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Patients at High Risk for Poor Cardiometabolic Outcomes: Is Switching Regimens an Option?

### 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.

Dr. Fichtenbaum, is switching regimens an option for patients with HIV who are at risk for poor cardiometabolic outcomes?

### Dr. Fichtenbaum:

Yeah, I think it is an option, but I think there's a little bit of a "but" involved in this as well. So the question is, if you're going to switch a regimen, how much benefit are you really going to gain from switching a regimen? And I think the answer has always been, with the numerous switch studies that have been done over many, many years, is you gain a little bit, but not a lot. And what I tend to look at this as is, long term, am I switching to a regimen that may be more cardiometabolic-friendly over many, many years and therefore probably we don't have good evidence that it's a bad thing to do? And therefore, I may consider this and talk to my patient about this idea of switching. So I think switch studies do demonstrate that you can improve lipid profiles, that you can improve cardiometabolic risk, and that you can avoid certain agents which may be contributing to a higher cardiometabolic risk.

One of the most controversial medications is abacavir, where there's a lot of retrospective data suggestive that there may be a higher risk, particularly from the D:A:D [Data Collection on Adverse events of Anti-HIV Drugs] cohort, where they looked at abacavir and found there was somewhere between a 20%-40% higher risk of a cardiac event with the use of abacavir. On the other hand, there are really no randomized, controlled prospective studies, and the question of a channeling bias has always come up. So these are some of the controversial things that we start to talk about when we think about switching and what's the best approach to use.

So I often have these shared decision-making discussions, talk about it, and in particular, nowadays I'm thinking about tenofovir alafenamide and integrase strand transfer inhibitors and weight gain, and I'm thinking, well, sometimes we could switch because we can at least maintain weight. We know that using, for example, tenofovir disoproxil fumarate, one can have a loss of somewhere between 1-2 kilos on average. And similarly, if you remove an integrase strand transfer inhibitor, there is no further weight gain, and the loss may be in the same neighborhood of a kilogram or 2. And that can make a difference in some people, so that's kind of my approach to thinking about switching and what we need to do, and I often consider many other factors.

### Dr. Segal-Maurer:

Yeah, I think you raise excellent points, and historically, I think, many of us agree that some switches make a lot of sense, such as the old thymidine analogues for lactic acidosis, hepatic steatosis, and certainly a lot of the mitochondrial toxicity. I think we all agree the older protease inhibitors [PIs] and some of the boosted PIs with dyslipidemia. I think you bring up an excellent point around abacavir. I think many of us agree at the very highest risk of cardiovascular risk, abacavir is probably not a good idea, and certainly the guidelines suggest that. But at other risks, I think the data, as you said, does have some questions. The data around TAF [tenofovir alafenamide], I think all of us are maybe split – I don't want to say down the line, but certainly some questions around some of those switches. Going

back to TDF may bring back some toxicity and certainly not reverse the weight [gain]. So it's always about managing expectations, but if patients are absolutely fixed that this is what's causing it, we really need to respond to that.

Well, this has been a brief but great discussion. Unfortunately, our time is up. Thank you so much, everyone, for listening.

**Announcer:**

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