HIV-Related Gynecologic Conditions: Overlooked Complications
Carola Marte, MD and Machelle Allen, MD

Research continues to characterize women as vectors of HIV transmission to men and fetuses rather than as the fastest growing group of HIV-infected people in the United States. This view perpetuates the medical and social bias that elevates the health of children above women, equates women's health with reproduction, and deemphasizes gynecologic concerns and their life-threatening potential.

The lack of attention to the health care needs of women is not new. Gynecology has long been segregated from general medicine. Visits to gynecologists, however, continue to be the only primary care for the majority of young women in this country. For many other women, their only contact with health care is during hospitalization for childbirth or emergency room visits for gynecologic complaints.

A broad spectrum of women is affected by HIV disease, and infection manifests in complex ways among women, many of whom are dealing with HIV-related challenges as both caretakers and patients. This article describes gynecologic manifestations of HIV disease, such as vaginal candidiasis and human papillomavirus, and the failure of many contraceptive methods to prevent HIV transmission.

The Case of Lydia

Lydia was an HIV-infected woman who suffered from a myriad of serious health problems and a “poor follow-up” record. She was poor, the mother of six, and uninsured, and married to a man earning near minimum wage. She lived over an hour’s subway ride from her medical clinic. When she missed appointments, it was the usual problems of poverty that detained her.

At the time of this examination, Lydia’s chart noted profound and increasing weight loss and anemia, as well as oral thrush but did not mention any gynecological complaints. Examination of Lydia’s pelvic area, however, revealed a yeast infection so severe that her vagina was raw and her perineal area (surrounding the genitals and anus) was painfully ulcerated. Although Lydia received treatment, she missed follow-up care because she could not afford to make her health a top priority. Three months later she returned with a severe yeast infection of the esophagus, which might well have been suppressed by the genital yeast medications.

Lydia’s story is like that of many other HIV-infected women. From the medical point of view, it becomes obvious that a condition affecting one mucous membrane—such as the vagina—can affect any other—such as the esophagus. Oral thrush is a marker for HIV disease staging or progression, whereas vaginal candidiasis, as well as a host of other HIV-related gynecologic manifestations, is often neither looked for nor asked about.

Vaginal Candidiasis

Vaginal candidiasis is the most common gynecologic disorder and one of the most common medical problems experienced by HIV-infected women. As with many other infections, it is not unique to HIV-infected individuals but among them, it tends to be more difficult to treat and recurs despite otherwise sufficient treatment. It often precedes oral thrush as a sign of HIV disease, and recurrent or persistent candidiasis is the most frequent early sign of HIV disease among women seeking HIV testing.

Successful treatment of vaginal candidiasis varies widely. For many women, topi-
Editorial: Avoiding Women
Robert Marks, Editor

Why has there been such hesitation to address the needs of HIV-infected women in the United States? The most obvious response is that women comprise only a fraction of the HIV-infected population, currently only 10 percent of reported U.S. AIDS cases. But these numbers are misleading. This little slice of the epidemic, dwarfed by the numbers of gay men who have died, and by the grief of gay men as their communities have been decimated, is the fastest growing AIDS epidemic in the U.S. Ten years ago, had we the foresight to attend to the "insignificant" epidemic among gay men that we should have today regarding the epidemic among women, tens of thousands would be alive.

Times of Scarcity

Numbers should not matter, but they do in times of scarcity. When resources abound, every individual is valuable; when resources recede, only the biggest, the loudest, the most powerful get saved. AIDS is essentially a disease of communities, and because specific communities have been disproportionately hit by the epidemic, the response to scarcity is to look after one's own.

There is no real solution to such competition: there is simply not enough. But if we, as AIDS providers, acknowledge that attending to the needs of one HIV-infected woman is as valuable as attending to the needs of one gay man, one drug user or, for that matter, one famous sports personality, we do not eliminate the scarcity, but we do temper the competition. And by cooperating we stand a better chance of increasing resources, achieving economies of scale, and maintaining critical exchanges of scientific information.

The Greatest Disincentive

The greatest disincentive to responding to AIDS among women, however, is the most fundamental: we shy away from the awesome task of addressing the societal problems women face when they attempt to access health care and protect themselves from HIV infection. Women are statistically poorer than men, more likely to be single parents, and more likely to be uninsured. Women's health issues continue to be relegated to a dim corner in medical practice.

Last, but not least, as Christine Miller quotes in the second article in this issue: "Women don't wear condoms." The result is that men traditionally decide whether women will be protected from transmission, and because of their economic dependence, women may have to choose between possible exposure and support for themselves and their children.

