Gimme A Break!

Whether your doc likes it or not, Structured Treatment Interruptions are on the verge. Mike Barr pumps the experts -- and 8 HIVers on holidays -- for the safest way to get off.

August 1, 2001 By Mike Barr

When it comes to stopping *antiretroviral therapy*, three things are certain: Everybody's talking about it, many of us are doing it, and nobody knows what to make of it. The rest is a riddle for researchers, few of whom are in any hurry to solve it. *Is continuous treatment the gold standard?* Or will a less drug-intensive approach turn out to be the way to go? The answer, when it comes, will conclude *the irreversible revolution in HIV treatment* strategy heralded by STIs, or structured treatment interruptions.

Cathy Elliott-Olufs, a leading treatment advocate at Los Angeles' Women Alive, has reached the point where she is rethinking her entire medical decision-making. "I was one of those people who went on meds long before I really needed them," she says. She started HAART in fall1996, at the height of the HIV eradication hype, when her CD4-cell count was 460 and viral load at 25,000. "Not because I was one of those 'hit early, hit hard' babies, but because my physician didn't know any better -- and neither did I."

By winter 1999, after being undetectable for three years and researching the pros and cons, this "gambler at heart" consulted with her doctor and decided to drop her Viracept/ddI/d4T cocktail. "I hadn't had a decent bowel movement in two years and my calves were wasting away before my eyes," she recalls. "I wanted to feel 'normal' again --even it if didn't last very long." Once off therapy, Elliott-Olufs had to handle a host of unknowns. "When I first stopped, I felt anxiety, even guilt," she says. "What if I was doing the wrong thing? What if my viral load went up and never came back down?"

From researchers to activists, the official spin on STIs to date has been mainly doom and gloom: People losing CD4 cells for good, brewing resistance, falling ill. "All the data convince me that there is no advantage to interrupting treatment in chronic infection," British AIDS czar Brian Gazzard, MD, says. "Your CD4 cell count is likely to drop very quickly to the lowest level ever. So all the advantage you've painfully built up over time may be lost."

Curiously, some of the sternest warnings are issued by fellow HIVers. "Please don't be stupid just to be in vogue," says New York City PWA Bill Bahlman, a longtime ACT UPer. "*You* may be forgiving of missed doses, but the virus is not. Treatment interruptions can be deadly!"

But this familiar “wait for new drugs or better data” chorus rings increasingly hollow, particularly for drug-resistant HIVers near the end of their combos. “Research has offered few definitive answers for someone in my situation,” says *POZ* publisher Brad Peebles, now on his third STI (see Publisher’s Letter). “Four, five years ago, we were in the grips of ’You must be on meds and undetectable,’” he says.“It was insane. There are a lot of people on treatment who don’t ’need’ to be.”

Following the orders of the experts is largely what got us into this mess, so an anti-authority backlash should surprise no one. But there is more than defiance to the current treatment-interruption craze. Last spring, officials at the Health and Human Services Department announced a radical reform of its HIV treatment guidelines -- an overdue response to the outcry over long-term effects of combination therapy. The standard of care -- early, aggressive treatment (once the CD4 count falls below 500 or viral load above 15,000 copies) -- was modified in favor of “monitoring” (waiting) until the CD4s cell are below 350 or viral load above 55,000. But for the many HIVers caught between the past and present, the feds offer only: “Patients who began HAART at CD4-cell counts above 350 may wish to discontinue treatment.”

Though such tight-lipped advice has little practicality, the feds’ AIDS top-dog, Anthony Fauci, MD, is willing to go further. “We are very concerned about toxicities associated with the long-term use of these drugs,” the NIAID head says of drug-related metabolic changes that put patients at risk of heart disease, diabetes and bone loss. His NIAID team is currently investigating intermittent, or “pulsing,” treatment schedules that would enable HIVers to treat for two months and then take one month off.

When Greg Lugliani, a GMHC and ACT UP vet who is now VP at MediSolutions, an HIV health-care communications company, started his triple cocktail, his lowest CD4 count was just under 400, his highest viral load a mere 10,000. Two months ago, he stopped his once-daily Viramune/Ziagen/Videx EC. “The guideline changes tipped me in favor ofa break. Under the new version I wouldn’t have started therapy anyway,” says Lugliani, who doubles as *POZ*’s Nurse Know-It-All. “My combo was effective and easy, but I wanted to keep my options open. Why risk burning through these drugs now?”

