HIV Rates May Be Low In High-Risk Adolescents

BY MARY ELLEN SCHNEIDER
New York Bureau

New York — HIV infection may not be a significant risk even among adolescent populations with a high prevalence of other sexually transmitted infections, according to a study of adolescents at a juvenile detention center in Houston.

Although chlamydia and gonorrhea were relatively common among this group of incarcerated teens—28% among girls and 9% among boys—the prevalence of HIV was low among those tested, with only two cases among boys and no cases among girls.

Researchers at the University of Texas evaluated 6,805 sexually active boys and 1,425 sexually active girls who were incarcerated at the Harris County Juvenile Detention Center in 2006 and 2007. The mean age of the population was 15 years old (range 13-16 years) and all identified themselves as heterosexual, Dr. William Risser said at a joint conference sponsored by the American Sexually Transmitted Diseases Association and the British Association for Sexual Health and HIV.

All of the detainees received a physical examination and health history, and a first-catch urine screening for chlamydia and gonorrhea. They also received an HIV and rapid plasma reagin (RPR) test for syphilis if they had suspicious symptoms, had not been tested for more than 1 year, had another sexually transmitted infection, had sold sex, or requested testing.

Among the 6,805 boys evaluated, 78% were sexually active in the month before admission to the facility, 69% had used a condom at last intercourse, and 29% reported that they had a new partner in the previous month. Nearly 8% of the boys tested positive for chlamydia, 0.68% tested positive for gonorrhea, and 1% tested positive for both organisms. Of the 2,524 boys who were tested for HIV, only 2 tested positive (0.08%). Of those who tested positive for HIV, their only admitted risk behavior was heterosexual intercourse, said Dr. Risser, director of the division of adolescent medicine at the university in Houston.

Among the 1,425 girls evaluated in the study, the rates of chlamydia and gonorrhea were higher, but there were no cases of HIV. About 74% reported that they were sexually active in the month before they were admitted to the facility, 49% said they had used a condom at last intercourse, 19% had a new partner in the previous month, and 9% said they had traded sex for drugs or money.

Overall, 17% of the girls tested positive for chlamydia, 5% tested positive for gonorrhea, and 6% were positive for both organisms. Of the 807 who underwent HIV testing, no one tested positive.

One of the factors in the low rates of HIV infection might have been the small amount of high-risk drug use. Other studies on the same population show that almost none used drugs other than marijuana. "I really believe that's true because culturally these kids don't use IV drugs," Dr. Risser said. ■

Diabetes Complicates Sexuality For Patients and Their Partners

BY ROBERT FINN
San Francisco Bureau

San Francisco — Consider the partners of diabetes patients when talking about sexual problems in diabetes, a research specialist in the field suggests.

Although only one member of a couple may have diabetes, "Partners are very often hidden patients," said Lawrence Fisher, Ph.D., at the annual scientific sessions of the American Diabetes Association. "Diabetes [exists] in interpersonal settings. It doesn't happen in social isolation. The most powerful and emotionally charged interpersonal setting is the adult couple." He listed six issues related to sexual intimacy that affect patients with diabetes:

Clinical depression is very common among people with diabetes, and even in patients without a formal diagnosis of depression, it's typical to find high levels of depressive affect and diabetes distress. Many of these patients are taking antidepressants, which have well-known sexual side effects. On top of that, "Being in a lousy mood is not the greatest time to have sex," said Dr. Fisher, professor in residency at the University of California, San Francisco.

Self-blame and shame are often issues in patients with diabetes, especially those with type 2. Consciously or unconsciously, many people think, "If only I had taken care of myself better, I wouldn't be having these sexual problems." Partners also may blame the patient with diabetes for sexual problems, further damaging the patient's self-esteem.

People with diabetes, especially with type 2, often feel socially and physically unattractive. An obese patient can have a poor body image that might inhibit him or her from initiating sexual activity. The other side of the coin is that partners may take it as a judgment about their own attractiveness when a man with diabetes is unable to achieve an erection.

Patients and partners often have specific worries about the effect of diabetes on sexual activity. Sexual intercourse can be physically demanding, and they worry about cardiovascular events and hypoglycemia. Having to plan for this, with blood testing before bed and snacks on the nightstand, for example, takes some of the spontaneity and fun out of sex. Furthermore, simply knowing that diabetes can lead to sexual failure can be a self-fulfilling prophecy.