When AIDS providers approach women with HIV disease, we also confront 5,000 years of sexism. Can we influence attitudes and philosophies that have evolved over millennia? The answer must be couched in terms that most of us working with AIDS have learned well: activism and innovation. AIDS has shown itself to be the crucible in which old assumptions about sex, drugs, and medicine can be melted down and recast. To this mix must be added sexism and its health care consequences.

Human Papillomavirus

Human papillomavirus (HPV) is thought to be the causative agent for most condylomata acuminata (genital warts) as well as for most cervical cancer, although it is important to note that the strains of HPV that cause warts are different from the strains that cause cancer. As in HIV-infected men, genital warts in HIV-infected women may exist as multiple small lesions or unusually large and profuse lesions. Although external warts in women initially occur on the perineum, they often extend to adjacent, moist epithelium, including the vagina, cervix, urethra, and rectum. Spontaneous regression of symptoms is far less common and recurrence after treatment is more pronounced in HIV-infected individuals than in uninfected people. This can result in a frustratingly long course of treatment.

Cervical disease, caused by HPV, is potentially fatal and is the most serious
Unusual or severe gynecologic conditions should raise the alert among practitioners that HIV infection may be involved.

References


Gynecologic disease for HIV-infected women. Cervical dysplasia (the premalignant changes noted on Pap smear screening) can progress to cervical cancer. Cervical cancer is curable if detected by a Pap smear before significant invasion.

Cervical dysplasia occurs at an unusually high rate in HIV-infected women, many of whom may not realize in time for preventive treatment that they are at increased risk for cervical cancer. Nearly all clinics for HIV-infected women report significantly increased rates of abnormal Pap smears, often five to ten times the expected rate. In addition, cervical dysplasia and cancer, like certain other viral diseases, may be more aggressive and persistent among seropositive women than among uninfected women.

Unfortunately, there are no prospective studies evaluating HPV disease among HIV-infected women. Such research could determine the prevalence of specific HPV strains, their recurrence rate after treatment, and the rate of progression from premalignant lesions to cancer. Such research could also aid in determining whether HIV-infected women require more intensive monitoring and more radical therapies. Many providers, following a clinically aggressive course until there is more information about the natural history of HPV disease in HIV-infected women, recommend Pap smears every six months for immunosuppressed women. All women with cervical abnormalities need colposcopy evaluation for biopsy and treatment with frequent follow-up. Since different HPV strains cause genital warts and cervical cancer, women who do not have genital warts must still be monitored carefully with Pap tests to detect cervical dysplasia, and the presence of genital warts does not mean a woman has cervical dysplasia or cancer.

Standard therapy for genital warts includes topical applications of podophyllin or trichloroacetic acid. Freezing with liquid nitrogen (cryosurgery), cauterization (electrosurgery), or laser treatment can be used to treat dysplasia as well as genital warts. None of these is contraindicated for HIV-infected women, although health care workers should be careful to minimize exposure to the vapor from laser therapy, because it may transmit HIV. In addition, experimental therapies, such as topical 5-fluorouracil (5-FU) maintenance therapy and intralensional alpha-interferon, are being used to treat recurrent disease in some places.

Genital Ulcers

Sexually transmitted diseases (STDs) are thought to play an important role in countries with rapidly increasing rates of heterosexual HIV transmission. Many inner cities in the U.S., for instance, areas in New York, Los Angeles, and Oakland, are experiencing a similar situation marked by the coexistence of substance abuse, multiple sexual encounters, poor access to health care, and a notable increase in STDs, especially syphilis and chancroid.

The presence of genital ulcer diseases (GUD)—STDs such as syphilis, gonorrhea, chancroid, and active herpes, that raise ulcers—are thought to increase the chance of HIV transmission among sexual partners. Recently it has been suggested that other STDs, such as chlamydia and trichomonas, may also enhance transmission, presumably because they also cause some inflammation of the genital mucosa. Since such infections in women are often internal and asymptomatic, barriers to routine health care magnify the dangers of untreated infection and the opportunity for increased transmission.

Syphilis is particularly serious, since it can lead to potentially fatal complications, such as kidney disease and neurosyphilis. For pregnant women, untreated or inadequately treated syphilis carries the additional risk of transmission to their children, and congenital syphilis has increased alarmingly in larger cities such as New York. Among people with HIV disease, however, syphilis may recur despite standard therapy benzathine penicillin injections. For this reason, and because of the potential danger of neurosyphilis (a complication to which HIV-infected individuals seem particularly susceptible), many physicians recommend performing spinal taps and treating with intravenous penicillin any HIV-infected person whose blood tests do not show an unambiguous cure after standard treatment.

