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My Patient Is Stable on ART, But Has Gained 30 Pounds: What Are My Options?

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 43-year-old African American woman presents with newly diagnosed HIV infection. She has a history [of] hypertension and a BMI of 35. Initial CD4 count is 275, and her viral load is 140,000 copies. She is taking amlodipine. Initial labs show no active hepatitis B and a serum creatinine of 0.9. Her father had a heart attack at the age of 60 years.

Now, Dr. Fichtenbaum, as a provider, do you take cardiometabolic, cardiovascular disease, and weight gain into account when prescribing antiretroviral therapy?

Dr. Fichtenbaum:
Yeah, absolutely. I mean, every individual person that I see, I like to have a shared decision-making discussion and talk about all of their current health risks, as well as any possible future risks that may occur as a result of what we do. And so I think it's really, really important to understand who is this person, what are their concerns, what are their health concerns, what are their health risks, and how do we craft a treatment strategy and plan that's going to really minimize their cardiometabolic risks going forward? So in thinking about this woman, in particular, I worry that her BMI is 35. She is already quite overweight, and I don't want to contribute to that. And her father had a history of heart disease, and she has high blood pressure – a very important traditional risk factor for cardiac disease. So I would talk with this patient very carefully about the different treatment options and think about first-line therapies with integrase strand transfer inhibitors and the risk of weight gain. I would talk about the possibility of using NNRTIs [non-nucleoside reverse transcriptase inhibitors] and things like rilpivirine or doravirine as potential options. And then I would talk about the different backbone preparations, like tenofovir alafenamide, and the risk of weight gain versus tenofovir disoproxil fumarate or TDF.

Dr. Segal-Maurer:
So I think you bring up excellent points, and I love this case, in that it really highlights somebody who has significant cardiovascular risk factors regardless of HIV. But in addition, the patient that we're presenting is HIV positive, and we know from the American Heart Association 2019 Scientific Statement that our HIV-infected people living with HIV have a much higher risk of all sorts of cardiovascular events, and these risks persist even after demographic clinical risk adjustment.

It bears to mention that with all of this, we didn't speak about her lipid profile, but the recent REPRIEVE study, that was an NIH study, showed that even in those with low or moderate risk, that we generally would not start or offer a statin therapy, actually were able to reduce their risk by over 35%. And part of the cohort were a very large percent of women, over 30%. So the traditional risk factors are important. I think taking into account REPRIEVE is very important, and I think that you bring up excellent points about, first, her risk of being a woman of color and some of the data around some of the outliers when it comes to weight gain with particular combinations. However, most people, as I think you mentioned or we will definitely get into with our next episodes, there's always that return to health

of 2-3 kilograms. So I think you were right; it is decision shared, that we discuss and we inform.

Well, this has been a great bite-sized discussion, but our time is up. Thanks, everyone, for listening.

Dr. Fichtenbaum:
Thank you.

Announcer:
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