ART*AIDS*AMERICA
An Exhibit

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Danger. Despair. Death. Shame. Fear. Hopelessness. Powerlessness. Isolation. Loss. Hope. These are some of the powerful themes apparent in the impressive and extensive visual arts exhibit ART*AIDS*AMERICA, which closed a national tour in Chicago at the Alphawood Gallery in April 2017. Co-curated by Jonathan David Katz, from the University at Buffalo, and Rock Hushka, curator of Contemporary and Northwest Art at Tacoma Art Museum, the exhibit toured to critical acclaim—and some controversy—at the Tacoma Art Museum, Bronx Museum of the Arts, and the Bernard A. Zuckerman Museum of Art at Kennesaw State University in Georgia before its Chicago appearance.

Many of these works were produced in the mid-1980s to mid-1990s, when AIDS was the leading cause of death among US men aged 20 to 40 years and a growing cause among urban women of color. Life-saving potent antiretroviral drug therapy was still a distant dream. An HIV diagnosis was a death sentence, and having AIDS was, more often than not, a disclosure of sexual orientation, an unwanted "outing" in a world where being gay and having AIDS could result in the loss of a job, estrangement from family and friends, and even homelessness. Public health officials, including the US federal government, were slow to acknowledge or respond meaningfully to the crisis. Political and social action groups like ACT UP were vital but rare forces for public awareness and for political agitation using tactics that were necessarily loud, graphic, and unsettling. The art of the time reflects these circumstances and the prevailing social climate. Hence, many of the works on display in this exhibit are shocking and difficult to view, often deliberately so.

One such work is Jonathan Horowitz's Archival *Iris Print of an Image Downloaded From the Internet With Two Copies of the* New York Post *Rotting in Their Frames*. The two upper panels are covers of issues of the *New York Post* that fondly memorialized Ronald Reagan, upon his death in 2004. Reagan notoriously did not utter the word "AIDS" in public until the late 1980s, well after thousands of persons in the United States had died of the disease. The lower half of the work is a black and white stark photograph of an emaciated young man in bed, cheeks sunken, eyes listless and bulging, seemingly near death, wearing a T-shirt bearing the words "IGNORANCE=FEAR."

Another is ACT UP New York/Gran Fury's *Let the Record Show,* a mixed-media installation originally from 1987, projected onto a large screen in the gallery's cavernous main room. It includes such infamous quotes as William F. Buckley's 1986 statement published as an op-ed piece in the *New York Times* that "Everyone detected with AIDS should be tattooed in the upper forearm to protect common-needle users, and on the buttocks to prevent the victimization of other homosexuals."

Eternal Lovers by Tino Rodriguez, 2010, Mexican American. Oil on wood. Two human skulls lock in a mouth-to-mouth kiss, stylistically evocative of *Dia de los Muertes* (Day of the Dead) images, but with the obvious reference to death replaced with love, life, growth. Courtesy of the artist.

Not surprisingly, and probably necessarily, the exhibit featured works where sexuality and illness are equally prominent themes, intertwined, coexistent, even inseparable. Patrick Webb's 1992 two-paneled painting *The Lamentation* and *By Punchinello's Bed* are large dark canvases that depict, in the first, a man wearing an anguished facial expression crouched by the bed and holding the hand of his gray-skinned, painfully thin partner. The partner is masked, a reference to the 18th-century Commedia dell'Arte figure of Punchinello as an everyman character, emphasizing how AIDS crosses all demographics. In the second panel Punchinello is dead, and a suited man, presumably again his partner, is standing upright next to the bed, expressionless, stiff, seeming just as lifeless. Many of these works equate sex or sexuality with danger or even death. Roger Brown's 1983 *Peach Light* is a large work in which the black silhouette of a human skeleton wearing a leatherman's cap is

of BREO with long-term ketoconazole and other known strong CYP3A4 inhibitors (e.g., ritonavir, clarithromycin, conivaptan, indinavir, itraconazole, lopinavir, nefazodone, nelfinavir, saquinavir, telithromycin, troleandomycin, voriconazole) *[see Warnings and Precautions (5.9), Clinical Pharmacology (12.3) of full prescribing information]*.