And there’s the rub. How to decide if you don’t “need” to be on the meds? And then how to stop them? For example, 3TC and the non-nukes can linger in the body for days after the PIs and other nukes have been washed away. Is it safe to stop everything in one fell swoop?

These are not Sphinx-like enigmas, but practical answers remain remote. Research into STI risks and benefits -- particularly for people with longtime HIV infection but no clinical symptoms -- has been slow to get going. The lion’s share of the money has been funneled into studying so-called auto-vaccination in new sero converters and the “reversal” of resistance in those at the end of their hope. (Probably the most exciting field of HIV research this year, auto-vaccination, or “auto-immunization,” is the theory that people with HIV, after HAART has lowered the virus in their blood to undetectable and enabled their immune systems to recover, may be able to benefit from treatment interruptions that “reprime” their regenerated CD4s to control the virus on their own.)

And the handful of government-sponsored studies about STIs are not expected to produce any results for several years.

Most researchers and clinicians are understandably worried that unsupervised treatment interruptions will breed drug resistance and cause patients to “burn through drugs unnecessarily.” Michael Youle, MD, co-investigator of several STI studies at London’s Chelsea and Westminster Hospital pointedly reminds his patients, “If you keep going on and off treatment, the likelihood of getting resistance is high.”But in the largest study to date, the Swiss-Spanish SSITT-1 trial,co-investigator Bernard Hirschel, MD, reports very few resistance problems so far -- after some 500 STIs in over 100 patients.

On the flip side, resistance concerns are cited equally often -- by doctors and patients alike -- as a reason to go *off* the drugs. “Extraordinarily high rates of adherence to an antiretroviral drug regimen are necessary to maintain control over HIV replication,” says Johns Hopkins’ John Bartlett, MD, who, along with Fauci, presides over the national guidelines panel. “HIV is very unforgiving in this regard.”

POZ’s Brad Peebles concedes that his own “really sloppy” adherence was a key factor in his decision to stop treatment the second time. “I just reached a point where I couldn’t take the meds properly,” he says of his winter 1999 bout of “treatment fatigue.” As his viral load promptly shot up to over 750,000, he felt like he’d been “hit by a train.” Three months later he was back on the same regimen; soon he was undetectable with 636 CD4s -- higher than ever.

Then last winter, Peebles’ viral load began creeping up -- 5,000,then 10,000 -- in two months’ time. Rather than risk more protease mutations, he tried STI No. 3. “I felt like, sure, there might be another regimen out there to get me back to undetectable,” he says,“but if I run through that one, where will I be? Better wait ’til I really need it than run out of options.”

Such reasoning tends to turn physicians livid. “If you are doing well on treatment, have integrated the pill taking into your daily life and have no unpleasant side effects, why stop it?” Berlin AIDS doc Wolfgang Schmidt asks -- rhetorically. “That’s crazy!”

But other clinicians have their ear closer to the ground. “The price we’re paying for long-term viral suppression is high,” says Fred Siegal, MD, HIV head at St. Vincent’s Hospital, who for nearly four years has supervised STIs in patients with a “CD4 cushion” (see “Holiday Checklist” below). “The high cholesterol and triglycerides are taking their toll -- forgetting about the lipodystrophy, insulin resistance and other side effects. I think there’s a sort of imperative to take people who don’t need these drugs off them.”

In July 2000, the activist powerhouses of three cities on two coasts-- Treatment Action Group (TAG) in New York City, Project Inform in San Francisco and the LA-based Foundation for AIDS and Immune Research --set out to make sense of all these ragtag STI tales. Following atypically deluxe retreat to which they invited the leading thinkers and practitioners in this newly emerging subspecialty, the coalition expertly summarized the results in a handsome folio: "Use of the term *interruption* presupposes that continuous treatment is the natural order. Perhaps we now know

enough to overturn this mode."

Or perhaps we don't. "My patients do what I tell them to do," says another frustrated doctor, who requested anonymity in exchange for speaking so bluntly. "They trust me. I decide what they do with their treatment. Now, after drumming into them for four years how important it is to not miss a dose of therapy, I'm supposed to tell them, 'Well, it turns out you never really needed to be on treatment in the first place?'"

