Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/medical-industry-feature/managing-hiv-perspectives-from-an-expert-panel/15160/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Managing HIV: Perspectives from an Expert Panel

ReachMD Announcer Introduction:
This audio recording was approved under cp-379769v1. You're listening to ReachMD. This medical industry feature, titled "Managing HIV: Perspectives from an Expert Panel," is sponsored by Janssen and features multiple experts sharing best practices for the management of people living with HIV. Let's get started.

ReachMD Announcer:
First, we'll hear from Dr. Frank Palella, Professor of Medicine at Northwestern University Feinberg School of Medicine. He'll begin by discussing what information needs to be prioritized when educating people about their HIV diagnosis and factors that influence the treatment decision. Let's hear from Dr. Palella now.

Dr. Frank Palella:
I think we spend a bit of time myth busting because people's impression of what an HIV diagnosis does and doesn't imply are often fraught with inaccurate information. We need to reorient patients with the truth as it is in 2022 including the fact that HIV diagnosis is not a death sentence.

I've found that it's important to stress that a diagnosis of HIV doesn't mean that there are going to be immediate, profound changes in the way they feel. It doesn't mean that their ability to conduct their lives, have relationships, dream and look forward with … will stop. It doesn't mean that they must feel uncomfortable.

It will mean that they will be on long-term antiretroviral or ARV therapy that requires them to routinely take medication. It does imply that they will have to intermittently see their healthcare provider, and it does mean, as with any adult, that they should be conscious of measures that are going to maintain health.

This may mean healthy lifestyle choices like avoidance of tobacco use, avoidance of recreational drug use, maintenance of fitness and control of weight. When I'm discussing treatments with a patient, we work together to tailor their plan to their needs.

I have to determine what treatment might fit in the patient's lifestyle as well as clinically assess any potential comorbidities or preexisting health concerns. We also have to consider other nonclinical factors like their work schedule that could potentially impact adherence, and if I do suspect that my patient might have challenges with adherence, I would choose an ARV with a high genetic barrier to resistance and a long half-life. I want to safeguard my patient against development of resistance as much as possible.

It is critical that the healthcare provider also stress the importance of viral suppression, which can be achieved by the patient adhering to the prescribed regimen. Patients need to understand that this may help them achieve and maintain an undetectable viral load making them virtually incapable of transmitting HIV sexually.

ReachMD Announcer:
And now here's Dr. Palella talking about pre-treatment considerations and treatment goals.

Voiceover:
Can you expand upon short and long-term treatment goals for people living with HIV? Are there pretreatment considerations that you evaluate when choosing an ARV regimen?

Dr. Frank Palella:
As an infectious disease specialist who focuses on the care of people living with HIV, my primary goal is to get patients on therapy that will be effective, that will maintain or improve their immune system, that will be tolerable in both the long and the short term and be

something that they can adhere to.

Fortunately, we have many treatment options. Most of them are a single-tablet regimen. One pill, once a day. Luckily, I've found that patients quickly realize it's not terribly challenging to fit a single-tablet regimen into their lifestyle.

In the short term, upon initiation of therapy, it's important for healthcare providers to identify any treatment limiting adverse side effects within the first days of treatment and to identify any potential concerns that may lead to patient nonadherence.

Within the first few weeks of treatment, it's also important to assess a viral load and have the discussion around becoming undetectable. So, understanding the concept of being virally undetectable also has a profound impact on patients. Then, when they experience virologic suppression, it let's them know that their antiretroviral therapy is really working.

Because therapy must be continued indefinitely, the focus of patient management has evolved from identifying and managing early ARV-related toxicities to individualizing therapy to avoid long-term adverse events. These long-term adverse events may include diabetes, other metabolic complications, atherosclerotic cardiovascular disease, as well as kidney dysfunction, bone loss and weight gain.

To achieve and sustain viral suppression over a lifetime, both long-term and short-term ART toxicities must be anticipated and managed. As a clinician who's been fortunate to be involved in research studies and publications on ARV-related weight gain, I'm particularly attentive to this potential side effect.

In my clinical experience, however, not all patients are predisposed to ARV-related weight gain. If I'm treating a patient whom the DHHS guidelines have noted as being at higher risk of weight gain with certain ARVs, including women, black and Hispanic patients, I certainly make note of it when I'm choosing an initial therapy.

