Bangkok Big Top

October 1, 2004 By David Gelman, MD

Elephants prancing on the logo of July's International AIDS conference in Thailand (see "Six Nights in Bangkok") trumpeted no big scientific breakthroughs. But for HIVers pondering pills and tweaking regimens, David Gelman, MD, tackles some treatment tidbits:

Superinfection

Getting a different strain of HIV on top of your first seems less common than we'd thought—if you've had HIV a while. Twenty-eight San Francisco HIVer couples didn't pass diverse viral strains to one another despite repeated condomless anal or vaginal sex. In 3,000-plus sexual escapades by 30 other HIVers, the only superinfection arose in a newly positive person. Looks like superinfection may strike only if you're re-exposed soon after the first infection.

Monotherapy

It's a HAART-era heresy: A small (30-HIVer) study showed folks just starting HIV meds may be able to get away with taking Kaletra (lopinavir plus ritonavir) alone. The trial was plagued by dropouts, due to problems mostly unrelated to HIV. But all who continued through 48 weeks got to viral loads under 400—without any resistance showing up.

STI

Strategic Treatment Interruption tips: A small study showed promise for five days on meds, two off—best with non-nuke combos. n Two trials said you can stop as long as you restart when CD4s drop below 350. n In another small trial, HIVers resistant to 3TC (Epivir) who took that drug alone during breaks did better than those off all meds.

26% of Fuzeon (T-20) takers still had their virus controlled after 96 weeks.

Plus: bone-cement injections fill sunken faces for only $500...haart suppressed viral load but didn't raise cd4 counts of hep C coinfectees...entry inhibitors keep showing promise...in once-daily dose, kaletra levels may be too low...antifungal fluconazole (like diflucan) may lift viramune (nevirapine) levels too high...

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