AIDS ReSearch Alliance

SPOTLIGHT

People & Developments / Winter 2005

INTERVIEW

—One on one with UCLA's Dr. Peter Anton

Peter serves as the Director of the ***UCLA Center for HIV and Digestive Diseases*** *and a Professor in the Department of Medicine/Division of Digestive Diseases, at the* ***David Geffen School of Medicine****. He is a member of the* ***CURE Center for Gastroenteric Biology*** *and the* **UCLA AIDS Institute***. He is a leading researcher on HIV and immunology of the gastrointestinal tract, and has been a member of the AIDS ReSearch Alliance* ***Medical Executive Committee (MEC)*** *since the summer of 1996.*

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Peter Anton, M.D.

AIDS Attacks Asia

by Neil S. Gordon

HIV Prevalence among sex workers and injecting drug users in Guangxi province, China: 1995-2000

Illustration courtesy of UNAIDS Global Report 2004

Source: Sentinel surveillance reports, National Center for HIV/AIDS Surveillance

ASIA has quickly become a major front in the war against AIDS. In the decades prior to the 1990's, no country in Asia had suffered a major AIDS epidemic. By the end of the last decade, the disease was well established across the region. According to a September 2002 report by the *National Intelligence Council*, China, India, Nigeria, Ethopia, and Russia all face an explosion of HIV/AIDS by the end of the decade, unless dramatic steps are taken *now* to control the spread of this pandemic.

The epidemic blanketing Asia is in fact a patchwork of many epidemics. The pattern of HIV infection across Asia is as diverse as the different societies that make up the countries, regions, states and metropolitan areas that are affected. As

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SPOTLIGHT

ARA envisions a future in which HIV and its effects are eliminated from infected individuals, and research yields effective and accessible methods to prevent new infections—eradicating the virus.

ARA's mission is to find and accelerate the development of effective treatments for HIV and its complications. We do this by conducting cutting-edge research and clinical trials in order to improve the longevity and quality of life for all people with immune deficiency.

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Message from the Executive Director

Through the Looking Glass: a primer in drug development

The controversy stemming from the recent withdrawal of Vioxx and similar drugs from the market place highlights interesting controversies regarding drug development and approval. How did a well-researched drug developed by a multinational pharmaceutical company survive three phases of clinical trials and FDA reviewers to win approval, in spite of the crucial flaws that are now known? And how were so many doctors seemingly snookered into inappropriately prescribing the drug to patients for whom the drug increased the risk of heart attack while providing no additional benefit?

There is a legitimate hue and cry that pharmaceutical companies have gone overboard in their sales pitches to both physicians and to patients, so that certain powerful drugs are now advertised in about the same manner as peanut butter. That should be addressed: the industry has not lived up to its commitments and the vast sums that they spend on marketing to consumers should be stopped.

Likewise, the FDA has come under criticism for too easily and quickly approving too many drugs. The rules allowing the FDA to "fast-track" drugs to market have taken a beating in the recent stories surrounding Vioxx and other COX-2 inhibitors. In part that is justified, since there may well be no reason to fast-track a "me too" drug that offers no improvement over existing treatment. But to over-focus on the FDA's role in this regard is short-sighted. After all, AIDS activists were largely responsible for some of the current fast-tracking regulations, and they are heroes for it. These new regs allowed the FDA to go forward without overcautious safety data when the accompanying delay in approval and access meant certain death for scores of people. Reform, but not repeal, is in order here.

Many doctors have complained that they lack the tools to remain adequately informed, given the current practices of pharmaceutical companies and the overload of data facing the FDA. They are right that poorly informed physicians ill-serve their patients.

As is often the case, however, a good look in the mirror provides a good starting point. Did you know that many of the drug company "researchers" are also treating physicians? It is not uncommon for a physician to serve as a "researcher" on a clinical trial for a new treatment, while also having the option of prescribing existing, effective drugs to treat the same condition. There is a big difference to the doctor however, depending upon the options these doctors choose. They can enroll a patient in a clinical trial of an unproven drug and receive several thousand dollars in return, or prescribe an existing medication and receive no additional income. In most professions this would be an intolerable example of a classic conflict of interest.

Physician-researchers are often the authors of the very journal articles that are later found to be skewed or even deceptive. In one case, a physician decided to publish the truth as he saw it: a large HIV vaccine trial showed no efficacy. The company was so outraged that it sued the physician, claiming the data from that trial were proprietary and the doctor had no right to publish his findings. How surprising is it, then, that there are so few cases of physcian-researchers standing up to a drug company's spin on the data when conclusions differ?

Jim Kahn, the doctor who broke ranks with his drug sponsor, explained that "the message to my colleagues is to realize you have the responsibility to publish [the results.] Don't wait for the sponsor to sanitize your research." That advice might fix the problem if doctors never fell victim to temptation. But for as long as the medical profession refuses to address a fundamental conflict of interest underlying much of the medical research in this country, this advice is inadequate. A simple act of self-regulation might prevent the harmful effects that now result from drug company advertising and an underfunded FDA. In doing so,doctors would be subject to far less disinformation and financial influence.

Anything less would be bad medicine.

Irl S. Barefield
Executive Director

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Trial Announcements

HIV SpectraPoint
SPECTRADIGITAL CORP.

Despite the critical development of anti-HIV medications and the resultant dramatic decrease in HIV-related deaths, long-term use of antivirals is often associated with the emergence of resistant HIV virus, leading to further disease progression in a significant portion of HIV-infected people.

The development of these drug-resistant strains has become a major cause of treatment failure. Several HIV drug resistance tests (*genotypic* and *phenotypic)* are currently available, but patients on failing therapy must often wait weeks for the results of these assays before they can start new regimens.

A rapid and more efficient test that could better predict the efficacy of each drug for a specific person before they begin a new regimen would increase the efficacy of their newly-prescribed regimens, and reduce the possibility of the development of a resistant HIV virus.

This study is designed to compare the efficacy of a novel and rapid testing method, called "HIV SpectraPoint," to the standard phenotypic assay.

This trial is for both HIV-positive and HIV-negative volunteers—please call for details. This study will enroll HIV-positive volunteers with documented genotypic evidence of resistance to any currently-available antiretroviral drug, and a viral load of greater than 500. Volunteers will be compensated $25 for their trouble.

For information about participation in this study, or to find out if there are other ARA studies for which you may be eligible, please contact Corie Castro at 310.358.2429.

Dr. Anton Interview

(continued from cover)

In 1998 and 1999, ARA collaborated with Dr. Anton and colleagues at UCLA, along with ***Cell Genesys, Inc.****, on work aimed at validating a technique for detecting and measuring the amount of virus within tissues, using rectal biopsy samples. They presented a poster at the* ***6th Conference on Retroviruses and Opportunistic Infections*** *in 1999 entitled, "HIV-1 is Detectable in Mucosal Biopsies in Patients with Undetectable Plasma Viral Loads." (These data were later published in the* ***Journal of Virological Methods*** *in 2001 as "Sensitive and reproducible quantitation of mucosal HIV-1 RNA and DNA viral burden in patients with detectable and undetectable plasma viral HIV-1 RNA using endoscopic biopsies," Anton PA, Poles MA, Elliott J, et al.)*

Since that time, Dr. Anton and the Division of Digestive Diseases at UCLA have worked on a number of projects with ARA, and currently are planning several studies: our prostratin project, a trial involving the use of microbicides for HIV transmission prevention, and a microbial food supplement (probiotic) study for the treatment of HIV-associated diarrhea. The microbicide study is also in collaboration with the ***National Institute of Health (NIH)*** *and others enumerated below, and the probiotic study is with* ***Alimentary Health, Ltd.*** *Prostratin has been an ongoing independent research project initiated by AIDS ReSearch Alliance, and has involved numerous independent collaborators and institutions worldwide.*

Neil Gordon, ARA's Director of Administration, spoke with Dr. Anton at the end of 2004, and we publish it here to help our readers understand some of the current medical thinking about the role of HIV in the gut, as well as the nature and extent of our collaborative research projects.

AIDS RESEARCH ALLIANCE (ARA): Peter, thank you for taking the time today from your busy schedule to talk about some of your work and your participation with ARA and its clinical trials.

How did you get your start in HIV/AIDS research?

PETER: It all started in about 1992, when I unfortunately started to get more referrals about patients and friends with HIV-related diarrhea and wasting. They were sent to me for evaluation of the causes of their diarrhea to see if we could come up with any new therapies. Sadly, there weren't too many options available. And people continued to die.