Patients and their partners often suffer from a lack of knowledge about diabetes and its effects on sexual intimacy. And they also tend to be ignorant about the normal effects of aging on sexuality. "This creates what I like to call 'diabetes scapegoating,' " Dr. Fisher said. "Any time anything happens, it's [the fault of] diabetes. And it may not be. It may be normal functioning for people of that age."

Cultural and personal beliefs, values, and sentiments about sexuality can often amplify the effects of diabetes. Some couples lack the language to talk about sexual difficulties. "In some cultures, even in long-standing relationships between partners, it is considered inappropriate for the partners to talk about their sexual activity," Dr. Fisher explained. ■

Manage Menopause With Reassurance, Relief, Reassessment

BY DOUG BRUNK
San Diego Bureau

Calgary, Alta. — Reassurance, relief, and reassessment are hallmark factors in providing practical management of menopausal symptoms.

"We need to remind women that menopausal symptoms are normal," Dr. Cynthia Stuenkel said at the annual meeting of the Society of Obstetricians and Gynaecologists of Canada. "For many women, vasomotor symptoms are self-limited. There is a small percentage of women in whom these symptoms go on for a very long period of time. But for most women these symptoms will abate within a number of years."

Dr. Stuenkel of the division of endocrinology and metabolism at the University of California, San Diego, also emphasized the importance of reassuring women that vaginal symptoms are easy to treat. "I'm surprised that I still encounter women who don't know that there is a whole aisle at their drugstore with vaginal moisturizers and vaginal lubricants, or the fact that we can just use vaginal estrogens," she commented.

Another key factor in the practical management of menopausal symptoms is providing "relief." Dr. Stuenkel makes it a point to tell healthy menopausal women that short-term hormone therapy is relatively safe, noting that use of hormone therapy has switched from an emphasis on prevention of heart disease and other disorders to a focus on symptom relief if necessary.

Women opposed to hormone therapy can try alternative strategies for relief of hot flashes, such as lowering their core temperature; getting regular exercise; and avoiding hot flash triggers such as coffee, alcohol, and spicy foods. Nonprescriptive remedies such as soy foods, isoflavones, black cohosh, and vitamin E may work for some women, "though in randomized clinical trials these have not been of particular benefit," said Dr. Stuenkel, who is a member of the Board of Trustees of the North American Menopause Society.

Clinical trials of paroxetine, fluoxetine, venlafaxine, gabapentin, and clonidine have shown some positive effect on hot flashes. However, the consensus is that for women who are able to take it, hormone therapy most effectively treats vasomotor and vaginal symptoms.

Dr. Stuenkel and other experts advocate initiating hormone therapy at lower doses than those used in the Women's Health Initiative. For example, low-dose forms of oral estrogen found to be effective for treatment of vasomotor symptoms include conjugated equine estrogens 0.3 mg, micronized 17-β-estradiol 0.5 mg, and ethinyl estradiol 2.5 mcg. Low-dose transdermal preparations found to be effective include the 17-β-estradiol patch 25 mcg, cutaneous gel 1-1.25 g, and estrogen lotion (one packet).

Compared with oral preparations of estrogen, Dr. Stuenkel said, transdermal preparations possibly lower levels of venous thromboembolic events, triglycerides, C-reactive protein, and sex hormone–binding globulin.

Another hallmark factor in the practical management of menopausal symptoms is reassessment. "We don't just make a plan and then put these women on autopilot forever," she said. "Have the symptoms been relieved? With the low-dose therapies it may take longer, and there may not be a complete obliteration of all symptoms, but there should be an improvement."

'We don't just make a plan and then put these women on autopilot forever.'

DR. STUENKEL

If you're giving hormone therapy and symptoms aren't improving at all, "there's a rare woman who may have an absorption problem, but remember to think about other possibilities, such as thyroid disease," Dr. Stuenkel advised.

How long a woman should remain on hormone therapy remains unclear. The mantra "lowest dose, shortest time" is widely accepted, "but what does that really mean?" Dr. Stuenkel asked. "I'm not sure we really know. The downside to long-term therapy is probably risk of breast cancer, which varies by type of hormone therapy, duration, and timing of exposure."

Women who quit hormone therapy cold turkey can expect their symptoms to peak at 8-12 weeks, Dr. Stuenkel said. She recommends a tapering schedule by days or by dose.

Dr. Stuenkel had no relevant financial disclosures to make.

The presentation was part of a session sponsored by Bayer HealthCare Pharmaceuticals. ■