7.2 Monoamine Oxidase Inhibitors and Tricyclic Antidepressants:
Vilanterol, like other beta$_2$-agonists, should be administered with extreme caution to patients being treated with monoamine oxidase inhibitors, tricyclic antidepressants, or drugs known to prolong the QTc interval or within 2 weeks of discontinuation of such agents, because the effect of adrenergic agonists on the cardiovascular system may be potentiated by these agents. Drugs that are known to prolong the QTc interval have an increased risk of ventricular arrhythmias.

7.3 Beta-Adrenergic Receptor Blocking Agents:
Beta-blockers not only block the pulmonary effect of beta-agonists, such as vilanterol, a component of BREO, but may also produce severe bronchospasm in patients with COPD or asthma. Therefore, patients with COPD or asthma should not normally be treated with beta-blockers. However, under certain circumstances, there may be no acceptable alternatives to the use of beta-adrenergic blocking agents for these patients; cardioselective beta-blockers could be considered, although they should be administered with caution.

7.4 Non–Potassium-Sparing Diuretics:
The electrocardiographic changes and/or hypokalemia that may result from the administration of non–potassium-sparing diuretics (such as loop or thiazide diuretics) can be acutely worsened by beta-agonists, especially when the recommended dose of the beta-agonist is exceeded. Although the clinical significance of these effects is not known, caution is advised in the coadministration of beta-agonists with non–potassium-sparing diuretics.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy:

Teratogenic Effects: Pregnancy Category C. There are no adequate and well-controlled trials with BREO in pregnant women. Corticosteroids and beta$_2$-agonists have been shown to be teratogenic in laboratory animals when administered systemically at relatively low dosage levels. Because animal reproduction studies are not always predictive of human response, BREO should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Women should be advised to contact their physicians if they become pregnant while taking BREO.

Fluticasone Furoate and Vilanterol: There was no evidence of teratogenic interactions between fluticasone furoate and vilanterol in rats at approximately 5 and 40 times, respectively, the maximum recommended human daily inhalation dose (MRHDID) in adults (on a mcg/m^2 basis at maternal inhaled doses of fluticasone furoate and vilanterol, alone or in combination, up to approximately 95 mcg/kg/day).

Fluticasone Furoate: There were no teratogenic effects in rats and rabbits at approximately 4 and 1 times, respectively, the MRHDID in adults (on a mcg/m^2 basis at maternal inhaled doses up to 91 and 8 mcg/kg/day in rats and rabbits, respectively). There were no effects on perinatal and postnatal development in rats at approximately 1 time the MRHDID in adults (on a mcg/m^2 basis at maternal doses up to 27 mcg/kg/day).

Vilanterol: There were no teratogenic effects in rats and rabbits at approximately 13,000 and 160 times, respectively, the MRHDID in adults (on a mcg/m^2 basis at maternal inhaled doses up to 33,700 mcg/kg/day in rats and on an AUC basis at maternal inhaled doses up to 591 mcg/kg/day in rabbits). However, fetal skeletal variations were observed in rabbits at approximately 1,000 times the MRHDID in adults (on an AUC basis at maternal inhaled or subcutaneous doses of 5,740 or 300 mcg/kg/day, respectively). The skeletal variations included decreased or absent ossification in cervical vertebral centrum and metacarpals. There were no effects on perinatal and postnatal development in rats at approximately 3,900 times the MRHDID in adults (on a mcg/m^2 basis at maternal oral doses up to 10,000 mcg/kg/day).

Nonteratogenic Effects: Hypoadrenalism may occur in infants born of mothers receiving corticosteroids during pregnancy. Such infants should be carefully monitored.