At that time diarrhea and wasting were the leading causes of death from AIDS; they were the causes of over 50% of AIDS deaths. About 80% of individuals had severe diarrhea and wasting at the time of their deaths. Fortunately, within the next couple of years, the advent of antivirals significantly changed the clinic population, so we weren't actually seeing that many patients.

The advantage of that was that it allowed us to focus on what were the particular vulnerabilities of the gut that allowed some of these infections to take hold, causing the diarrhea and contributing to the wasting. Really, that was the start of the research program that grew out of a clinical need to figure out what was going on with diarrhea and wasting.

ARA: So much of your research has centered on HIV and its relationship to the gut. What's your understanding of the connection between HIV and the gut, and how has your research furthered your understanding of this link?

PETER: Some of the readers of ARA's *Searchlight* magazine will remember this from years ago: we had an article featuring the role of HIV & the gut *(see* Searchlight *issues Winter '98/'99, Spring '99 and Fall '99, available at ARA's website http://www.aidsresearch.org/searchlight).*

Actually, many gastroenterologists and HIV specialists don't fully appreciate that the gut is the body's largest immune system, with between 50% to 80% of the body's immune cells housed in its 26 feet of intestine. Only two percent of the immune system's cells are in the blood, so you can get an idea of how many immune cells are housed in the gut. The kinds of cells that are in the gut are, by necessity, activated and memory cells, which means they are turned on and ready to attack when they see something foreign, such as bacteria or a virus.

The other factor about the gut is that it's separated from the outside world, meaning the *lumen* where the food and liquid and stool pass, by only a single cell. So one has to have a very active immune surveillance system ready and able to respond quickly to breaches in the integrity of the system.

It so happens that HIV takes advantage of this; if you give HIV a choice to infect a resting naïve cell, like those that exist in the blood, or an activated memory cell—hands down it will always go for the activated memory cell. And so it's sort of like Willie Sutton's explanations of why they rob banks—it's because that's where the money is. That's why HIV goes for the gut—it is where all the right kind of cells are.

Then you compound that with the fact that this placement will help HIV produce millions of new virions per cell—they are released from that newly infected cell, and there's a perfectly receptive target microns away, and so the spread through the intestine can be pretty rapid. It was shown in monkeys, and more recently in some papers, in humans, showing that in acute infection, the virus, regardless of the root of infection—whether it's the blood, vaginal exposure, rectal—it seems to home directly to the gastrointestinal lining, where these cells that I've just described to you are, and massively infect and severely deplete CD4 T cells. Within 7-14 days you'll have significant depletion of CD4 T cells in the gut, with no significant changes in CD4 T cells in the blood.

What probably happens then later is a kind of homeostasis, so it balances out—sets a new balance. So that when you take biopsies and inspect the tissue, it looks more normal, but you actually have already lost a lot of healthy T-cells in the beginning. The major point is that the gut is the site where HIV first goes, and where the first loss occurs.

What we think happens then, and some of our earlier work with ARA has shown this, after the acute episode, HIV actually triggers a state of significant inflammation. The inflammatory response is the body's method of responding to injury or infection or some breach in its profile. In the setting of inflammation, you get increased local messages that are sent to the blood saying "we're having a battle going on this one area; send in more troops." And so you recruit cells from the blood to the local area.

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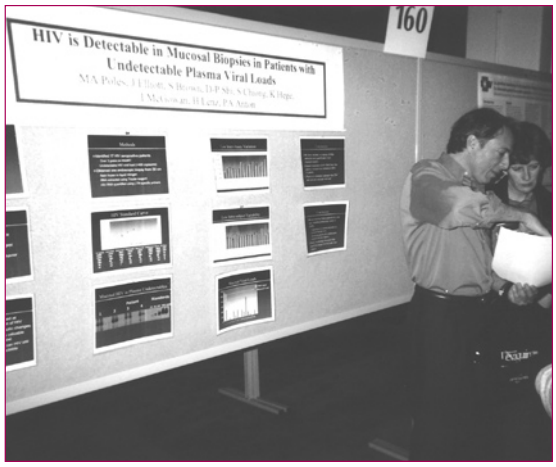

Dr. Anton explains the mucosal biopsy poster data to an interested conference participant. ARA, UCLA, USC and Cell Genesys, Inc., presented this poster at the 6th Conference on Retroviruses and Opportunistic Infections in 1999.

ARA's Medical Director Dr. Stephen J. Brown, and Drs. Anton & Ian McGowan, both of the UCLA Center For HIV & Digestive Diseases, in front of their mucosal biopsy study poster.

Dr. Anton Interview

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This is exactly what HIV wants to happen. So it triggers the body to ask for more recruits, which is exactly the kind of targets that it likes to infect. So the gut is just sitting there as the…

ARA: Perfect host.

PETER: The perfect host, exactly. And actually HIV is the perfect exploitive pathogen.

ARA: So, what implications might this have for therapy, Peter?

PETER: Actually, there was an interesting study we did a few years ago in conjunction with AIDS ReSearch Alliance and Proctor & Gamble—one of the first investigations into whether there was a role for anti-inflammatory therapy in HIV. This was just a pilot study; the larger studies are likely to be carried out in Phase I/II form in India or Africa where HIV prevalence is higher and fewer people are on anti-viral therapies.

We would be exploring the use of anti-inflammatory agents—these would be special forms of drugs that are used in colitis and Crohn's disease, which are chronic inflammatory bowel diseases. Can these agents be used as adjunctive therapies in slowing down the pace of HIV?

It would not be directly antiviral—what these anti-inflammatories would do is reduce the inflammatory milieu, thereby hopefully reducing the recruitment and homing of new target cells to the major source of spread, which is the gut, and therefore slow the pace of the disease over the course of 8-10 years.

If we're trying to assess the impact of these anti-inflammatories in people that are already taking antivirals, it might be unreasonable to expect to see yet a further significant (meaning greater than a half-log) drop in viral load, beyond that already accomplished with ART (antiretroviral therapy): the next form of this question may be best asked with volunteers not presently on ART. That's one of the requirements we'd make for a new antiviral getting approved. With the preliminary data we got from the earlier study, we know now that we don't even need to be doing ongoing biopsies. The changes in the blood cells—the changes in the plasma viral load will be adequate to deduct whether one of these anti-inflammatories is going to have a significant initial, and then lasting, impact.

It is important that readers not think that that ibuprofen or aspirin may be one of the anti-inflammatories that we're considering. Both of those options have been studied and may have potential in the future, but the trials that we're talking about would be using anti-inflammatories that are limited to the gut, that do *not* get absorbed and do *not* have any other systemic effects.

So that's a whole new strategy—looking at anti-inflammatory components and trying to control HIV from that angle.

ARA: You mentioned that ARA has collaborated with UCLA on a few different research projects. What are some of the other projects, and are there any plans in the future for further collaborations?

PETER: It's been a very fruitful relationship over the last six–eight years. One of the more interesting studies that has progressed into a second clinical trial was our initial study looking at the gastro-intestinal tract as an important reservoir in people that were well-controlled with antivirals. We looked at individuals that were fully suppressed, meaning they had no detectable plasma viral loads.

With ARA's assistance, we recruited, I believe it was, twenty individuals who were willing to come in every three months for a year, for blood and flexible sigmoidoscopies to obtain biopsies. This was a huge commitment by these people. The advantage of having the biopsy samples, which we obtained using the flexible sigmoidoscopy, (involving a simple test, which everybody over the age of fifty would have for colon cancer screening anyway) is that we can get samples of tissue.

In assays that we've developed in the lab and that are now used by several groups, we can quantify HIV—both HIV/DNA, which is a reflection of how much HIV virus is in the reservoir, and HIV/RNA, which is a reflection of the amount of HIV that is able to reproduce and replicate. Virus in the blood is also measured by HIV/RNA, which tells how much replicant-competent virus is there. HIV/RNA would yield the total amount of virus. So the aim, of course, in the blood, is to get to undetectable.

In these individuals that we have seen over time (and the paper's nearly finished now and ready to be submitted) HIV/RNA was only found in a fraction—between 15 and 30%—of the individual's samples. HIV/DNA was found in *all* of the volunteers. What this tells us is that the gut is a large reservoir, given the huge extent of cells. And we have some measurements that we can then use to measure decreases, if one actually has a therapy that might decrease it.

