EACS
European
AIDS
Clinical
Society

GUIDELINES

Version 7.1
November 2014

English

Table of Contents

EACS Guidelines are available online at www.eacsociety.org and in the EACS Guidelines App

Imprint

Publisher	European AIDS Clinical Society (EACS)
Panel Chairs	Jens D. Lundgren (Guidelines Coordinator), Jose M Gatell, Hansjakob Furrer, Jürgen Rockstroh
Guidelines Assistant Coordinator	Lene Ryom
Graphic Design	Notice Kommunikation & Design, Zurich
Version, Date	7.1, November 2014
Copyright	EACS, 2014

These Guidelines were developed by the European AIDS Clinical Society (EACS), a not-for-profit organisation, whose mission is to promote excellence in standards of care, research and education in HIV infection and related co-infections, and to actively engage in the formulation of public health policy, with the aim of reducing HIV disease burden across Europe.

Panel Members

Medical Secretariat

The EACS Medical Secretariat is responsible for the coordination and update of the EACS guidelines based on the recommendations from the four EACS panels.

Guidelines Chair and Coordinator:	
Jens D Lundgren	**Copenhagen, Denmark**
Assistant Coordinator: Lene Ryom	**Copenhagen, Denmark**

HIV Treatment

Chair: Jose M Gatell	**Barcelona, Spain**
Vice-Chair: Anton Pozniak	**London, United Kingdom**
Young scientist: Christian Manzardo	**Barcelona, Spain**
Antonella d'Arminio Monforte	Milan, Italy
Jose Arribas	Madrid, Spain
Manuel Battegay	Basel, Switzerland
Nikos Dedes	Athens, Greece
Anna Maria Geretti	Liverpool, United Kingdom
Anders Horban	Warsaw, Poland
Christine Katlama	Paris, France
Jens D. Lundgren	Copenhagen, Denmark
Christina Mussini	Modena, Italy
François Raffi	Nantes, France
Peter Reiss	Amsterdam, The Netherlands
Hans Jürgen Stellbrink	Hamburg, Germany

Co-morbidities

Chair: Jens D Lundgren	**Copenhagen, Denmark**
Vice-Chair: Georg Behrens	**Hannover, Germany**
Young scientist: Lene Ryom	**Copenhagen, Denmark**
Manuel Battegay	Basel, Switzerland
Mark Bower	London, United Kingdom
Paola Cinque	Milan, Italy
Simon Collins	London, United Kingdom
Juliet Compston	Cambridge, United Kingdom
Gilbert Deray	Paris, France
Stéphane De Wit	Brussels, Belgium
Christoph A. Fux	Aarau, Switzerland
Giovanni Guaraldi	Modena, Italy
Patrick Mallon	Dublin, Ireland
Esteban Martinez	Barcelona, Spain
Catia Marzolini	Basel, Switzerland
Socrates Papapoulos	Leiden, The Netherlands
Renaud du Pasquier	Lausanne, Switzerland
Neil Poulter	London, United Kingdom
Peter Reiss	Amsterdam, The Netherlands
Alessandra Vigano	Milan, Italy
Ian Williams	London, United Kingdom
Alan Winston	London, United Kingdom

Co-infections

Chair: Jürgen Rockstroh	**Bonn, Germany**
Vice-Chair: Massimo Puoti	**Milan, Italy**
Young scientist: Christoph Boesecke	**Bonn, Germany**
Sanjay Bhagani	London, United Kingdom
Raffaele Bruno	Pavia, Italy
Diego García	Sevilla, Spain
Maxime Journiac	Paris, France
Karine Lacombe	Paris, France
Stefan Mauss	Dusseldorf, Germany
Lars Peters	Copenhagen, Denmark
Vicente Soriano	Madrid, Spain
Andri Rauch	Bern, Switzerland
Cristina Tural	Barcelona, Spain
Chris Ward	Cardiff, Wales

Opportunistic Infections

Chair: Hansjakob Furrer	**Bern, Switzerland**
Vice-Chair: Jose M Miro	**Barcelona, Spain**
Young scientist: Valentin Gisler	**Bern, Switzerland**
Luigia Elzi	Basel, Switzerland
Paola Cinque	Milan, Italy
Gerd Fätkenheuer	Cologne, Germany
Ole Kirk	Copenhagen, Denmark
Amanda Mocroft	London, United Kingdom
Philippe Morlat	Bordeaux, France
Anton Pozniak	London, United Kingdom
Alain Volny-Anne	Paris, France

Governing Board Members

Manuel Battegay (President)	Basel, Switzerland
Fiona Mulcahy (Vice-President)	Dublin, Ireland
Anna Maria Geretti (Secretary)	Liverpool, United Kingdom
Nathan Clumeck (Treasurer)	Brussels, Belgium
Peter Reiss (Immediate Past President)	Amsterdam, The Netherlands
Jose Arribas	Madrid, Spain
Antonella d'Arminio Monforte	Milan, Italy
Jose Gatell	Barcelona, Spain
Christine Katlama	Paris, France
Jens D. Lundgren	Copenhagen, Denmark
Anton Pozniak	London, United Kingdom
Jürgen Rockstroh	Bonn, Germany
Mike Youle	London, United Kingdom

Abbreviations

Antiretroviral drug (ARV) abbreviations

3TC	lamivudine
ABC	abacavir
ATV	atazanavir
COBI	cobicistat
d4T	stavudine
ddI	didanosine
DLV	delavirdine
DRV	darunavir
DTG	dolutegravir
EFV	efavirenz
EVG	elvitegravir
ENF	enfuvirtide
ETV	etravirine
FI	fusion inhibitor
FPV	fosamprenavir
FTC	emtricitabine
IDV	indinavir
INSTI	integrase strand transfer inhibitor
LPV	lopinavir
MVC	maraviroc
NRTI	nucleos(t)ide reverse transcriptase inhibitors
NNRTI	non-nucleoside reverse transcriptase inhibitors
NVP	nevirapine
PI	protease inhibitors
PI/r	protease inhibitors pharmacologically boosted with ritonavir
RAL	raltegravir
RPV	rilpivirine
RTV	ritonavir (used as booster=/r)
SQV	saquinavir
TDF	tenofovir
TPV	tipranavir
ZDV	zidovudine

Other Abbreviations

ACE	angiotensin converting enzyme
ALP	alkaline phosphatase
ALT	alanine aminotransferase
aMDRD	abbreviated modification of diet in renal disease formula
ART	antiretroviral therapy
AST	aspartate aminotransferase
BMD	bone mineral density
BMI	body mass index
BP	blood pressure
cART	combination antitroviral treatment
CKD	chronic kidney disease
CMV	cytomegalovirus
CNS	central nervous system
COPD	chronic obstructive pulmonary disease
CSF	cerebrospinal fluid
CVD	cardiovascular disease
CXR	chest X-ray
DAA	direct acting antiviral drug
DXA	dual energy X-ray absorptiometry
ECG	electrocardiogram
eGFR	estimated glomerular filtration rate
FBC	full blood count
FDC	fixed dose combination
FRAX	fracture risk assessment tool
GT	genotype
HAV	hepatitis A virus
HBV	hepatitis B virus
HCV	hepatitis C virus
HDL-c	HDL-cholesterol
HIVAN	HIV-associated nephropathy
HPV	human papillomavirus
HSR	hypersensivity reaction
IGRA	interferon-gamma release assay
IHD	ischaemic heart disease
IM	intramuscular
IV	intravenous
IVDU	intravenous drug use
LDL-c	LDL-cholesterol
LGV	lymphogranuloma venereum
Mg	magnesium
MSM	men who have sex with men
PO	per oral
PAP	papanicolaou test
PEG-IFN	pegylated-interferon
PPI	proton pump inhibitor
PPD	purified protein derivative
PSA	prostate specific antigen
PTH	parathyroid hormone
RBV	ribavirin
SC	subcutaneous
SVR	sustained virological response
STI	sexually transmitted infection
TC	total cholesterol
TDM	therapeutic drug monitoring
TG	triglycerides
UA/C	urine albumin/creatinine ratio
UP/C	urine protein/creatinine ratio
VL	viral load (HIV-RNA)
WB	western blot
Zn	zinc

Part I Assessment of HIV-positive Persons at Initial & Subsequent Visits

	Assessment	At HIV diagnosis	Prior to starting ART	Follow-up frequency	Comment	See page
HISTORY						
Medical	Complete medical history including	+	+	First visit	On transfer of care repeat assessment	
	• Family history (e.g. premature CVD, diabetes, hypertension, CKD)	+		First visit	Premature CVD: cardiovascular events in a first degree relative (male < 55, female < 65 years)	31-33
	• Concomitant medicines(i)	+	+	Every visit		
	• Past and current co-morbidities	+	+	Every visit		
	• Vaccination history	+		First visit	Measure antibody titres and offer vaccinations where indicated	
Psychosocial	Current lifestyle (alcohol use, smoking, diet, exercise, drug use)	+	+	6-12 months	Adverse lifestyle habits should be addressed more frequently	30
	Employment	+	+	As indicated Every visit	Provide advice and support if needed Provide counselling if needed	
	Social and welfare	+	+			
	Psychological morbidity	+	+			
	Partner and children	+			Test partner and children if at risk	
Sexual and reproductive health	Sexual history	+		6-12 months	Address issues concerning sexual dysfunction Risk of sexual transmission should be addressed where indicated	56-58
	Safe sex	+				
	Partner status and disclosure	+			Consider starting ART in serodifferent couples	
	Conception issues	+	+			
HIV DISEASE						
Virology	Confirmation of HIV Ab pos	+		3-6 months At virological	More frequent monitoring of HIV-VL at start of ART Perform genotypic resistance test before starting ART if not previously tested or if at risk of super-infection	7-11
	Plasma HIV-VL	+	+			
	Genotypic resistance test and sub-type	+	+/-			
	R5 tropism (if available)		+/-		Screen if considering R5 antagonism in regimen	
Immunology	CD4 absolute count and % (optional: CD8 and %)	+	+	3-6 months	Consider less frequent monitoring for stable persons on ART with high CD4 counts(ii)	7-11
	HLA B5701 (if available)	+	+/-		Screen before starting ABC containing ART, if not previously tested	
CO-INFECTIONS						
STIs	Syphilis serology	+		Annual/ as indicated	Consider more frequent screening if at risk	56
	STI screen	+		Annual/ as indicated	Screen if at risk	
Viral Hepatitis	HAV serology	+		Annual/ as indicated	Screen at risk; vaccinate if non-immune	55-56,64
	HCV screen	+			Annual screen if ongoing risk. **Measure HCV-RNA if HCV Ab pos or if acute infection suspected.**	
	HBV screen	+	+		Annual screen in susceptible persons; vaccinate if non-immune	
Tuberculosis	CXR	+		Re-screen if exposure	Consider routine CXR in persons, from high TB prevalence populations. See Diagnosis and Treatment of TB in HIV-positive persons	82
	PPD if CD4 count >400	+				
	IGRA in selected high-risk populations (if available)	+				
Others	Varicella zoster virus serology	+			Offer vaccination where indicated	55
	Measles/Rubella serology	+			Offer vaccination where indicated	
	Toxoplasmosis serology	+				
	CMV serology	+				
	Leishmania serology	+/-			Screen according to travel history/origin	
	Tropical screen (e.g. Schistosoma serology)	+/-			Screen according to travel history/origin	

	Assessment	At HIV diagnosis	Prior to starting ART	Follow-up frequency	Comment	See page
CO-MORBIDITIES						
Haematology	FBC	+	+	3-12 months		
	Haemoglobinopathies	+			Screen at risk persons	
	G6PD	+			Screen at risk persons	
Body composition	Body-mass index	+	+	Annual		30
Cardiovascular disease	Risk assessment (Framingham score[iii])	+	+		Should be performed in all men > 40 years and women > 50 years without CVD	31
	ECG	+	+/-	Annual	Consider baseline ECG prior to starting ARVs associated with potential conduction problems	
Hypertension	Blood pressure	+	+	Annual		32-33
Lipids	TC, HDL-c, LDL-c, TG[iv]	+	+	Annual	Repeat in fasting state if used for medical intervention (i.e. ≥ 8h without caloric intake)	37
Glucose	Serum glucose	+	+	6-12 months	Consider oral glucose tolerance test / HbA1c if fasting glucose levels of 5.7-6.9 mmol/L (100-125 mg/dL)	35-36
Pulmonary disease	CXR	+/-		As indicated	Consider CXR if prior history of pulmonary disease	
	Spirometry			As indicated	Screen for COPD in at risk persons[xii]	
Liver disease	Risk assessment[v]	+	+	Annual		45-47
	ALT/AST, ALP, Bilirubin	+	+	3-12 months	More frequent monitoring prior to starting and on treatment with hepatotoxic drugs	
Renal disease	Risk assessment[vi]	+	+	Annual	More frequent monitoring if CKD risk factors present and/or prior to starting and on treatment with nephrotoxic drugs[ix]	41-42
	eGFR (aMDRD)[vii]	+	+	3-12 months		
	Urine dipstick analysis[viii]	+	+	Annual	Every 6 months if eGFR < 60 mL/min, If proteinuria ≥ 1+ and/or eGFR< 60 mL/min perform UP/C or UA/C[vii]	
Bone disease	Bone profile: calcium, PO_4, ALP	+	+	6-12 months		38, 40
	Risk assessment[x] (FRAX®[xi] in persons > 40 years)	+	+	2 years	Consider DXA in specific persons	
Vitamin D	25(OH) vitamin D	+		As indicated	Screen at risk persons	39
Neurocognitive impairment	Screening questionnaire	+	+	2 years	Screen all persons without highly confounding conditions. If abnormal or symptomatic, see algorithm page 63 for further assessment.	63
Depression	Questionnaire	+	+	1-2 years	Screen at risk persons	59-61
Cancer	Mammography			1-3 years	Women 50-70 years	29, 47
	Cervical PAP			1-3 years	Sexually active women	
	Anoscopy and PAP (MSM)			1-3 years	Evidence of benefit not known	
	Ultrasound and alpha-foetoprotein			6 months	Controversial/Persons with cirrhosis and persons with HBV irrespective of fibrosis stage	
	Others				Controversial	

i Review all concomitant medicines which may potentially interact with ARVs or increase co-morbidities, see Drug-drug Interactions between DAAs and ARVs Drug-drug Interactions between Antidepressants and ARVs Drug-drug Interactions between Antihypertensives and ARVs Drug-drug Interactions between Analgesics and ARVs Drug-drug Interactions between Antimalarial Drugs and ARVs and www.hiv-druginteractions.org

ii If stable on ART with undetectable VL and CD4 cell count > 350/µL, consider less frequent CD4 cell count monitoring every 6-12 months.

iii A risk equation developed from HIV populations is available, see www.cphiv.dk/tools.aspx. Of note, if an individual receives medication to control dyslipidaemia and/or hypertension, the estimation should be interpreted with caution.

iv A calculator for LDL-cholesterol in cases where TG is not high can be found at www.cphiv.dk/tools.aspx.

v Risk factors for chronic liver disease include alcohol, viral hepatitis, obesity, diabetes, insulin resistance, hyperlipidaemia and hepatotoxic drugs.

vi Risk factors for CKD: hypertension, diabetes, CVD, family history, black African ethnicity, viral hepatitis, low current CD4 count, smoking, older age, concomitant nephrotoxic drugs.

vii eGFR: use the abbreviated modification of diet in renal disease (aMDRD) formula based on serum creatinine, gender, age and ethnicity; see www.cphiv.dk/tools.aspx. The Cockcroft-Gault (CG) equation may be used as an alternative.

viii Some experts recommend UA/C (urinary albumin creatinine ratio) or UP/C (urinary protein creatinine ratio) as a screening test for proteinuria in all persons. UA/C predominantly detects glomerular disease. Use in persons with diabetes. UP/C detects total protein secondary to glomerular and tubular disease.