8.2 Labor and Delivery:
There are no adequate and well-controlled human trials that have investigated the effects of BREO during labor and delivery. Because beta-agonists may potentially interfere with uterine contractility, BREO should be used during labor only if the potential benefit justifies the potential risk.

8.3 Nursing Mothers:
It is not known whether fluticasone furoate or vilanterol are excreted in human breast milk. However, other corticosteroids and beta$_2$-agonists have been detected in human milk. Since there are no data from controlled trials on the use of BREO by nursing mothers, caution should be exercised when it is administered to a nursing woman.

8.4 Pediatric Use:
BREO is not indicated for use in children and adolescents. The safety and efficacy in pediatric patients (aged 17 years and younger) have not been established.

In a 24- to 76-week exacerbation trial, subjects received BREO 100/25 (n=1,009) or fluticasone furoate 100 mcg (n=1,010). Subjects had a mean age of 42 years and a history of one or more asthma exacerbations that required treatment with oral/systemic corticosteroids or emergency department visit or in-patient hospitalization for the treatment of asthma in the year prior to study entry. *[See Clinical Studies (14.2) of full prescribing information.]* Adolescents aged 12 to 17 years made up 14% of the study population (n=281), with a mean exposure of 352 days for subjects in this age-group treated with BREO 100/25 (n=151) and 355 days for subjects in this age-group treated with fluticasone furoate 100 mcg (n=130). In this age-group, 10% of subjects treated with BREO 100/25 reported an asthma exacerbation compared with 7% for subjects treated with fluticasone furoate 100 mcg. Among the adolescents, asthma-related hospitalizations occurred in 4 subjects (2.6%) treated with BREO 100/25 compared with 0 subjects treated with fluticasone furoate 100 mcg. There were no asthma-related deaths or asthma-related intubations observed in the adolescent age-group.

Effects on Growth: Orally inhaled corticosteroids may cause a reduction in growth velocity when administered to children and adolescents. A reduction of growth velocity in children and adolescents may occur as a result of poorly controlled asthma or from use of corticosteroids, including ICS. The effects of long-term treatment of children and adolescents with ICS, including fluticasone furoate, on final adult height are not known. *[See Warnings and Precautions (5.17); Use in Special Populations (8.4) of full prescribing information.]*

8.5 Geriatric Use:
Based on available data, no adjustment of the dosage of BREO in geriatric patients is necessary, but greater sensitivity in some older individuals cannot be ruled out.

Clinical trials of BREO for COPD included 2,508 subjects aged 65 and older and 564 subjects aged 75 and older. Clinical trials of BREO for asthma included 854 subjects aged 65 years and older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger subjects.

8.6 Hepatic Impairment:
Fluticasone furoate systemic exposure increased by up to 3-fold in subjects with hepatic impairment compared with healthy subjects. Hepatic impairment had no effect on vilanterol systemic exposure. Use BREO with caution in patients with moderate or severe hepatic impairment. Monitor patients for corticosteroid-related side effects *[see Clinical Pharmacology (12.3) of full prescribing information]*.

8.7 Renal Impairment:
There were no significant increases in either fluticasone furoate or vilanterol exposure in subjects with severe renal impairment (CrCl less than 30 mL/min) compared with healthy subjects. No dosage adjustment is required in patients with renal impairment *[see Clinical Pharmacology (12.3) of full prescribing information]*.

10 OVERDOSAGE
No human overdosage data has been reported for BREO. BREO contains both fluticasone furoate and vilanterol; therefore, the risks associated with overdosage for the individual components described below apply to BREO. Treatment of overdosage consists of discontinuation of BREO together with institution of appropriate symptomatic and/or supportive therapy. The judicious use of a cardioselective beta-receptor blocker may be considered, bearing in mind that such medicine can produce bronchospasm. Cardiac monitoring is recommended in cases of overdosage.