So that leads us to the next study, which is the study of prostratin. Prostratin is a non tumor promoting phorbol ester. There are animal studies going on right now—we would eventually like to use prostratin in a human clinical trial to see if it can reduce the latent reservoir in people whose viral loads are already well-controlled with antiretroviral therapy.

ARA: Prostratin is one of the drugs on which ARA is currently doing independent research.

PETER: And this is what's been so exciting, that ARA was the one that started the pursuit of this with the aim of coming up with a novel effective therapy. This is not something that a drug company would pursue, there's not a lot of money involved, and it was also starting out on a tenuous scientific basis —that the latent reservoirs of virus can be activated, stimulated by prostratin, and with a one-two punch the virus can be significantly diminished, perhaps even eliminated from the body.

ARA has sponsored much of the research in this area, and, along with Dr. Zack at UCLA and others around the country, and around the world, have advanced the science. Hopefully continued research into this area will be as exciting and rewarding as the promising pre-clinical work has been. *(To read more about prostratin, go to http://www.aidsresearch.org and click on the prostratin links towards the bottom of the home page.)*

ARA: You are about to embark on an exciting new collaborative effort, with the National Institutes of Health (NIH), ARA, Johns Hopkins and others. Can you tell me a bit about the Microbicide Development Project?

PETER: Yes, we are very excited about this project… well, four projects actually, representing different phases of the research. We were recently awarded 12 million dollars by the NIH to study topical rectal microbicides, and we also have the support of three corporate sponsors to initiate these efforts: Biosyn, Inc., Gilead Sciences, and Tibotec-Virco. UCLA will be involved in all phases of the undertaking.

The NIH and the corporate sponsors will be involved in the initial project, which is the preclinical development phase. AIDS ReSearch Alliance will join UCLA, Johns Hopkins, the University of Washington/Mullins Molecular Retrovirology Lab, the L.A. County Dept. of Public Health—STD Division, and the Baltimore Dept. of Health in Project Three of the research, which will focus on rectal health, behavioral features of anal intercourse, and the quantification of acceptability of five different formulations of rectal microbicides.

The NIH, UCLA, ARA, Johns Hopkins, BioSyn and the Mullins Molecular Retrovirology Lab will finish up Project Four of the undertaking, which involves exploratory human trials, studying safety and efficacy of the candidate microbicide. *(See http://mdp.ctrl.ucla.edu for more information on this microbicide research project.)*

ARA: And we'll be collaborating on another study: the Microbial Food Supplement study…

PETER: …for the treatment of HIV-associated diarrhea. Since the overall prevalence of HIV-related diarrhea continues to be a problem, despite the drop in opportunistic infections due to anti-retrovirals, it's important to continue to find treatments for this significant symptom. It's possible that the non-specific HIV-associated diarrhea is a results of imbalances in the intestinal flora. Inexpensive microbial food supplements, also known as probiotics, may improve intestinal microbial balance, and therefore decrease the symptoms of diarrhea in those taking it.

ARA: Great — well, we are excited about our future collaborations as well. Thank you for taking the time to talk to us today...

AIDS Attacks Asia

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such, a state-by-state approach to understanding the region is necessary. The following survey characterizes the epidemic in a few of the countries in the region. We look at economic and social factors driving the growth of the epidemic, how the virus is being spread, and what is being done to combat HIV/AIDS throughout the region.

How large is this problem? Well, the numbers are startling. China alone is projected to have 10 to 15 million HIV/AIDS cases by 2010. India is expected to have a staggering 20 to 25 million.[1] *UNAIDS* reports that in 2003 there were more than 1 million new HIV infections in Asia and the Pacific. Added to the estimated 9 million already infected, and there could be 10 million people are living with HIV/AIDS in Asia. But the numbers alone do not tell the whole story. While the prevalence of HIV in some regions remains relatively low, the population of Asia is 60 percent of the world total, so even low prevalence translates in to huge numbers of HIV infections. What's more, the low percent prevalence of HIV often masks serious, localized epidemics.[2]

China is a perfect example of this principle. The low national incidence of HIV infection obscures the fact that serious, concentrated epidemics have been underway for several years in regions of China including the Yunnan, Xinjiang, Guangxi, Sichuan, Henan, and Guangdong provinces.[3] Economic and social liberalization in China has been accompanied by an increase in high-risk behaviors such as injection drug use and unsafe sex practices, which have, in turn, led to ever increasing infection rates. Furthermore, the Chinese government has failed to accurately disclose the depth and breath of the epidemic in their country, making assessment difficult.

India is another case where the future looks grim. In just a decade, India has seen a dramatic rise in the estimated number of HIV infections. Infections have grown from a few thousand in the 1990's to between 3.8 and 4.6 million children and adults living with HIV in 2002.[4] According to the *National AIDS Control Organization*, AIDS is spreading among men who have sex with men (MSM), injection drug users, infants infected at birth at rate of one in twenty—and yet the general population apart from these groups remains the main source of infection. This is a set-up for catastrophe.

Thailand was the country in the region struck earliest with the AIDS epidemic. While prevention efforts in the region have been relatively successful and a notable reduction in new infections has been achieved, there are indications of a resurgence of infections in the region. Prevalence among adults is estimated at 1.8 percent and is the leading cause of death. Many men still do not use condoms in non-commercial sexual relationships, and HIV remains largely unchecked among MSM's. Injection drug users remain extremely vulnerable to HIV infection with nearly 40 percent of IDUs in Thailand's major urban areas testing positive in 2000.[2]

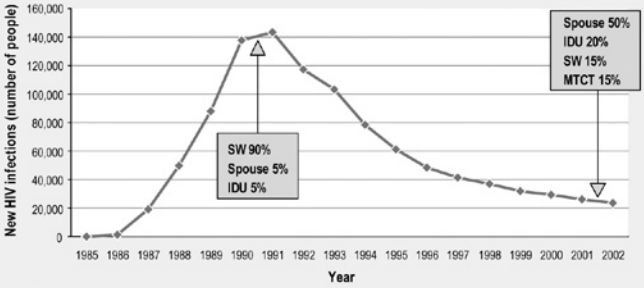
Indonesia has seen an explosion of HIV infection recently, as well. As the world's fourth most populous country, it serves as an example of how rapidly an HIV epidemic can develop. Infection rates have risen sharply among sex workers, IDUs, and blood donors. The last group is of greatest concern, since it serves as an indicator of the spread of HIV in the greater population.

The *UNAIDS* report on HIV/AIDS suggests that Indonesia stands at a crossroads in its HIV/AIDS epidemic. Massive economic and political disruption in recent years has produced dramatic changes in Indonesia's national-risk environment. The country is experiencing new, rapidly developing sub-epidemics in several provinces and communities. Indonesia now perceives HIV/AIDS as a serious threat to its national development and prosperity.[5]

Economic and Social Factors driving the Epidemic

The first communities to be seriously affected by HIV/AIDS in Asia and the Pacific were the male and female commercial sex workers (CSWs) and injection drug users (IDUs). Infection was quickly spread to sex industry clients and the sexual partners of both CSWs and IDUs. Even today, the epidemic's

Estimated number of new HIV infections in Thailand by year and changing mode of transmission



Spouse: heterosexual transmission of HIV in cohabitating partnerships; SW: HIV transmission through sex work; IDU: HIV transmission through injecting drug use; MTCT: mother-to-child transmission of HIV

Source: Thai Working Group on HIV/AIDS Projections, 2001

Illustration courtesy of UNAIDS Global Report 2004

rapid expansion in Asia is due to injection drug use and continued survival sex on the part of many sex workers.

The spread of HIV throughout the region is fueled by population shifts and increasing economic depravity. Its growth expands geographically along trucking routes, traveling salesmen, sailors, soldiers, fishermen, and migrant workers. And the sex industry concentrates extremely high rates of infection in localized areas with equally high rates of sexual activity. The combination is deadly. Few countries in the region have mounted an effective response to the drug related HIV epidemic through peer education or syringe-exchange programs. Political will to combat HIV among IDUs has been virtually nonexistent as there is the false perception that the epidemic is self-contained within this highly marginalized population.[6] Thailand, often hailed as a positive example for its efforts to stem the epidemic has essentially declared war on drug users and drug suppliers rather than adopting risk reduction strategies shown to work in these core groups. Reports of extra-judicial killings of drug users number in the thousands, according to the US Department of State[7], hardly serving to save lives.

