My Thoughts on the New Guidelines.

December 1, 2009 By Paul Dalton

Happy World AIDS Day just doesn't sound right does it?

Haven't blogged in a while. Why? No real reason- just a bit of ennui plus inertia. But today is **our** day, so here is what I am thinking today.

The new Guidelines were released this morning. I am a community member on the panel that writes the recommendations, and this update includes some important changes. Just so we are clear- I do not speak for the Guidelines panel- these are just my thoughts.

One major change is the 'when to start' language. Specifically starting treatment with a CD4 count between 350 and 500 in now recommended. There was significant difference of opinion on how to characterize the strength of evidence for this- most saying the evidence is strong, but a significant minority seeing the evidence as more moderate. Treatment with a CD4 count above 500 is talked about- basically stating that the panel was evenly split between those basically supporting treating virtually everyone with HIV and those who feel that the evidence is just not strong enough and that treatment could be initiated, but should not be recommended.

My thinking? I have come to believe that, in most cases treatment is better than no treatment. The panel bases it's guidelines on the available evidence- which is where these questions become sticky. There simply isn't a large, prospective, randomized, controlled clinical trail answering the 'when to start' question. Lacking this gold standard means we have to look at other forms of research- non-randomized trials, retrospective analyses, cohorts and so on- to build the recommendations.

To me the data, while not straight forward, are convincing. Most of the studies done in the past 5 years or so show strong benefit of treatment, in most cases. While there is no debate that HIV drugs can cause harm, it is increasingly clear that the untreated virus wreaks much havoc, beyond CD4 counts. Looking at heart disease, liver disease, kidney disease, cognitive function, aging- whatever measure you look at, people on meds seem to do better than those not on treatment.

The other major changes are in the 'what to start' section where Kaletra was 'demoted' to alternative (while still preferred for pregnant women), and Isentress was added to the 'preferred' list. This boils down to side effects- most widely used HIV drugs work well now in terms of reducing viral load- the real differences (for the most part) are around toxicity. Simply put, Kaletra's effect on lipids (fats) and some data suggesting it might increase the risk of heart attack, dragged it down to alternative.

Adding Isentress to the 'preferred' first line group made sense to me. The STARTMRK data show it works quite well as part of initial therapy. The real question for me is more philosophical- given

how well this drug works in later treatment and with no back up integrase drug in the foreseeable future, is it wise to use this drug as a first option. In my opinion- probably not. But that is just my opinion- the data support its use this way, and so I supported adding it to the list.

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