ix Additional screening is required for persons receiving TDF and perhaps for certain PIs e.g. ATV and LPV/r, see ARV-associated Nephrotoxicity

x Classic risk factors: older age, female gender, hypogonadism, family history of hip fracture, low BMI (≤ 19 kg/m^2), vitamin D deficiency, smoking, physical inactivity, history of low impact fracture, alcohol excess (> 3 units/day), steroid exposure (minimum 5 mg for > 3 months).

xi WHO fracture risk assessment (FRAX®) tool: www.shef.ac.uk/FRAX

xii A diagnosis of COPD should be considered in persons over the age of 35 who have a risk factor (current or ex- smoker) and who present with exertional breathlessness, chronic cough, regular sputum production,

Part II ART of HIV-positive Persons

Assessing HIV-positive Person's Readiness to Start and Maintain ART

Goal: to help persons start and/or maintain ART	
Successful ART requires a person's readiness to start and adhere to the regimen over time. The trajectory from problem awareness to maintenance on ART can be divided into five stages. Knowing a person's stage, health care providers use appropriate techniques to assist them to start and maintain ART.	Identify the person's stage of readiness using WEMS[i] techniques, and start discussion with an open question/invitation: "I would like to talk about HIV medicines." <wait> "What do you think about it?" Based on the person's response, identify his/her stage of readiness and intervene accordingly.[ii]

Stages of readiness to start ART	
Precontemplation: *"I don't need it, I feel good."* *"I don't want to think about it."*	Support: Show respect for the person's attitude. / Try to understand the person's health and therapy beliefs. / Establish trust. / Provide concise, individualised information / Schedule next appointment.
Contemplation: *"I am weighing things up and feel torn about what to do about it."*	Support: Allow ambivalence. / Support the person in weighing pros and cons. / Assess the person's information needs and support his/her information seeking. / Schedule the next appointment.
Preparation: *"I want to start, I think the drugs will allow me to live a normal life."*	Support: Reinforce the person's decision. / Decide with the person which is the most convenient regimen. / Educate the person on adherence, resistance and side effects. / Discuss integration into daily life. / Respect the person's self-assessment. Ask: How confident are you that you can take your medicines as we discussed (specify) once you have started? Use VAS 0-10[iii] Consider skills training: • Medicines-taking training, possibly MEMS • Directly observed therapy with educational support • Use aids: mobile phone alarm, pillboxes • Involve supportive tools/persons where appropriate
Action: ***"I will start now."***	**'Final check': With a treatment plan established, is the person capable of taking ART?**
Maintenance: *"I will continue" or "I have difficulties continuing over the long run"* Caveat: A person can relapse to an earlier stage, even from "maintenance" to "precontemplation"	Assess: Adherence every 3-6 months[iv] Evaluate adherence: For persons with good adherence: show respect for their success. Assess: The person's own perception of ability to adhere to, and continue, treatment. Ask: In the next 3-6 months, how confident are you that you can take your medicines? Use VAS 0-10[iii] For a person without sufficient adherence: use mirroring techniques[v] on problems, ask open questions to identify dysfunctional beliefs. Assess: Stage of readiness and provide stage-based support Assess: Barriers and facilitators[vi] Schedule next appointment and repeat support

Screen for and talk about problems and facilitators	
Consider systematic assessment of: • Depression[vii], see page 59-60 • Cognitive problems[viii], see page 63 • Harmful alcohol or recreational drug use, see page 28, 30	Consider talking about: • Social support and disclosure • Health insurance and continuity of drug supply • Therapy-related factors
Recognise, discuss and reduce problems wherever possible in a multidisciplinary team approach.	

I will not manage — I will manage

0 — 10

i WEMS: Waiting (> 3 sec), Echoing, Mirroring, Summarising [1]

ii The person presenting in the clinic may be at different stages of readiness: precontemplation, contemplation or preparation. The first step is to assess this stage, and then to support/intervene accordingly. In the case of late presentation (< 350 CD4 cells/μL), the initiation of ART should not be delayed. The person should be closely followed and optimally supported. Schedule the next appointment within a short time, i.e. 1-2 weeks.

iii VAS (= Visual Analogue Scale; range from 0 to 10, i.e. 0= I will not manage, 10= I am sure I will manage).

iv Suggested adherence questions: "In the past 4 weeks how often have you missed a dose of your HIV medicines: every day, more than once a week, once a week, once every 2 weeks, once a month, never?" / "Have you missed more than one dose in a row?" [2].

v Mirroring: reflecting back on what a person has said or non-verbally demonstrated (e.g. anger or disappointment) WITHOUT introducing new material by asking questions or giving information.

vi Adherence to long-term therapies [3].

vii Ask: "During the past month have you often been bothered by feeling down, depressed or hopeless?" / "During the past month have you often been bothered by little interest or pleasure in doing things?" / "Is this something with which you would like help?" / If answers are positive, then sensitivity is 96%, specificity 89% [4].

viii Ask: "Do you feel having problems to concentrate in your daily life?" / "Do you feel slowed in your thinking?" / "Do you feel having problems with your memory?" / "Did relatives or friends express that they feel you have problems with your memory or difficulty concentrating?" [5].

ix We recommend the AUDIT-Fast tool to determine harmful alcohol use: "How often have you had 6 or more units (if female), or 8 or more (if male), on a single occasion in the last year?" If the answer is weekly or daily, i. e. screening positive, stop here. If the answer is less than that, ask three more questions. When screening for harmful substance use, drop the first quantitative question and replace "drinking" with "recreational substance" [6].

x Algorithm adapted from [7]

Recommendations for Initiation of ART in HIV-positive Persons without Prior ART Exposure[i]

Recommendations are graded while taking into account both the degree of progression of HIV disease and the presence of, or high risk for, developing various types of (co-morbid) conditions

Present condition/circumstance	Current CD4 count[ii,iii]	
	350-500	> 500
Asymptomatic HIV infection	C	C
To reduce transmission of HIV	C	C
Symptomatic HIV disease (CDC B or C conditions) incl. tuberculosis	R	R
Primary HIV infection	C	C
Pregnancy (before third trimester)	R	R
Conditions (likely or possibly) associated with HIV, other than CDC stage B or C disease:	R	R
• HIV-associated kidney disease	R	R
• HIV-associated neurocognitive impairment	R	R
• Hodgkin's lymphoma	R	R
• HPV-associated cancers	R	R
• Other non-AIDS-defining cancers requiring chemo- and/or radiotherapy	C	C
• Autoimmune disease – otherwise unexplained	C	C
• High risk for CVD (> 20% estimated 10-yr risk) or history of CVD	C	C
Chronic viral hepatitis:		
• HBV requiring anti-HBV treatment	R	R
• HBV not requiring anti-HBV treatment	R[iv]	C
• HCV for which anti-HCV treatment is being considered or given	R[v]	C
• HCV for which anti-HCV treatment not feasible	R	C

i,ii **ART is always recommended in any HIV-positive person with a current CD4 count below 350 cells/µL.**
For persons with CD4 counts above this level, the decision to start ART should be individualised and considered, especially if a person is requesting ART and ready to start, has any of the conditions mentioned above and/or for any other personal reasons. Priority should be given to treating persons with CD4 counts below 350 cells/µL and for persons with higher CD4 counts if they suffer from one of the above-mentioned conditions before placing resources into treatment as prevention.
Time should always be taken to prepare the person, in order to optimise compliance and adherence.
Genotypic resistance testing is recommended prior to initiation of ART, ideally at the time of HIV diagnosis; otherwise before initiation of ART. If ART needs to be initiated before genotypic testing results are available, it is recommended to include a ritonavir-boosted PI in the first-line regimen. Before starting treatment, the HIV-VL level and CD4 count should be repeated to obtain a baseline to assess subsequent response.

iii **R** use of ART is recommended
C use of ART should be considered and actively discussed with the HIV-positive person; under these circumstances, some experts would recommend starting ART whereas others would consider deferral of ART; this clinical equipoise reflects that whereas certain data, such as hypotheses on pathophysiology and chronic immune activation, supports starting ART, this needs to be balanced against the risk of known or undiscovered adverse drug reactions from use of ART, and hence the risk/benefit ratio for use of ART under these circumstances has not yet been well defined.

iv See figure page 65 for indication of HBV treatment in HBV/HIV co-infected persons

v Initiation of ART is recommended to optimise the outcome of HCV treatment.

Initial Combination Regimen for ART-naive Adult HIV-positive Persons

Recommended Regimens(*)

A drug from column A should be combined with the drugs listed in column B(**)

A	B	Remarks
NNRTI	**NRTI**	
EFV(i) RPV(ii)	ABC/3TC(vii) or TDF/FTC	ABC/3TC co-formulated TDF/FTC co-formulated EFV/TDF/FTC co-formulated RPV/TDF/FTC co-formulated
PI/r		
ATV/r(iv) DRV/r(iv)	ABC/3TC(vii) or TDF/FTC	ATV/r: 300/100 mg qd DRV/r: 800/100 mg qd
INSTI		
EVG + COBI	TDF/FTC	TDF/FTC/EVG/COBI co-formulated(ix)
DTG	ABC/3TC or TDF/FTC	DTG 50 mg qd TDF/FTC co-formulated ABC/3TC/DTG co-formulated
RAL	ABC/3TC or TDF/FTC	RAL: 400 mg bd

Alternative Regimen Components

NNRTI	Remarks
NVP(iii)	
PI/r	
LPV/r(v)	
NRTI	
TDF/3TC ZDV/3TC	ZDV/3TC co-formulated
CCR5 inhibitor	
MVC(vi)	Only if CCR5 tropic HIV(viii) Unlicensed in Europe for naive HIV-positive persons
Alternative combinations	
DRV/r + RAL	Only if CD4 counts > 200 cells/µL and HIV-VL < 100,000 copies/mL
LPV/r + 3TC	Only one randomised trial available

* Only drugs currently licensed for initiation of therapy by the EMA are taken into consideration (in alphabetical order)

** Generic HIV drugs are becoming more available and can be used as long as they replace the same drug and do not break recommended fixed dose combinations.

i EFV: not recommended to be initiated in pregnant women or women with no reliable and consistent contraception; continuation is possible if EFV is already started before pregnancy; not active against HIV-2 and HIV-1 group O strains.

ii RPV: only if CD4 count > 200 cells/µL and HIV-VL < 100,000 copies/mL; PPI contraindicated, H2 antagonists to be taken 12h before or 4h after RPV.

iii NVP: Use with extreme caution in women with CD4 counts > 250 cells/µL and men with CD4 counts > 400 cells/ µL and only if benefits outweigh the risk; not active against HIV-2 and HIV-1 group O strains.

iv Castle study (LPV/r vs. ATV/r) showed better tolerability of ATV/r; [7]. Coadministration with PPI is contraindicated for treatment-experienced persons. If coadministration is judged unavoidable, close clinical monitoring is recommended and doses of PPI comparable to omeprazole 20 mg should not be exceeded and must be taken approximately 12 hours prior to the ATV/r.
Artemis study (LPV/r vs. DRV/r) showed better efficacy and tolerability of DRV/r [8].

v ACTG 5142 study showed lower virological efficacy of LPV/r vs. EFV. No PI mutations emerged with LPV/r plus 2 NRTI failures. PI mutations were seen with LPV/r + EFV failures. LPV to be used in cases where oral absorption is the only alternative, especially in intensive care [9].

vi Not licensed in Europe for naive persons.

vii ABC contra-indicated if HLA B*5701 positive. Even if HLA B*5701 negative, counselling on HSR risk still mandatory. ABC should be used with caution in persons with a high CVD risk and/or persons with a VL > than 100,000 copies/mL.

viii Only if unavailability or intolerance to other recommended NRTIs.

ix Should not be initiated in persons with eGFR < 70 mL/min. It is recommended that EVG/COBI/TDF/FTC not be initiated in persons with eGFR < 90 mL/min unless this is the preferred treatment.

Acute HIV infection

Definition of Acute primary HIV infection

High-risk exposure within previous 2-8 weeks, and
- Detectable HIV-VL in plasma (p24 Ag and/or HIV-VL > 1000 copies/mL) and/or
- Negative or indeterminate serologic testing (negative or weakly positive ELISA, and WB ≤ 1 band) plus HIV-VL
- Recommendation: confirm HIV infection by HIV antibody test (WB) performed 2 weeks later

Treatment

- Treatment should be considered in all persons. See page 7
- If treatment is considered, the HIV-positive person should preferable be recruited into a clinical trial
- Some experts recommend treatment as a tool for prevention of HIV transmission

Resistance testing

- Recommended in all situations as soon as acute HIV infection is diagnosed, even if treatment not initiated
- In case it cannot be performed, store a plasma sample for testing

Transmission

- Recognise STIs, including syphilis, gonorrhoea, chlamydia (urethritis and LGV), HPV, HBV and HCV, see page 56
- Counsel newly diagnosed person on high risk of transmission and preventive measures (condoms), including notifying and testing partners

Switch Strategies for Virologically Suppressed Persons

Definition of virologically suppressed

Confirmed HIV-VL< 50 copies/mL

Indication

Switch for toxicity
- Documented toxicity
- Management of potential drug interactions
- Side effects
- Planned pregnancy

Switch for prevention of long-term toxicity
- Prevention of long-term toxicity (pre-emptive switch)
- Ageing and/or co-morbidity with a possible negative impact of drug(s) in current regimen, e.g. on CVD risk, metabolic parameters.

Switch for simplification
Wish to simplify regimen
Actual regimen no longer recommended

Principles

1. A PI/r may be switched for simplification, prevention or improvement of metabolic abnormalities or adherence facilitation to unboosted ATV, an NNRTI, RAL or EVG + COBI only if full activity of the 2 NRTIs remaining in the regimen can be guaranteed.
2. Simplification of a complex multidrug regimen in antiretroviral-experienced persons with 1) substitution of drugs difficult to administer (ENF) and/or with poor activity (NRTI in case of multiple NRTI resistance) and/or poor tolerability and 2) addition of new well-tolerable, simpler and active agent(s).
3. Bd to qd NRTI or PI/r switch for simplification, prevention of long-term toxicity.
4. Intra-class switch if drug-specific related adverse event.
5. Review the complete ARV history and available resistance test results.
6. Avoid switching to a drug with a low genetic barrier in the presence of a backbone compromised by the possibility of archived class resistance.

Strategies not recommended

a. Intermittent therapy, sequential or prolonged treatment interruptions
b. 2-drug combination, i.e. 1 NRTI + 1 NNRTI or 1 NRTI + 1 PI without RTV or 1 NRTI + RAL, or 2 NRTIs
c. Triple NRTI combinations

Other strategies

PI/r monotherapy with qd DRV/r or bd LPV/r might represent an option in persons with intolerance to NRTIs or for treatment simplification or in illicit drug users with documented frequent interruption of cART. Such a strategy only applies to persons without history of failure on prior PI-based therapy and who have had HIV-VL < 50 copies/mL in at least the past 6 months and who do not have chronic HBV. LPV/r + 3TC or ATV/r + 3TC may be better options.

