# The Skinny on Lipo

Treatment options for fat-gone-haywire

May 1, 1999 By Linda Grinberg

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For growing numbers of PWAs, enthusiasm for protease inhibitors is waning, due to increasingly intolerable side effects (see "Honeymoon to HAARTache"). Thrown on the horns of a terrible dilemma—grappling with whether to risk viral rebound by stopping treatment or switching to protease-sparing regimens that may not provide long-term viral suppression—disheartened PWAs are often guiltily missing doses and failure rates are climbing. Piled atop a litany of other side effects, lipodystrophy has become, for some, the last straw. "One of my greatest fears is that I'll have a general system failure due to the drugs," says Sean Casey Venable, a PWA in Lewes, Delaware. "I told my doc I wasn't sure how much longer I could live this way. I might discontinue all therapy and let the disease take its course. I'm going to think about it some more."

In the face of growing problems with side effects, adherence and viral resistance, some researchers are questioning the "hit early, hit hard" gospel. "We are doing a lot of opinion-based medicine and need more evidence-based medicine," says Australian researcher David Cooper, MD. He suggests we revisit bedrock assumptions, noting that the decline in U.S. death rates has paralleled that of Britain, where the standard of care is to delay treatment for asymptomatic patients with high CD4 counts and stable viral loads. He cautions that it is unclear whether the rates will remain similar over time. "There is no question that the risk/benefit favors PIs in symptomatic disease," Cooper says. "In asymptomatic infection the benefit is not known and protease-sparing regimens might be considered, but I'm reluctant to switch anybody at the present time." Martin Delaney of Project Inform concurs. "So far there is only inconsistent anecdotal evidence as to whether switching therapy helps combat lipodystrophy," he says. "Even less is known about the relative risks and benefits of taking extended drug holidays."

The good news is, there may be several potential treatments to alleviate lipodystrophy-related problems such as altered body shape, increased blood sugar and elevated lipids (cholesterol and triglycerides). Lipid-lowering drugs, such as Lipitor, may help, but they have yielded inconsistent results in studies of PWAs, and can cause neuropathy. Liposuction may offer temporary improvement for buffalo hump. But removal of visceral fat, deep in the abdominal cavity, is highly risky as it can cause hemorrhaging.

Data from small studies of human growth hormone (HGH) show partial improvements in buffalo humps and abdominal fat. Unfortunately, the $20,000 to $30,000 annual price tag may put the

drug out of reach for many. Because HGH has been approved only for HIV wasting, it may not be covered for lipodystrophy under some insurance plans. (However, some PWAs have successfully used their wasted limbs to justify coverage.) Serono, the manufacturer of Serostim, has an ambitious research agenda to assess the drug's usefulness for treating lipodystrophy.

The diabetic medication Metformin may also hold promise. A recent preliminary report, based on an eight-week study in 21 PI-experienced patients with central obesity, showed decreases in waist-to-hip ratios, triglycerides and insulin levels. Metformin may ultimately prove to be a relatively inexpensive treatment, though not without its potential side effects.

Preliminary research indicates that the benefit of exercise and diet is modest, at best. Neither appears to have a measurable impact on deep visceral fat or elevated lipids, though both may reduce superficial fat, unrelated to lipodystrophy. Diet, exercise and weight training help tone and build muscle tissue, which, in turn, may improve the appearance of truncal obesity and wasting in the limbs. For patients at risk for cardiovascular disease and diabetes, smoke cessation, aerobic exercise and lowered sugar and fat intake are recommended. However, before beginning any new regimen, it is advisable to consult with your health care provider. Some PWAs are experimenting with various combinations of vitamins, minerals and amino acids—but without controlled data, their utility remains unclear (see "Take That, Fat!," *POZ*, October 1998). Until there is a coordinated research agenda, those affected will continue casting about in the dark, sharing anecdotal experiences and guessing.

**FAT CHAT**

For those taking protease combos, two e-mail lists offer a forum to share experiences and hash out problems about everything from drug choices and dosages to side effects and their remedies:

**LIPIDLIST**, set up by ACT UP/ Golden Gate, welcomes discussion of PWAs' metabolic problems. To subscribe, send an e-mail to **listproc@critpath.org**. In the first line, type "subscribe lipidlist" and then your first and last name.

**PI-TREAT**, started by a PWA, is open to any issue concerning protease inhibitors. To learn more, visit **www.pozlink.com**. To subscribe, send an e-mail to **requests@pozlink.com** with the word *help* in the subject line or body of the message.

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