Infosheet #20 *from the series* ***"For a Better QL of PLWHA!"***

TREATMENT SIMPLIFICATION

(the IX International Congress
"**Drug Therapy** in **HIV Infection**",
XI 2008, Glasgow)

(translated from Latvian)

This congress revealed that now the momentum is shifting to the many implications of life- long treatment. Much more attention is being paid to co-morbidities such as cardio- vascular, renal or bone diseases. The **shift from treating the virus to treating the patient** is most welcome!

One of the main messages from this congress is **treatment simplification**. It may be reached by different means:

a) **single tablet regimens,**
b) **monotherapy,**
c) **decreased doses.**

b) E.g., *abstract P067* concludes that *Saquinavir/ r* **monotherapy** *(twice daily)* may be a valid and economic option as a nucleoside- sparing strategy for virologically suppressed HIV+ patients without prior history of virologic failure to PI – containing regimens, especially in those with intolerance or toxicities to nucleosides. This is a new nucleoside- sparing maintenance strategy prompted by high antiviral potency and low toxicity of *SQV*.

c) Toxicity of *Tipranavir/ r* 500/ 200 mg regimen has led scientists find ways to minimize it *(#P066)*. They found out that patients on 200mg based regimen could benefit from a **decreased dose** (500/ 100) of *Ritonavir*. However, due to large inter- individual differences, this strategy should only be performed using TDM *(therapeutic drug monitoring)*.

The ongoing discussion on **when to start** has taken a new turn.
Patients' viewpoint was revealed during Gus Cairns *(EATG)* presentation on the results of a large patients' questionnaire.
Italian scientists *(#P010)* retrospectively *(8 year follow- up)* assessed immune restoration in patients with sustained virological suppression *(HIV- RNA<400 for at least 6 consecutive months)*. The study shows that these patients experienced a significant immune recovery over 8 years of HAART.
Scientists found out that a complete immune recovery *(defined in the study as CD4>700)* was achieved only in patients with baseline CD4>350. *(This observation strengthens the hypothesis that starting HAART at CD4<50 could not be adequate to obtain a complete immunological recovery).*
Current guidelines recommend to initiate HAART at CD4<350. However, recent studies have shown a higher immune restoration when HAART was started at CD4>350.
After 5 years of therapy 29%, 69% and 82% of patients with baseline CD4, respectively, <200, 200- 350 and >350, exceeded the threshold of CD4=500.

Among patients with baseline CD4>350, mean CD4 reached a plateau with a complete immunological recovery by 4 years of suppressive HAART.
CD4 increased even after 8 years without ever reaching a full immunological recovery in patients with baseline CD4<200.
Patients aged >50 years had a slower but similar immune recovery.
Italian scientists found no significant differences in immunological response according to baseline VL, HIV risk factor, sex, HCV co- infection and HAART regimen.

Another Italian study *(#P030)* suggests that in patients undergoing a **treatment interruption** there is an increased relative risk of developing AIDS or death; this risk is decreased if a relatively high CD4 threshold is chosen to re-initiate the treatment.

Vitamin D has a role also in immunity. VitD deficiency may also have an effect in the progression of HIV.
British scientists *(P#116)* are discussing whether vitD deficiency is cause or effect. A significant number *(66,2%)* of their HIV+ patients had either vitD deficiency or insufficiency. There also appears to be a lower CD4 in the vitD deficient group of patients. It is yet not known whether specific ART contributes to vitD deficiency.

During the congress there was a hot discussion around the **new Swiss guidelines**.

A.Kalnins,
AGIHAS