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Panel Updates Guidelines for Treatment of Adult HIV Infection

TORONTO – With antiretroviral therapy for adults with HIV infection continuing to evolve, the International AIDS Society – USA Panel has issued updated recommendations for the treatment of HIV, according to a report in the August 16 issue of *JAMA*, a theme issue on HIV/AIDS.

Scott M. Hammer, M.D., of the Columbia University College of Physicians and Surgeons, New York, presented the recommendations of the report today at a *JAMA* media briefing at the International AIDS Conference in Toronto.

In the last 25 years, acquired immunodeficiency syndrome (AIDS) has grown to pandemic proportions, resulting in 25 million deaths worldwide and an estimated 40 million persons living with human immunodeficiency virus (HIV), according to background information in the article. Guidelines for antiretroviral therapy are important for clinicians worldwide given the complexity of the field and the varied clinical situations in which these agents are used.

To provide physicians and other HIV clinicians with current recommendations for the use of antiretroviral therapy in HIV-infected adults in circumstances for which there is relatively unrestricted access to drugs and monitoring tools, the International AIDS Society–USA (IAS-USA) panel has updated its recommendations as warranted by new developments in the field. The 16-member noncompensated panel was appointed, based on expertise in HIV research and patient care internationally. Data published or presented at selected scientific conferences since mid-2004 through May 2006 were identified and reviewed by all members of the panel. The researchers identified 181 citations regarding antiretroviral agent trials that were considered potentially relevant.

New guidelines were drafted by a writing committee and reviewed by the entire panel. The recommendations of the panel are centered on 4 key issues: when to start antiretroviral therapy; what to start; when to change; and what to change.

The researchers write that initiation of antiretroviral therapy continues to be recommended in all symptomatic persons and in asymptomatic persons after the CD4 cell count falls below 350/ μ L and before it declines to 200/ μ L.

The panel members report that since the last edition of these guidelines, clinical trial and cohort studies have led to refinements in the choice of initial regimen. “The recommended initial regimen remains a combination of 2 nucleoside (or nucleotide) reverse transcriptase inhibitors (nRTIs) with either a nonnucleoside reverse transcriptase inhibitor (NNRTI) or a protease inhibitor (PI) boosted with low-dose ritonavir. Given the high degree of comparability of the recommended components of these regimens in treatment-naive persons with drug-susceptible virus, the choice of regimen centers on acceptability; predicted tolerance; pill burden; comorbid conditions; short-term, mid-term, and long-term adverse event profiles; and successful alternatives should the initial regimen fail and drug resistance emerge. The successful outcomes of several ‘switch studies’ suggest that the initial choice of regimen does not preclude safely changing drugs once viral suppression is achieved.”

They add that adherence to antiretroviral therapy in the short-term and the long-term is crucial for treatment success and must be continually reinforced.

The researchers write that therapy should be changed when toxicity or intolerance mandate it or when treatment failure is documented. The virologic target for patients with treatment failure is now a plasma HIV-1 RNA level below 50 copies/mL, a goal that is now achievable in a substantial proportion of patients. Once antiretroviral therapy is initiated, plasma HIV-1 RNA level should be checked relatively frequently (e.g., every 4-8 weeks) until it reaches levels below the limits of detection of the assay and regularly thereafter (e.g., 3-4 times per year).

“In the nearly 2 decades since zidovudine was introduced, 21 additional agents in 5 drug classes have been approved; potent combination therapy has become a worldwide standard of care; morbidity and mortality in the developed world have been substantially reduced, and major antiretroviral rollouts have been initiated in the developing world. Balanced against this progress is the identification of major unpredicted toxic effects and recognition of the limitations that drug class cross-resistance place on alternate treatment regimens in the setting of treatment failure.”

“Given the rapid evolution of knowledge, clinicians are challenged to stay abreast of new information that can affect practice. Therapeutic choices rooted in the pathogenesis of HIV disease and individualization of therapy to maximize benefit are the principles that remain constant in a rapidly changing environment,” the researchers conclude.

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