Transmission and Access to Treatment of HIV/AIDS

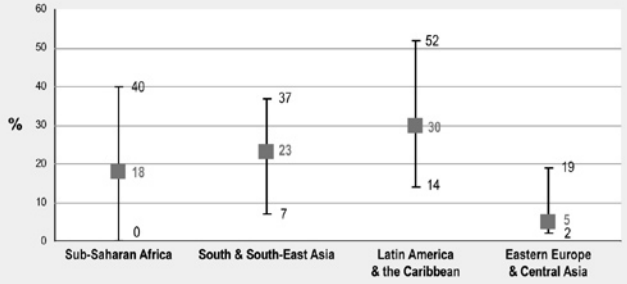
While the transmission of HIV/AIDS in Asia is primarily through heterosexual sex and injection drug use, there are several other important avenues of HIV transmission to consider.

As elsewhere, the number of men who have sex with men is much larger than the number who identify as "gay." In many parts of Asia, MSMs are limited to clandestine practices that are not publicly acknowledged nor often discussed. MSMs are hard to reach with prevention messages, and condom use remains low among this population.

An alarming number of children have been infected with HIV in Asia and the Pacific. One cause of the high incidence of HIV among children is the stigma that surrounds HIV/AIDS. For fear of raising suspicion of their HIV status, few HIV positive women are willing to seek antiretroviral (ARV) treatment or bottle-feed their infants. The results are startling: up to 63,000 children under the age of 15 in Asia were newly infected with HIV in 2003 according to one UNAIDS estimate.[2]

In the rural provinces of central China poor farmers often sell blood to poorly run blood-banks that re-use needles, contributing yet one more source of needle-borne transmission. Blood banks in the region remain largely unregulated. Therefore, then, the infected blood that infects poor farmers who

Percentage of young women (15-24 years old) with comprehensive HIV and AIDS knowledge, by region, by 2003



Note: For each region, the percentage is shown for countries with low, median and high values.

Sources: United Nations Development Programme (2002), *Botswana AIDS Impact Survey (BAIS 2001): Survey Results and and Indicators Summary Report. Gaborone;* UNICEF, *Multiple Indicator Survey (2000);* FHI, *Behavioral Surveillance Survey (2001)* and Measure DHS+, *Demographic and Health Surveys (1998-2002).*

Illustration courtesy of UNAIDS Global Report 2004

sell their blood is itself sold and pooled for use in blood transfusions and other healthcare purposes, creating the sorry paradox that one main source for infection in parts of Asia is its healthcare systems. This is an alarming situation that has left 12 to 13 percent of blood plasma recipients HIV positive.[8] The problem is compounded by the lack of sterile injection equipment in healthcare settings and inconsistent use of hygienic practices for cleaning reusable medical supplies.

The news in Asia is not all bad. The governments of several Asian countries have taken an aggressive stance against the epidemic. The increasing rate at which access to ARVs is becoming available is encouraging. The Thai government has developed a national treatment strategy and has announced that it plans to make treatment available to 50,000 HIV-positive citizens by the end of 2005. At least five other countries in the region, China, India, the Philippines, Indonesia, and Vietnam have, or will soon have, generic manufacturing programs for ARVs. China's Executive Vice Minister of Health recently announced that his country would provide free access to HIV drugs for all HIV positive people in the central provinces, as well as for the rural poor who could not afford them.[9] The Malaysian government has been buying AZT and providing it free for at least a decade, and Indonesia recently announced plans to supplement the cost of ARVs on a small trial basis. Significant progress has been made by the public sector in many Asian nations, but much work still needs to be done.[6]

Across the region, treatment programs face a variety of obstacles, from limited health care infrastructure and a lack of financial resources, to limited education and training opportunities. Not one of the countries in the region has undertaken the

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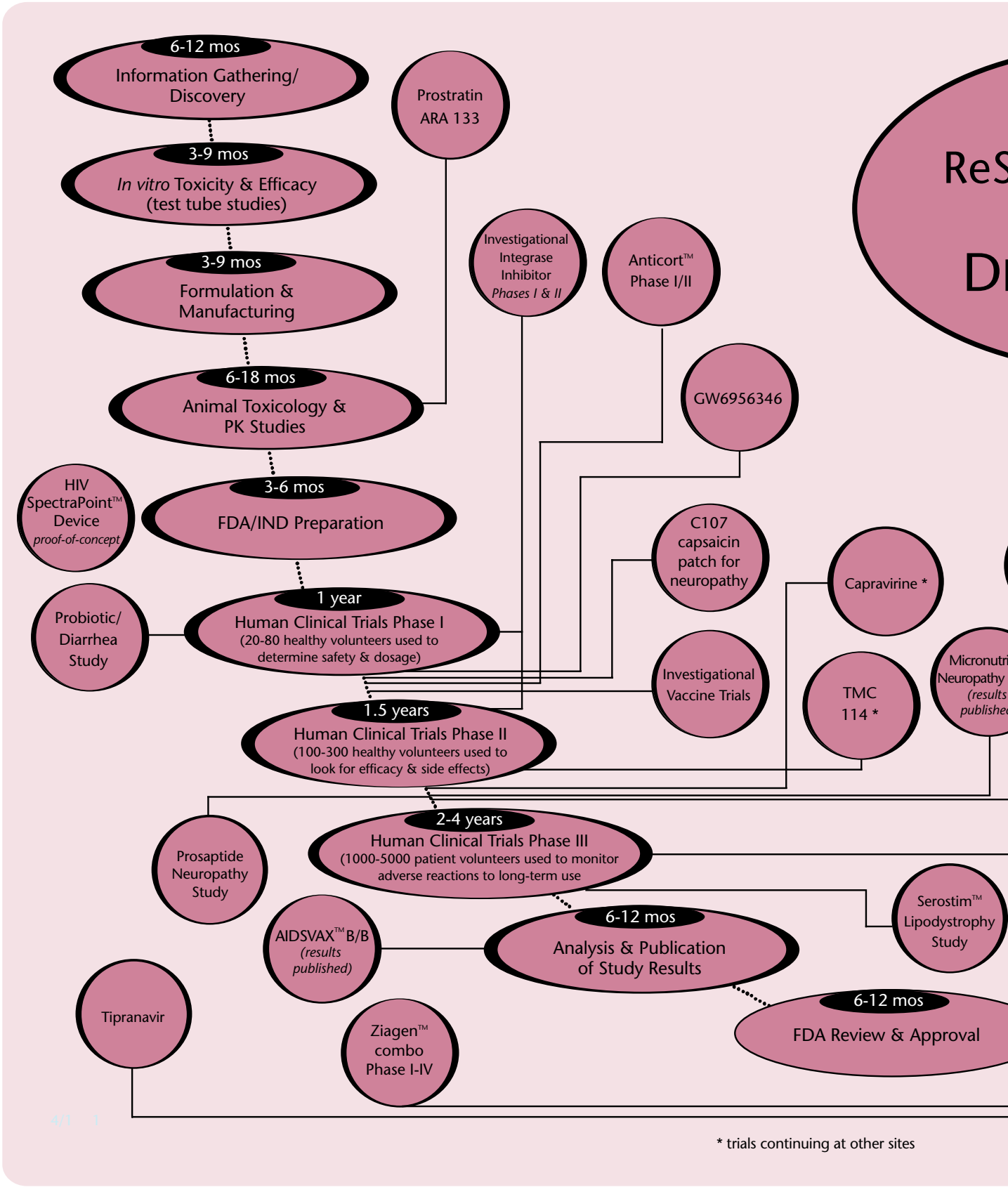
STUDY	DESCRIPTION	STATUS
Pre-clinical & basic research AIDS ReSearch Alliance	ARA is engaged in a number of ongoing preclinical and basic research projects not ready for human clinical trials. We include this information here to ensure that our supporters know that this chart reflects only a part of our mission-driven work to ameliorate and, we hope, one day end the epidemic. *(Various)*	Ongoing
C0603 Savient Pharmaceuticals, Inc. and the Neuro-AIDS ReSearch Consortium (NARC)	A study testing the safety and effectiveness of a new medication called prosaptide for the relief of HIV/AIDS-associated neuropathic pain. *(Pain alleviation)*	Enrollment & study ongoing
HIV SpectraPoint SpectraDigital Corporation	A study testing the effectiveness of a new diagnostic device, HIV SpectraPoint, in both HIV positive and HIV negative volunteers. *(Antiretroviral testing)*	Enrollment & study ongoing
Investigational Integrase Inhibitor Major Pharmaceutical Co	A study to compare the safety and activity of an investigational integrase inhibitor plus tenofovir and lamivudine (3TC) versus afavirenz plus tenofovir and lamivudine (3TC) in antiretroviral-naïve, HIV-infected volunteers *(Antiviral therapy)*	Enrolling
AI424103 Bristol-Myers Squibbs	A study to compare the effectiveness, safety and effect on serum lipids (fat in the blood) of atazanavir plus ritonavir plus tenofovir versus lopinavir plus ritonavir plus tenofovir, each with either didanosine EC or stavudine XR, in HIV-1 infected volunteers receiving an NNRTI-containing HAART regimen who are experiencing their first virologic failure. (Antiviral therapy)	Enrolling
Investigational HIV-1 Vaccine Major Pharmaceutical Co	A study testing the safety, tolerability and effectiveness of an investigational HIV-1 vaccine in healthy volunteers at high risk of HIV-1 infection. *(Preventative HIV Vaccine)*	Enrollment pending
A4301010 Agouron Pharmaceuticals, Inc.	A study testing the safety and effectiveness of a new Viracept™ formulation as a component of HAART for antiviral treatment of treatment-naïve volunteers. *(Antiviral therapy)*	Enrollment complete; study ongoing

