Infosheet #5 *from the series* ***For a Better QL of PLWHA!***

DRUG HOLIDAYS. YES OR NO?

(the **VII CROI:** Conference on
RETROVIRUSES and **OPPORTUNISTIC INFECTIONS,**
San Francisco, I/II.2000)

(translated from Latvian)

This conference is rated as the highest forum on scientific and clinical HIV and OI research.

The question **when to start** therapy is still essential.
The Washington university clinical study shows that a delayed start results in better virology outcomes and less opportunities for developing resistances. There is no evidence on an improved immune system or HIV eradication by starting early (abstr. #523).

Since the **first combination** fails in half of cases, it has to be chosen carefully (R. Murphy, MD). Mixing the 16 ARV drugs theoretically gives 3360 combinations. Here are some of them.
E.g., *ABC + AMP* quickly suppresses HIV- 1 replication and is usually well tolerated (#336).
NVR + ZDV + LMV is equally effective in patients with low and even high VL (>100.000) (#517).
Once daily *Emtricitabine (FTC) + ddI + EFV* in therapy- naïve patients after 24 weeks lowered VL<400, increased CD4 cell count and was well tolerated (#518).
Once daily *EFV + NVP* combination: it may be necessary to increase the EFV dose to 800 mg (#80).
Single pill combination of *ABC + LMV + ZDV* (twice daily) is biologically equal to its contents, has no dietary restrictions, is well- tolerated, easy to swallow and not disgusting (#98).

In order to evade **cross- resistance** – do not use combinations consisting of all the 3 ARV classes (#80)!
Using *NLF* as the first PI causes less cross- resistances compared to other PIs (dr. L. Prescott).

Discussion on **drug holidays** still goes on. 5/8 of patients on HAART had to restart therapy on the sixth week with their CD4 counts and CD4/CD8 ratios lowered. In contrast, patients on *Hydroxyurea + ddI* ("PANDA" clinical study) at the 8th week had a very small VL increase at stable CD4 and CD8 counts. This is the first study showing that STIs in chronically infected patients are feasible (#352).

60% of patients after 2 yrs on PIs are experiencing **lipodistrophy**.
Switching to another ARV class does not guarantee its disappearance - lipodystrophy may not progress, though.

Some comparisons:
Comparing PIs: *AMP* is less prone to cause lipodystrophy than *IND*.
d4T causes much more lipodystrophy cases than *ZDV* (#756).
14% of patients after 3 years on *RTV + SQV* are experiencing shrinkage in buttocks (D. W. Cameron).

While due to ARV combinations the virus is decreasing in bloodstream, it may continue replicating in sperm.
33% of men on PIs are experiencing **sexual dysfunction**.
Abbott has a new salvage in its pipeline – an erectile medication *Uprima*.
Its effect is reached in 75% of men who sucked the pill for 20 min.
Compared to *Viagra* it has less of side effects.

Newly elaborated blood tests help to define the approximate timing of HIV infection. These tests have proved that **oral sex** has been the cause of HIV transmission in 8% of cases in San Francisco (abstr. #473).

A.Kalnins,
AGIHAS