But professional pride and official inertia might just be excuses for sticking with the status quo. The bottom line, of course, is money. Does anyone expect our pill-pushing medical culture and its deep-pocket pharmaceuticals to advance an off-drug agenda? Imagine glossy bus-stop ads of rugged mountaineers trumpeting, "I stopped my drugs, and I'm just fine!"

In an address last fall (commemorating, of all things, the four-year anniversary of the Vancouver AIDS conference), British Columbia physician-researcher Julio Montaner, MD, was the first to publicly put a price tag on the when-to-start retrenchment. According to Montaner, strict adherence to the 1998 U.S. federal guidelines would mean that 95 percent of all 800,000 Americans with HIV would be on combination therapy. The new guidelines, however, take a 60 percent bite out of those numbers (320,000). At an annual drug cost of, say, $12,000 per person, strict adherence to the 2001 revisions would mean a dip in yearly HIV drug sales of $5 billion.

Some activists charge that if pharma-sponsored academic and government researchers have their way, any studies of stopping -- or cycling -- antiretroviral therapy will get little more than token interest. Whether because of corporate greed or a don't-rock-the-boat conservatism, the view of a number of marquee activists is that the right studies are intentionally not being done. "Many researchers want the treatment interruptions to fail just because they're against their ideology," says TAG's Mark Harrington. "They believe that people should be on therapy most or all of the time." Protocols that do get rubber-stamped may well be designed to show failure: viral-load restart thresholds set impossibly low; pre-interruption therapies and patient populations, poorly chosen. Sound paranoid? An example: Despite the fact that strategies that *suppress* the immune system have so far provided the best results, all but two of the STI trials in progress (see "On an Off Trial") or slated for enrollment in the U.S. use immune *stimulation* before dropping the drugs.

If HIVers are poor in studies and data, we have we have our share of anecdotes and common-sense. For those lucky folks with loads of CD4sand no symptoms when they first started HAART, the evidence increasingly suggests that stopping therapy after years of successful viral suppression need not be complicated. The new crop of CD4s are PacMan'd away and previously dormant killer CD8s spring into action once the virus is set free from the chemotherapeutic patrols. You may drop some of your CD4-cell gain and even feel flu-ish as your viral load shoots up, but eventually a new equilibrium is likely established between the immune system and the virus.

Consider Elliott-Olufs. She and her doc carefully monitored her counts on a monthly basis after stopping the drugs. "My viral load peaked at 25,000 and then settled at a comfortable 15,000-ish,"

she says. “Although my T cell count dropped dramatically during the first three months off treatment, it eventually leveled out -- never falling below 400.” As for Lugliani, his viral load, undetectable for several years on HAART, rose to 6,000 copies after his first STI month and had pulled back to 3,800 by the end of month three. So far, he’s lost 100CD4s in the process.

Jeff Harris, MD, of San Francisco’s Gladstone Institute, one of the few U.S. groups to study the feasibility of STIs in HAART-treated HIVers with successful viral suppression, says he is seeing a similar pattern in his two-year study. “Nearly all patients have a rebound of virus within the first few weeks, which then comes down about 10-fold by week six,” he says. The Gladstone group, including such leading AIDS docs as Mike McCune and Steve Deeks, is looking at cycling -- rotating six months on treatment and two months off -- over 24 months. If weekly tests show CD4s falling by more than half, volunteers go back on HAART. At NIAID, Fauci’s team has also observed that the virus comes back “with a vengeance” within four weeks in most patients.

David Barr (no relation to the author), former director of the Forum for Collaborative Research on HIV, a Clinton-era group that encourages cooperation in research among government, academia, community and industry, is yet another leading treatment activist who recently went off meds. After many years on HAART, Barr’s viral load broke through its longstanding undetectability; tests showed signs of resistance to nuke and non-nukes alike. “I didn’t know what else to do,” he says of his decision to ditch the drugs. “My T cells were high, so I wasn’t worried about disease progression.” Four weeks off his Viramune/d4T/Ziagen combo, Barr watched his virus skyrocket from the low 20,000s to just over 600,000 and his CD4s crash from 775 to 430.After a month, the numbers were still the same. He grew feverish, achy, fatigued. “I felt just like I did before starting HAART in 1996,” he says. “It was scary and depressing. The threat of AIDS came back with a vengeance -- and I wanted my pills!” A week later, Barr jumped back on the cocktail, this time a regimen of Kaletra/Epivir/ Videx EC/tenofovir.