STUDY	DESCRIPTION	STATUS
C107 NeurogesX	A study testing the safety and effectiveness of a new treatment called a capsaicin patch for the relief of HIV/AIDS-associated neuropathic pain. *(Pain alleviation)*	Enrollment complete; study ongoing
C0604 Savient Pharmaceuticals, Inc. and the Neuro-AIDS ReSearch Consortium (NARC)	A roll-over study testing the safety and effectiveness of a new medication called prosaptide for the relief of HIV/AIDS-associated neuropathic pain. *(Pain alleviation)*	Enrollment complete; study ongoing
Serostim® 25373 Serono Laboratories	A roll-over study testing the safety and effectiveness of a growth hormone in treating HIV-associated lipodystrophy. *(Fat redistribution therapy)*	Enrollment complete; study ongoing
C112 NeurogesX	A study testing the safety and effectiveness of a new treatment called a capsaicin patch for the relief of HIV/AIDS-associated neuropathic pain. *(Pain alleviation)*	Enrollment & study pending
GW695634G GlaxoSmithKline	A study testing the safety, tolerability and effectiveness of four oral dosing regimens of GW695634G versus placebo. *(Antiviral therapy)*	Enrollment & study complete; report pending
Zerit® (Stavudine, d4T) Bristol-Myers Squibbs	A study to evaluate and compare the safety and efficacy of extended-release stavudine compared with standard stavudine for antiviral activity. *(Antiviral drug/improved dosing)*	Enrollment & study completed; report pending

New clinical trials are added frequently—for information about enrolling in any of our studies, contact ***Corie Castro*** *at* **310.358.2429**. *Transportation to our clinical research facility is usually available on request. For priority notification of new or enrolling clinical trials, sign up for our* ***Priority Notification Program*** *by calling the above number or visiting our website at* **www.aidsresearch.org**. *Para informacíon en español, llame 310.360.3876.*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3-6 mos
FDA/IND Preparation
1 year
Human Clinical Trials Phase I
(20-80 healthy volunteers used to determine safety & dosage)
1.5 years
Human Clinical Trials Phase II
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2-4 years
Human Clinical Trials Phase III
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Analysis & Publication of Study Results
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Prostratin ARA 133
Investigational Integrase Inhibitor *Phases I & II*
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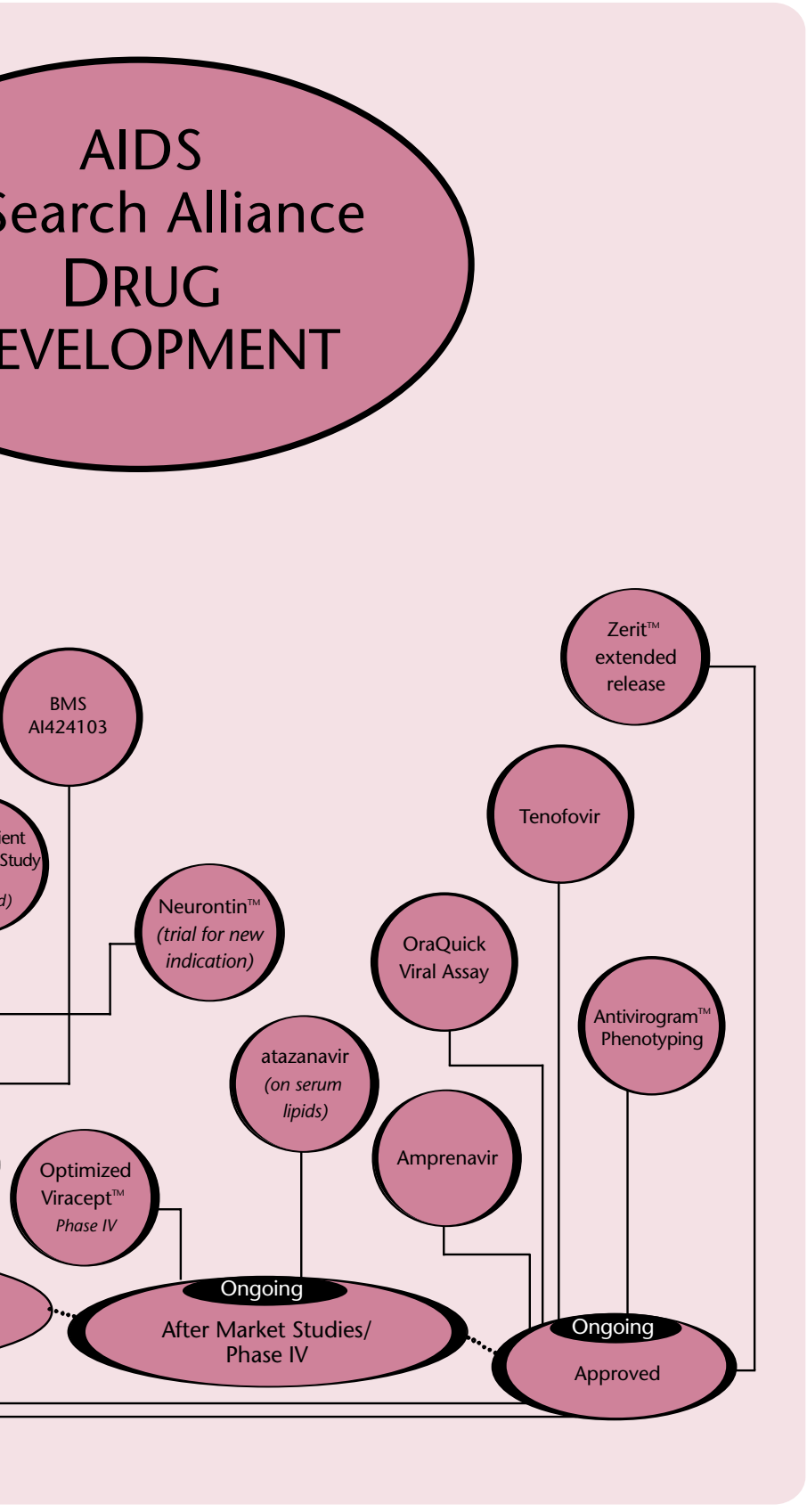

Drug Development at ARA

—*An Overview*

Most of the prescription drugs you take spent many years of research—from test-tubes, animal studies, and human trials—before they ended up in your medicine cabinet. That process can usually take anywhere from seven to fifteen years.

The AIDS community never had the luxury of time—life-saving medicines were needed immediately. That's why AIDS ReSearch Alliance was formed. We remain committed to avoiding the red-tape found in traditional medical research, and to shortening the time it takes to move a compound from the lab into human trials (and hopefully FDA approval).

And we do this without sacrificing patient safety or scientific rigor. This time-line chart of our current/recent research will give you an overview of our work, and where we are with each of these promising therapies. Research is all we do. Your dollars fund this important effort to move effective HIV treatments forward swiftly and safely.

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The families, individuals, foundations and companies listed below recognize that AIDS won't end without medical research; they form the bedrock upon which our vital work rests. Their generosity enables AIDS ReSearch Alliance to continue searching for better treatments against HIV and innovative ways to stop its spread. Regardless of dollar amount, they are making the difference in this epidemic.

