, Meta-Analysis of Sexual and Vertical Transmission, and Therapeutic Issues [Bonacini M and Puoti M. Arch Intern Med 2000;160:336]

▲ Prospective Randomized Two-Arm Controlled Study to Determine the Efficacy of a Specific Intervention to Improve Long-Term Adherence to Highly Active Antiretroviral Therapy [Tuldra A, et al. JAIDS 2000;25:221]

▲ Dose-Finding Study of a Once-Daily Indinavir/Ritonavir Regimen [Hugen PWH, et al. JAIDS 2000;25:236]

▲ Dose-Finding Study of Once-Daily Indinavir/Ritonavir Plus Zidovudine and Lamivudine in HIV-Infected Patients [Mallolas J, et al. JAIDS 2000;25:229]

▲ Risk Factors for Hepatotoxicity in HIV-1-Infected Patients Receiving Ritonavir and Saquinavir With or Without Stavudine [Gisolf EH, et al. CID 2000;31:1234]

▲ Prevalence of Hypogonadism Among Men with Weight Loss Related to Human Immunodeficiency Virus Infection Who Were Receiving Highly Active Antiretroviral Therapy [Rietschel P, et al. CID 2000;31:1240]

▲ A Randomized, Double-Blind Trial Comparing Azithromycin and Clarithromycin in the Treatment of Disseminated Mycobacterium avium Infection in Patients with Human Immunodeficiency Virus [Dunne M, et al. CID 2000;31:1245]

▲ Aspergillosis Among People Infected with Human Immunodeficiency Virus: Incidence and Survival [Holding KJ, et al. CID 2000;31:1253]

▲ Impact of Switching from Human Immunodeficiency Virus Type 1 Protease Inhibitors to Efavirenz in Successfully Treated Adults with Lipodystrophy [Martinez E, et al. CID 2000;31:1266]

▲ Eradication of Cryptosporidia and Microsporidia Following Successful Antiretroviral Therapy [Miao YM, et al. JAIDS 2000;25:124]

Source of listings: AETC National Resource Center

Delta ETC

CONTINUING EDUCATION PROGRAMS

NEW ORLEANS, LOUISIANA
A preceptorship for NPs, PAs, RNs: Comprehensive Nursing Management of the HIV Disease Continuum—May 14-16, 2001. 23 Contact Hours. Contact: Dana Gray, 504-568-6792 or dgray@lsuhsc.edu

JACKSON, MISSISSIPPI
A multidisciplinary preceptorship for primary care providers: Comprehensive Management of HIV Disease—May 24-25, 2001. Discipline-specific CEUs. Contact Jessie Lindsay at 601-984-5542 or jlindsay@medicine.umsmed.edu

NEW ORLEANS, LOUISIANA
A clinical preceptorship for physicians: Care and Management of the Patient with HIV Disease—August 6-7, 2001. 13.5 CMEs from AAFP. Contact: Dana Gray, 504-568-6792 or dgray@lsuhsc.edu

HIV Clinician

LSU—Delta Region AIDS Education & Training Center
1542 Tulane Avenue
New Orleans, LA 70112

Return Service Requested

Non-Profit Org.
U.S. Postage
PAID
New Orleans, LA
Permit No. 1017

HIV Clinician is published four times a year by the Delta Region AIDS Education and Training Center (ETC), 136 S. Roman St., New Orleans, LA 70112.

Executive Editor and Project Director
Jane E. Martin, MA, RN, C-FNP

Editor
Toni Newton

Non-commercial reproduction of this newsletter is encouraged. The opinions expressed are those of the authors and are not necessarily those of the Delta ETC. The Delta ETC is funded through the Ryan White Care Act by HRSA Grant 1H4AHA00002-01.



www.deltaetec.org