And while the implications of ARV-related weight gain are unknown, we do know how weight gain, specifically weight gain that results in increased trunk fat or what we call visceral adipose tissue, or VAT, can have a negative impact on individuals in the general population. One study suggests that increases in VAT are correlated with increased odds of hypertension, metabolic syndrome and type 2 diabetes among other things.

Please remember, we've already achieved what was, at one point, hard to imagine. We've extended the lifespan of persons living with HIV to nearly match persons who are living without HIV. The challenges now are more nuanced in that we want not only to extend lifespan but to extend health span, which means a state of optimal health over the long term.

ReachMD Announcer:
The next expert we'll hear from is Dr. Grace McComsey, Professor of Medicine and Pediatrics at Case Western Reserve University and Vice President of Research at the University Hospitals Health System, who will talk about what information should be prioritized when educating about their diagnosis and treatment. Here she is now.

Voiceover:
A new diagnosis of HIV can be overwhelming for a patient. Dr. McComsey, what information do you prioritize when educating the patient about their diagnosis and potential treatment decisions?

Dr. Grace McComsey:
I tailor the discussion depending on the attitude of the patient I'm speaking with. So, some patients understand the idea of living with HIV. However, there are others, mostly younger patients, who don't seem to grasp the severity of their diagnosis, and they don't take their HIV diagnosis seriously. With them I worry about adherence and the risk of transmission prior to that viral becoming undetectable.

Unfortunately, with those patients, I do scare them a bit during our initial conversation. I want to clarify that despite all the advances, successes and treatments, people are still dying from HIV/AIDS. I tell these patients the choice is yours. You can elect to be sick, to possibly die, or you can elect to live a long life if you are adherent to your medication.

In general, we strongly consider adherence when we have initial conversations with the patient, especially if we're identifying causes for concern. If I uncover any of these adherence concerns, I discuss the many treatment options available. Boosted PIs and integrase inhibitors are good choices in these patients, but I tend to avoid NNRTIs in patients who may be nonadherent.

We also need to remember that part of the adherence story involves the possibility of unwanted side effects. No HIV treatment is perfect. They all have side effects. However, newer antiretrovirals are generally much better tolerated than regimens used in the past. Living with unwanted side effects like diarrhea or nausea doesn't have to be the case. It is important that patients let us know how they're feeling and stay in close contact with us so that if needed, we can individualize their treatment plan to fit their needs.

For those patients who are taking their diagnosis and the prospect of their treatment seriously, I rapidly initiate therapy following DHHS guidelines. If patients delay treatment, especially those who have many sexual partners, they put others at risk for contracting HIV. And for this reason, helping patients become undetectable and reducing the potential for sexual transmission of HIV as soon as possible by utilizing rapid initiation strategy is an important goal of mine. And when starting any regimen, it's important to set patients up for success by giving them the simplest antiretroviral schedule possible.

ReachMD Announcer:
And here's Dr. McComsey discussing pre-treatment considerations and treatment goals.

Voiceover:
Can you expand upon short and long-term treatment goals for people living with HIV? Are there pretreatment considerations that you evaluate when choosing an ARV regimen?

Dr. Grace McComsey:
Assessing preexisting comorbidities is an important step in my pretreatment checklist. I consider my patient's baseline health and evaluate the highest risks for each patient in terms of safety of the drugs and go from there. For example, if I have a patient with pre-diabetes or they're already overweight when they start their medications, that, in my opinion, is really important information.

In the short term, getting patients to an undetectable viral load as soon as possible is still the number one goal. Patients still have a sigh of relief when they reach that milestone. They know there's a drastically reduced risk of transmitting the virus to other people, and they feel like they can breathe and live again.

Obviously, to get patients to that point, we as providers need to consider general short-term tolerability to avoid any possibility that they may abandon the drug. For instance, weight is a big deal nowadays, and I think it's going to become even a bigger issue going forward.

Recent data suggests black, Hispanic and female patients living with HIV are at highest risk for ARV-related weight gain. In my opinion, given what we know from the general population about weight gain and it's potential metabolic consequences such as increased risk for type 2 diabetes, ARV-related weight gain is an issue that healthcare providers should take seriously.

Because therapy must be continued indefinitely, the focus of patient management has evolved from identifying and managing early ARV-related toxicities to individualizing therapy to avoid long-term adverse events. These include diabetes and other metabolic complications, atherosclerotic cardiovascular diseases as well as kidney dysfunction, bone loss and weight gain. To achieve and sustain viral suppression over a lifetime, both long term and short-term ARV toxicities must be anticipated and managed.