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—Buddha (Siddartha Gautama)

"Where the determination is, the way can be found."

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>
> *—Martin Luther King, Jr.*

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> *—Victor Hugo*

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"Brother of all,
with generous hand…"

— *Walt Whitman,*
LEAVES OF GRASS

AIDS Attacks Asia

continued from page 8

comprehensive education and training for health workers necessary for the safe and effective delivery of HIV medications. While generic manufacturing has increased the availability of ARVs, the need far exceeds production capacity and the classes of drugs available are limited. Even in countries like China, where, according to one report, ARVs have been distributed to more than 6000 people in the central provinces, neither the health care workers administering the drugs nor the patients taking them have received adequate training about their safe and proper use.[6]

Asia as a whole has the highest prevalence of HIV in the world outside of Africa.[10] An effective response to the multiple epidemics facing Asia and the Pacific will require regional plans focused on the overlapping epidemics. Local, state and regional government entities must increase the resources committed to HIV/AIDS programs and must also balance the need for continued prevention efforts with the growing demand for HIV treatment. The continued growth of new HIV infections and the progression of existing infections to symptomatic AIDS will pose a significant challenge to both national health care budgets and existing health care infrastructures, as will consistent under-funding, notably by the United States, of the *World AIDS Fund*.

Footnotes

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[3] Yin N, Mei S, Li L, Wei FL, Zhang LQ, Cao YZ. Study on the epidemiology and distribution of human immunodeficiency virus-1 and hepatitis C virus infection among intravenous drug users and illegal blood donors in China. Zhonghua Liu Zing Bing Xue Za Zhi. 2003; 24(11):962-955

[4] National AIDS Control Organization (NACO). HIV/AIDS Surveillance in India. 2003. Available online at www.naco.nic.in/indianscene/esthiv.htm.

[5] USAID's HIV/AIDS program in Indonesia, December 2003. Available online at: http://www.usaid.gov/our_work/global_health/aids/Countries/ane/indonesia_dec03.pdf

[6] Frost, Kevin R. HIV/AIDS in Asia: The Next Threat. Numedx October 2004.

[7] US Department of State. Human Rights Report: Thailand. February 2004.

[8] Wu Z, Rou K, Detels R. Prevalence of HIV infection among former commercial plasma donors in rural eastern China. Health Policy Plan. 2001; 16(1):41-46.

[9] Speech By Executive Vice Minister of Health, Mr. Gao Qiang, at the HIV/AIDS High-Level meeting of the UN General Assembly, September 22, 2003. Available online at: http://www.china-un.ch/eng/56493.html.

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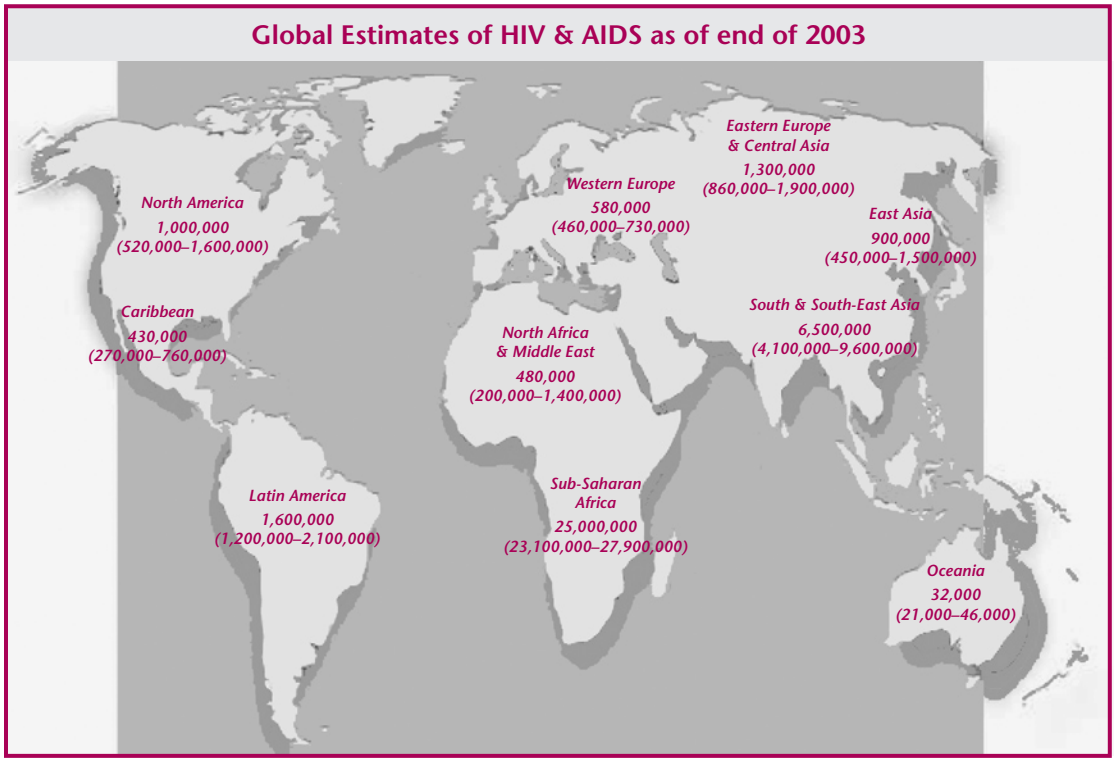


Illustration courtesy of UNAIDS Global Report 2004

ARA: Expanding Our Reach

Board of Directors

The ARA Board of Directors is proud to welcome its newest member, interior designer and singer **Michael Allen**. Board member **Sandy Bresler**, who was instrumental in bringing Mr. Allen onto our Board, said, "Michael brings a world of enthusiasm and talent to ARA, as well as a wealth of contacts from the Palm Springs area, where we are continuing to expand our base." Michael's singing and designing careers have taken him around the globe, and brought him to Rancho Mirage, where he currently resides, and where his design firm is based.

Photo by Ethan Kaminsky

Michael Allen

Michael starting singing lessons at the early age of seven, becoming a junior cantor at his New Rochelle temple and appearing on the **Milton Berle Show**, the **Children's Hour** and **Star-Time Kids**. He attended **Boston University** and, while graduating with a B.S. in radio & television production, never lost his enthusiasm for singing, continuing to perform in small Massachusetts nightclubs while earning his degree.

After graduation, he moved to New York City, and while working as a waiter, he saw **Lauren Bacall**, **Jacqueline Susann** and Jackie's husband **Irving Mansfield** enter the restaurant. He spontaneously auditioned for them, and won himself a spot on Merv Griffin's **Celebrity Talent Scouts**, which led to numerous appearances on Johnny Carson's **Tonight Show**, an MGM recording contract, and multiple bookings on other t.v. shows and in area hotspots. He appeared on Broadway, made albums and toured worldwide, headlining at N.Y.'s **Copacabana**.

With, as he says, "the advent of disco," Michael moved into another love, the world of interior design; his flair and experience have garnered him such clients as **Princess Grace of Monaco**, the **Sinatra family**, **Rock Hudson**, **Jack Jones**, **Johnny Mathis**, **Leslie Anne Warren** and **Rob Lowe**. His work has been covered in area & national lifestyle magazines.

Recently a compilation of Michael's best-loved songs, **"Michael Allen Sings,"** was released on CD, spurring a renewal of interest in Michael's renditions of timeless ballads, as he successfully straddles the two worlds of design and entertainment.

Medical Staff

Photo by Karen J. Wellenkamp

Grace Gachanja

Grace Gachanja, R.N., M.P.H., joined our clinical staff this summer as a Clinical Trials Coordinator. She replaces Michele Vertucci, R.N., who was promoted to Clinical Trials Coordinator/Manager, stepping into that role after Sergio Codina, R.N., left the position after nine years and moved upstate to live in Eureka.

An experienced medical professional with over twelve years of nursing background, Grace also has a Masters in Public Health, as well as a B.S. in Health Education and Promotion.

Grace was born and raised in Nairobi, Kenya, and went on to attend the **Nairobi Hospital School of Nursing**, receiving her Kenya Registered Nurse Diploma (KRN) in 1992 and her Kenya Registered Midwife Diploma (KRM) from **Pumwani Maternity Hospital School of Midwifery** in Nairobi in 1995.

She moved to the U.S. in 1997, studying at **Western Illinois University** and receiving her B.S., and continuing her studies at the **University of Illinois** at Springfield, taking her M.P.H. in May, 2002, and graduating with honors. She worked at a number of nursing jobs while continuing her education.

