Medical News

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AIDS Research Intensifying: 88 Medicines in Testing, 14 Approved

Progress in acquired immunodeficiency syndrome (AIDS) research is intensifying, with 88 medicines in development-a 42% increase over the number in testing in 1990, according to a survey released in November 1991 by the Pharmaceutical Manufacturers Association (PMA).

'This progress is evident both in long-term and short-term comparisons with previous PMA surveys," said Gerald J. Mossinghoof, PMA president.

Key results of the survey included the following:

- During the past 12 months, three medicines for AIDS and AIDS-related conditions have been approved by the Food and Drug Administration (FDA), bringing the total to 14 in four years. Another five medicines are at the FDA awaiting approval.
- The number of medicines in development by the research-based pharmaceutical industry has more than tripled since 1987, when PMA conducted its first survey on AIDS medicines.
- These medicines are being developed by 64 companies, compared with 40 in 1990.
- No vaccines were in testing in 1987; today there are seven.

Emotional and Social Impact of Herpes Severe and Long-Lasting, Survey Says

The emotional, social, and psychological impact of genital herpes is serious, long-lasting, and little-changed from a decade ago, according to a survey of 3,000 people with herpes released in November 1991.

The survey, conducted by the American Social Health Association (ASHA), details the challenges people with herpes face, not only in coping with the disease, but also in dealing with social and sexual relationships, as well as with medical care.

"Herpes may have been replaced by the acquired immunodeficiency syndrome (AIDS) in the public eye, but it's still very much with us, and it continues to be a serious problem," said Peggy Clarke, MPH, ASHA's executive director, who presented the survey findings at a recent meeting of herpes support group coordinators in Houston, Texas. 'While there are more than one million people infected with the human immunodeficiency virus (HIV), there are over 30 million people infected with herpes. And while not fatal, the consequences of herpes are every bit as personally traumatic as they were ten years ago."

According to Clarke, the survey will help ASHA develop new patient outreach and physician education programs designed to improve quality of life for those with herpes, a recurrent viral disease.

The survey, consisting of 200 questions, was mailed to the 5,000 readers of the *helper* (the ASHA newsletter for people with herpes) in July 1991 to explore their experiences regarding their disease, medical treatment, and social and emotional issues. The questionnaire contained five sections: medical history, healthcare, treatment, personal impact, and general information. The response rate was 62%, and the survey was conducted under an education grant from the Burroughs Wellcome Company.

According to survey responses, the first outbreak of herpes is a traumatic time for those infected. Eighty-two percent reported feeling depressed, 75% feared rejection, 69% reported feelings of isolation, and 55% feared discovery. 'With subsequent outbreaks, some of these feelings decrease," said Clarke. But in the long term, people with herpes still report depression and fear of rejection. Among those who had had outbreaks within the past 12 months, 52% reported feelings of depression, and 52% said they feared being rejected in social situations.

In addition to concerns about support from friends and colleagues, people with herpes often have trouble getting the help they seek from healthcare

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providers. "Seventy-nine percent of respondents switched to a healthcare provider other than the one who initially diagnosed their herpes," said Clarke. "Sixty-four percent gave the initial provider a 'poor' rating in the area of advice on emotional issues related to herpes. This confirms what we at ASHA have heard from patients for a long time-that many physicians have great difficulty in working with patients diagnosed with herpes and other sexually transmitted diseases. Establishing personal rapport with the patient is one of the keys to successful treatment, and helping physicians become more comfortable with taking a sexual history and discussing sexuality is a goal of ASHA's planned physician education efforts."

From the Centers for Disease Control

TUBERCULOSIS AMONG RESIDENTS OF SHELTERS FOR THE HOMELESS, OHIO, 1990

During 1990, 17 cases of clinically active pulmonary tuberculosis (TB) occurred among residents of homeless shelters in three Ohio cities (Cincinnati, Columbus, and Toledo). This report summarizes the results of investigations of these cases by the Ohio Department of Health.

Cincinnati

During March 1990, health officials in Cincinnati were notified of three TB cases among residents of a 200-bed shelter for homeless adults. One of these (index case) occurred in a man with a history of alcohol abuse who died from respiratory failure and at autopsy was found to have cavitary pulmonary TB. From April through November 1990, eight additional cases of pulmonary TB were identified among residents of the shelter. Of the 11 total case-patients, seven were sputum-smear-positive, indicating potential infectiousness, and ten were culture-positive. Four case patients were known acquaintances of the index patient.

Mycobacterial isolates from the ten culture-positive patients and isolates obtained from ten persons not associated with the outbreak (controls) were sent to the Centers for Disease Control (CDC) for typing by restriction fragment-length polymorphism (RFLP). The control isolates were obtained from a convenience sample of ten persons with apparently unrelated TB cases reported during 1990 from Cincinnati and nearby counties in Ohio and Kentucky. Nine of the ten outbreak-related isolates, including the isolate from the index patient, and two control isolates had identical RFLP banding patterns. The two control isolates that shared an RFLP banding pattern with outbreak isolates were obtained from patients who, like the index patient, resided in Cincinnati and had a history of alcohol abuse.

Columbus

During March 1990, staff from a local hospital emergency room notified the public health department in Columbus of a case of sputum-smear-positive pulmonary TB in a resident (index patient) of a homeless shelter; TB had been diagnosed during January, but the patient had been lost to followup for two months. During those two months, he had resided in a shelter in Toledo, 135 miles north of Columbus. The public health department notified the Columbus shelter director and initiated a voluntary, city-wide TB screening and case-finding program for residents and staff of men's shelters and soup kitchens; 95% of these facilities participated.

On average, 768 persons daily occupied the participating men's shelters and soup kitchens in Columbus. During April 24 through May 24, 1990, the city health department administered Mantoux tuberculin skin tests (five tuberculin units [TU] of purified protein derivative [PPD]) to 363 residents and 123 (69%) of 178 staff. Of the 486 skin tests administered, 403 (83%) were read (291 residents and 112 staff). Among 81 skin-tested residents of the shelter in which the index patient resided, 32 (40%) had tuberculin skin test reactions $\geq$10 mm induration, compared with 47 (22%) of 210 skin-tested residents of other Columbus men's shelters and soup kitchens (relative risk= 1.8, 95% confidence interval= 1.2-2.5). Among the 27 staff members at the shelter in which the index patient resided, seven (26%) had tuberculin skin test reactions $\geq$10 mm induration, compared with nine (11%) of 85 staff members in other men's shelters and soup kitchens (p = .06, Fisher's exact test, two-tailed).

Following the screening program in Columbus, vouchers for chest radiographs were issued to 95 persons with tuberculin reactions $\geq$10 mm induration (previous tuberculin status not reported) and 30 persons with previously known tuberculin reactions. Of these 125 persons, 111 (89%) had radiographs and 40 (32%) reported to the TB clinic for evaluation and treatment after the radiograph. Isoniazid (INH) prophylaxis was recommended for 37 of the 40 persons; 28 (76%) of the 37 did not return after their initial clinic visit, eight (22%) completed prophylaxis, and one (3%) stopped treatment because of adverse reactions. One resident who had a tuberculin reaction $\geq$10 mm induration and two who refused a chest radiograph had culture-negative pleural TB diagnosed in June 1990.

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