Virological Failure

Definition	Confirmed HIV-VL > 50 copies/mL 6 months after starting therapy (initiation or modification) in persons that remain on ART. Depending on the VL assay, this limit could be higher or lower.
General measures	Review expected potency of the regimen
	Evaluate adherence, compliance, tolerability, drug-drug interactions, drug-food interactions, psychosocial issues
	Perform resistance testing on failing therapy (usually routinely available for HIV-VL levels > 350-500 copies/mL and in specialised laboratories for lower levels of viraemia) and obtain historical resistance testing for archived mutations
	Tropism testing
	Consider TDM
	Review antiretroviral history
	Identify treatment options, active and potentially active drugs/combinations
Management of virological failure (VF)	If HIV-VL > 50 and < 500-1000 copies/mL
	Check for adherence
	Check HIV-VL 1 to 2 months later
	If genotype not possible, consider changing regimen based on past treatment and resistance history
	If HIV-VL confirmed > 500/1000 copies/mL, change regimen as soon as possible. What to change will depend on the resistance testing results:
	No resistance mutations found: re-check for adherence, perform TDM
	Resistance mutations found: switch to a suppressive regimen based on drug history; multidisciplinary expert discussion advised
	Goal of new regimen: HIV-VL < 400 copies/mL after 3 months, HIV-VL < 50 copies/mL after 6 months

In case of demonstrated resistance mutations	General recommendations:
	Use at least 2 and preferably 3 active drugs in the new regimen (including active drugs from previously used classes)
	Any regimen should use at least 1 fully active PI/r (e.g. DRV/r) plus 1 drug from a class not used previously e.g. fusion, integrase or CCR5 antagonist (if tropism test shows R5 virus only), or 1 NNRTI (e.g. ETV), assessed by genotypic testing
	Defer change if < 2 active drugs available, based on resistance data, except in persons with low CD4 count (< 100 cells/μL) or with high risk of clinical deterioration for whom the goal is the preservation of immune function through partial reduction of HIV-VL (> 1*$\log_{10}$ reduction) by recycling
	If limited options, consider experimental and new drugs, favouring clinical trials (but avoid functional monotherapy)
	Treatment interruption is not recommended
	Consider continuation of 3TC or FTC in particular situations even if documented resistance mutation (M184V/I)
	If many options are available, criteria of preferred choice include: simplicity of the regimen, toxicity risks evaluation, drug-drug interactions, and future salvage therapy

Treatment of HIV-positive Pregnant Women

Pregnant women should be monitored every month and as close as possible to the predicted delivery date

Criteria for starting ART in pregnant women (see different scenarios)	Same as for non pregnant
Objective of treatment in pregnant women	Full plasma HIV-VL suppression at least by third trimester and specifically at time of delivery
Resistance testing	Same as for non pregnant women, i.e. before starting ART and in case of virological failure
SCENARIO	
1. Women planning to be pregnant while already on ART	1. If under EFV, switch to another NNRTI or boosted PI because of risk of neural tube defects
2. Women becoming pregnant while already on ART	2. Maintain ART unless under EFV: switch to another agent (NVP or PI/r) if before 8 weeks (because of risk of neural tube defects)
3. Women becoming pregnant while treatment naive irrespective of whether they fulfil the criteria (CD4) for initiation of ART	3. Starting ART at beginning of 2nd trimester is highly recommended
4. Women whose follow-up starts after week 28 of pregnancy	4. Start ART immediately and consider adding RAL to obtain rapid HIV-VL decline in case of high HIV-VL
5. Women whose HIV-VL is not undetectable at third trimester	5. Perform resistance testing and consider adding RAL to obtain rapid HIV-VL decline
Antiretroviral regimen in pregnancy	Same as non pregnant
	NVP not to be initiated but continuation is possible if started before pregnancy
	EFV should be avoided during first trimester because of increase in neural tube defects*
	Among PI/r, prefer LPV/r, SQV/r or ATV/r
	If RAL, DRV/r: could be continued
Drugs contra-indicated during pregnancy	ddI + d4T, triple NRTI combinations
iv ZDV during labour	Benefit uncertain if HIV-VL < 50 copies/mL
Single dose NVP during labour	Not recommended
Caesarean section	Benefit uncertain if HIV-VL < 50 copies/mL at week 34-36. In this case, consider vaginal delivery only

* According to prospective studies [10-11]

ART in TB/HIV Co-infection

Principles

Persons with TB should be started on standard TB therapy with 2 months Rifampicin/Isoniazid/Pyrazinamide +/- Ethambutol followed by 4 months Rifampicin/Isoniazid (choice of drugs and length of treatment depends on drug susceptibility and site of disease), see Diagnosis and Treatment of TB in HIV-positive persons

All persons with TB/HIV co-infection should start ART irrespective of CD4 count. Treatment supervision and adherence evaluation are very important

Suggested timing of ART initiation in TB/HIV co-infection according to CD4 Count

< 100 cells/μL(*) As soon as TB treatment is tolerated and wherever possible within 2 weeks

> 100 cells/μL(**) Can be deferred until between 8 and 12 weeks of TB treatment, especially when there are difficulties with drug-drug interactions, adherence and toxicities

Although a RCT showed that early ART (within 2 weeks) did not reduce mortality in TB meningitis, recommendations on ART initiations should be based on the CD4 cell count in HIV-positive persons with TB co-infection.

* Be aware of IRIS reaction in persons starting ART at low CD4 levels and with early initiation of ART. Corticosteroids should be considered for treatment of symptomatic IRIS, with dosages and duration tailored according to response.

** Although the data suggests a cut-off of 50 cells/μL, because of the daily variability in CD4, a cut-off of 100 cells/μL may be more appropriate.

Recommended 1st line ARV combination with anti-TB medicines

TDF/FTC/EFV, ABC/3TC/EFV or TDF/FTC/RAL

Alternatives

1. If HIV-VL < 100,000 copies/mL, fixed-dose combination of ABC/3TC/ZDV bd +/- TDF could also represent a short-term alternative until anti-TB treatment has been completed.
2. Rifampicin plus double dose LPV/r or with RTV super boosted (400 mg bd) + LPV

Where combinations are not recommended or to be used with caution or because of resistance/intolerance, specialist HIV treatment advice should be sought.

- PI/r + TDF/FTC, using rifabutin instead of Rifampicin
- Use with caution

Important Drug-Drug Interactions between ART and Rifampicin / Rifabutin

ARV drug class	Specific ARVs	Drug- drug interactions and recommended adjustment of dose of either or both drugs
NRTIs		Rifampicin: standard dose of all drugs
		Rifabutin: standard dose of all drugs
PI/r	ATV/r, DRV/r, LPV/r or SQV/r	Rifampicin: not recommended
	Monitor liver enzymes and, whenever possible, perform TDM for PI/r	Rifabutin: dose as 150 mg x 3/week(i). PI/r at standard dose
NNRTIs	EFV	Rifampicin: No dose change required. EFV: standard dose (some recommend 800 mg if not black African); ARV TDM recommended after 2 weeks
		Rifabutin: 450 mg daily. EFV: standard dose
	NVP	Neither Rifampicin nor Rifabutin recommended
	RPV	Rifampicin: not recommended
		Rifabutin: standard dose. RPV dose should be increased (use with caution)
	ETV	Rifampicin: not recommended
		Rifabutin: standard dose of both drugs (few data – use with caution)
INSTI	EVG	Rifampicin: not recommended
		Rifabutin: 150 mg x 3/week. EVG: standard dose
	RAL	Rifampicin: standard dose. RAL 800 mg bd and perform TDM for RAL (standard dose may also work)
		Rifabutin: standard dose of both drugs

i Initial pharmacokinetic studies in healthy volunteers showed that concentrations of Rifabutin and its active metabolite were significantly increased when combined with PI/r. Thus, a reduction of Rifabutin dosage to 150 mg x3/week was recommended to reduce the risk of Rifabutin related toxicity. However, more recent pharmacokinetic data derived from HIV/TB co-infected persons have shown that the coadministration of LPV/r or ATV/r with Rifabutin (150 mg x3/week) resulted in Rifabutin concentrations that were lower than those observed with rifabutin 300 mg x1/day without PI/r suggesting that Rifabutin dosage may be inadequate. Cases of relapses with acquired Rifamycin-resistant TB have been described in co-infected persons treated with rifabutin 150 mg x3/week and LPV/r or ATV/r. The US guidelines for HIV treatment recommend the administration of Rifabutin at 150 mg x1/day with PI/r. Due to the limited safety data with this dose and combination, persons receiving Rifabutin 150 mg x1/day with PI/r should be closely monitored for Rifabutin related toxicities (i.e. uveitis or neutropenia).

Post-exposure Prophylaxis

Post-exposure Prophylaxis (PEP) recommended in case of

Risk	Nature of exposure	Status of source person
Blood	Subcutaneous or intramuscular penetration with iv or im needle, or intravascular device	HIV-positive or serostatus unknown, but presence of HIV risk factors
	Percutaneous injury with sharp instrument (lancet), im or sc needle, suture needle Contact > 15 min of mucous membrane or non intact skin	HIV-positive
Genital secretions	Anal or vaginal sex	HIV-positive or serostatus unknown but presence of HIV risk factors
	Receptive oral sex with ejaculation	HIV-positive
Intravenous drug use	Exchange of syringe, needle, preparation material or any other material	HIV-positive

- Rapid testing of the source person for HCV and HIV (if HIV-status unknown) recommended
- If source person HIV-positive on ART, order resistance testing if HIV-VL detectable
- Individualise PEP according to the source's treatment history and previous resistance tests
- PEP to be started ideally < 4 hours after the exposure, and no later than 48 hours
- Duration of PEP: 4 weeks
- Standard PEP regimen: TDF/FTC (alternative: ZDV/3TC); LPV/r tablets 400/100 mg bd
- Full sexual health screen in case of sexual exposure
- Follow-up:
  - HIV serology + HBV and HCV, pregnancy test (women) within 48 hours of exposure
  - Re-evaluation of PEP indication by HIV expert within 48-72 hours
  - Assess tolerability of PEP regimen
  - Transaminases, HCV-PCR and HCV serology at month 1 if source person HCV-positive (observed or suspected)
  - Repeat HIV serology after 2 and 4 months, syphilis serology after 1 month if sexual exposure

Adverse Effects of ARVs & Drug Classes

Bold: Frequent effects
Red: Severe effects
Black: Neither Frequent nor Severe[i]

	Skin	Digestive	Liver	CV	Musculo-skeletal	Genito-urinary	Nervous	Body fat	Metabolic	Other
NRTI										
ABC	Rash*	Nausea* Diarrhoea*		IHD						*Systemic hyper-sensitivity syndrome (HLA B*5701 dependent)
ZDV	Nail pigmen-tation	Nausea	Steatosis		Myopathy, Rhabdo-myolysis			**Lipoatrophy**	Dyslipi-daemia, Hyperlacta-taemia	Anaemia
d4T		Pancreatitis	**Steatosis**				**Peripheral neuropathy**		**Dyslipi-daemia,** Hyperlacta-taemia	
ddI			Steatosis, Liver fibrosis	IHD					Hyperlacta-taemia	
3TC										
FTC										
TDF					↓ BMD, Osteomalacia ↑ Fractures risk	↓ eGFR, Fanconi syndrome				
NNRTI										
EFV	Rash		Hepatitis				**Dizziness, Sleep disturbanc-es,** Depression		**Dyslipi-daemia,** Gynaeco-mastia	**↓ plasma 25(OH) vitamin D,** Teratogen-esis
ETV	Rash									
NVP	Rash*		Hepatitis*							*Systemic hypersen-sitivity (CD4- and gender-dependent)
RPV	Rash		Hepatitis			↓ eGFR	Depression, Sleep disturbances, headache			
PI										
ATV		**Nausea and Diarrhoea**[ii]	Jaundice Cholelithiasis			↓ eGFR, Ne-phrolithiasis			Dyslipi-daemia	
DRV	Rash					Nephrolithi-asis			Dyslipi-daemia	
FPV	Rash			IHD					**Dyslipi-daemia**	
IDV	**Dry skin,** Nail dystrophy		Jaundice	IHD		**Nephrolithi-asis**		**↑ Abdominal fat**	**Dyslipi-daemia,** Diabetes mellitus	
LPV				IHD		↓ eGFR			**Dyslipi-daemia**	
SQV									Dyslipi-daemia	
TPV			Hepatitis				Intracranial haemorrhage		Dyslipi-daemia	

FI										
ENF	Injection nodules									Hypersensitivity
ITI										
RAL		Nausea			Myopathy, Rhabdomyolysis		Mood changes			
DTG	Rash		Nausea			↓ **eGFR**(iii)	Headache			Systemic hypersensitivity syndrome (<1%)
EVG/ COBI		**Nausea, Diarrhoea**	**Hyperbilirubinemia**			↓ **eGFR**(iii)	Headache			
CCR5 inhibitors										
MVC			Hepatitis	IHD						↑ Infections risk

i **"Frequent effects" (events expected in a least 10% of treated HIV-positive persons), in bold**
"Severe effects" (events that can put a person´s life at risk and represent a medical emergency), in red
Neither frequent nor severe effects, in black
ii Frequency and severity differs between individual ARVs.
iii Due to inhibition of renal tubular creatinine secretion without affecting glomerular filtration itself
* Refers to effects seen in relation to hypersensitivity reactions.

Note: the adverse effects included in the table above are not exhaustive, but represent the most important effects with a likely causal relation. Nausea, diarrhoea and rash are frequently observed in persons on ART, and these symptoms are indicated in the table for drugs where clinical experience suggests a possible causal link.

Drug-drug Interactions between ARVs and Non-ARVs[i]

	non-ARV drugs	ATV/r	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	DTG	EVG/c	RAL	ABC	FTC	3TC	TDF	ZDV
cardiovascular drugs	atorvastatin	↑	↑	↑490%	↓43%	↓37%	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	fluvastatin	↔	↔	↔	↑	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	pravastatin	↔	↑81%	↔	↓44%	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	rosuvastatin	↑213%	↑48%	↑107%	↔	↑	↔	↔	↔	↔	↑38%	↔	↔	↔	↔	↔	↔
	simvastatin	↑	↑	↑	↓68%	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	amlodipine	↑[iii]	↑	↑[iii]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	diltiazem	↑[iii]	↑	↑[iii]	↓69%	↓E	↓	E	E	↔	↑	↔	↔	↔	↔	↔	↔
	metoprolol	↑[iii]	↑	↑[iii]	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	verapamil	↑[iii]	↑	↑[iii]	↓	↓E	↓	E	E	↔	↑	↔	↔	↔	↔	↔	↔
	warfarin	↑ or ↓	↓	↓	↑ or ↓	↑	↑ or ↓	↔	↔	↔	↑ or ↓	↔	↔	↔	↔	↔	↔
CNS drugs	diazepam	↑	↑	↑	↓	↑	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	midazolam (oral)	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	triazolam	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	citalopram	↑[iii]	↑	↑[iii]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	mirtazapine	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	paroxetine	↑↓?	↓39%	↑↓?	↔	↔	↔	↔	↔	↔	↑↓?	↔	↔	↔	↔	↔	↔
	sertraline	↓	↓49%	↓	↓39%	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	bupropion	↓	↓	↓57%	↓55%	↔	↓	↔	↔	↔	↑?	↔	↔	↔	↔	↔	↔
	pimozide	↑[iii]	↑	↑[iii]	↑	↓	↓	↔[iv]	↔	↔	↑	↔	↔	↔	↔	↔	↔
	carbamazepine	↑D	↑	↑D	↓27%D36%	D	↓D	D	D	D	D	D	↑	↔	↔	↔	↑[ix]
	lamotrigine	↓39%[ii]	↓[ii]	↓50%	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	phenytoin	↓D	↓D	↓D	↓D	D	↓D	D	D	D	D	D	D	↔	↔	↔	↓
anti-infectives	clarithromycin	↑[iii]	↑	↑[iii]	↓	↓E	↓	E	E	↔	↑E	↔	↔	↔	↔	↔	D
	fluconazole	↔	↔	↔	↔	E86%	E100%	E	↔	↔	↑?	↔	↔	↔	↔	↔	E74%
	itraconazole	↑E	↑E	↑E	↓	↓E	↓61%	E	E	↔	↑E	↔	↔	↔	↔	↔	↔
	rifabutin	↑	↑E50%	↑	↓38%	D37%	↑17%	D	*	↔	↑D	↔	↔	↔	↔	↔	↔
	rifampicin	D72%	D	D	D26%	D	D58%	D80%	D	D54%[x]	D	D40%	D	↔	↔	↔	D47%
	voriconazole	↓	↓	↓	↓E	↑E	↓E	E	E	↔	↑E	↔	↔	↔	↔	↔	↔
miscellaneous	antacids	D	↔	↔	↔	↔	↔	D	↔	D	D	D	↔	↔	↔	↔	↔
	PPIs	D	↔	↔	↔	↔	↔	D	↔	↔	↔	E	↔	↔	↔	↔	↔
	H2 blockers	D	↔	↔	↔	↔	↔	D	↔	↔	↔	E	↔	↔	↔	↔	↔
	alfuzosin	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	beclometasone inhal.	↑?[v]	↓11%	↑?[v]	↔	↔	↔	↔	↔	↔	↑?[v]	↔	↔	↔	↔	↔	↔
	buprenorphine	↑67%	↑[vi]	↔	↓50%	↓25%	↔	↔	↔	↔	↑35%	↔	↔	↔	↔	↔	↔
	budesonide inhal.	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	ergot derivatives	↑	↑	↑	↑	↑	↓	E	↔	↔	↑	↔	↔	↔	↔	↔	↔
	ethinylestradiol	↓[vii]	↓	↓	↔[viii]	↔	↓	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
	fluticasone inhal.	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	methadone	↓[ii, iii]	↓16%	↓53%[iii]	↓52%	↑6%	↓≈50%	↓16%	↔	↔	↔	↔	↓	↔	↔	↔	E29-43%
	salmeterol inhal.	↑[iii]	↑	↑[iii]	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	sildenafil (erec. dys.)	↑	↑	↑	↓	↓37%	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	St John's wort	D	D	D	D	D	D	D	D	D	D	↔	↔	↔	↔	↔	↔
	varenicline	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔

Comments:

i This table summarises the drug-drug interactions between HIV therapy and some commonly prescribed co-medicines as well as the drug-drug interactions of particular clinical relevance. This table is not exhaustive, for additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, see www.hiv-druginteractions.org (University of Liverpool).

