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AIDS - New Zealand

INTRODUCTION

This fourteenth issue of 'AIDS - New Zealand', provides information about the occurrence of acquired immunodeficiency syndrome (AIDS) in New Zealand to 30 June 1992. These reports are produced quarterly by the AIDS Epidemiology Group, which is jointly funded by the Health Research Council of New Zealand and the Department of Health. We aim to give timely and relevant details about the problem of HIV/AIDS in New Zealand. Not all tables and figures will be updated in every edition.

AIDS IN NEW ZEALAND

Twelve people were notified as having AIDS in the second quarter of 1992. All were male. The total number notified since monitoring began was 335 on 30 June 1992. The cumulative incidence of AIDS in New Zealand to this time was 10.2/100,000.

Figure 1 depicts the annual and cumulative numbers of notifications since 1984.

The numbers relate to the year in which we were notified of a person having AIDS.

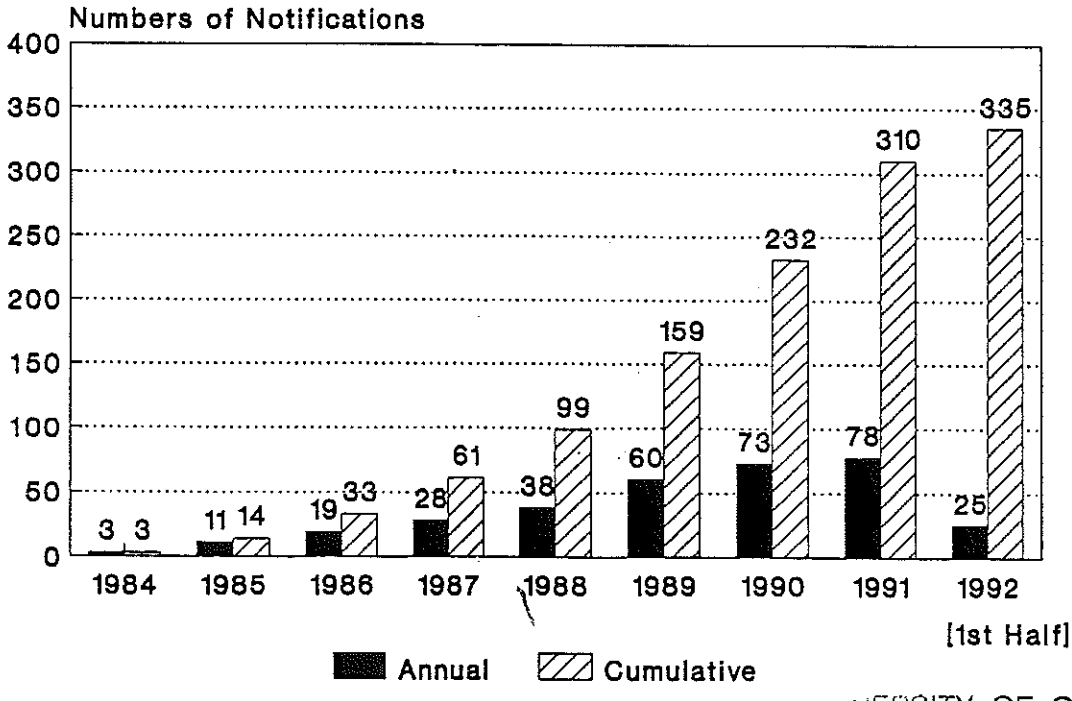

Figure 1 AIDS notifications in New Zealand

Notifications made over the last three months have followed recent trends and have not given us any reason to alter our commentary made in the previous issue of 'AIDS - New Zealand' published in May 1992. Then we noted that over the last two years the rate of increase in the number of people with AIDS appears to have slowed.

All the twelve people notified were men. Eleven were men who had had sex with men, while the likely means of acquiring HIV could not be determined by the notifying physician for the remaining person.

HIV POSITIVE TESTS

In the three months of April, May and June 1992, 22 people were found to be infected with HIV. Of these 22, 20 were male and 2 female. The total number found to be infected in New Zealand to the end of June 1992 was therefore 763.

Care must be taken in interpreting the HIV antibody data, as it is certain that not everyone at risk will have been tested.

RISK BEHAVIOUR CATEGORIES

The risk behaviours most likely to have resulted in HIV transmission in (a) people notified as having AIDS, and (b) those who were found to be infected by HIV, during the 12 months to 30 June 1992, and in total to that date, are shown in Table 1. The gender of these

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Table 1 Category of risk behaviour by date of notification of people with AIDS, and those identified as HIV antibody positive

	AIDS				HIV antibody positive			
	12 Months to 30.6.92		Total 30.6.92		12 Months to 30.6.92		Total 30.6.92	
	No.	%	No.	%	No.	%	No.	%
Homo/bisexual	54	88.5	286	85.4	77	72.6	437	57.3
Homosexual & IDU*	3	4.9	7	2.1	0	0	7	0.9
IDU*								
Male	0	0	5	1.5	1	0.9	14	1.8
Female	1	1.6	2	0.6	2	1.9	4	0.5
Haemophiliac	0	0	4	1.2	0	0	31	4.1
Transfusion Related								
Male	0	0	1	0.3	0	0	2	0.3
Female	0	0	1	0.3	0	0	5	0.7
Unknown	0	0	0	0	0	0	5	0.7
Heterosexual								
Male	1	1.6	10	3.0	2	1.9	9	1.1
Female	0	0	6	1.8	5	4.7	18	2.4
Perinatal								
Male	0	0	0	0	1	0.9	1	0.1
Female	0	0	1	0.3	0	0	1	0.1
Unknown/Not stated								
Male	2	3.3	12	3.6	15	14.1	209	27.4
Female	0	0	0	0	3	2.8	12	1.6
Unknown	0	0	0	0	0	0	8	1.0
TOTAL	61	100.0	335	100.0	106	100.0	763	100.0

*IDU - Injecting drug user

people is also presented.