But what if he had remained on his roller-coaster ride another month or two? Would his CD4-cell dive have recovered, his viral surge reined in by a regenerated immune response? Or would he have ended up with a viral load in the millions and few drugs to get it back? An interesting study cobbled together by the nonprofit CPCRA (Community Programs for Clinical Research on AIDS) may shed some light on Barr’s prickly predicament. Set to start in October, the 6,000-strong SMART (Strategies for Management of Antiretroviral Therapy) study will randomly assign volunteers either to stay the antiretroviral course or to try periodic interruptions of treatment. Those in the “drug conservation” group will remain off meds until their CD4s fall below 250. New mathematical models predict that it could take a full two years for CD4s to reach that point, though such an assertion flies in the face of available evidence.

At SMART’s close, a comparison will be made -- based on clinical factors such as quality of life and resistance, as well as on a cost-benefit analysis of health care expenditures -- between continuous and interrupted treatment strategies. These data may finally solve the riddle. Barr, meantime, is in no mood for experiments. “If some data come along that say I can pulse my therapy, great, but I won’t do it until then,” he says. “Many people on STIs seem to be succumbing to exhaustion. I hope they are monitoring themselves closely -- and not forgetting that however bad the drugs may

be, AIDS is worse."

With a drug pipeline expected to spout only second-generation me-too products for the foreseeable future, a game plan of minimally acceptable drug exposure seems smart -- experts' approval or not. The long list of complicated, life-threatening HAART-related side effects only supports such risk-taking. Harlem Hospital's Wafaa El-Sadr, MD,the SMART principal investigator, couldn't agree more. "Sure, there are risks associated with treatment interruptions," she says, "but there are also risks with antiretroviral therapy. We don't *know* which way is better -- that's why we're doing the study."

While entertaining the occasional doubt, Peebles, Lugliani and Elliott-Olufs share the conviction that the benefits of STIs overshadow the risks. As Elliott-Olufs says, "It's been wonderful. I never expected to go off meds this long. I am so grateful for this reprieve." Yet in the end, what we all long to be released from may be more than just treatment fatigue. Barr, who has clocked more than 15 years fighting HIV in the streets, the board rooms and his body, zeroes in on the heart of the matter. "I took a treatment interruption because I didn't know what else to do -- not because I wanted to," he says. "What I really want is an AIDS holiday, not a drug holiday."

ON AND OFF TRIAL

Itchin' to take a drug break? Wanna add to collective STI knowledge? Check out one of these clinical trials studying treatment interruptions and intermittent ("pulsed") therapy.

AACTG 5024
TRIAL: Compares STI w/ IL-2, w/ ALVAC vaccine or with both vs. w/o
CRITERIA: On stable antiretroviral therapy for six months; CD4s > 350; viral load < 50
STATUS: 64-week study; currently
enrolled 41 out of 100
CONTACT: Multiple sites, 800.TRIALS.A

AACTG 5068
TRIAL: Compares STI w/ vs. w/o use of ALVAC vaccine
CRITERIA: On first combination regimen; CD4s > 500 for at least 6 months;
viral load < 50
STATUS: 24-month study; currently enrolled 7 out of 100
CONTACT: Multiple sites, 800.TRIALS.A

AACTG 5086
TRIAL: Compares immediate vs. deferred (four-month STI) treatment
in salvage situation
CRITERIA: Drug-resistant HIV; CD4s > 150; "high" viral load
STATUS: 64-week study; currently enrolled 3 out of 220
CONTACT: Multiple sites, 800.TRIALS.A

AACTG 5102
TRIAL: Compares STI w/ vs. w/o use of IL-2
CRITERIA: No history of drug failure; no steroids; CD4s > 500; viral load < 200
STATUS: Still in development; 80 slots
CONTACT: Multiple sites, 800.TRIALS.A

Cornell/New York Hospital
TRIAL: Compares STI w/ vs. w/o use of IL-2, ALVAC or the two together
CRITERIA: On stable antiretroviral therapy for six months; no hepatitis B or C;
CD4s > 400; viral load < 50
STATUS: 25-week study; currently enrolled none out of 92
CONTACT: 212.241.6886

CPCRA 064
TRIAL: Compares immediate vs. deferred
(4-month STI) treatment in salvage situation
CRITERIA: Drug-resistant HIV; viral load > 10,000; also enrolls adolescents (> 13 yrs)
STATUS: 24-month study; currently enrolled 150 out of 480
CONTACT: Multiple sites, 800.TRIALS.A