Colour legend

- no clinically significant interaction expected.
- these drugs should not be coadministered.
- potential interaction which may require a dosage adjustment or close monitoring.
- potential interaction predicted to be of weak intensity (< 2 fold ↑AUC or < 50% ↓AUC). A dosage adjustment is *a priori* not recommended unless the drug has a narrow therapeutic index.

Note: the symbol (green, amber, red) used to rank the clinical significance of the drug interaction is based on www.hiv-druginteractions.org.

Legend:

↑ potential elevated exposure of non-ARV drug
↓ potential decreased exposure of non-ARV drug
↔ no significant effect
E potential elevated exposure of ARV
D potential decreased exposure of ARV
Numbers refer to decreased/increased AUC of non-ARV/ARV drugs as observed in drug interactions studies

ii no PK changes with unboosted PI
iii ECG monitoring is recommended
iv rilpivirine's manufacturer recommends caution when coadministering with another drug susceptible to prolong QT interval
v increase in concentration of active metabolite observed with RTV 100 mg bd alone but without significant effect on adrenal function
vi concentration of parent drug unchanged but concentration of metabolite increased
vii increase in ethinylestradiol with unboosted ATV
viii no effect on ethinylestradiol but ↓ progestin
ix potential haematological toxicity
* no dose adjustment for MVC in absence of PI. With PI (except TPV/r; FPV/r), give MVC 150 mg bd

Drug-drug Interactions between Antidepressants and ARVs

antidepressants		ATV/r	DRV/r	LPV/r	SQV/r	EFV	ETV	NVP	RPV	MVC	DTG	EVG/c	RAL
SSRI	citalopram	↑ [a]	↑	↑ [a]	↑ [a]	↓	↓	↓	↔	↔	↔	↑	↔
	escitalopram	↑ [a]	↑	↑ [a]	↑ [a]	↓	↓	↓	↔	↔	↔	↑	↔
	fluvoxamine	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔
	fluoxetine	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔
	paroxetine	↑↓?	↓39%	↑↓?	↑↓?	↔	↔	↔	↔	↔	↔	↑↓?	↔
	sertraline	↓	↓49%	↓	↓	↓39%	↓	↓	↔	↔	↔	↑	↔
SNRI	duloxetine	↑↓	↑↓	↑↓	↑↓	↔	↔	↔	↔	↔	↔	↑	↔
	venlafaxine	↑	↑	↑	↑	↓	↓	↓	↔	D	↔	↑	↔
TCA	amitriptyline	↑	↑	↑	↑ [b]	↔	↔	↔	↔	↔	↔	↑	↔
	clomipramine	↑	↑	↑	↑ [b]	↓	↓	↓	↔	↔	↔	↑	↔
	desipramine	↑	↑	↑5%	↑	↔	↔	↔	↔	↔	↔	↑	↔
	doxepin	↑	↑	↑	↑ [b]	↔	↔	↔	↔	↔	↔	↑	↔
	imipramine	↑ [a]	↑	↑ [a]	↑ [a]	↓	↓	↓	↔	↔	↔	↑	↔
	nortriptyline	↑ [a]	↑	↑ [a]	↑ [ab]	↔	↔	↔	↔	↔	↔	↑	↔
	trimipramine	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔
TeCA	maprotiline	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔
	mianserine	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔
	mirtazapine	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔
Others	bupropion	↓	↓	↓57%	↓	↓55%	↔	↓	↔	↔	↔	↑?	↔
	lamotrigine	↓32%	↓	↓50%	↓	↔	↔	↔	↔	↔	↔	↔	↔
	nefazodone	↑	↑	↑	↑	↓	↓ E	↓	E	E	↔	↑	↔
	St John's wort	D	D	D	D	D	D	D	D	D	D [c]	D	↔
	trazodone	↑	↑	↑	↑ [b]	↓	↓	↓	↔	↔	↔	↑	↔

Legend

↑	potential elevated exposure of the antidepressant
↓	potential decreased exposure of the antidepressant
↔	no significant effect
D	potential decreased exposure of ARV drug
E	potential elevated exposure of ARV drug
a	ECG monitoring is recommended
b	coadministration contraindicated in the European SPC. However, US prescribing information recommends TDM for antidepressants. The charts reflect the more cautious option. Numbers refer to decreased AUC of the antidepressant as observed in drug-drug interactions studies.
SSRI	selective serotonin reuptake inhibitors
SNRI	serotonin and norepinephrine reuptake inhibitors
TCA	tricyclic antidepressants
TeCA	tetracyclic antidepressants

Colour legend

- no clinically significant interaction expected.
- these drugs should not be coadministered.
- potential interaction, which may require a dosage adjustment or close monitoring.
- potential interaction predicted to be of weak intensity (< 2 fold ↑AUC or < 50% ↓AUC). A dosage adjustment is *a priori* not recommended.

Comment

The symbol (red, amber, green) used to rank the clinical significance of the drug interaction is based on www.hiv-druginteractions.org (University of Liverpool). For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, refer to the above-mentioned website.

Drug-drug Interactions between Antihypertensives and ARVs

antihypertensives		ATV/r	DRV/r	FPV/r	IDV/r	LPV/r	SQV/r	EFV	ETV	NVP	RPV	MVC	DTG	EVG/c	RAL	ABC	FTC	3TC	TDF	ZDV
ACE inhibitors	cilazapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	enalapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	lisinopril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	perindopril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	quinapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	ramipril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	trandolapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
angiotensin antagonists	candesartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	irbesartan	↓	↓	↓	↓	↓	↓	↑	↑	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
	losartan	↓[a]	↓[a]	↓[a]	↓[a]	↓[a]	↓[a]	↑[b]	↑[b]	↔	↔	↔	↔	↓[a]	↔	↔	↔	↔	↔	↔
	olmesartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	telmisartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	valsartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
β blockers	atenolol	↔[d]	↔	↔	↔	↔[d]	↔[d]	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	bisoprolol	↑[d]	↑	↑	↑	↑[d]	↑[d]	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	carvedilol	↑↓[d]	↑↓	↑↓	↑↓	↑↓[d]	↑↓[d]	↑↓	↑↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	metoprolol	↑[d]	↑	↑	↑	↑[d]	↑[d]	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	propranolol	↑[d]	↑	↑	↑	↑[d]	↑[d]	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
calcium channel blockers	amlodipine	↑[c]	↑	↑	↑80%	↑	↑[c]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	diltiazem	↑[c]	↑	↑	↑	↑	↑[c]	↓69%	↓E	↓	E	E	↔	↑	↔	↔	↔	↔	↔	↔
	felodipine	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	lacidipine	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	lercanidipine	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	nicardipine	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓E	↓	E	E	↔	↑	↔	↔	↔	↔	↔	↔
	nifedipine	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	nisoldipine	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	verapamil	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓E	↓	E	E	↔	↑	↔	↔	↔	↔	↔	↔
diuretics	amiloride	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	bendroflumethiazide	?	?	?	?	?	?	?	?	?	↔	↔	↔	?	↔	↔	↔	↔	↔	↔
	chlortalidone	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	furosemide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	E	↔
	indapamide	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	torasemide	↓	↓	↓	↓	↓	↓	↑	↑	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
Others	doxazosin	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	spironolactone	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔

Legend

↑	potential elevated exposure of the antihypertensive
↓	potential decreased exposure of the antihypertensive
↔	no significant effect
D	potential decreased exposure of ARV drug
E	potential elevated exposure of ARV drug
a	[parent drug] decreased but [active metabolite] increased
b	[parent drug] increased but [active metabolite] decreased
c	ECG monitoring recommended
d	risk of PR interval prolongation

Numbers refer to decreased AUC of the antihypertensive as observed in drug-drug interactions studies.

Colour legend

- no clinically significant interaction expected.
- these drugs should not be coadministered.
- potential interaction, which may require a dosage adjustment or close monitoring.
- potential interaction predicted to be of weak intensity (< 2 fold ↑AUC or < 50% ↓AUC). A dosage adjustment is *a priori* not recommended.

Note: although some drug interactions are predicted to potentially require a dosage adjustment based on the drug's metabolic pathway, clinical experience with a particular antihypertensive and ARV drug may indicate that dosage adjustments are not an *a priori* requirement.

Comment

The symbol (red, amber, green) used to rank the clinical significance of the drug interaction is based on www.hiv-druginteractions.org (University of Liverpool). For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, refer to the above-mentioned website.

Drug-drug Interactions between Analgesics and ARVs

	analgesics	ATV/r	DRV/r	FPV/r	IDV/r	LPV/r	SQV/r	EFV	ETV	NVP	RPV	MVC	DTG	EVG/c	RAL	ABC	FTC	3TC	TDF	ZDV
non-opioid analgesics	aspirin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	j	↔
	celecoxib	↔	↔	↔	↔	↔	↔	↑a	↑a	↔	↔	↔	↔	↔	↔	↔	↔	↔	j	↔
	diclofenac	↔	↔	↔	↔	↔	↔	↑a	↑a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↑j	↔
	ibuprofen	↔	↔	↔	↔	↔	↔	↑a	↑a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↑j	↔b
	mefenamic acid	↔	↔	↔	↔	↔	↔	↑a	↑a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↑j	↔
	naproxen	↔	↔	↔	↔	↔	↔	↑a	↑a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↑j	↔b
	nimesulide	↔	↔	↔	↔	↔	↔	↑a	↑a	↔	↔	↔	↔	↔	↔	↔	↔	↔	j	↔
	paracetamol	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	piroxicam	↔	↔	↔	c	↔	↔	↑a	↑a	↔	↔	↔	↔	↔	↔	↔	↔	↔	j	↔
opioid analgesics	alfentanil	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	buprenorphine	↑67%	↑d	↔	↑	↔	↑	↓50%	↓25%	↔	↔	↔	↔	↑35%	↔	↔	↔	↔	↔	↔
	codeine	↑g	↑g	↑g	↑g	↑g	↑g	↑g	↑g	↑g	↔	↔	↔	↑g	↔	↔	↔	↔	↔	↔
	dihydrocodeine	↓↑	↓↑	↓↑	↓↑	↓↑	↓↑	↓↑	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	fentanyl	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	methadone	↓e	↓16%	↓18%	↓	↓53%e	↓19%ef	↓52%	↑6%	↓≈50%	↓16%e	↔	↔	↑7%	↔	↓	↔	↔	↔	E
	morphine	↓	↓	↓	↓	↓	↓	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	oxycodone	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	pethidine	↓h	↓h	↓h	↓c,h	↓h	↓h	↓h	↔	↓h	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	sufentanil	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	tramadol	↑g	↑g	↑g	↑g	↑g	↑g	↓i	↔	↔	↔	↔	↔	↑g	↔	↔	↔	↔	↔	↔

Legend

↑ potential elevated exposure of the analgesic
↓ potential decreased exposure of the analgesic
↔ no significant effect
D potential decreased exposure of ARV drug
E potential elevated exposure of ARV drug
a clinical significance unknown. Use the lowest recommended dose particularly in persons with risk factors for cardiovascular disease, those persons at risk of developing gastrointestinal complications, persons with hepatic or renal impairment, and in elderly persons
b potential additive haematological toxicity
c manufacturer's recommendation
d [parent drug] unchanged but [metabolite] increased
e both drugs can potentially prolong the QT interval; ECG monitoring recommended
f coadministration contraindicated in the European SPC. However, US prescribing information advises caution. The charts reflect the more cautious option
g potential decrease of the analgesic effect due to the reduced conversion to the active metabolite
h [parent drug] decreased and increase [neurotoxic metabolite]
i [parent drug] decreased but no change [more active metabolite]
j potential risk of nephrotoxicity, which is increased if NSAID is used for a long duration, if the person has a pre-existing renal dysfunction, has a low body weight or receives other drugs that may increase TDF exposure. Concurrent use of NSAIDs with TDF warrants monitoring of renal function. Numbers refer to increased or decreased AUC of the analgesic as observed in drug-drug interactions studies.

Colour legend

no clinically significant interaction expected.
these drugs should not be coadministered.
potential interaction, which may require a dosage adjustment or close monitoring.
potential interaction predicted to be of weak intensity (< 2 fold ↑AUC or < 50% ↓AUC). A dosage adjustment is *a priori* not recommended.

Comment

The symbol (red, amber, green) used to rank the clinical significance of the drug interaction is based on www.hiv-druginteractions.org (University of Liverpool). For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, refer to the above-mentioned website.