Of the other GUDs, herpes in women, as in men, has been the most difficult to treat. Like candida and HPV, it is likely to recur more frequently and to be more aggressive in HIV-infected women. Persistent or recurrent herpes can be treated with oral acyclovir on a regular schedule.
Pelvic Inflammatory Disease

Pelvic inflammatory disease (PID, or tubal infection) is also caused by STD organisms, especially chlamydia and gonorrhea, although almost no research has been done on this disease in seropositive women. Several hospitals in areas where HIV disease is prevalent have reported that women with particularly severe PID and who require intravenous treatment or surgery are likely to be HIV-infected.

One of the major problems with PID in HIV-infected women is that often its only symptom is chronic abdominal pain. It may go untreated because neither patients nor clinicians are sufficiently aware of the diagnosis.

Contraception and Safer Sex

Women who wish to avoid pregnancy face the dilemma that family planning methods preventing fertilization do not necessarily guard against HIV or STD transmission. Oral contraceptives, favored by younger women, in particular, are effective and easily controlled by women but do not protect against disease transmission. On the other hand, condoms, which reduce transmission, are less effective contraceptives, and their use is often outside a woman's control.

A related problem is that much of the safer sex counseling for women has taken place in family planning and prenatal clinics. However, the large number of women without young children or who have had tubal ligations (which, unlike barrier contraceptives, prevent pregnancy but not HIV infection) do not attend these clinics. Consequently, women are in a position where they must use one form of contraception to effectively prevent conception and another to effectively prevent HIV transmission.

Conclusion

In the U.S., while the overall rate of new HIV infection stabilizes, there is a dramatic increase in heterosexual transmission rates and the numbers of infected women. At the same time, gynecology is omitted from most protocols of infectious disease clinics, from HIV-related research and funding, and from HIV and AIDS information sources such as textbooks. The historical neglect of women's health care issues provides a context for the dangerous myth that HIV disease and AIDS affect only the marginalized "other": drug addicts and gay men. Women themselves, their providers, and their partners are misled to ignore women's vulnerability to the disease.

The most important lesson to be learned from an examination of the gynecologic manifestations of HIV disease is that the list of illnesses that clinicians and patients are told will appear in HIV-infected people is incomplete. This means that symptoms of HIV disease may be overlooked, opportunities for treatment, especially preventive treatment, may be missed, and that some gynecologic conditions will progress to the point of being life-threatening. In particular, unusual or severe gynecologic conditions should raise the alert among practitioners that HIV infection may be involved. Conversely, both HIV-infected women and their providers should be scrupulous about making gynecologic examination a part of the health care regimen.

References


Reducing Risk among Female Partners of Injection Drug Users

Christine Miller

In most cultures, steeped in an ethos that says men are dominant, it is in their sexual relationships that women find themselves to have the least control. For some women, this lack of control translates directly into an elevated risk of HIV infection. The female partners of injection drug users, in particular, are at high risk of infection and may be the least able to exert power to reduce risk.

A San Francisco study of 77 women whose partners had injected drugs offers some insights into the strategies women have used and can use to protect themselves from sexual transmission.1,2 These strategies range from enlisting drug using partners to help define and diminish risk, to getting drug users to reduce needle sharing and seek treatment, to encouraging drug using partners to use condoms.

Accurate Information and Risk Perception

Access to information is a crucial precursor to the accurate perception of risk that is necessary to motivate risk reduction. Most fundamentally, women must be aware of the risk posed by a sexual partner's drug use. Assessing personal risk requires talking to male partners about their behaviors, a potentially complicated process. For example, women may not acknowledge a partner's drug use, especially if they themselves do not use drugs, and partners may conceal drug use, antibody status, and other risk factors.

Women may also fear confrontation when risk behaviors are openly acknowledged. Female partners are often hindered by a sense of powerlessness, low self-esteem, and social isolation. A substantial number also report economic and emotional dependency, and some are subject to physical abuse. As a result of all of these factors, women may fail to get accurate information, to perceive risks in realistic terms, and to protect themselves.

Talk is a crucial prerequisite for assessing risk and introducing safer sex. Most culturally prescribed gender roles, however, discourage women from initiating such discussions. The profound nature of these roles has led some researchers to conclude that it may be harder to implement safe sex than to alter injection practices.2

Influencing Injection Practices

Women may also attempt to change their partners' drug use patterns. They may encourage users to seek treatment or to stop sharing needles. Some women clean their partners' needles: one woman in the San Francisco study washed her partner's dirty needles as part of her regular household chores. They may seek a supply of clean needles. They may also provide or insist upon the use of bleach.