10.1 Fluticasone Furoate:
Because of low systemic bioavailability (15.2%) and an absence of acute drug-related systemic findings in clinical trials, overdosage of fluticasone furoate is unlikely to require any treatment other than observation. If used at excessive doses for prolonged periods, systemic effects such as hypercorticism may occur *[see Warnings and Precautions (5.8)]*. Single- and repeat-dose trials of fluticasone furoate at doses of 50 to 4,000 mcg have been studied in human subjects. Decreases in mean serum cortisol were observed at dosages of 500 mcg or higher given once daily for 14 days.

10.2 Vilanterol:
The expected signs and symptoms with overdosage of vilanterol are those of excessive beta-adrenergic stimulation and/or occurrence or exaggeration of any of the signs and symptoms of beta-adrenergic stimulation (e.g., seizures, angina, hypertension or hypotension, tachycardia with rates up to 200 beats/min, arrhythmias, nervousness, headache, tremor, muscle cramps, dry mouth, palpitation, nausea, dizziness, fatigue, malaise, insomnia, hyperglycemia, hypokalemia, metabolic acidosis). As with all inhaled sympathomimetic medicines, cardiac arrest and even death may be associated with an overdose of vilanterol.

17 PATIENT COUNSELING INFORMATION
Advise the patient to read the FDA-approved patient labeling (Medication Guide and Instructions for Use).

Asthma-Related Death
Inform patients with asthma that LABA, such as vilanterol, one of the active ingredients in BREO, increase the risk of asthma-related death and may increase the risk of asthma-related hospitalization in pediatric and adolescent patients. Also inform them that currently available data are inadequate to determine whether concurrent use of ICS or other long-term asthma control drugs mitigates the increased risk of asthma-related death from LABA.

Not for Acute Symptoms:
Inform patients that BREO is not meant to relieve acute symptoms of COPD or asthma and extra doses should not be used for that purpose. Advise patients to treat acute symptoms with an inhaled, short-acting beta$_2$-agonist such as albuterol. Provide patients with such medication and instruct them in how it should be used.

Instruct patients to seek medical attention immediately if they experience any of the following: decreasing effectiveness of inhaled, short-acting beta$_2$-agonists; need for more inhalations than usual of inhaled, short-acting beta$_2$-agonists; significant decrease in lung function as outlined by the physician.

Tell patients they should not stop therapy with BREO without physician/provider guidance since symptoms may recur after discontinuation.

Do Not Use Additional Long-acting Beta$_2$-agonists:
Instruct patients not to use other LABA for COPD and asthma.

Local Effects:
Inform patients that localized infections with *Candida albicans* occurred in the mouth and pharynx in some patients. If oropharyngeal candidiasis develops, it should be treated with appropriate local or systemic (i.e., oral) antifungal therapy while still continuing therapy with BREO, but at times therapy with BREO may need to be temporarily interrupted under close medical supervision. Advise patients to rinse the mouth with water without swallowing after inhalation to help reduce the risk of thrush.

Pneumonia:
Patients with COPD have a higher risk of pneumonia; instruct them to contact their healthcare providers if they develop symptoms of pneumonia.

Immunosuppression:
Warn patients who are on immunosuppressant doses of corticosteroids to avoid exposure to chickenpox or measles and, if exposed, to consult their physicians without delay. Inform patients of potential worsening of existing tuberculosis; fungal, bacterial, viral, or parasitic infections; or ocular herpes simplex.

Hypercorticism and Adrenal Suppression:
Advise patients that BREO may cause systemic corticosteroid effects of hypercorticism and adrenal suppression. Additionally, inform patients that deaths due to adrenal insufficiency have occurred during and after transfer from systemic corticosteroids. Patients should taper slowly from systemic corticosteroids if transferring to BREO.

Reduction in Bone Mineral Density:
Advise patients who are at an increased risk for decreased BMD that the use of corticosteroids may pose an additional risk.

Ocular Effects:
Inform patients that long-term use of ICS may increase the risk of some eye problems (cataracts or glaucoma); consider regular eye examinations.