ReachMD Announcer:
The last expert we'll hear from is Dr. Elizabeth Race, an Infectious Disease Specialist at Prism Health North Texas. She'll first share her perspective on what information needs to be prioritized when educating patients about their diagnosis and treatment. Here's Dr. Race now.

Voiceover:
Can you expand upon short and long-term treatment goals for people living with HIV? Are there pretreatment considerations that you evaluate when choosing an ARV regimen?

Dr. Elizabeth Race:
When patients return for their first post-ARV initiation visit, which some people like to have just two weeks into therapy, I focus on tolerability. Is there any evidence of an allergic or hypersensitivity reaction? Are they experiencing things like GI or neuropsychiatric side effects?

So, my short-term goal is looking at tolerability as an aspect of adherence, and if I have any concerns around adherence, it is important to consider therapies that have a high genetic barrier to resistance as well as a long half-life. In my opinion, these are both important treatment characteristics in these scenarios.

Another increasingly important consideration in my practice, and one that, in my opinion, is going to be a very important factor for all clinicians moving forward, is ARV-related weight gain.

Twenty years ago, the top long-term factor was the viral load or looking at the CD4 count. Now, most modern regimens are very effective. So, we're looking more closely at other complications, like ARV-related weight gain.

The DHHS guidelines note that ARV-related weight gain should be a pretreatment consideration. As providers, we're instructed from day one to do no harm, and as the long-term consequences of this weight gain are unknown, in certain situations, I'm going to avoid treatments that are associated with higher levels of weight gain.

So, in my patient populations at highest risk for ARV-associated weight gain, women and black and Hispanic people, if they have concerns over weight gain, I avoid the use of integrase-based regimens as guideline notes that these groups are disproportionately impacted by this weight gain.

We know that in the general population, weight gain associated with increases in trunk fat, also known as visceral adipose tissue, is associated with negative outcomes, including hypertension, metabolic syndrome and type 2 diabetes among other things.

I feel it's also important to keep a running log of weight from when my patient became virally suppressed. Often, I'll see that after they're virally suppressed, their weight starts creeping up. Over the course of three to four visits, they might put on 15 pounds. When a patient gains weight slowly like that, it can be easy to miss, but from my clinical perspective, it is absolutely something that needs to be addressed both in the short and long term and evaluated to determine if it's ARV related and whether other regimens are needed.

ReachMD Announcer:
And we'll close with Dr. Race discussing how to counsel people living with HIV who are on multi-tablet regimens to switch therapies in order reduce pill burden.

Voiceover:
With the evolution of HIV care and the emergence of single-tablet regimens, or STRs, how do you counsel patients who are on multi-tablet regimens to update their regimen to STRs and reduce pill burden?

Dr. Elizabeth Race:
In my practice, it's something I do with almost 100% of my patients. When a single-tablet formulation of a multi-tablet regimen becomes available, I tell the pharmacist they can process the prescription immediately. We don't need to have the patient come in. I'll just call them, and I'll let them know about this development.

If the patient is not comfortable with the new formulation, we can easily go back to what they were taking before. I generally reevaluate leaving a patient on a multi-tablet regimen when a single tablet regimen is available. I find it really helps with adherence, which is, of course, incredibly valuable.

I try to recognize when my patients are having tolerability issues with their antiretroviral, or ARV. With weight gain, I take notice when it doesn't plateau and also when it accumulates rapidly or around the waist. I tell providers and patients alike, there is a cost to doing nothing.

If a patient falls into one of these higher risk groups, female, African American, Hispanic, or if they are already experiencing ARV-related weight gain, then the cost of doing nothing is likely going to be additional weight gain. In addition to tracking weight, I also monitor the potential increase in blood pressure, cholesterol and hemoglobin A1C.

If a patient is upset about that weight gain, or if I consider it clinically relevant, then I take action. That means adjusting their ARV regimen to a class that has a lower incidence of weight gain.

It's important to acknowledge to the patient that we don't really have any ARVs that are not associated with weight gain while also noting every treatment is different. There are some that have a lower incidence of weight gain. Plus, one patient's response to an ARV may be different from that of another, so we tailor the regimens to each patient's unique needs. Ultimately, my job as a provider is to choose the ARV that is best for my patients.

ReachMD Announcer Close:
This medical industry feature was sponsored by Janssen. To revisit any part of this discussion, visit ReachMD dot com slash industry feature. This is ReachMD. Be Part of the Knowledge.