Other women attempt to "domesticate" the drug habit by negotiating changes that bring risk behaviors more under their scrutiny and control. For example, couples

Special Publications

WORLD, Women Organized to Respond to Life-threatening Diseases, is a monthly newsletter featuring profiles of women with HIV disease and articles on services for women and issues affecting women. For a free subscription, write: P.O. Box 11535, Oakland, CA 94611, (510) 658-6930.

The Journal of the American Medical Association published a theme issue on pelvic inflammatory disease (PID). The November 13 issue (Vol. 266, No. 18) includes reports on PID prevention, diagnosis, and risk.

AIDSFILE, published by San Francisco General Hospital Medical Center, devoted its Summer 1991 issue to HIV disease in women. The issue included articles on the epidemiology, treatment during pregnancy, and participation in clinical trials. For a free copy, write: AIDSFILE, SFGH, Ward 84, 995 Potrero Avenue, San Francisco, CA 94110.

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See also references cited in articles in this issue.
may agree that male partners will shoot up only at home or that there will be a limit on the number of people with whom male partners will share needles.

While domestication is not a risk reduction approach women can adopt unilaterally, some researchers believe that it may be less threatening to both members of the relationship. Because it can parallel the traditional role of women as caretakers, domestication of drug use poses less risk of conflict than does sexual negotiation, which contradicts this role. For a woman who is not in a preexisting caretaker role, as is true for many women, domestication may not be a useful strategy.

Domestication may seem to be detrimental in two ways: it seems to reinforce stereotypical roles that assign women subservient positions in intimate relationships; and it facilitates drug use and so seems antithetical to drug treatment. But, from the female partner's perspective, these less desirable approaches may function as reasonable adaptations in the face of the threat to life posed by HIV.

Condoms: Power vs. Prevention

The phrase, "Women don't wear condoms," sums up the problem. Condom use requires the cooperation of the male partner, and may require changes in attitudes and behavior for both partners. Interventions that rely on women to introduce and insure condom use, once again, ask them to assume new roles, and like initiating talk about sex, can upset the existing power balance in a relationship. In response, women risk potential domestic conflict, including even violence.

Power imbalances within relationships tend to function at unconscious levels and are often maintained by both partners through denial and emotions such as fear. When women assert their needs within the often emotionally-charged context of a sexual relationship, they challenge traditional power roles, and as a result, both partners may feel anxious and threatened. In relationships where male partners are addicted to alcohol or opiates, there may be an additional sensitivity about condom use because of difficulty in maintaining an erection as a result of substance use. In response to the dilemma, women who are psychologically or economically dependent on partners that expose them to HIV need to seek remedies outside their relationships. Access to social service, economic, and peer group support may be the only way for them to balance the lack of control within these relationships.

Last Resorts

Women often anticipate hostile reactions when sizing up the costs and benefits of reducing HIV transmission risk. When talk and pressure to use condoms fail and when women cannot know with any certainty the injection practices of their sex partners, many simply avoid sex as a strategy to reduce risk. They may eventually leave an important relationship because of its HIV risk.

Occasionally couples do successfully switch to safer sex practices. Such relationships tend to have established pre-existing communication skills and to lean in general toward egalitarian solutions to conflict. Perhaps the most accurate predictor of HIV-related condom use is the already successful use of condoms for birth control.

Conclusion

Interventions that promote the consistent use of condoms continue to elude researchers, but improved barrier methods of contraception and disease protection that do not require male cooperation may be years away. Until better female-controlled methods become available, the issue of power in heterosexual relationships and the ability of women to exert influence over male condom use will continue to dominate research efforts.

Furthermore, lasting behavioral change may prove more difficult to maintain than to initiate. Heterosexual partners of injection drug users need more durable interventions—targeted more precisely in recognition of their ethnic, cultural, and socioeconomic diversity—in order to achieve the goal of consistent and long-term risk reduction.

The FOCUS Binder

As FOCUS enters its seventh year, it is clear that it provides not only a current guide to AIDS research and counseling, but also a history of the psychosocial response to the epidemic. To make it easier for subscribers to keep track of past issues and to keep that history at their fingertips, FOCUS is now three-hole-punched so that it can be stored in binders.

In January, we will offer to subscribers a specially-imprinted binder ($12.95, including shipping and handling). For more information or to order a binder, please call 415-476-6430.
In Review

AIDS and Women Bibliography

AIDS and Women: A Sourcebook is a basic reference tool for people who are beginning to work with or study women with HIV disease, and a useful compilation of references and resources for people who may not be able to do in-depth research on issues related to women. Unfortunately, the book contains some inaccurate and outdated information.