Risks Associated with Beta-agonist Therapy:
Inform patients of adverse effects associated with beta$_2$-agonists, such as palpitations, chest pain, rapid heart rate, tremor, or nervousness.

Hypersensitivity Reactions, Including Anaphylaxis:
Advise patients that hypersensitivity reactions (e.g., anaphylaxis, angioedema, rash, urticaria) may occur after administration of BREO. Instruct patients to discontinue BREO if such reactions occur. There have been reports of anaphylactic reactions in patients with severe milk protein allergy after inhalation of other powder medications containing lactose; therefore, patients with severe milk protein allergy should not use BREO.

BREO ELLIPTA was developed in collaboration with Theravance

GlaxoSmithKline
Research Triangle Park, NC 27709

Revised 7/2016 BRE:7BRS

posed against a background of concentric reddish circles evocative of blood cells.

Some pieces boldly assert gay sexuality in spite of visible disease. One effective example is Mark I. Chester's 1989 photographic series entitled *Robert Chesley - ks portraits*. The first photo depicts the subject sitting bare-chested with multiple cutaneous Kaposi sarcoma lesions visible on his torso and arms. In the subsequent photos, he is shown donning a Superman costume and, in the penultimate photo, fully costumed except for his erect penis. In the final photo, he is similarly clad but bound in restraints, seemingly made impotent and powerless.

There are works in which same-sex intimacy unabashedly shines through and is celebrated without a hint of the sense of danger or shame that pervaded gay life in America at the time. One is Michael Martinez's photographic still from the video *Lost Boys*, depicting the upper bodies and (partial) faces of two healthy appearing young men happily engaging in apparently mutually satisfying sexual pleasure, with the lower halves of their bodies out of the frame.

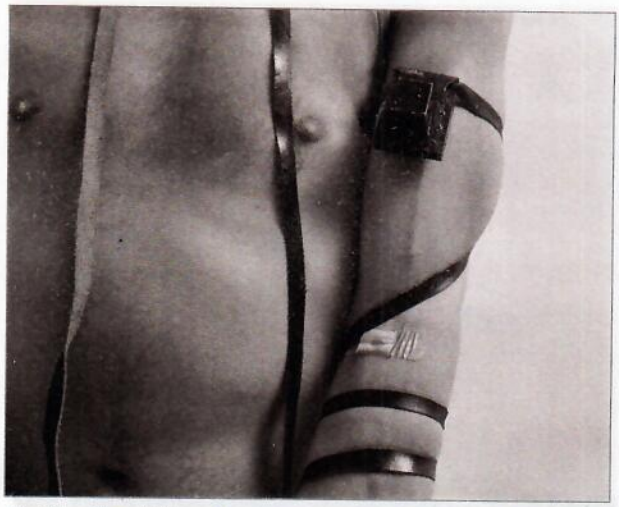
Religious iconography is utilized shrewdly and effectively in many of the works. In Jerome Caja's 1993 *Shroud of Curad*, a miniature work on a typical modern-day adhesive bandage, with a Florentine-esque gold and red oval frame, the central white art of the bandage bears a Christ-like facial image made of blood and eyeliner that is highly evocative of the one on the *Shroud of Turin*. Another is Catherine Opie's 2000 Polaroid *Ron Athey/The Sick Man (From Deliverance)*, which depicts two nude, extensively tattooed and pierced men, one black and one white, striking poses deliberately suggestive of the Madonna and dead Christ as depicted in any one of several well-known Renaissance versions of the *Pietà*.

More contemporary images are not entirely absent, including ones of apparently antiretroviral-treated persons who survived but are visibly and readily identifiable as HIV infected. In Boris Torres' 2009 *Love Forever* painting, two middle-aged nude men are half-immersed in a body of water, apparently recreating, and bear the tell-tale stigmata of HIV-associated lipodystrophy—protuberant abdomens, prominent dorsocervical fat pads, and the sunken cheeks of facial lipoatrophy. Such were the prices commonly paid by recipients of life-saving but more toxic earlier antiretroviral therapies.

