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Managing ART for Optimal Cardiometabolic Health

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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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. Let's discuss a case.

A 47-year-old white man was started on abacavir-lamivudine-dolutegravir 5 years after being diagnosed with HIV infection. His current CD4 count is 635, and his HIV viral load has been consistently undetectable for the past 4.5 years. He was recently diagnosed with hypertension and is taking lisinopril. His serum creatinine is 1.1. His mother had a cardiac stent placed at the age of 67.

Now, Dr. Fichtenbaum, how would you approach treatment for this patient, especially as it regards his antiretroviral therapy?

Dr. Fichtenbaum:
Well, I think the most important thing is to recognize that this patient's been doing very well. They take their medication very well, and they've been undetectable. So the old adage, you don't like to break what isn't broken, I think is really true. But I like to think about the long-term risks that this patient may be facing, and so I think we need to have a conversation about cardiometabolic risk. He's 47, he has a family history of cardiovascular disease. He also is on a regimen that includes abacavir, which may have some cardiometabolic risk. There are some data, particularly from the D:A:D cohort, demonstrating a 20%-40% higher chance of a cardiac event. So I really need to think about the long run of the health of this individual, and we need to have a shared decision-making conversation about what makes sense. And I think about different kinds of backbones, that maybe switching to a tenofovir-based backbone may be wiser for this patient. I think about whether or not using an NNRTI, like rilpivirine or doravirine, where sticking with a high barrier [to] resistance integrase strand transfer inhibitor makes sense. And sometimes, I might offer injectable therapy, as well, for people who are interested in that.

So I think the key is to have a discussion, give the patient time. Sometimes I'll tell people, "Take a little time. Do some research. Let's talk about it in a week or two, and we can make a decision." So I think it's important to have that conversation and think about long-term cardiometabolic risk.

Dr. Segal-Maurer:
Yeah, I think you raise excellent points. We know from a number of long cohorts, such as NA-ACCORD [North American AIDS Cohort Collaboration on Research and Design] cohort, that our patients living with HIV are living much longer than they used to many years ago, which is a wonderful testament to our care of them and the newer antiretroviral agents. But what that means is we need to be planning for decades here and for mitigating their risk, which we do know occurs at younger ages. So it's an excellent opportunity, as you're discussing this case, to really focus on mitigating his risk. And we know, certainly with the very highest cardiometabolic risks, abacavir is probably not an ideal component of a backbone. And certainly, you've mentioned tenofovir alafenamide would be, in many providers' minds, a better option or at least just removing that abacavir. And I think you bring up excellent points. If we were to change, would we just take out that abacavir? It has to do with [whether] he had any kind of mutations at baseline before he started, certainly that would impact our decision-making.

And then the question is, would we go to a high barrier to resistance non-nuc, such as doravirine? Would we stay with an integrase inhibitor-based regimen? Certainly with everything else going on, I don't think TDF would play as much in my considerations – a little concerning with his hypertension. Of course, you brought up the injectables, and always, always, our primary focus is on mitigating traditional risk factors. We did not get into his exercise, his diet, any kind of cigarette smoking, and certainly lipids, which of course are the primary focus. And then we try to help with our options and then try antiretroviral therapy.

Well, this has been a brief but great discussion. Thank you all for tuning in.

Announcer:
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