Each chapter includes an annotated list of selected resources on the topic. The first five chapters cover routes of HIV transmission and epidemiology, and include information for sexual partners of hemophiliacs, a topic not often dealt with in books on women and HIV disease. A large section of the book is devoted to groups of women such as lesbians, incarcerated women, sex workers, pregnant women, women in Africa, and women of color. Each of these chapters covers the basic issues for that population, including a brief discussion and a list of selected resources. However, this section fails to adequately address issues of substance use in women, and HIV disease among young women.

The book's greatest flaw is its reliance on information that is sometimes out of date and other times inaccurate. Over the past two years, there has been an explosion of articles on women and HIV disease. The absence of any citations since 1989 or statistics later than early 1990 makes AIDS and Women far less useful than it might have been. The use of the outdated terminology such as "HTLV-III/LAV" is symptomatic of a sloppiness that compromises the book.

The last two chapters address safe sex and the medical management of HIV disease in a potentially misleading way and ignore some of the basic precepts of community-based education and prevention efforts. Among the more glaring inaccuracies, the authors inappropriately conclude that the most important safe sex message is to avoid having sex with anyone at risk for HIV infection and question the ability of condoms to offer protection from HIV. In addition, they include articles from the popular press, such as People and Glamour, in resources lists, while omitting the often more accurate articles from PWA coalition newsletters and community-based treatment newsletters.

The book is well-organized, easy to read, and a starting point for further research. It will be helpful to people looking for lists of articles on women and HIV disease, but, because it is somewhat outdated, it is probably best used as a starting point in a library search of more recent and comprehensive books and journal articles.

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Recent Reports

National Survey of Women

A 1988 survey of 7,578 women found that 28 percent had either adopted less hazardous sexual practices or had partners who used condoms. Women who characterized themselves as having a "very strong chance" of getting AIDS, women who had greater numbers of lifetime partners, women ages 15 to 19, and unmarried women were the most likely to take such precautions.

Based on a subset of the National Survey of Family Growth, researchers estimate that the report represents the beliefs of 51 million women, ages 15 to 44, who have had sexual intercourse at least once. Subjects were interviewed between January and August 1988.

The most common behavioral changes included using condoms for disease prevention, limiting sex to one man, stopping sex with unknown men, and having sex less often. Of the 1,094 women (12 percent) who used condoms, 76 percent did so after hearing about AIDS. Of the 1,169 women (13 percent) who limited sex to one man, 62 percent did so after hearing about AIDS. A combined analysis of marital status and numbers of sexual partners led to a predictable result: among married women with only one lifetime partner, only 5 percent took precautions against STDs; among unmarried women with five or more lifetime partners, 65 percent took these precautions.

The study data may be limited by a lack of detail. For example, responses do not
Inject drug users were significantly more likely to have evidence of hepatitis B exposure and to report a history of STDs. The mean T-helper cell count was 507 for the injection drug users and 504 for the heterosexuals.

Early Treatment

The San Francisco AIDS Foundation has published the second edition of its book *Early Care for HIV Disease*, a practical guide to help people in the early stages of HIV infection maintain or improve their physical and mental health. Chapters cover topics such as HIV treatments, diet and nutrition, paying for medical care, and facing the psychological challenges of being infected. The new edition includes expanded information on treatments for opportunistic infections and on issues affecting women with HIV disease.

FOCUS Staff Writer John Tighe and former AIDS Health Project Program Evaluator Jeffrey M. Moulton, PhD are coauthors with Ronald A. Baker, PhD, Editor of *BETA*, the AIDS treatment magazine published by the AIDS Foundation. The 130-page book is available at bookstores and by mail ($9.95, plus $4.00 shipping) from Impact AIDS, 3692 18th Street, San Francisco, CA 94110, (415) 861-3397.

Next Month

HIV prevention efforts for drug users are often limited to outreach and antibody test counseling, interventions that do not address the chronic nature of HIV risk. As counselors increase their emphasis on maintenance of risk reduction, however, they are integrating traditional psychotherapeutic approaches into prevention programs for drug users.

In the January issue of *FOCUS*, William C. Grace, PhD, Sander G. Genser, MD and Ro Nemeth-Coslett, PhD of the National Institute of Drug Abuse discuss specific psychotherapeutic elements and how they can be applied to prevention counseling.

For many practitioners the rhythm and texture of the lives of drug-dependent people remains foreign. Also in the January issue, Janet Johnson-Wise, MSW, at the HIV/STD Control Branch of the North Carolina State Division of Epidemiology, portrays a day in the life of an injection drug user.