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Factors to Consider When Thinking About Switching a Patient's ARV Regimen

Announcer:
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Dr. Segal-Maurer:
This is CME on ReachMD, and I'm Dr. Sorana Segal-Maurer. Here with me today is Dr. Carl Fichtenbaum.

Dr. Fichtenbaum, if you're switching therapies based on cardiovascular concerns in a patient with HIV, what are some factors you consider?

Dr. Fichtenbaum:
Yeah, so the things I consider, first of all, are the opinion of the patient, foremost how they feel about it. Many of my patients, of course, have this "if it ain't broke, don't fix it, Doc" kind of approach. And so I take that into account, and then we have to have a discussion about cardiometabolic risk. So I take into account kidney function, whether or not they have a history of hepatitis that we need to address, if they have any drug–drug interactions that I need to consider, and then I take into account what their lipid levels are, what their other traditional risk factors are, and then what our goals are. Are we trying to get a regimen that's a little bit more tolerable, or one that's going to minimize their risk and give them a little bit more benefit? So oftentimes, I'm looking at historically patients who may be on an efavirenz regimen or on a boosted protease regimen and we want to make a switch. And I say, well, I think it makes sense for us to think about NNRTIs along with an appropriate backbone, and we could consider rilpivirine or doravirine as appropriate NNRTIs. And then we'd talk about integrase strand transfer inhibitors and whether that makes sense, and I look at their BMI and their weight, and we talk about could there be weight gain with certain agents. And these are the considerations that I go through in my mind, in talking with a patient about making a switch.

Dr. Segal-Maurer:
So, excellent points. I think the patient's view, if it is they who wish to switch, there's always the convenience, the tolerability. Single-tablet regimens are easier than multi-tablet regimens. Certainly intramuscular injectables – less often visits. Also managing the patient's expectations if they want to switch for a particular reason. And certainly, if they have cardiometabolic risk, we frequently will drive some of their options. Certainly reviewing the resistance in the past or even doing archived mutations with pro-viral DNA can be useful in many instances. And I myself, as I'm sure as you would, you're looking for agents with high barrier to resistance. We would never want to switch for cardiometabolic risk and then have virologic failure. So agents in the non-nuc class with higher barrier to resistance, such as doravirine, would be ideal. The integrase inhibitor class is always of consideration. And I don't know as much about the boosted PIs – certainly good barrier to resistance, but if we're trying to get away from dyslipidemia and other cardiometabolic issues, maybe we may or may not consider those.

I think the other thing that we didn't bring in is avoiding new adverse events, right? Because patients may want to switch, may be interested in switching, but the last thing they want are new adverse events for them to be dealing with. So certainly, some of the injection site reaction of the current injectables can sometimes be a turnoff for some of our patients, but there's always weighing what's

better for that particular individual. So the DHHS guidelines gives us an excellent summary of some of these considerations, and they are certainly many.

You did mention the traditional risk factors, and that's probably the very first thing to grapple with, and as you mentioned, managing expectations, shared decision-making, I know you emphasized that, and I just cannot say how important it is that you partner with the patients.

Well, this has been a brief but great discussion. That's our time, and thanks for tuning in.

Announcer:
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