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Article

HIV post-exposure therapy for drug users in treatment

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Abstract

The purpose of this study was to evaluate the attitudes of drug treatment program providers concerning human immunodeficiency virus (HIV) post-exposure therapy (PET) for drug users enrolled in drug treatment. This was a cross-sectional evaluation of drug treatment program providers in four methadone maintenance programs (MMPs) in New Haven, Connecticut. Thirty-five MMP providers including: 29 MMP treatment staff (physicians, nurses, counselors) and 6 primary care provider staff (physicians, nurse practitioners, and nurses) participated in the study. The providers were presented with four case vignettes of individuals exposed to HIV through a needle stick ("stick"): a phlebotomist with occupational exposure (Case A) and three drug users with nonoccupational exposure to HIV (Cases B, C, and D). Case B had the same estimated future risk as Case A (three sticks/4 years) and the other cases had increased risk: Case C (four to six sticks/year) and Case D (monthly "sticks"). For each vignette, providers were asked whether they would offer HIV PET ("yes" or "no"). In addition, focus groups were held within each group of providers who were asked: "What role should drug treatment programs play in the implementation of PET?" All MMP staff (29/29) and primary care providers (6/6) felt that the phlebotomist with occupational exposure should be offered PET. The percent of MMP and Primary care provider staff recommending PET for the other cases were: Case B (MMP staff: 86% [25/29], PCPs: 100% [6/6]), Case C (MMP staff: 69% [20/29], PCPs: 33% [2/6]), and Case D (MMP staff: 59% [17/29], PCPs: 17% [1/6]). The "common themes" that were identified in the focus groups included: concern that MMPs lack resources to provide PET, the ethics of withholding PET, the "limit" on the number of times PET should be offered, and the role of PET in the overall HIV prevention message. Both MMP staff and PCPs felt that MMPs should have an "indirect" role in providing HIV PET by providing education and referral only. MMP staff and PCPs differed in their likelihood of offering HIV PET to drug users enrolled in MMPs. The possibility of HIV PET for drug users in treatment raises significant implementation issues for MMPs that will require further study if HIV PET becomes widely used in drug users. © 1999 Elsevier Science Inc. All rights reserved.

Keywords: HIV; Substance abuse; Antiretroviral therapy; Drug treatment programs; Prevention

1. Introduction

The prevention of human immunodeficiency virus (HIV) infection in humans has focused on primary prevention by altering behaviors associated with a high risk of HIV transmission. Thus, emphasis has been placed on recommendations to decrease the risk of transmission through sexual contact (Royce et al., 1997) and needle sharing (Schoenbaum et al., 1989). More recently, secondary prevention of HIV infection has been developed through the use of antiretroviral therapy. For example, occupational exposure in health-care workers through needle-stick injuries has been associated with a risk of transmission of approximately 0.3% (Tokars et al., 1993) and antiretroviral therapy with zidovudine has been estimated to decrease the risk of seroconversion in uninfected individuals who are exposed to a needle stick by approximately 79% (Centers for Disease Control and Prevention, 1995, 1996). Similarly, zidovudine therapy was demonstrated in one study to decrease the risk of perinatal transmission of HIV from 22.6% to 7.6% (Sperling et al., 1996).

Referred to as post-exposure therapy (PET) or post-exposure prophylaxis (PEP), secondary prevention of HIV infection with antiretroviral therapy is now officially "recommended" by the Centers for Disease Control and Prevention (CDC) in the case of "highest" and "increased" risk occupational exposures to HIV infection in health care workers (Centers for Disease Control and Prevention, 1996) With the advent of newer antiretroviral therapies (Carpenter et al., 1997), PET has become considerably more complex and expensive than simple therapy with zidovudine. When used, a minimum of two drugs (zidovudine and lamivudine) and often three drugs (zidovudine, lamivudine, and indinavir) are recommended to be taken for 4 weeks (Centers

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for Disease Control and Prevention, 1996). This involves taking at least eight pills a day (using thrice daily dosing) (Centers for Disease Control and Prevention, 1996) at a cost of approximately $800 (Katz & Gerberding, 1997).