Drug-drug Interactions between Antimalarial Drugs and ARVs

Effect of ARVs on antimalarial drugs and key metabolite

Legend:
Arrows indicate effect of antiretrovirals on antimalarial drug/key metabolite
Green no clinically significant interaction expected
Orange potential interaction (consider treatment ahead of travel and therapeutic drug monitoring)
Red clinically relevant interaction, do not use or use with caution

Mefloquine (M)		
Key Metabolite **Indication**	**CYP 3A4** **Prophylaxis** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	↓	No
RPV, RAL, MVC, DTG	→	No
PI, COBI	↑ M may reduce PI/C (RTV ca 35%)	Potential

Artemisinins (A)		
Artemisinins and its key metabolite, dihydroartemisinin, are active compounds		
Key Metabolite **Indication**	**CYP 2B6, 3A4, 2C19** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	↓ A & dihydroartemisin; A & metabolites reduce NVP, but not EFV/ETR	do not use or use with caution
RPV, RAL, MVC, DTG	→ A may reduce RPV, MVC	Potential
PI, COBI.	↑ Increase A: monitor toxicity (liver)	Potential

Lumefantrin (L)		
Key Metabolite **Indication**	**CYP 3A4** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	↓	Potential
RPV, RAL, MVC, DTG	→	No
PI, COBI	↑ LPV increases L 2-3x	do not use or **use with caution**

Atovaquone (A), Proguanil		
• Atovaquone increases ZDV levels by 35% • Synergy with atovaquone is related to proguanil, not its active metabolite; therefore presumably no net effect of induction/inhibition		
Key Metabolite **Indication**	**CYP 2C19** **Prophylaxis** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	↓ ETV is increased	Potential
RPV, RAL, MVC, DTG	→	No
PI, COBI	↓ At & P take with fat meal, consider dose increase	Potential

Doxycycline		
Key Metabolite **Indication**	**N/A** **Prophylaxis**	**Significance**
NNRTI (EFV, NVP, ETV)	possibly ↓	Potential
RPV, RAL, MVC, DTG	→	No
PI, COBI	→	No

Chloroquine		
Key Metabolite **Indication**	**CYP 3A4, 2D6** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	→	No
RPV, RAL, MVC, DTG	→	No
PI, COBI	→	No

Quinine (Q)		
Key Metabolite **Indication**	**CYP 3A4, 2D6** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	↓ Consider dose increase	Potential
RPV, RAL, MVC, DTG	→	No
PI, COBI	↑ RTV increases Q 4x: consider dose reduction, monitor toxicity (tinnitus). CAVE: PI & Q prolong QT	Potential

Primaquine		
Key Metabolite **Indication**	**CYP 1A2, 2D6, 3A4** **(Prophylaxis)** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	N/A	Potential
RPV, RAL, MVC, DTG	→	No
PI, COBI	N/A	

Dose Adjustment of ARVs for Impaired Hepatic Function

NRTIs	
ABC	**Child-Pugh Score** 5–6: 200 mg bd (use oral solution)
	Child-Pugh Score > 6: Contraindicated
ddI	Contraindicated
	If used no dosage adjustment
d4T	Contraindicated
	If used no dosage adjustment
FTC	No dosage adjustment
3TC	No dosage adjustment
TDF	No dosage adjustment
TDF/FTC	No dosage adjustment
ZDV	Reduce dose by 50% or double the interval between doses if Child-Pugh > 9
NNRTIs	
DLV	No dosage recommendation; use with caution in persons with hepatic impairment
EFV	No dosage adjustment; use with caution in persons with hepatic impairment
TDF/FTC/EFV	
ETV	**Child-Pugh score** < 10: no dosage adjustment
NVP	**Child-Pugh score** > 6: contraindicated

PIs	
ATV	Child-Pugh Score 7–9: 300 mg once daily
	Child-Pugh Score > 9: not recommended
	RTV boosting is not recommended in persons with hepatic impairment (Child-Pugh Score > 7)
DRV	Mild to moderate hepatic impairment: no dosage adjustment
	Severe hepatic impairment: not recommended
FPV	**PI-naive persons only:**
	Child-Pugh Score 5–9: 700 mg bd
	Child-Pugh Score 10–15: 350 mg bd
	PI-experienced persons:
	Child-Pugh Score 5–6: 700 mg bd + RTV 100 mg qd
	Child-Pugh Score 7–9: 450 mg bd + RTV 100 mg qd
	Child-Pugh Score 10–15: 300 mg bd + RTV 100 mg qd
IDV	Mild to moderate hepatic insufficiency: 600 mg q8h
LPV/r	No dosage recommendation; use with caution in persons with hepatic impairment
NFV	Mild hepatic impairment: no dosage adjustment
	Moderate to severe hepatic impairment: not recommended
RTV	Refer to recommendations for the primary PI
SQV	Mild to moderate hepatic impairment: use with caution
	Severe hepatic impairment: contraindicated
TPV	Child-Pugh score < 7: use with caution
	Child-Pugh score > 6: contraindicated
FI	
ENF	No dosage adjustment
CCR5 Inhibitor	
MVC	No dosage recommendations. Concentrations will likely be increased in persons with hepatic impairment
INSTI	
RAL	No dosage adjustment

Note: Hepatic dysfunction is a good indication for TDM as clinical experience with these dose adjustments is very limited

Dose Adjustment of ARVs for Impaired Renal function

		eGFR[i] (mL/min)				Haemodialysis
		≥ 50	30-49	10-29	< 10	
NRTIs						
ABC	300 mg q12h	No dose adjustment required	No dose adjustment required	No dose adjustment required		
ddI[ii]	≥ 60 kg	400 mg q24h	200 mg q24h	150 mg q24h	**> 60 kg: 100 mg/24h**	
	< 60 kg	250 mg q24h	125 mg q24h	100 mg q24h	**< 60 kg: 75 mg/24h**	
d4T	> 60 kg	30 mg q12h	15 mg q12h	15 mg q24h	15 mg q24h	15 mg q24h AD[iv]
	< 60 kg	40 mg q12h	20 mg q12h	20 mg q24h	20 mg q24h	20 mg q24h AD[iv]
FTC		200 mg q24h	200 mg q48h	200 mg q72h	200 mg q96h	200 mg q96h
3TC		300 mg q24h	150 mg q24h	100 mg q24h[iii]	50-25 mg q24h[iii]	50-25 mg q24h[iii] AD[iv]
TDF[vii]		300 mg q24h	300 mg q48h	Not recommended (300 mg q72-96h, if no alternative)	Not recommended (300 mg q7d, if no alternative)	300 mg q7d AD[iv]
ZDV		300 mg q12h	No dose adjustment required		100 mg q8h	100 mg q8h
ABC/3TC		Use individual drugs				
ZDV/3TC						
ABC/3TC/ZDV						
TDF/FTC		q24h	q48h	Use individual drugs		
NNRTIs						
EFV		600 mg q24h	No dose adjustment required			
ETV		200 mg q12h	No dose adjustment required			
NVP		200 mg q12h	No dose adjustment required			

	eGFR[i] (mL/min)				Haemodialysis
	≥ 50	30-49	10-29	< 10	
PIs					
ATV/r	300/100 mg q24h	No dose adjustment required[v,vi]			
DRV/r	800/100 mg q24h 600/100 mg q12h	No dose adjustment required[v]			
FPV/r	700/100 mg q12h	No dose adjustment required[v]			
LPV/r	400/100 mg q12h	No dose adjustment required[v]			
SQV/r	1000/100 mg q12h	No dose adjustment required[v]			
TPV/r	500/200 mg q12h	No dose adjustment required[v]			
Other ART					
RAL	400 mg q12h	No dose adjustment required[v] (dose AD[iv])			
TDF/FTC/EVG/COBI	Do not initiate if eGFR < 70 mL/min	Discontinue if eGFR < 50 mL/min			
MVC: co-administered without CYP3A4 inhibitors[viii]	300 mg q12h	No dose adjustment required			
MVC: co-administered with CYP3A4 inhibitors[viii]	if eGFR < 80 mL/min 150 mg q24h[viii] except: 150 mg q12h if co-administered with FPV/r				

i eGFR according to the abbreviated MDRD (Modification of Diet in Renal Disease) formula. The Cockcroft-Gault (CG) equation may be used as an alternative.
ii Dose reduction if combined with TDF
iii 150 mg loading dose
iv AD: after dialysis
v Limited data available in persons with renal impairment; pharmacokinetic analysis suggests no dose adjustment required
vi Associated with nephrotoxicity; consider alternative PI if pre-existing CKD
vii Associated with nephrotoxicity; consider alternative ART if pre-existing CKD
viii See summary of product characteristics for specific recommendations; use with caution if eGFR < 30 mL/min

Administration of ARVs in Persons with Swallowing Difficulties

Drug	Formulation	Crush tablets	Open capsules	Comment
NRTI				
ABC	tablet (300 mg) solution 20 mg/mL	yes		bitter taste
ddI	capsule (125, 200, 250, 400 mg)	no	no	use powder: contains Ca and Mg antacids, dissolve in ≥ 30 mL of water (add apple juice), take on empty stomach
d4T	capsule (20, 30, 40 mg) oral solution 1 mg/mL	no	yes	take on empty stomach
FTC	capsule (200 mg) solution 10 mg/mL	no	yes	dissolve in ≥ 30 mL of water, contains Na 460 µmol/mL Bioequivalence: 240 mg solution = 200 mg capsule adjust dosage accordingly
3TC	tablet (150, 300 mg) solution 10 mg/mL	yes		
TDF	tablet (245 mg)	yes		better: dissolve in ≥ 1 dL of water/orange or grape juice (bitter taste)
ZDV	capsule (250 mg)	no	no	sticky, bitter taste
	syrup 10 mg/mL			better: use syrup or iv 6 mg/kg per day in glucose 5%
TDF/FTC	tablet (200/245 mg)	yes		better: dissolve in ≥ 1 dL of water/orange or grape juice (bitter taste)
ABC/3TC	tablet (300/600 mg)	no		use solution of individual compounds
ZDV/3TC	tablet (150/300 mg)	yes		disperse in ≥ 15 mL water, alternative: use solution of individual compounds
ABC/3TC/ZDV	tablet (150/300/300 mg)	no		use solution of individual compounds
NNRTI				
EFV	tablet (600 mg)	yes		difficult to dissolve; solution has lower bioavailability; if > 40 kg use 720 mg
	capsule (50, 100, 200 mg)	no	yes	
	solution 30 mg/mL			
ETV	tablet (200 mg)	no		disperse in ≥ 5 mL water
NVP	tablet (200, 400 mg[(i)]) suspension 10 mg/mL	yes[(i)]		dissolve in water
TDF/FTC/EFV	tablet (200/245/600 mg)	no		
TDF/FTC/RPV	tablet (200/245/25 mg)	no		
PI				
ATV	capsule (150, 200, 300 mg)	no	yes	difficult to open; take with food
DRV	tablet (400, 600 mg) solution 100 mg/mL	yes		take with food
FPV	tablet (700 mg) suspension 50 mg/mL			bitter taste; adults take suspension on empty stomach
IDV	capsule (200, 400 mg)	no	no	
LPV/r	tablet (200/50 mg) solution 80, 20 mg/mL	no		42% alcohol, do not dilute with water (risk of precipitation), rinse with milk (no water); take with food, bitter taste: dilute with chocolate milk
NFV	tablet (250 mg)	yes		difficult to dissolve; better: use powder
RTV	tablet (100 mg) solution 80 mg/mL	no		43% alcohol, do not dilute solution (risk of precipitation), rinse with milk (no water); bitter taste; take with food
SQV	tablet (500 mg)	no		
	capsule (200 mg)	no	yes	
TPV	capsule (250 mg) solution 100 mg/mL	no	no	higher bioavailability of oral solution: no dosing recommendation for adults
Others				
MVC	tablet (150, 300 mg)	yes		
RAL	tablet (400 mg)	yes		bitter taste
TDF/FTC EVG/COBI	tablet (200/245/150/150 mg)	no		

Drug	Formulation	Crush tablets	Open capsules	Comment
Prophylaxis/treatment of opportunistic infections				
Azithromycin	tablet (250 mg) suspension 40 mg/mL	no		
Cotrimoxazole	tablet (400/80 mg, forte 800/160 mg) solution 40/8 mg per mL	yes; forte difficult		dilute solution 3-5 times with water (high osmolality)
Fluconazole	capsule (50-200 mg) suspension 40 mg/mL	no	yes	
Pyrimethamine	tablet (25 mg)	yes		take with food
Valganciclovir	tablet (450 mg)	no	no	difficult to dissolve
Rifampicin	tablet (450, 600 mg)	yes		take on empty stomach
	capsule (150, 300 mg)	no	yes	
	suspension 20 mg/mL			
Rifabutin	capsule (150 mg)	no	yes	dissolve in water
Isoniazid	tablet (100, 150, 300 mg)	yes		take on empty stomach
Pyrazinamide	tablet (500 mg)	yes		
Ethambutol	tablet (100, 400 mg)	yes		difficult to dissolve better: use iv solution
Rifampicin/Isoniazid	tablet (150/100, 150/75 mg)	yes		take on empty stomach
Rifater (Rifampicin, Isoniazid, Pyrazinamide)	tablet (120/50/300 mg)	yes		take on empty stomach
Rimstar (Rifampicin, Isoniazid, Pyrazinamide, Ethambutol)	tablet (150/75/400/275 mg)	yes		take on empty stomach
Ribavirin	capsule (200 mg)	no	yes	disperse in orange juice, take with food

i Extended release effect lost. Note: NVP 400 mg once daily (immediate release) can lead to sub-therapeutic trough levels in individuals with higher body weight (≥ 90 kg) compared to NVP 200 mg twice daily. Therefore, twice-daily NVP administration should be preferred in individuals with higher body weight

Part III Prevention and Management of Co-morbidities in HIV-positive Persons

Co-morbidities include cardiovascular, renal, hepatic, metabolic, neoplastic and bone pathologies, central nervous system disorders and sexual dysfunction. Although HIV and other infections may be involved in their pathogenesis, this section of the EACS guidance focuses on preventive and/or management principles other than use of antivirals and other anti-infectious agents in adult and adolescent HIV-positive persons. These co-morbidities are becoming increasingly important for HIV-positive persons as a consequence of increased life expectancy resulting from effective ART. Several demonstrated and proposed HIV-associated risk factors may contribute to their development, which include residual immunodeficiency, immune activation, inflammation and coagulation, co-infections (e.g. HCV, CMV) that may persist in spite of controlled HIV replication, as well as adverse effects of ART.

Health care professionals involved with the care of HIV-positive persons who are not familiar with the use of ART should consult HIV specialists before introducing or modifying any type of medicines for co-morbidity in an HIV-positive person.

Conversely, many HIV physicians are not specialists in co-morbidities, and should seek expert advice where appropriate in the prevention and management of such conditions. Situations where consultation is generally recommended are indicated in this document.

Preventing or managing these co-morbidities in HIV often involves polypharmacy, which increases the risk of suboptimal adherence and hence may compromise the continued benefit of ART. Additionally, the possibility of drug-drug interactions with ARVs should always be carefully considered prior to introducing any other medicine, see page 17, www.hiv-druginteractions.org and online documents referred to in the text.

These recommendations are intended to provide the best guide to clinical management, and it is recognised that the level of evidence to support the recommendations may vary substantially. Indeed, there is limited evidence from randomised controlled trials on best management of co-morbidities in HIV. As a result, current management is mainly derived from general medical guidelines. These recommendations therefore represent the collective consensus opinion of a panel of experts in the field of HIV and the respective range of co-morbidities, and no attempt to rate the underlying evidence and strength of the panel's recommendations was undertaken.

Depending on future clinical research findings, these recommendations will be regularly updated as required. The online version at www.eacsociety.org and the EACS Guidelines App contain more detailed information and links to other relevant websites; these will be regularly updated.
The current recommendations highlight co-morbidities that are seen frequently in the routine care of HIV-positive persons and those for which specific issues should be considered.

Drug Dependency and Drug Addiction

Characteristics of drugs used as opioid substitution therapy (OST)[i]

Feature	Methadone	Buprenorphine
Dose required to prevent withdrawal symptoms according to degree of opioid dependency	Linear relationship (from 10-300 mg per day)	Linear relationship for persons with less opioid dependency only – ceiling effect (max daily dose 24 mg)
Interaction with ARVs	Methadone plasma concentrations are reduced if used together with NNRTIs or PIs: • NVP & EFV: ↓ 50% • ETV: ↓ < 10% • LPV/r: ↓ 50% • SQV/r, DRV/r, FPV/r: ↓ 15-25% • ATV, IDV: ↓ < 10%	Buprenorphine (B) and active metabolite norbuprenorphine (N) plasma concentrations are reduced if combined with NNRTIs and increased if combined with some PIs • EFV: ↓ up to 50% (B) and 70% (N) • ATV/r, IDV, SQV/r: ↑ 50-100% (B&N) • DRV/r: ↑ 50% (N) • **CAVE:** B reduces ATV; do not use without ritonavir or cobicistat boosting
	CAVE: withdrawal symptoms if combined with ARV that decreases plasma concentration and risk of drug toxicity if such ARVs are interrupted – reverse if ARVs increase plasma concentration	
Risk of overdose	Yes	No if used as a co-formulation with naloxone
Causing QT prolongation on ECG	Yes (dose-response relationship)[ii]	No
Risk of obstipation	High	High
Type of administration	Tablet or liquid	Tablet applied sublingual
Risk of further impairment in persons with existing liver impairment	Yes	Yes

i See Drug-drug Interactions between Analgesics and ARVs

ii ECG recommended for daily methadone doses exceeding 50 mg; special caution with concomitant use of other drugs known to cause QT prolongation (e.g. certain PIs such as SQV/r as well as albuterol (USAN) or salbutamol (INN), amiodarone, amitriptyline, astemizole, chloroquine, clomipramine and moxifloxacin).