Relocating to Iowa in 2003, she worked as both charge nurse in geriatric care for **TravelKare** in Cedar Rapids, and as an operating room nurse for **Mercy Medical Center**.

Her early life spent in Kenya opened her eyes to the enormous impact of HIV/AIDS on Africa and the rest of the world, and she decided to a pursue a career in HIV research, guided by her public health education and her strong interest in alleviating and eradicating this disease. She moved to Los Angeles to work at ARA, bringing her twelve-year-old son, Luther, who now attends a L.A. area junior high school.

Revolutions:

spinning a solution to the AIDS crisis

Photos by Karen J. Wellenkamp

Stephen L. Fefferman, Psy.D., M.F.T. and Paul Kaplan, ARA's honorees at "Revolutions: A Spin Event."

In November, 2004, AIDS ReSearch Alliance launched "Revolutions: A Spin Event" in honor of longtime ARA volunteers **Stephen L. Fefferman, Psy.D., M.F.T.**, and **Paul Kaplan**. Paul has been an ARA volunteer since the spring of 1999, working closely with Development Direct Vincent Cummings on fundraising and events. Stephen has been with the organization in various advisory capacities since its founding in 1989, serving on ARA's Institutional Review Board since 1996 and becoming its Chair in 1998.

The spin-a-thon was held at the Wilshire **Meridian Sports Club** in Los Angeles; our thanks go to club manager **Ian Cooper** for arranging this donated space for our event, and to the club's management and employees, including Group Fitness Director **Deborah Praver**, who were so generous with their time and consideration of this event.

Both Paul & Stephen received framed certificates of appreciation and engraved gifts from ARA, in thanks for their many years of past and ongoing volunteer support of ARA and its research programs. Paul gave his thanks extemporaneously, while Stephen made some remarks on the furtherance of HIV/AIDS medical research *(see the following page for his comments)*.

Fifteen hardy volunteers spun for the ninety minute intense workout, lead by trainer **Zino Macaluso** and assisted by trainer **Lynn Lieberman**. Another twenty ARA supporters cheered on the plucky spinners, bringing them water, towels and high-protein snacks. The workout was followed by a raffle held for the spin participants; gifts were donated for the event and included a massage donated by massage therapist **Liam Wolf**.

Our thanks go to spin participants *(listed below)*, spin donors *(also listed below)*, trainer Zino Macaluso, who led the spin, event planner and trainer Lynn Lieberman, who also assisted with the event organization and spinner recruitment, and the Wilshire Meridian Sports Club, especially Ian Cooper and Deborah Praver. We would also like to thank our honorees Paul and Stephen, and **Gelson's Market** for their donation of beverages and high-energy snacks.

Riders: Matthew Bazar, David Besbris, Jason deVillier, Chandra Galasso, Neil Gordon, Janie Michaels Grauman, Maureen Grosberg, Anna Hudson, Regina Kan, Alex Kaufman, Yoon Jin Kim, Chad Osborn, Loy Rackley, Michelle Simek

Donors: Linda & Brian Baldini, Stephen J. Brown, M.D., Dr. Peter & Sue Center, Aldore D. Collier, David M. Desbris *(in honor of SAG & AFTRA)*, Stephen L. Fefferman, MFT, Psy.D., Chandra Galasso, Elise Gordon, Neil Gordon, Janie Michaels Grauman, Maureen Grosberg, Beverly G. Heller, Gloria J. Hendler-Mandell, Royce Kaplan-Wintz & Doug Wintz, Alex Kaufman, Stuart R. Kramer, Owen Laster, Lynn & Ed Lieberman, Thomas & Laurie McCarthy, R. Michael Miller, Rebekah Mirsky, Cathy & Pat Monaco, Ellen Pasternack, Edward Robbins, Ira Schlesinger, Stanley & Susan Skriloff, Don Cunningham Smith, Sybil Trubin, Jamie Weiss

Riders get in place for the gruelling 90-minute spin.

Trainer Zino Macaluso helps a spinner adjust his machine for the workout.

Spinner Regina Kan accepts some much-needed water during the spin.

From Dr. Fefferman

Stephen L. Fefferman, Psy.D., M.F.T. has been involved with ARA since its founding in 1989, has served on its Institutional Review Board (IRB) since 1996, and has been IRB chair since 1998. Below are his (excerpted) remarks made when he was honored for his many years of service at the ARA November "Revolutions: Spinning a Solution to the AIDS Crisis" spin fundraiser.

Stephen L. Fefferman, Psy.D., M.F.T

When I received the phone call from ARA asking me if they could honor me at this event, I was stunned. I said, you want to honor me? I mean, you are asking me if you can honor me?

You see, when you are brought up Jewish you usually experience your first real honor by being given an Allah during the Shabbat Services; this usually happens at age 13 when you go up to the pulpit and recite in Hebrew the prayers before and after the torah reading.

This is not a temple—I am so relieved I don't have to say this in Hebrew. However, I do find myself thinking about why I am being bestowed with such mitzvah (blessing).

So, I am going to try in English to tell you about myself and ARA…

By 1989, the AIDS epidemic had already ravaged an entire generation of young men and women. During the Passover Holiday that year as always my family gathered for the Seder; during the course of these evenings there is always some type of discussion about current affairs.

This one started something like this: my brother Bradley asked, "So what do you think about how President Regan dealt with this AIDS Epidemic?" The table went silent and I sat there hoping no one heard the question and someone would just make a comment about the Dodgers or the weather. When a sufficient amount of time had passed, making it clear that neither the Dodgers, God or the Messiah was going to intervene, I said, "Mr. Reagan was derelict in his duties—he sat in the Oval Office knowing that people were dying from AIDS and did nothing. The message to America was that AIDS is not killing ***Americans****, only homosexuals."*

Surprisingly, my Grandma Ohrbach joined in. "My mother told me that the reason the family had to leave Romania was because they were no longer Romanian, but only Jews." She was clearly making the connection that President Reagan did not consider her grandson an American but just a homosexual, not worthy of consideration.

That same year, Dr. Paul Rothman, (ARA's late co-founder with the late Matthew Rushton) who was my personal physician, friend and a leading Los Angeles physician, and my business partner, Mr. Charles Wilcox, M.F.T. both invited me to lunch with them. During lunch, Paul discussed forming an organization that would conduct research on HIV/AIDS. My questions emerged: how do we do this and remain ethical, abide by the law, and protect those we want to serve? I was given my first education about what an IRB is through my work at ARA.

Some medical research background: in Macon County, Alabama, in 1932, 399 African-American men with untreated syphilis entered a study to determine the natural history of the venereal disease. In 1947 penicillin was a known cure for syphilis, yet it was withheld from these black men participating in the study. Unfortunately, It was not until 1972 that a journalist exposed the experiment.

Something else happened in 1947 that was a watershed for medical ethics and medical care, which was created in response to the atrocities of Nazi "medicine" inflicted on victims of the concentration camps. A ten-point statement on medical ethics, which became known as the Nuremberg Code, was established. Among other things, the code called for volunteer consent to experiments and defined and barred physical and mental suffering of participants.

John Heller, M.D., then director of the Public Health Service's Division of Venereal Diseases, said he saw no connection between the Nazi atrocities and the Tuskegee study. "For the most part, doctors and civil servants simply did their jobs. Some merely 'followed orders,' others worked for 'the glory of science.' "

Researchers from the U.S. Public Health Service continued to conduct a long-running study in Tuskegee, Alabama, on the course of syphilis in untreated African-American men and chose not to provide penicillin to study participants.

Hindsight is ***always*** *20/20 vision, so let's bring this issue of ethical responsibility to present day.*

Unlike medical treatment, a clinical study of a new compound is not treatment, just as a new compound is not medication. The risks are unknown and there may be no found benefits. In addition, what should be done with any collected material after the research is conducted, and how should it be stored, or should it be stored? Who should have access to this information? All these and many more issues of volunteer protection must be addressed before an individual agrees to participate in a clinical trial.

ARA's Institutional Review Board *is a panel of outside experts and community members who discuss these issues before approving a clinical trial to ensure that the trials are conducted in an ethical manner and that volunteers are informed about their rights, the study procedures and potential risks.*

In 1989, I made a commitment to Dr. Rothman that he had my support until I was no longer needed. That wherever and however he needed me I was committed to this new organization. We the members of the AIDS Research Alliance IRB make this solemn commitment to you: that every study participant who has the courage to volunteer for an ARA study is protected by the standards set by Nuremburg Code.