The exhibit is wide-ranging in both form and content and includes works by no less than Keith Haring, Roger Brown, Robert Mapplethorpe, Judy Chicago, and Annie Liebovitz. But also, and possibly more importantly, it includes works by artists whose names are less recognizable, persons who sought to chronicle and draw attention to their own plight and/or to that of persons whom they cared about and often for. Not surprisingly, the exhibit can feel voyeuristic at times as a result. Many of the artists are deceased, a fact that enhances a sense of urgency and poignancy and that imbues the exhibit with a sense of wistfulness for lives lost and opportunities missed. Indeed, were it not for the works that include audio/video installations, one could imagine a reverent silence pervading the entire exhibit, as one would expect at a memorial, and the voices of these artists being lost entirely to history.

Unveiling of a Modern Chastity by Izhar Patkin, 1981, American. Rubber, latex, and ink on canvas. Troubled by the sight of a group of young men with skin lesions waiting their turn in his dermatologist's office, the artist created this work in 1981, a year before the Centers for Disease Control and Prevention's first description of AIDS, to resemble the Kaposi sarcoma lesions he was seeing. He titled the work to reflect what he felt might be a forthcoming change in gay sexual culture. Courtesy of the artist.

By no means is the AIDS crisis over, nor has the urgency depicted in many of these images vanished. The need to address in a timely fashion the diagnosis, treatment, and prevention of HIV infection is undiminished. In the United States, the faces and geographic locations of affected and at-risk persons have evolved and more contemporary works of art exist elsewhere to profile those persons—including photographs of and by urban contemporary HIV-positive persons exhibited less than a mile from the Alphawood gallery at Chicago's DePaul University Art Museum in a show entitled *One Day This Kid Will Get Larger*. This latter exhibit clearly stands on its own merits and has important images and unique perspectives to present, particularly regarding themes of race, youth, and pop culture in America at a time when the HIV epidemic is increasingly one affecting persons of color. Appropriately, there are considerably more images featuring women in this show than in the ART*AIDS*AMERICA exhibit. In many ways, a show such as this one, in which images of death and despair and vanquishing illness are rare, is a descendant of the larger ART*AIDS*AMERICA exhibit, and



Akedah by Albert J. Winn, 1995, American. Gelatin silver print. The artist wrote: "Every month ... I need to undergo a blood test. During the process a tourniquet is bound tightly about my upper arm. ... Having my blood drawn has become a ritual in what sometimes seems is a new religious practice, an AIDS ritual. Over time, I've transformed this ritual in relation to my Judaism. I wonder if like Isaac, I am being sacrificed. This time to science. I pray that an angel will intercede and spare my life... . I look at the rubber strap and see *tefillin* [phylacteries]. ... Except for the needle stick the binding feels the same." Courtesy of Scott R. Portnoff.

was made possible by the advances in HIV treatment and resources that the earlier works screamed for.

Thankfully, ART*AIDS*AMERICA, a particularly stunning, beautiful, and wide-ranging exhibit, is more of an emotionally moving historical chronicle and warning against complacency in the future than it is a depiction of contemporary abject despair. The US Centers for Disease Control and Prevention estimates that more than half of currently diagnosed HIV-infected persons in the United States are now aged 50 years or older and that the life expectancy for persons who are promptly diagnosed and effectively treated is approaching that of similarly aged HIV-uninfected persons. Such statistics are heartening but belie the fact that, in parts of the world hardest hit by AIDS, the epidemic continues barely abated. The power of art not merely to reflect but to effect much-needed responses to the AIDS epidemic in such places has yet to be fully realized.

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Section Editor: Roxanne K. Young, Associate Senior Editor.

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for the Disclosure of Potential Conflicts of Interest and none were reported.

Additional Information: Many additional images are available at https://artblart.com/2015/12/20/exhibition-art-aids-america-at-tacoma-art-museum-tacoma/.

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