Cancer: Screening Methods[(i)]

Problem	Persons	Procedure	Evidence of benefit	Screening interval	Additional comments
Anal cancer	MSM	Digital rectal exam ± PAP test	Unknown; advocated by some experts	1-3 years	If PAP test abnormal, anoscopy
Breast cancer	Women 50-70 years	Mammography	↓ Breast cancer mortality	1-3 years	
Cervical cancer	Sexually active women	PAP test	↓ Cervical cancer mortality	1-3 years	Target age group should include the 30 to 59-year age range at least. Longer screening interval if prior screening tests repeatedly negative
Colorectal cancer	Persons 50-75 years	Faecal occult blood test	↓ Colorectal cancer mortality	1-3 years	Benefit is marginal
Hepatocellular carcinoma	Persons with cirrhosis & Persons with HBV irrespective of fibrosis stage	Ultrasound and alpha-foetoprotein	Earlier diagnosis allowing for improved ability for surgical eradication	Every 6 months	
Prostate cancer	Men > 50 years	Digital rectal exam ± prostate specific antigen (PSA)	Use of PSA is controversial	1-3 years	Pros: ↑ early diagnosis Cons: Overtreatment, no ↓ cancer-related mortality

i Screening recommendations derived from the general population.

These screenings should preferably be done as part of national general population-screening programmes. Although non-Hodgkin's lymphoma has a higher incidence in HIV-positive persons than in the general population, it is currently unknown whether it can be screened.
Careful examination of skin should be performed regularly to detect cancers such as Kaposi's sarcoma, basal cell carcinoma and malignant melanoma.

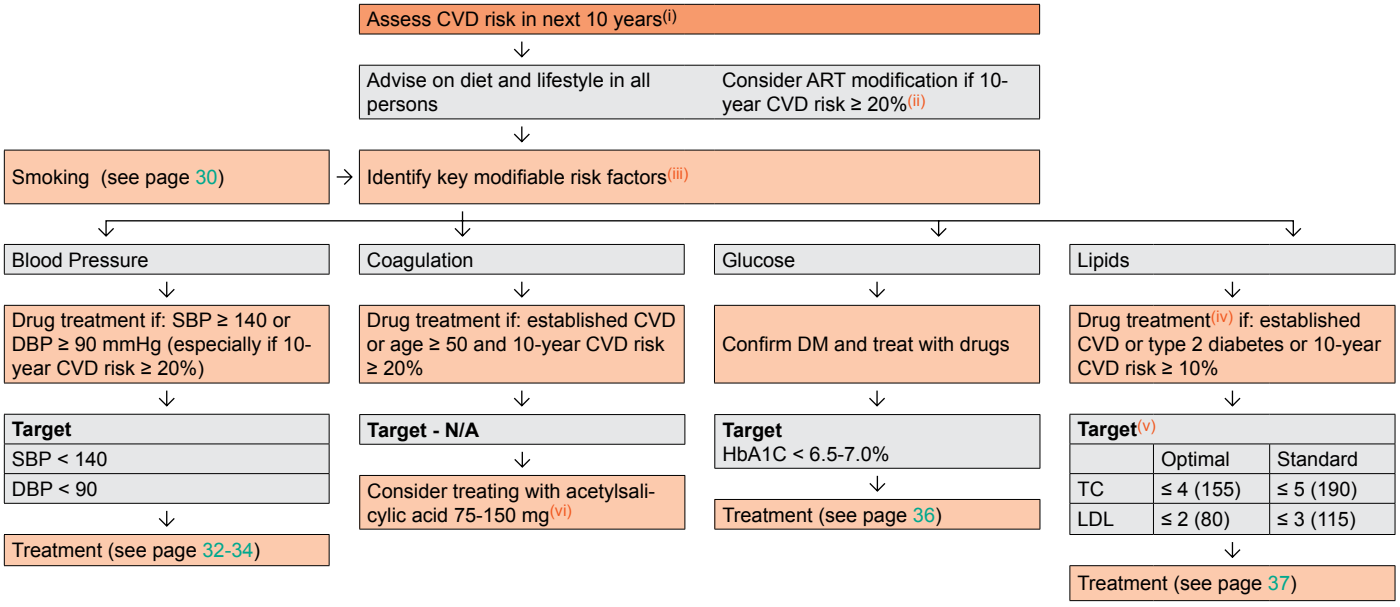
Lifestyle Interventions[i]

Smoking cessation	• Brief unambiguous statement about need to stop smoking • If person is not contemplating, try to motivate and emphasise positive short-term aspects (more money for better things, better taste for food, better skin, less dyspnoea), and long-term benefits (prevention of COPD, IHD, stroke, lung cancer) • If person is contemplating, try to fix stop date, establish reward system • Use nicotine substitution (patch, chewing gum, spray), varenicline or bupropion during weaning phase if necessary. Note: both varenicline and bupropion may cause central nervous system side effects including suicide; bupropion may interact with PIs and NNRTIs, see page 17. • Consider referring person to specialised stop smoking clinics • Anticipate relapses, explain and consider them as part of the weaning process to final nicotine abstinence
Dietary counselling	• Dietary intervention should not interfere with the dietary requirements necessary for appropriate absorption of ART drugs • Keep caloric intake balanced with energy expenditure • Limit intake of saturated fat, cholesterol and refined carbohydrates • Reduce total fat intake to < 30% and dietary cholesterol to < 300 mg/day • Emphasise intake of vegetables, fruit and grain products with fibre • Cut back on beverages and foods with added sugar. • Choose and prepare foods with little or no salt. Aim to eat less than 1,500 mg of sodium per day. • Emphasise consumption of fish, poultry (without skin) and lean meat • Consider referral to dietician, one-week food and drink diary to discover 'hidden' calories • Avoid binge eating ('yo-yo dieting') • In persons with HIV-related wasting and dyslipidaemia, address wasting first and consider referral to dietician • Persons who are obviously overweight should be motivated to lose weight. Starvation diets are not recommended (immune defence mechanisms potentially decreased). Malnutrition has to be addressed where observed. Normal BMI range: 18.5-24.9; Overweight: 25.0-29.9, Obesity: > 30.0 kg/m^2
	• The following questions are helpful to determine average alcohol intake **1.** How often do you drink alcohol: never, ≤ 1/month, 2-4x/month, 2-3x/week, > 4x/week **2.** If you drink alcohol, how much typically at a time: 1-2, 3-4, 5-6, 7-9, > 10 drinks **3.** How many times do you have 6 or more alcoholic drinks at one occasion: never, < 1/month, 1x/month, 1x/week, more or less daily. • Intake of alcohol should be restricted to no more than one drink per day for women and two drinks per day for men (< 20-40 g/d). • In particular, persons with hepatic disease, adherence problems, inadequate CD4 cell increase, tumours, past tuberculosis, diarrhoea and other conditions associated with high alcohol intake should be motivated to decrease or stop alcohol intake.
Exercise promotion	• Promote active lifestyle to prevent and treat obesity, hypertension and diabetes • Encourage self-directed moderate level physical activity (take the stairs, cycle or walk to work, cycling, swimming, hiking etc.) • •Emphasise regular moderate-intensity exercise rather than vigorous exercise • Achieve cardiovascular fitness (e.g. 30 minutes brisk walking > 5 days a week) • Maintain muscular strength and joint flexibility

i Based on recommendations by the US Preventive Services Task Force

Prevention of CVD

Principles: The intensity of efforts to prevent CVD depends on the underlying risk of CVD, which can be estimated[i]. The preventive efforts are diverse in nature and require involvement of a relevant specialist, in particular if the risk of CVD is high and always in persons with a history of CVD.



i Use the Framingham equation or whatever system local National Guidance recommends; a risk equation developed from HIV populations is available: see www.cphiv.dk/tools.aspx. This assessment and the associated considerations outlined in this figure should be repeated annually in all persons under care, see page 4-5, to ensure that the various interventions are initiated in a timely way.

ii Options for ART modification include:
(1) Replace PI/r with NNRTI, RAL or another PI/r known to cause less metabolic disturbances, see page 15-17
(2) Replace d4T and consider replacing ZDV or ABC with TDF or use an NRTI-sparing regimen.

iii Of the modifiable risk factors outlined, drug treatment is reserved for certain subgroups where benefits are considered to outweigh potential harm. Of note, there is a combined benefit of various interventions in target groups identified. Per 10 mmHg reduction in systolic blood pressure, per 1 mmol/L (39 mg/dL) reduction in TC and with use of acetylsalicylic acid, each reduces risk of IHD by 20-25%; the effect is additive. Observational studies suggest that smoking cessation results in about 50% less risk of IHD – and this is additive to other interventions.

iv See discussion on drug treatment of persons with lower CVD risk at www.nhlbi.nih.gov/guidelines/cholesterol/atp3_rpt.htm

v Target levels are to be used as guidance and are not definitive – expressed as mmol/L with mg/dL in parenthesis. In case LDL cannot be calculated because of high triglyceride levels, the non-HDL-c (TC minus HDL-c) target should be used which is 0.8 mmol/L (30 mg/dL) higher than the corresponding LDL-c target. Target levels for TG are not listed because an independent contribution from TG to CVD risk is uncertain, and hence whether this condition should be treated, see page 37.

vi Evidence for benefit when used in persons without a history of CVD (including diabetics) is less compelling. BP should be reasonably controlled before aspirin use in such a setting.

Hypertension: Diagnosis, Grading and Management

Other risk factors, asymptomatic organ damage or disease	Blood pressure (mmHg)	Blood Pressure (mmHg)	Blood pressure (mmHg)	Blood Pressure (mmHg)
	High normal SBP 130-139 or DBP 85-89	Grade 1 hypertension SBP 140-159 or DBP 90-99	Grade 2 hypertension SBP 160-179 or DBP 100-109	Grade 3 hypertension SBP ≥ 180 or DBP ≥ 110
No other risk factors	• No BP intervention	• Lifestyle changes[i] for several months • Then add BP drugs targeting < 140/90	• Lifestyle changes[i] for several weeks • Then add BP drugs targeting < 140/90	• Lifestyle changes[i] • Immediate BP drugs targeting < 140/90
1-2 risk factors	• Lifestyle changes[i] • No BP Intervention	• Lifestyle changes[i] for several weeks • Then add BP drugs targeting < 140/90	• Lifestyle changes[i] for several weeks • Then add BP drugs targeting < 140/90	• Lifestyle changes[i] • Immediate BP drugs targeting < 140/90
≥ 3 risk factors	• Lifestyle changes[i] • No BP intervention	• Lifestyle changes[i] for several weeks • Then add BP drugs targeting 140/90	• Lifestyle changes[i] • BP drugs targeting < 140/90	• Lifestyle changes[i] • Immediate BP drugs targeting < 140/90
Organ damage, CKD stage 3 or diabetes	• Lifestyle changes[i] • No BP intervention	• Lifestyle changes[i] • BP drugs targeting < 140/90	• Lifestyle changes[i] • BP drugs targeting < 140/90	• Lifestyle changes[i] • Immediate BP drugs targeting < 140/90
Symptomatic CVD, CKD stage ≥ 4 or diabetes with organ damage/risk factors	• Lifestyle changes[i] • No BP intervention	• Lifestyle changes[i] • BP drugs targeting < 140/90	• Lifestyle changes[i] • BP drugs targeting < 140/90	• Lifestyle changes[i] • Immediate BP drugs targeting < 140/90

BP blood pressure
DBP diastolic blood pressure:
SBP systolic pressure

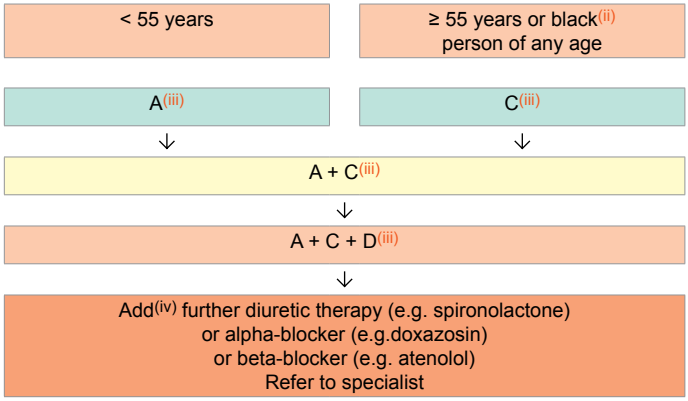
Repeated blood pressure measurements should be used for stratification

i Recommended lifestyle interventions, see page 29

Table adapted from [1].

Hypertension: Drug Sequencing Management

Choosing drugs[i] for persons newly diagnosed with hypertension



Abbreviations + details

A ACE inhibitor (e.g. Perindopril, Lisinopril or Ramipril) or low cost angiotensin receptor blockers (ARB) (e.g. Losartan, Candesartan)

C Dihydropyridine calcium-channel blocker (e.g. Amlodipine). If not tolerated or if deemed at high risk of heart failure, 'D' drugs can be used instead. Where a C drug is preferred but not tolerated, Verapamil or Diltiazem may be used (note: dose with caution with PIs as these may increase plasma concentrations of these calcium-channel blockers, potentially leading to toxic reactions)

D Thiazide-type diuretic* e.g. Indapamide or Chlorthalidone

i Some calcium-channel blockers interact marginally with the pharmacokinetics of ARVs, see Drug-drug Interactions between Antihypertensives and ARVs

ii Black persons are those of African or Caribbean descent, and not mixed race, Asian or Chinese persons

iii Wait 2-6 weeks to assess whether target, see page 31, is achieved; if not, go to next step

iv Requirement of 4-5 drugs to manage hypertension needs specialist training

* This excludes thiazides (e.g. HCTZ, Bendroflumethiazide etc.)

Drug-drug Interactions between Antihypertensives and ARVs

	antihypertensives	ATV/r	DRV/r	FPV/r	IDV/r	LPV/r	SQV/r	EFV	ETV	NVP	RPV	MVC	DTG	EVG/c	RAL	ABC	FTC	3TC	TDF	ZDV
ACE inhibitors	cilazapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	enalapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	lisinopril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	perindopril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	quinapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	ramipril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	trandolapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
angiotensin antagonists	candesartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	irbesartan	↓	↓	↓	↓	↓	↓	↑	↑	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
	losartan	↓[a]	↓[a]	↓[a]	↓[a]	↓[a]	↓[a]	↑[b]	↑[b]	↔	↔	↔	↔	↓[a]	↔	↔	↔	↔	↔	↔
	olmesartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	telmisartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	valsartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
β blockers	atenolol	↔[d]	↔	↔	↔	↔[d]	↔[d]	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	bisoprolol	↑[d]	↑	↑	↑	↑[d]	↑[d]	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	carvedilol	↑↓[d]	↑↓	↑↓	↑↓	↑↓[d]	↑↓[d]	↑↓	↑↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	metoprolol	↑[d]	↑	↑	↑	↑[d]	↑[d]	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	propanolol	↑[d]	↑	↑	↑	↑[d]	↑[d]	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
calcium channel blockers	amlodipine	↑[c]	↑	↑	↑80%	↑	↑[c]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	diltiazem	↑[c]	↑	↑	↑	↑	↑[c]	↓69%	↓E	↓	E	E	↔	↑	↔	↔	↔	↔	↔	↔
	felodipine	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	lacidipine	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	lercanidipine	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	nicardipine	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓E	↓	E	E	↔	↑	↔	↔	↔	↔	↔	↔
	nifedipine	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	nisoldipine	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	verapamil	↑[c]	↑	↑	↑	↑	↑[c]	↓	↓E	↓	E	E	↔	↑	↔	↔	↔	↔	↔	↔
diuretics	amiloride	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	bendroflumethiazide	?	?	?	?	?	?	?	?	?	↔	↔	↔	?	↔	↔	↔	↔	↔	↔
	chlortalidone	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	furosemide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	E	↔
	indapamide	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	torasemide	↓	↓	↓	↓	↓	↓	↑	↑	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
Others	doxazosin	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	spironolactone	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔

Legend

↑	potential elevated exposure of the antihypertensive
↓	potential decreased exposure of the antihypertensive
↔	no significant effect
D	potential decreased exposure of ARV drug
E	potential elevated exposure of ARV drug
a	[parent drug] decreased but [active metabolite] increased
b	[parent drug] increased but [active metabolite] decreased
c	ECG monitoring recommended
d	risk of PR interval prolongation

Numbers refer to decreased AUC of the antihypertensive as observed in drug-drug interactions studies.