CPCRA "SMART"
TRIAL: Compares continuous vs. on/off treatment strategies
CRITERIA: CD4s >350; also enrolls adolescents (> 13 yrs)
STATUS: Still in development; enrollment set for October 2001
CONTACT: Multiple sites, check www.smart-trial.org

Gladstone/UCSF
TRIAL: Compares continuous vs. intermittent treatment (six months on, two months off)
CRITERIA: On stable antiretroviral therapy; pre-treatment CD4 low > 100;
viral load < 50 for at least 3 months
STATUS: 24-month study; currently enrolled 10 out of 20
CONTACT: 415.695.3820

NIH I-0020
TRIAL: Compares continuous vs. intermittent treatment (two months on, one month off)
CRITERIA: CD4s > 300; viral load < 50
STATUS: 22-month study; currently enrolled none out of 70
CONTACT: 800.411.1222

Wistar/U Penn
TRIAL: Compares continuous vs. intermittent treatment, followed by unlimited STI
CRITERIA: CD4s > 400; viral load < 100 for 3 years
STATUS: 56-week study; currently enrolled 20 out of 52
CONTACT: 215.985.4448, ext. 226

CLUB MED

8 HIVERS on treatment-interruption trips share their stories, stats and strategies

Cathy Elliott-Olufs

Treatment status OFF

Number of STIs 1

Length of current/recent interruption 18 months

Reasons for interruption "I wanted to feel normal again. I might as well while I could afford to lose a few T cells."

Doc's reaction "He understood my rationale and supported me in my decision."

Combo prior to interruption Viracept/ddI/d4T

Stats prior to interruption CD4s: 760; Viral load: undetectable

Stats during interruption CD4s: 399; Viral load: 15,000

Returned to treatment? NO. Her vitals fall under federal guidelines for deferring HAART.

Recommend to a friend? "I do my best to provide information about the pros and cons. It's all one big giant experiment anyhow."

Barton Benes

Treatment status OFF

Number of STIs 2

Length of current/recent interruption 3 months

Reasons for interruption Side effects. "I had a terrible rash."

Doc's reaction "He said it was OK, but when my T cells reach 350, he will start me again on meds."

Combo prior to interruption Viramune/3TC

Stats prior to interruption CD4s: 500; Viral load: Undetectable

Stats during interruption CD4s: 400; Viral load: 50,000

Returned to treatment? "I'm planning to go on a different combo when I go back on."

Recommend to a friend? "Only if they have terrible side effects. I would recommend that they change combinations rather than stop. I'll never do another STI. I'm feeling terrible."

David Barr

Treatment status ON

Number of STIs 1

Length of current/recent interruption 6 weeks

Reasons for interruption Viral load. “I felt I was only increasing my drug resistance by staying on meds.”

Doc’s reaction No comment.

Combo prior to interruption Viramune/d4T/Ziagen

Stats prior to interruption CD4s: 775; Viral load: 24,000

Stats during interruption CD4s: 430; Viral load: 602,000; “This was scary.” Became “feverish, achy, fatigued.”

Returned to treatment? YES. Kaletra/3TC/Videx EC/tenofovir. “I now have a good deal of resistance. I need a really potent regimen.”

Recommend to a friend? “We should really wait for study results. AIDS is much worse than side effects.”

Kevin Irvine

Treatment status OFF

Number of STIs 1

Length of current/recent interruption 7 years

Reasons for interruption “The medications weren’t doing anything at all to the HIV in my system.”

Doc’s reaction “I have had 10 different docs during 12 years, and I’ve pretty much run the show.”

Combo prior to interruption AZT/ddC

Stats prior to interruption CD4s: 230

Stats during interruption CD4s: 200-600; Viral load:1,500-5,000; One bout of shingles and pneumonia. Otherwise a symptomatic. “My quality of life has been very high.”

Returned to treatment? NO

Recommend to a friend? “Without hesitation, yes!”

Monica johnson

Treatment Status ON

Number of STIs 1

Length of current/recent interruption 1 year

Reasons for interruption “I was sick of taking pills.”

Doc’s reaction “He and I work very well together. Basically he does what I want.”

Combo prior to interruption Combivir/Crixivan

Stats prior to interruption CD4s: 650; Viral load: undetectable

Stats during interruption CD4s: 650; Viral load: 80,000

Returned to treatment? YES

Recommend to a friend? “It’s a personal choice that should be thought out with your doctor.”