If nonoccupational PET is to be made available more widely for "high-risk" exposures from needle-sharing and sexual behavior, drug users provide special challenges for practitioners who may be asked to provide this therapy. Drug abuse and dependence is associated with behaviors that are disorganizing and may make it difficult to gain access to and comply with PET. In addition, ongoing drug use is associated with repeated high-risk drug use and sexual behaviors, raising the possibility of repeated need for PET. This raises several concerns, for example, the possibility of promoting the development of drug-resistant strains of HIV. The concept of PET after sexual assault has been considered as one potential aspect of postassault care for survivors of sexual assault (Gostin et al., 1997). Although there is no empiric data in the literature on the use of PET in drug users, Katz and Gerberding (1997) recently recommended PET for "high-risk exposure" (e.g., needle sharing with an HIV-infected partner) ". . . when the exposure occurs in isolation or involves someone who intends to stop engaging in such behavior" (Katz & Gerberding, 1997).

If drug users are to be considered as candidates for PET, "stable" participants in drug treatment programs—especially methadone maintenance programs (MMPs)—may be relatively "ideal" candidates. Along with out-of-treatment drug users in long-term recovery, such individuals may have the greatest potential for avoiding further exposure after completing an episode of PET. If patients enrolled in MMPs become potential candidates for PET, these programs, which are often the only and/or most frequented source of health care for their patients, may be asked to play a role in providing access to PET.

The objective of this study was to examine the possibility of PET from the perspective of drug treatment providers. Specifically two questions were posed: "Which drug users enrolled in treatment are appropriate candidates for PET?" and "What role should drug treatment programs play in the implementation of PET?"

2. Materials and methods

Data for this study was collected from a cohort of drug treatment providers. Two data collection techniques were utilized: case vignettes and focus groups.

2.1. Study site and subjects

Drug treatment providers were enrolled from programs affiliated with the Substance Abuse Treatment Unit at the Yale University School of Medicine and the APT Foundation in New Haven, CT. The providers contacted represented four MMPs, which have a total of approximately 1,100 patients. These programs also include a nearby primary care clinic for patients enrolled in these drug treatment programs (O'Connor et al., 1992). The providers interviewed (physicians, nurses, and counselors) all provided direct care for program enrollees. The HIV seroprevalence among injection drug users enrolled in these programs is estimated to be approximately 30%.

2.2. Case vignettes

To obtain information concerning the first study question: "Which drug users enrolled in treatment are appropriate candidates for PET?," four case vignettes (A–D) were written in order to examine the threshold of acceptable ongoing risk above which HIV PET would not be offered by the drug treatment providers interviewed (Table 1). Prior to presenting the cases to the providers, basic information about HIV transmission was briefly discussed and research about the potential effectiveness of occupational PET (Tokars et al., 1993) and perinatal HIV prophylaxis (Sperling et al., 1996) was reviewed. In addition, the current CDC guidelines for PET (Centers for Disease Control and Prevention, 1996) were presented and discussed.

Following an opportunity for questions from the study participants, the four case vignettes (Table 1) were given to

Table 1
Four cases vignettes: "Would you offer HIV PET to this patient?"

A.	A 35-year-old MMP phlebotomist who has been working in the program for 5 years sustained a needle stick while drawing blood on a patient who is probably HIV positive. S/he has sustained 3 needle sticks in the past 4 years	
	Yes _____	No _____
B.	A 35-year-old MMP patient who has been on the program for 5 years shared a needle with an individual who is probably HIV positive. S/he has been abstinent (negative urines) for the past year and has had 3 "slips" in the past 4 years.	
	Yes _____	No _____
C.	A 35-year-old MMP patient who has been on the program for 5 years shared a needle with an individual who is probably HIV positive. S/he has had intermittent "slips" (4–6) over the past year (positive urines) and in each of the past years.	
	Yes _____	No _____
D.	A 35-year-old MMP patient who has been on the program for 5 years shared a needle with an individual who is probably HIV positive. S/he has had regular "slips" (monthly) over the past year (positive urines) and in each of the past 4 years.	
	Yes _____	No _____

HIV = human immunodeficiency virus; PET = post-exposure therapy; MMP = methadone maintenance program.

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