Further, that every minute of time you have unselfishly given to raise every hard-earned dollar donated to ARA will go to finding a cure for AIDS, studied at a standard of ethics that will allow you to one day say with a sense of pride and dignity. "I was part of the cure."

I would like to mention the members of Aids Research Alliances Institutional Review Board. Without these individuals I would not be able to make these commitments.

AIDS ReSearch Alliance Institutional Review Board

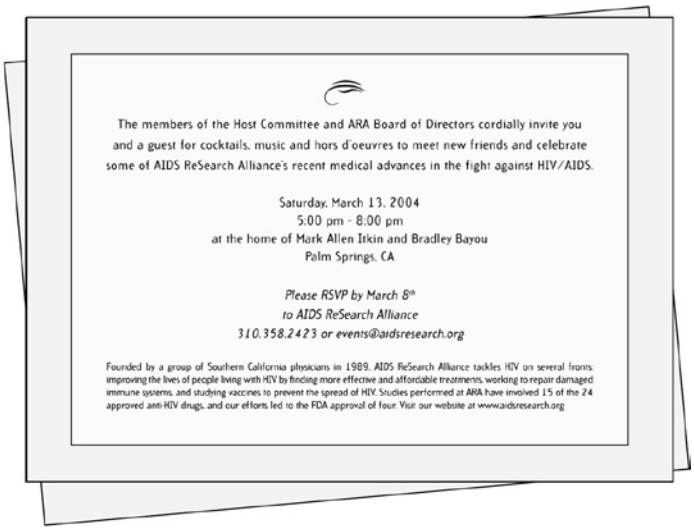
Kristin Allen, Dawn Brewer, John Dratz, Jr., José Cabreros Castro II, Michael D. Grahn, Esq., Anthony Mills, M.D., Herminio Reyes, Ph.D., and Seymour Young, M.D. (Vice-chair).

These individuals give their time freely and without any form of compensation other than the personal satisfaction that we as a board experience, knowing that there ***will*** *be a cure for this horrific disease. We highly respect ARA, and are committed to maintaining the highest ethical standards while helping ARA search for that cure.*

Thank you for this honor, which I accept in the memory of my friend, Dr. Paul Rothman, and my cousin, Mr. Richard Ohrbach.

Celebrating ARA's Supporters and Successes

In 2004, over 300 friends gathered in Palm Springs and Hollywood for our "Afternoon Among Friends" donor events. These parties, with chilled drinks, cool jazz and wonderful bites, offered both long-time donors and new supporters the chance to hear from key members of ARA's research team about on-going progress in the fight against AIDS.



The members of the Host Committee and ARA Board of Directors cordially invite you and a guest for cocktails, music and hors d'oeuvres to meet new friends and celebrate some of AIDS ReSearch Alliance's recent medical advances in the fight against HIV/AIDS.

Saturday, March 13, 2004
5:00 pm - 8:00 pm
at the home of Mark Allen Itkin and Bradley Bayou
Palm Springs, CA

Please RSVP by March 8th
to AIDS ReSearch Alliance
310.358.2423 or events@aidsresearch.org

Founded by a group of Southern California physicians in 1989, AIDS ReSearch Alliance tackles HIV on several fronts: improving the lives of people living with HIV by finding more effective and affordable treatments, working to repair damaged immune systems, and studying vaccines to prevent the spread of HIV. Studies performed at ARA have involved 15 of the 24 approved anti-HIV drugs, and our efforts led to the FDA approval of four. Visit our website at www.aidsresearch.org

In Palm Springs, board member **Mark Allen Itkin** and his partner, **Bradley Bayou**, graciously opened their stunning mid-century house to guests who collected under gathering stars. **Dr. Peter Anton**, who serves on ARA's Medical Executive Committee, presented an update on the ARA-designed research project investigating the potential of prostratin, a compound that might result in a treatment to aid in the eventual eradication of HIV. *Circle of Hope* donor **Tim Parrott** describe his personal reasons for supporting AIDS research while ARA Board Chair **Arnie Kassoy** made a challenge to the guests, offering to increase donations collected at the event with a matching gift from the Board of Directors.

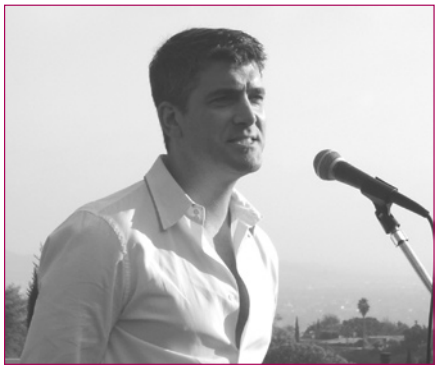
Palm Springs Host Committee

Gary Carlson
Michael Childers
Ian de Freitas & Jim Torrance
John England
Ed Killam III
Dan Logan and Steven Sole
Paul Moore
Tim Parrott
Thomas Rollerson & Michael Erickson
Michael Ross
Mike Slattery

In Los Angeles, guests were welcomed poolside to the lovely hillside home of **Ernie Zayat** and **Jonathan Smilove**. **Dr. Stephen Brown**, ARA Medical Director, and **Dr. Sy Young**, who serves on ARA's Institutional Review Board, detailed current trials at ARA, including our multiple neuropathy studies and Merck's exciting new vaccine candidate—a "naked DNA" inoculation made of genetic material from the AIDS virus. **Paul Kaplan**, a long-time *Circle of Hope* donor and ARA volunteer, marked the anniversary of his brother Herb's death from AIDS, saying he "truly feels medical research is the only way to stop this senseless loss."

Photo by Jon Bernard

Los Angeles hosts Jonathan Smilove and Ernie Zayat relax in the comfort of their innovative modern-styled master bathroom.



Dr. Seymour Young, Vice-chair of ARA's IRB, speaks to the assembled party-goers about ARA's current and upcoming research.

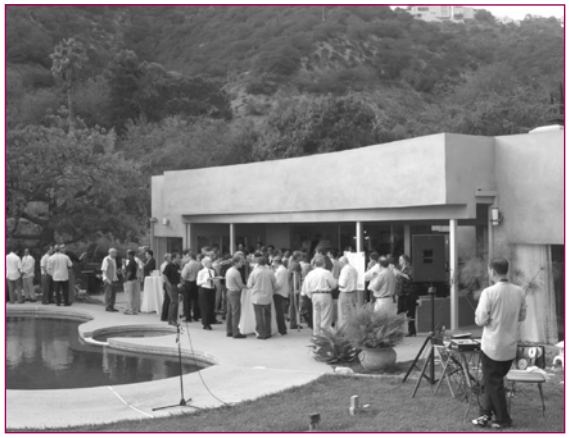
Richard Bloch, ARA volunteer since 1990, listens attentively to his friend and co-volunteer Paul Kaplan. Paul had earlier spoken to attendees about the death of his brother, Herb, from AIDS, his own HIV status, and the importance of HIV/AIDS research.

ARA's Executive Director Irl S. Barefield and Medical Director Dr. Stephen J. Brown listen as ARA Board Chair Arnie Kassoy speaks on the urgent necessity of continued HIV/AIDS research.

Los Angeles Host Committee

Richard Bloch
Michael Delmont, D.D.S.
Tim Engel
Sam Furney & Robert Bolz
David Hart, M.D.
Wilbert Jordan, M.D.
Mark Katz, M.D.
Steve Tyler
Dan Ricketts, Esq. & Steve Frankel
John Tobias & Jesse Sovella
Vance Walker & John Pardee
Steven Ward
Tim Whitney, Psy.D. & Dennis Parmer, M.D.

Thanks to everyone who joined us at these two events and who answered the calls to support our ongoing research agenda. Look out for return events in 2005, as well as an event in San Diego. If you would like information about attending or hosting an ARA donor party, please contact Vincent Cummings at 310.358.2423.



Party attendees throng poolside at the hosts' Hollywood Hills residence. The 1950s home is nestled up to the green hillside, providing spectacular views in all directions.

Photo by Jon Bernard

ARA donors and friends Danny Gibson, Bart Kogan, Dr. Peter Kraus, and Bill Weinberger.

Photos on this page by Karen J. Wellenkamp & Armond Bagdasarian, except where noted.

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ZUCCA ristorante

For ticket information:
310.358.2423
www.artseen4aids.org

AIDS ReSearch Alliance