AIDS and HIV infection continues to be reported most frequently among men who have had sex with men.

The information on HIV positive results is provided to laboratories performing the confirmatory testing. The high number of people where the risk behaviour is 'unknown/not stated' reflects the lack of such information provided with the test request. To minimise the number in this group it is important that information on likely means of transmission is included on the request form.

OUTCOME

The outcome for the 335 people notified as having AIDS by 30 June 1992, as known to us at the time of publication, is shown in Table 2.

Table 2 Outcome of people with AIDS

Alive	79
Known to have died	245
Lost to follow up	3
Overseas	8
Total	335

REGIONAL DISTRIBUTION OF AIDS IN NEW ZEALAND

Table 3 shows the numbers, and rates per 100,000 population, of people notified with AIDS from the geographic areas (Figure 2) which comprise the four Regional Health Authorities (RHA) that are presently being established. The population figures used to derive the rates have been taken from the populations within the area health board boundaries for 1989, that have been combined to from the RHAs.

As is seen AIDS is more commonly notified from the Northern RHA.

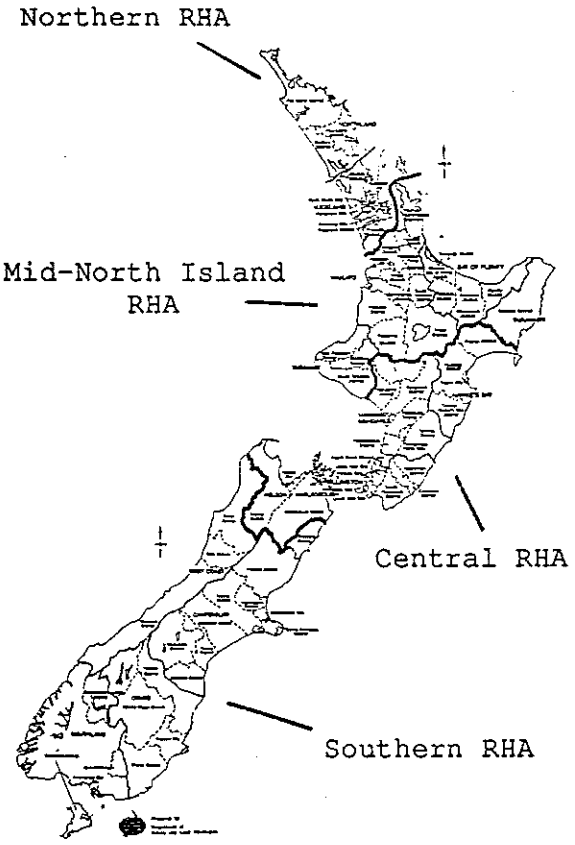

Figure 2 Regional Health Authority Boundaries

Table 3 Regional distribution of number and notification rate (per 100,000 total population) of people notified with AIDS to 30.6.92

Regional Health Authority	12 Months to 30.6.92	Total to 30.6.92	Cumulative Notification Rate per 100,000
Northern RHA	32	192	18.6
Mid-North Island RHA	12	33	4.9
Central RHA	14	86	10.2
Southern RHA	3	24	3.2
Total	61	335	10.2

MANAGEMENT GUIDELINES FOR PEOPLE INFECTED WITH HIV

Recently guidelines for management of people infected with HIV have been circulated by the Department of Health. Some of the recommendations are reproduced below.

It is advised that people found to be infected should have regular monitoring of their CD4 lymphocyte count. The CD4 lymphocytes are a specific type of white blood cell that circulate in the blood stream and are important in the body's defence against infection.

There is a close relationship between a falling CD4 lymphocyte count and risk of opportunistic infections. These are infections caused by microorganisms that in people with normal immunity do not usually cause illness, but can do so when a person's immune system is working inefficiently.

The measurement of CD4 counts can vary considerably even when samples are taken from the same person quite closely together. This is because of actual variation, and because of variations in the laboratory measurement. Isolated low CD4 counts can occur at times of illness which subsequently recover. What is most important in monitoring the effect of HIV infection is the trend over time.

It is recommended that people who have CD4 counts which are below 500 per cubic mm and falling should be considered for treatment with the drug zidovudine (AZT), although it is probably most useful for people with counts lower than 350 per cu mm. This drug, when used appropriately, appears to be able to slow the progression of HIV infection and thus delay the onset of AIDS. The virus can develop resistance to zidovudine, and in this situation, or where there is progression of the disease whilst on treatment the use of other drugs such as di-deoxyinosine (ddI) or di-deoxycytosine (ddC) may be considered.

As the CD4 count approaches and then falls below 200 per cu mm, the chance of *Pneumocystis carinii* pneumonia (PCP) increases. Prophylaxis (treatment to prevent infection), is recommended when the CD4 count reaches this level. The drugs most commonly used for this are cotrimoxazole, dapsone, or pentamidine (the latter needs to be given as a special aerosol).

Doctors are being encouraged to accept the infected person's use of alternative approaches to therapy, as they may contribute to their emotional and psychological well-being. Ideally the relationship between the infected person and their doctor will be such that the medical practitioner is informed about alternative therapies used in conjunction with orthodox treatment.

[Abridged from 'Management Guidelines for HIV/AIDS' by RJ Meech, Chairman, Medical & Scientific Advisory Sub-Committee on AIDS. Published in Circular letter to medical practitioners 1/92. Department of Health, June 1992]

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