Colour legend

- no clinically significant interaction expected.
- these drugs should not be coadministered.
- potential interaction which may require a dosage adjustment or close monitoring.
- potential interaction predicted to be of weak intensity (< 2 fold ↑AUC or < 50% ↓AUC). A dosage adjustment is *a priori* not recommended.

Note: although some drug interactions are predicted to potentially require a dosage adjustment based on the drug's metabolic pathway, clinical experience with a particular antihypertensive and ARV drug may indicate that dosage adjustments are not an *a priori* requirement.

Comment

The symbol (red, amber, green) used to rank the clinical significance of the drug interaction is based on www.hiv-druginteractions.org (University of Liverpool). For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, refer to the above-mentioned website.

Type 2 Diabetes: Diagnosis

Diagnostic Criteria[i]

	Fasting plasma glucose mmol/L (mg/dL)[ii]	Oral glucose tolerance test (OGTT) 2-h value mmol/L (mg/dL)[iii]	HbA1c[iv] (mmol/mol)
Diabetes	≥ 7.0 (126) OR→	≥ 11.1 (200)	≥ 6.5% (≥ 48)
Impaired glucose tolerance (IGT)	< 7.0 (126) AND→	7.8 – 11.0 (140-199)	Prediabetes 5.7-6.4% (39-47)
Impaired fasting glucose (IFG)	5.7– 6.9 AND (100-125)	< 7.8 (140)	

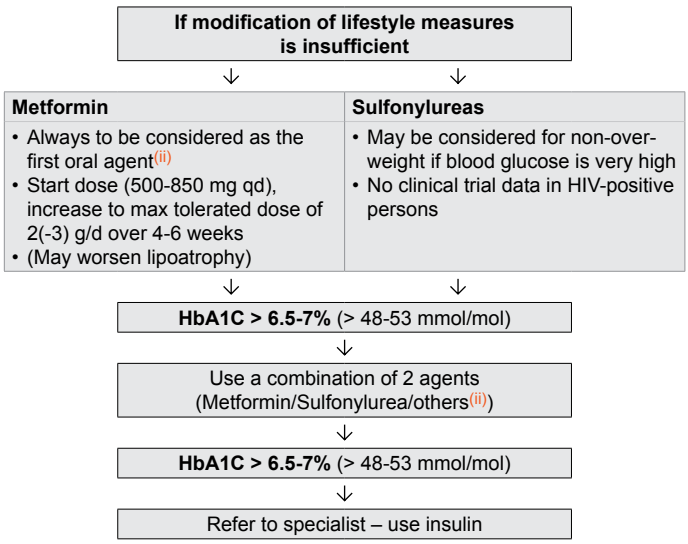
i As defined by WHO and [2]

ii An abnormal finding should be repeated before confirming the diagnosis

iii Recommended in persons with fasting blood glucose of 5.7 - 6.9 mmol/L (100-125 mg/dL) as it may identify persons with overt diabetes

iv Do not use HbA1c in presence of haemoglobinopathies, increased erythrocyte turnover and severe liver or kidney dysfunction. Falsely high values are measured under supplementation with iron, vitamin C and E as well as older age (age > 70: HbA1c +0.4 %). HbA1c values in treated HIV-positive persons, particularly when on ABC, tend to underestimate type 2 diabetes. Both IGT and IFG increase CVD morbidity and mortality, and increase the risk of developing diabetes by 4-6 fold. These persons should be targeted for lifestyle intervention, and their CVD risk factors must be evaluated and treated.

Type 2 Diabetes[i]: Management



Treatment goals:

Prevention of hyper-/hypoglycaemia, glucose control (HbA1c < 6.5-7% without hypoglycaemia, fasting plasma glucose 4-6 mmol/L (73-110 mg/dL), prevention of long-term complications

- Normal blood lipids, see page 31, and blood pressure < 130/80 mmHg, see page 32.
- Acetylsalicylic acid (75-150 mg/d) considered in diabetics with elevated underlying CVD risk, see page 31.
- Nephropathy, polyneuropathy and retinopathy screening should be performed as in diabetic persons without HIV
- Consultation with a specialist in diabetology is recommended

i Type 1 diabetes should be treated according to national guidelines.

ii Very limited data for any oral antidiabetic agents in terms of CVD prevention, and no data in HIV-positive persons. Incretins (DDP4 inhibitors [e.g. Saxagliptin, Sitagliptin] and GLP-1 agonists [e.g. Liraglutide & Exenatide] are currently being evaluated in several major morbidity/mortality studies (neutral results to date); no clinically significant drug-drug interaction or adverse effects on CD4 cell counts expected; clinical use of Pioglitazone questioned by its side effects; HbA1c targets up to 7.5% can be considered for older persons with long-standing type 2 diabetes and evidence of CVD.

Dyslipidaemia

Principles: Higher LDL-c levels increase risk of CVD and reduction thereof reduces this risk (see table below for drugs used on this indication); the reverse is probably true for HDL-c but trial data are less compelling. The CVD risk implications from higher than normal TG levels are even less clear, as TG has not consistently been shown to independently predict the risk of CVD. Furthermore, the clinical benefit of treating moderate hypertriglyceridaemia is uncertain; very high TG (> 10 mmol/L or > 900 mg/dL) increase risk of pancreatitis.

Diet (more fish), exercise, maintaining normal body weight, reducing alcohol intake and stopping smoking tends to improve HDL and triglyceride levels. Reducing dietary saturated fat intake improves LDL-levels; if not effective, consider change of ART then consider lipid-lowering medication, see page 31. Statins should be used by all those with established vascular disease and among those with type 2 diabetes or at high risk of CVD, irrespective of lipid levels.

Drugs used to lower LDL-c

DRUG CLASS	DRUG	DOSE	SIDE EFFECTS	Advise on use of statin together with ART	
				use with PI/r	use with NNRTI
Statin(i)	Atorvastatin(ii)	10-80 mg qd	Gastrointestinal symptoms, headache, insomnia, rhabdomyolysis (rare) and toxic hepatitis	Start with low dose(v) (max: 40 mg)	Consider higher dose(vi)
	Fluvastatin(iii)	20-80 mg qd		Consider higher dose(vi)	Consider higher dose(vi)
	Pravastatin(iii)	20-80 mg qd		Consider higher dose(vi,vii)	Consider higher dose(vi)
	Rosuvastatin(ii)	5-40 mg qd		Start with low dose(v) (max: 20 mg)	Start with low dose(v)
	Simvastatin(ii)	10-40 mg qd		Contraindicated	Consider higher dose(vi)
Cholesterol uptake ↓(i)	Ezetimibe(iv)	10 mg qd	Gastrointestinal symptoms	No known drug-drug interactions with ART	

i A statin is preferred first-line therapy; different statins have variable intrinsic LDL-c lowering ability

ii, iii, iv Target levels for LDL-c, see page 31. In persons where LDL-c targets are difficult to achieve, consult/refer to specialist

ii, iii, iv Expected range of reductions of LDL-c: ii 1.5-2.5 mmol/L (60-100 mg/dL), iii 0.8-1.5 mmol/L (35-60 mg/dL), iv 0.2-0.5 mmol/L (10-20 mg/dL)

v, vi The ARV may v inhibit (statin toxicity, ↓ dose) or vi induce (=less effect of statin, ↑ dose gradually to achieve expected benefit ii, iii) the excretion of the statin

vii **Exception:** If used with DRV/r, start with lower dose of Pravastatin

Bone Disease: Screening and Diagnosis

CONDITION	CHARACTERISTICS	RISK FACTORS	DIAGNOSTIC TESTS
Osteopenia • Postmenopausal women and men aged ≥ 50 years with T-score -1 to -2.5 **Osteoporosis** • Postmenopausal women and men aged ≥ 50 years with T-score ≤ -2.5 • Premenopausal women and men aged < 50 years with Z-score ≤ -2 and fragility fracture	• Reduced bone mass • Increased prevalence of fractures in people with HIV • Asymptomatic until fractures occur Common in HIV • Up to 60% prevalence of osteopenia • Up to 10-15% prevalence of osteoporosis • Aetiology multifactorial • Loss of BMD observed with antiretroviral initiation • Greater loss of BMD with initiation of certain ARVs[i]	Consider classic risk factors[ii] Consider DXA in any person with ≥ 1 of:[iii] 1. Postmenopausal women 2. Men ≥ 50 years 3. History of low impact fracture 4. High risk for falls[iv] 5. Clinical hypogonadism (symptomatic, see Sexual Dysfunction) 6. Oral glucocorticoid use (minimum 5 mg/d prednisone equivalent for > 3 months) Preferably perform DXA in those with above risk factors prior to ART initiation. Assess effect of risk factors on fracture risk by including DXA results in the FRAX® score (www.shef.ac.uk/FRAX) • Only use if > 40 years • May underestimate risk in HIV-positive persons • Consider using HIV as a cause of secondary osteoporosis[v]	**DXA scan** **Rule out causes of secondary osteoporosis if BMD abnormal**[vi] **Lateral spine X-rays** (lumbar and thoracic) if low spine BMD, osteoporosis on DXA, or significant height loss or kyphosis develops. (DXA-based vertebral fracture assessment [VFA] can be used as an alternative to lateral spine X-ray).
Osteomalacia	• Defective bone mineralisation • Increased risk of fractures and bone pain • Vitamin D deficiency may cause proximal muscle weakness • High prevalence (> 80%) of vitamin D insufficiency in some HIV cohorts	• Dark skin • Dietary deficiency • Avoidance of sun exposure • Malabsorption • Obesity • Renal phosphate wasting[vii]	Measure 25(OH) vitamin D in all persons at presentation ng/ml / nmol/L Deficiency: < 10 / < 25 Insufficiency: < 20 / < 50 If deficient or insufficient, check PTH levels Consider vitamin D replacement if clinically indicated, see page 39
Osteonecrosis	• Infarct of epiphyseal plate of long bones resulting in acute bone pain • Rare but increased prevalence in HIV	**Risk factors:** • Low CD4 cell counts • Glucocorticoid exposure • IVDU	**MRI**

i Greater loss of BMD observed with initiation of regimens containing TDF and some PIs. Additional loss and gains in BMD observed with switch to and away from TDF-containing ARV regimens, respectively. Clinical relevance to fracture risk not determined.

ii Classic risk factors: older age, female gender, hypogonadism, family history of hip fracture, low BMI (≤ 19 kg/m2), vitamin D deficiency, smoking, physical inactivity, history of low impact fracture, alcohol excess (> 3 units/day), steroid exposure (minimum prednisone 5 mg/d or equivalent for > 3 months)

iii If T-score normal, repeat after 3-5 years in groups 1 and 2; no need for re-screening with DXA in groups 3 and 4 unless risk factors change and only rescreen group 5 if steroid use ongoing.

iv Falls Risk Assessment Tool (FRAT) www.health.vic.gov.au/agedcare/maintaining/falls/downloads/ph_frat.pdf

v Although use of HIV as a secondary risk factor in FRAX® has not been validated, including HIV as a secondary cause in a risk assessment will help to estimate risk in persons with risk factors for fracture along with low BMD.

vi Causes of secondary osteoporosis include hyperparathyroidism, hyperthyroidism, malabsorption, hypogonadism/amenorrhoea, diabetes mellitus, and chronic liver disease.

vii For diagnosis and management of renal phosphate wasting, see Indications and Tests for Proximal Renal Tubulopathy (PRT).

Vitamin D Deficiency: Diagnosis and Management

Vitamin D	Test	Therapy[i]
Deficiency: < 10 ng/mL (< 25 nmol/L)[ii] **Insufficiency:** < 20 ng/mL (< 50 nmol/L)	25 hydroxy vitamin D (25(OH) vitamin D) If deficient, consider checking parathyroid hormone (PTH), calcium, phosphate[iii], alkaline phosphatase	If vitamin D deficient, replacement recommended. Various regimens suggested[iv] Consider re-checking 25(OH) vitamin D levels 3 months after replacement. After replacement, maintenance with 800-2000 IU vitamin D daily.
Vitamin D deficiency prevalent in both HIV+ and HIV- populations – may not be directly associated with HIV. **Factors associated with lower vitamin D:** • Dark skin • Dietary deficiency • Avoidance of sun exposure • Malabsorption • Obesity • Chronic kidney disease • Some ARVs[v]	Check vitamin D status in persons with history of: • low bone mineral density and/or fracture • high risk for fracture Consider assessment of vitamin D status in persons with other factors associated with lower vitamin D levels (see left column)	Replacement and/or supplementation of 25(OH) vitamin D is recommended for persons with vitamin D insufficiency[vi] and: • osteoporosis • osteomalacia • increased PTH (once the cause has been identified) Consider retesting after 6 months of vitamin D intake

i Can be provided according to national recommendations/availability of preparations (oral and parenteral formulations). Combine with calcium where there is insufficient dietary calcium intake. Consider that in some countries food is artificially fortified with vitamin D.

ii Some experts consider a value of ≤ 30 ng/mL as vitamin D deficiency. Low vitamin D has a prevalence of up to 80% in HIV cohorts and was associated with increased risk for osteoporosis, type 2 diabetes, mortality and AIDS events. Consider seasonal differences (in winter approximately 20% lower than in summer).

iii Consider that hypophosphataemia can be associated with TDF therapy. This phosphate loss through proximal renal tubulopathy may be independent of low vitamin D, see page 42. A combination of low calcium + low phosphate +/- high alkaline phosphatase may indicate osteomalacia and vitamin D deficiency.

iv Expect that 100 IU vitamin D daily leads to an increase in serum 25(OH) vitamin D of approximately 1 ng/mL. Some experts prefer a loading dose of e.g. 10,000 IU vitamin D daily for 8-10 weeks in persons with vitamin D deficiency. The principal goal is to achieve a serum level > 20 ng/mL (50 nmol/L) and to maintain normal serum PTH levels. Combine with calcium where potential for insufficient dietary calcium intake. The therapeutic aim is to maintain skeletal health; vitamin D supplementation has not been proven to prevent other co-morbidities in HIV-positive persons.

v The role of HIV-therapy or specific drugs remains unclear. Some studies suggest an association of EFV with reductions in 25(OH)D but not 1.25(OH)D. PIs may also affect vitamin D status by inhibiting conversion of 25(OH)D to 1.25(OH)D.

vi The implications of vitamin D levels that are below the physiological reference range but not markedly reduced and the value of supplementation are incompletely understood

Approach to Fracture Reduction in HIV-positive Persons

Reducing risk of fractures	• Aim to decrease falls by addressing fall risks(i) • Ensure sufficient dietary calcium (1-1.2 g daily) and vitamin D (800-2,000 IU daily) intake(ii) • Where appropriate, screen for osteoporosis(iii) and refer to national/regional guidelines on treatment of osteoporosis – If no guidelines available, consider bisphosphonate(iv) treatment in all osteoporotic postmenopausal women and men > 50 years old (BMD T-score ≤ -2.5) and those with a history of fragility fracture. Consider treatment based on BMD alongside consideration of other risk factors for fracture, especially age. – Use bisphosphonate and ensure adequate calcium and vitamin D intake – No significant interactions between bisphosphonates and antiretrovirals – If antiretroviral naive, consider options for ART that preserve BMD(v) – If diagnosed with osteoporosis and requiring therapy, consider optimising ART to preserve or improve BMD(vi) • In complicated cases (e.g. young men, premenopausal women, recurrent fracture despite bone protective therapy), refer to osteoporosis specialist • If on bisphosphonate treatment, repeat DXA after 2 years and reassess need for continued treatment after 3-5 years

i Falls Risk Assessment Tool (FRAT), see www.health.vic.gov.au/agedcare/maintaining/falls/downloads/ph_frat.pdf

ii See page 39 for diagnosis and management of vitamin D deficiency.

iii See page 38 for screening and diagnosis of bone disease in HIV.

iv Bisphosphonate treatment with either of: Alendronate 70 mg once weekly po; Risedronate 35 mg once weekly po; Ibandronate 150 mg oral monthly or 3 mg iv every 3 months; Zoledronic acid 5 mg iv once yearly.

v BMD loss is greatest in the first year after ART initiation, with more BMD loss with ART regimens containing TDF and some PIs. Consider relative risk/benefit of using these agents in persons with high fracture risk.

vi In persons on effective ART, a switch to TDF can lead to further BMD loss while a switch away from TDF (alongside optimisation of vitamin D status) in one study of older men with low BMD resulted in increased BMD.

