Hitting the Switch

Suddenly you're facing a fork in the road?-your doc wants to change your combo. Should you follow your Doc's lead or hit the breaks? David Gelman, MD, drives some points home.

September 1, 2003 By David Gelman, MD

You and your HIV meds are on track, heading for a nice, long trip. You've racked up good miles on the combo by faithfully taking the pills on time nearly every time. The regimen, short on side effects and other drama, rocks. But after a trend of rising viral loads, your doc smells resistance, and he's urging you to hop off that lovely combo.

A change of direction ain't easy. If your combo gave you side-effect woes, you'd be relieved to ditch it. But being told to dump the meds you've grown accustomed to can pit your intuition against your doctor's advice. It also raises some creepy questions: Has your HIV progressed more than you thought? Has your virus mutated, developing the ability to resist not only your drugs but others in their class (cross-resistance)? Will your next combo treat you worse?

Just ask HIVer Ken Howard, an LA psychotherapist who treats other HIVers. "After my viral load crept up to about 20,000, my doctor wanted me to change regimens," he says. "That left me with anxiety about the new regimen. I know what it's like to have both few and many side effects—and I'd rather have few."

The first stop on the shifting-meds itinerary is a resistance test. If it comes back clean (no resistance), then *you* gotta come clean—about missing doses, which allows the virus to reproduce. (You can also investigate rarer causes, such as poor absorption.) But if the test indicates resistance to one or more drugs, you've arrived at another challenge: interpreting results.

Scarier still, many docs are stumped by resistance tests (see "Remedial Testing" below)—and by the job of adjusting your meds in response to the test results. There's no simple route to the perfect med regimen, but the following steps can help you make the *best* decision when pondering a change of HAART.

1. Roll up your sleeve

That first step, the resistance test, is either genotype or phenotype (see "Test Drive"). Skip the exam if your viral load is low (500 or less); the lab probably can't generate conclusive results. And you must be on meds for the test to help—only then can it show which ones are working. Since genotype results can take a frustrating two weeks and phenotypes up to four, channel the stress by gathering some essential data: As in all things HIV, the more you know, the better you'll

do—and the better your doc will do at mixing that next cocktail.

Drop by www.aidsmeds.com to get acquainted with every pill. If you're familiar with the current list, you'll later be able to recognize the ones your doc suggests and say, "What about med X instead?" You'll also know whether to ask about cross-resistance.

Compile your treatment history. Include every HIV med, when you started it, and when and why you stopped. If your memory creaks, ask your doc or local ASO for an illustrated HAART chart.

Snag your lab and chart info from former physicians, hospitals and clinics. You may want your current doc to request these, since some offices won't charge MDs for the copies.

2. Win the consultation prize

On test day, schedule a subsequent office visit to discuss the results, factoring in the time lag for labs to arrive. Request more than 15 minutes—you'll have lots to review. Once you and Doc are face to face, don't play it down if he gives you bad news—that you have multiple protease resistance, say. Now that results are in hand, Doc should be supportive, helping you start the process of making an informed decision.

Remember that mutations can make your virus resist some meds *partially*, others *totally*. Total or near-total resistance to one or more of your meds, especially in a first or second regimen, clearly supports a combo change. But resistance results are only part of the puzzle. "There needs to be a balance between what you can handle in your life and what your doctor sees on paper," Howard says. "It takes a lot of frank communication" (see "The Great Doctor-Patient Faceoff").

Insist that your doc take the holistic view. Have your CD4s been consistently low? Even if a new combo brings you back to undetectable, will its side effects outweigh that benefit? And how many options will remain if you need to switch again?

Ask your doc to explain precisely which meds your virus is resisting—and the risk of putting off a change. Understanding why you need to switch may make you more comfortable and adherent if you do. If you decide to wait, it might help to agree on how high you'll let your viral load go before you hit the switch.

Don't jump to conclusions: The idea that "undetectable = success" and "detectable = failure" isn't the whole story anymore, especially for treatment-experienced folks. At least one study has shown that HIVers with viral loads between 50 and 10,000 can still gain CD4 cells if the viral load remains stable over time. While these folks still risk developing more resistance, it seems to occur more slowly than for those on meds with viral loads topping 10,000. "I took the risk of being detectable for a while instead of switching meds right away," Howard says. "I'm a Libra, and it's all about balance."

“Ask [your] physician how confident he feels about his interpretation of resistance tests,” says Anthony Urbina, MD, of St. Vincent’s Hospital in New York City, who runs a resistance workshop for docs. “Poor decisions based on interpreting these tests can have dire consequences.”

Switching an HIVer’s meds—whether, when and how—is the toughest job most HIV docs face in daily practice. Even if you have confidence in your doc’s recommendation—and especially if you don’t—brace for the next step.

3. Take two

Strongly consider getting a second opinion. Maybe you fear your first doc will think you don’t trust her. Get over it: This is your body and your life. Politeness doesn’t count.

A patient’s right to a second opinion is a hallowed medical tradition, endorsed by most doctors, especially for complicated decisions with long-term implications. A second view is useful when the decision rests on interpretation rather than solely on hard clinical facts. Evaluating HIV resistance and picking a new combo is exactly when a second opinion makes sense. Even the most experienced docs look for help: “For complex reports in patients with multiple mutations, I find it helpful to curbside some of my colleagues and ask their opinions,” Urbina says. A conscientious doctor might even recommend another physician, and the office staff should help arrange the lab and paperwork.

Pick a second-opinion-giver with a large HIV practice—preferably one outside your own doctor’s medical group (so she won’t defer to your doc’s opinion).

Double-check your health plan: Most cover doctor appointments for second opinions, but some have procedures to follow.

Take all your lab work and relevant charts to the second doc. You can also bring, in a sealed envelope, your own doc’s recommendation for your next combo. The consulting physician can discuss his choice with you, then open the envelope to review your doc’s thoughts. But this isn’t *Match Game*, so expect some disagreement. Take notes on the consulting doc’s opinion back to your own physician and hash it out. There is no “right” answer, but the work you’ve done has upped the chance of getting the “best” answer.

4. Take a deep breath

Getting on top of your medical decision-making is hard work. Whether you end up switching to a new combo or sticking with the old one, you’re working with your doctor like an informed, involved patient, and in that important sense, you’re on the right track.

REMIDIAL TESTING

Understanding resistance tests—and adjusting treatment based on the results—is an art many

docs have yet to master

Reading resistance is rough: At a recent AIDS conference, Carlos Salama, MD, and colleagues at Elmhurst Hospital in New York City asked 100 HIV providers to match six groups of HIV drugs with their associated mutations (linking K103N with Sustiva and Viramune, say, or M184V with 3TC). Only 24 percent of providers—and 54 percent of those who described themselves as "expert"—got four or more right.

Practice makes perfect: "Recent data show improving knowledge among providers," Salama says. Further, he says, "knowledge was associated with increasing case load, up to 250 patients per provider." That means the more HIV patients you take on, the better you get at HIV care.

Need help? Get it: Salama says collaboration among docs is key. "Especially in large clinic settings," he explains, "every provider should have a resistance test expert to turn to for help with difficult-to-interpret results." If you're on your own, there's always the phone—or the Web....

For resistance and other med-switching issues, start with these sites:

- www.iasusa.org/resistance_mutations/
- hivdb.stanford.edu/
- resdb.lanl.gov/Resist_DB/default.htm
- hivinsite.ucsf.edu (search for "Resistance")
- www.thebodypro.com/tpan/mayjun_03/hiv_decisions.html

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