Scott Williams

Treatment Status OFF

Number of STIs 1

Length of current/recent interruption 2 years

Reasons for interruption Toxicity. Feels hydroxyurea and a steroid “put my liver over the edge.”

Doc’s reaction “My doc and I decided my body need a break to recuperate.”

Combo prior to interruption 2 nukes and a PI, plus hydroxyurea.

Stats prior to interruption CD4s: 400; Viral load: 3000

Stats during interruption CD4s: same; Viral load: 24,000

Returned to treatment? NO. “I’m determined to be cautious rather than emotionally react.”

Recommend to a friend? Friends have done STIs “and most have not experienced the good fortune I have.”

Greg Lugliani

Treatment Status OFF

Number of STIs 1

Length of current/recent interruption 2 months

Reasons for interruption New HAART guidelines. “Also, I wanted to preserve some treatment options for the future.”

Doc’s reaction “My doctor and I have grown more open with each other.”

Combo prior to interruption Viramune/Ziagen/Videx EC. “Effective and easy.”

Stats prior to interruption CD4s: 700; Viral load: undetectable

Stats during interruption CD4s: 600; Viral load: 3,800

Returned to treatment? NO. “I’m so delighted not be taking those darn drugs.”

Recommend to a friend? “People in my situation -- good responses to meds, ability to tolerate them -- should consider STI as an option.”

Brad Peebles

Treatment Status OFF

Number of STIs 3

Length of current/recent interruption 5 months

Reasons for interruption Toxicity, avoiding resistance, adherence problems, “wanting to see what my body would do.”

Doc’s reaction “He was opposed” the first time. “Now he is much more relaxed about the bre break.”

Combo prior to interruption Agenerase/d4T/3TC

Stats prior to interruption CD4s: 636; Viral load: 10,000

Stats during interruption CD4s: 249; Viral load: shot up to 274,000, then dropped to 144,000

Returned to treatment? “I’m waiting on a recent test result to decide whether to go back or not.”

Recommend to a friend? “I think there a hell of a lot of people on meds who don’t ’need’ to be.”

HOLIDAY CHECKLIST

Need-to-know before you go

- CD4 “cushion.” Expect to lose up to half of your CD4s—or watch them fall back to pre-HAART levels, often quickly. With a nadir of 200 or below, an STI could give you more than you bargain for.
- Support of your doctor. Develop a plan together and stick to it. You may feel anxious or even ill during the STI. The worse thing you can do is stop, change your mind, start again, stop again.

It’s best to have your health-care partner to ride through this with you.

- Frequent lab tests. Most experts recommend monthly viral load and CD4 cell tests until these counts stabilize. This generally takes three to four months, minimum. After that, quarterly monitoring is still a good idea—if not essential.
- Dramatic viral rebound. If you’ve been undetectable for a while, your HIV specific immune responses (mostly killer CD8s) will no longer be primed to fight back a new burst of virus. If the post-STI surge of HIV is large enough, you could experience a seroconversion illness. (Brad Peebles felt like a train had hit him. David Barr felt achy, feverish and tired.)
- 3TC and NNRTI complications. Although most STI studies stop all drugs simultaneously, some do not allow people on NNRTIs to enroll. The non-nukes (Sustiva, Viramune, Rescriptor)—as well as 3TC/Epivir—are cleared from the body much more slowly than the other HIV meds. (Estimates range from a couple of days to an entire week.) The risk of resistance is low but real.
- An escape route. Develop a detailed plan for going back on HAART. The SMART study will put people back on meds if their CD4s dip below 250. The Swiss-Spanish study uses a cut-off of 400. It’s like a game of chicken: How much can you take before you blink? It’s best to decide these thresholds beforehand—and factor in the one week to one month it takes for a confirmatory test. Will you go back on the same drugs, modify your regimen or go for something totally new? All but about 10 percent of previously “undetectables” seem to go back to undetectable when restarting the same regimen. If you’re testing for resistance, remember to draw the blood before you stop the drugs—otherwise the results are meaningless.
- For HIVers with chronic hep B or C: If you’re taking 3TC in your HIV cocktail, stopping it could cause a flare-up of your liver enzymes and your hepatitis viral load. Talk to your doctor!

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http://beta.docker.poz.com/article/Gimme-A-Break-1216-8096