Kidney Disease: Diagnosis and Management

Diagnosis of Kidney Disease

		eGFR[i]		
		≥ 60 mL/min	30-59 mL/min	< 30 mL/min
Proteinuria[ii]	UP/C[iii] < 50	Regular follow-up		• Check risk factors for CKD and nephrotoxic medicines including ART[iv] • Discontinue or adjust drug dosages where appropriate[v] • Perform renal ultrasound • Urgent referral to nephrologist
	UP/C[iii] 50-100	• Check risk factors for CKD and nephrotoxic medicines including ART[iv] • Discontinue or adjust drug dosages where appropriate[v] • Perform renal ultrasound • If haematuria present with any level of proteinuria refer to nephrologist. • Refer to nephrologist if new CKD or progressive decline in eGFR		
	UP/C[iii] > 100			

Management of HIV-associated Kidney Disease[vi]

Prevention of progressive renal disease	Comment
1. ART	Start ART immediately where HIV-associated nephropathy (HIVAN)[vii] or HIV immune complex disease strongly suspected. Immunosuppressive therapy may have a role in immune complex diseases. Renal biopsy to confirm histological diagnosis recommended
2. Start ACE inhibitors or angiotensin-II receptor antagonists if: a. Hypertension and/or b. Proteinuria	**Monitor eGFR and K^+ level closely on starting treatment or increasing dose** a. Blood pressure target: < 130/80 mmHg
3. General measures: a. Avoid nephrotoxic drugs b. Lifestyle measures (smoking, weight, diet) c. Treat dyslipidaemia[viii] and diabetes[ix] d. Adjust drug dosages where necessary	CKD and proteinuria are independent risk factors for CVD

i eGFR: use abbreviated MDRD based on serum creatinine, gender, age and ethnicity. The Cockcroft-Gault (CG) equation may be used as an alternative.
If not previously known to have CKD, confirm pathological eGFR within 2 weeks. Use of COBI, DTG and boosted PIs, is associated with an increase in serum creatinine/reduction of eGFR due to inhibition of proximal tubular creatinine transporters without impairing actual glomerular filtration: consider new set point after 1-2 months

ii Urinalysis: use urine dipstick to screen for haematuria. To screen for proteinuria, use urine dipstick and if ≥ 1+ check urine protein/creatinine (UP/C), or screen with UP/C. Proteinuria defined as persistent if confirmed on ≥ 2 occasions > 2-3 weeks apart. If UP/C not available, use urine albumin/creatinine (UA/C), see note[iii]

iii UP/C in spot urine is preferred to UA/C as detects total urinary protein secondary to glomerular and tubular disease. UA/C largely detects glomerular disease and can be used for screening for HIV-associated renal disease where UP/C is not available, but is not appropriate for screening for tubular proteinuria secondary to drug nephrotoxicity (e.g. TDF). If both UP/C and UA/C are measured, UP/C > UA/C suggests tubular proteinuria. Screening values for UA/C are: < 30, 30-70 and > 70. UA/C should be monitored in persons with diabetes. UPC ratio is calculated as urine protein (mg/L) / urine creatinine (mmol/L); may also be expressed as mg/mg. Conversion factor for mg to mmol creatinine is x 0.000884.

iv Repeat eGFR and urinalysis as per screening table, see page 5

v See Dose Adjustment of ARVs for Impaired Renal Function

vi Joint management with a nephrologist

vii HIVAN suspected if black ethnicity & UP/C > 100 mg/mmol & no haematuria

viii See page 37

ix See page 35-36

ARV-associated Nephrotoxicity

Renal abnormality*	ARV	Management[vi]
Proximal tubulopathy with any combination of: 1. Proteinuria: urine dipstick ≥ 1, or confirmed increase in UP/C > 30 mg/mmol[i] 2. Progressive decline in eGFR and eGFR < 90 mL/min[ii] 3. Phosphaturia[iii]: confirmed hypophosphataemia secondary to increased urine phosphate leak	**TDF**	**Assessment:** • Tests for proximal renal tubulopathy/renal Fanconi syndrome[iii] • Consider renal bone disease if hypophosphataemia of renal origin: measure 25(OH) vitamin D, PTH, DEXA **Consider stopping TDF if:** • Progressive decline in eGFR and no other cause • Confirmed hypophosphataemia of renal origin and no other cause • Osteopenia/osteoporosis in the presence of increased urine phosphate leak
Nephrolithiasis: 1. Crystalluria 2. Haematuria[iv] 3. Leucocyturia 4. Loin pain 5. Acute renal insufficiency	**IDV** **ATV** **(DRV)**	**Assessment:** • Urinalysis for crystalluria/stone analysis • Exclude other cause for nephrolithiasis • Renal tract imaging including CT scan **Consider stopping IDV/ATV if:** • Confirmed renal stones • Recurrent loin pain +/- haematuria
Interstitial nephritis: 1. Progressive decline in eGFR[ii] 2. Tubular proteinuria[iii]/ haematuria 3. Eosinophiluria (if acute)	**IDV** **ATV**[v]	**Assessment:** • Renal ultrasound • Refer nephrologist **Consider stopping IDV/ATV if:** • Progressive decline in eGFR and no other cause

* Use of COBI, DTG, RPV, but also PIs, is associated with an increase in serum creatinine/reduction of eGFR due to inhibition of proximal tubular creatinine transporters without impairing actual glomerular filtration: consider new set point after 1-2 months

i UP/C in spot urine detects total urinary protein including protein of glomerular or tubular origin. The urine dipstick analysis primarily detects albuminuria as a marker of glomerular disease and is inadequate to detect tubular disease.

ii eGFR, according to the abbreviated MDRD (Modification of Diet in Renal Disease) formula. The Cockcroft-Gault (CG) equation may be used as an alternative.

iii See Indications and Tests for Proximal Renal Tubulopathy (PRT)

iv Microscopic haematuria is usually present

v ATV may cause decline in eGFR – also without clinical detected nephrolithiasis – but exact pathology and clinical significance remain unclear

vi Tools to predict risk of kidney disease while using different nephrotoxic ARVs are currently beeing developed

Indications and Tests for Proximal Renal Tubulopathy (PRT)

Indications for proximal renal tubulopathy tests	Proximal renal tubulopathy tests[iv], including	Consider stopping TDF if
• Progressive decline in eGFR[i] & eGFR < 90 mL/min & no other cause and/or • Confirmed hypophosphataemia[ii] and/or • Confirmed increase in UP/C[iii] • Renal insufficiency even if stable (eGFR < 60 mL/min) • Tubular proteinuria[v]	• Blood phosphate and urinary phosphate excretion[vi] • Blood glucose and glucosuria • Serum bicarbonate and urinary pH[vii] • Blood uric acid level and urinary uric acid excretion[viii] • Serum potassium and urinary potassium excretion	• Confirmed proximal renal tubulopathy with no other cause

i eGFR according to the abbreviated MDRD formula (Modification of Diet in Renal Disease). The Cockcroft-Gault (CG) equation may be used as an alternative.

ii Serum phosphate < 0.8 mmol/L or according to local thresholds; consider renal bone disease, particularly if alkaline phosphatase increased from baseline: measure 25(OH) vitamin D, PTH

iii UP/C in spot urine, detects total urinary protein, including protein of glomerular or tubular origin. The urine dipstick analysis primarily detects albuminuria as a marker of glomerular disease and is inadequate to detect tubular disease

iv It is uncertain which tests discriminate best for TDF renal toxicity. Proximal tubulopathy is characterised by: proteinuria, hypophosphataemia, hypokalaemia, hypouricaemia, renal acidosis, glucosuria with normal blood glucose level. Renal insufficiency and polyuria may be associated. Most often, only some of these abnormalities are observed

v Tests for tubular proteinuria include retinol binding protein, α1- or β2 -microglobulinuria, cystatin C, aminoaciduria

vi Quantified as fractional excretion of phosphate (FEPhos): (PO_4(urine) / PO_4(serum)) / (Creatinine(urine) / Creatinine(serum)) in a spot urine sample collected in the morning in fasting state. Abnormal > 0.2 (> 0.1 with serum phosphate < 0.8 mmol/L)

vii S-bicarbonate < 21 mmol/L and urinary pH > 5.5 suggests renal tubular acidosis

viii Fractional excretion of uric acid (FEUricAcid): (UricAcid(urine) / UricAcid(serum) / (Creatinine(urine) / Creatinine(serum)) in a spot urine sample collected in the morning in fasting state; abnormal > 0.1

Dose Adjustment of ARVs for Impaired Renal function

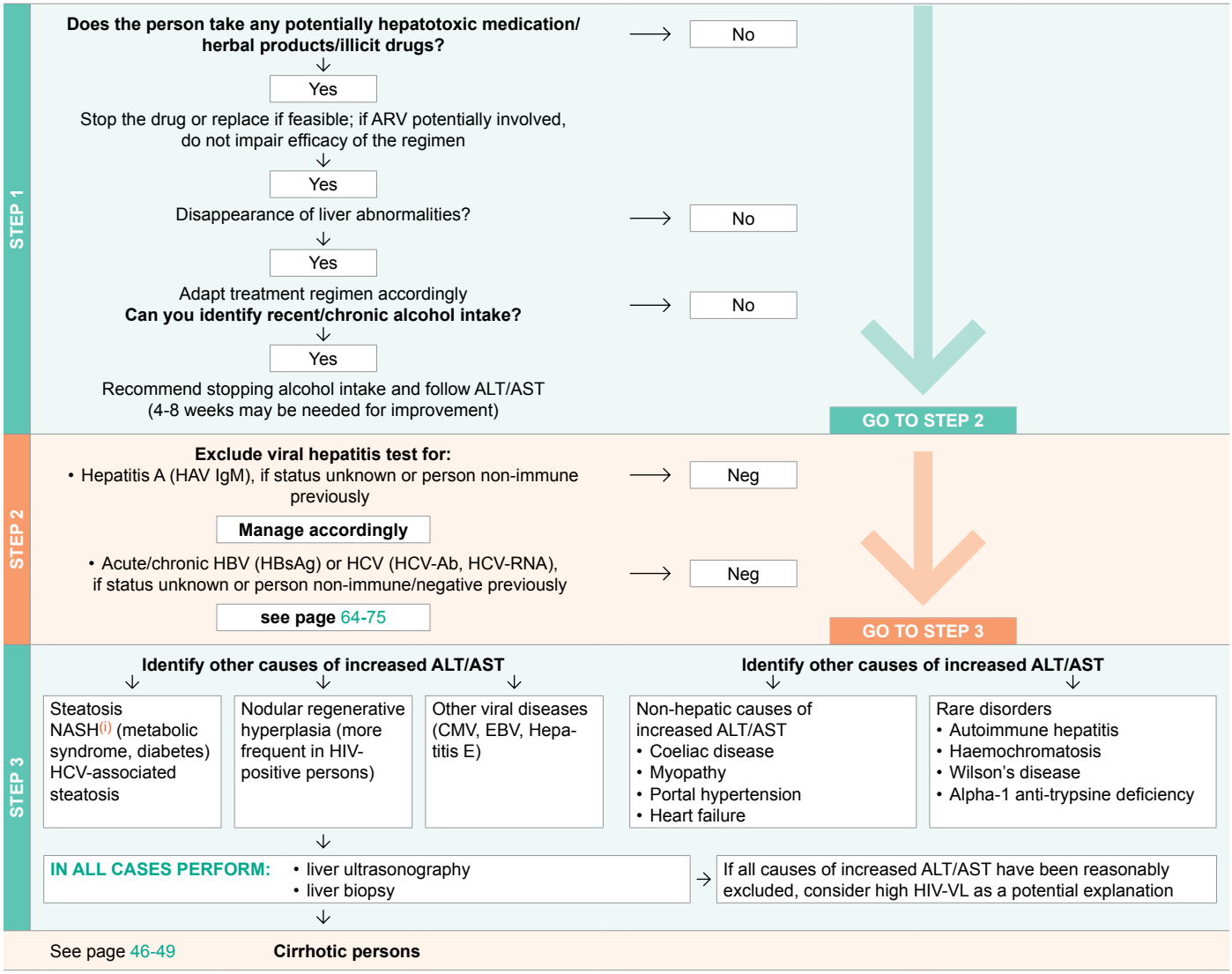
		eGFR[i] (mL/min)				Haemodialysis
		≥ 50	30-49	10-29	< 10	
NRTIs						
ABC	300 mg q12h	No dose adjustment required	No dose adjustment required	No dose adjustment required		
ddI[ii]	≥ 60 kg	400 mg q24h	200 mg q24h	150 mg q24h	**> 60 kg: 100 mg/24h**	
	< 60 kg	250 mg q24h	125 mg q24h	100 mg q24h	**< 60 kg: 75 mg/24h**	
d4T	> 60 kg	30 mg q12h	15 mg q12h	15 mg q24h	15 mg q24h	15 mg q24h AD[iv]
	< 60 kg	40 mg q12h	20 mg q12h	20 mg q24h	20 mg q24h	20 mg q24h AD[iv]
FTC		200 mg q24h	200 mg q48h	200 mg q72h	200 mg q96h	200 mg q96h
3TC		300 mg q24h	150 mg q24h	100 mg q24h[iii]	50-25 mg q24h[iii]	50-25 mg q24h[iii] AD[iv]
TDF[vii]		300 mg q24h	300 mg q48h	Not recommended (300 mg q72-96h, if no alternative)	Not recommended (300 mg q7d, if no alternative)	300 mg q7d AD[iv]
ZDV		300 mg q12h	No dose adjustment required		100 mg q8h	100 mg q8h
ABC/3TC		Use individual drugs				
ZDV/3TC						
ZDV/3TC/ABC						
TDF/FTC		q24h	q48h	Use individual drugs		
NNRTIs						
EFV		600 mg q24h	No dose adjustment required			
ETV		200 mg q12h	No dose adjustment required			
NVP		200 mg q12h	No dose adjustment required			

	eGFR[i] (mL/min)				Haemodialysis
	≥ 50	30-49	10-29	< 10	
PIs					
ATV/r	300/100 mg q24h	No dose adjustment required[v,vi]			
DRV/r	800/100 mg q24h 600/100 mg q12h	No dose adjustment required[v]			
FPV/r	700/100 mg q12h	No dose adjustment required[v]			
LPV/r	400/100 mg q12h	No dose adjustment required[v]			
SQV/r	1000/100 mg q12h	No dose adjustment required[v]			
TPV/r	500/200 mg q12h	No dose adjustment required[v]			
Other ART					
RAL	400 mg q12h	No dose adjustment required[v] (dose AD[iv])			
TDF/FTC/COBI/EVG	Do not initiate if eGFR < 70 mL/min	Discontinue if eGFR < 50 mL/min			
MVC: co-administered without CYP3A4 inhibitors[viii]	300 mg q12h	No dose adjustment required			
MVC: co-administered with CYP3A4 inhibitors[viii]	if eGFR < 80 mL/min 150 mg q24h[viii] except: 150 mg q12h if co-administered with FPV/r				

i eGFR according to the abbreviated MDRD (Modification of Diet in Renal Disease) formula. The Cockcroft-Gault (CG) equation may be used as an alternative.
ii Dose reduction if combined with TDF
iii 150 mg loading dose
iv AD: after dialysis
v Limited data available in persons with renal impairment; pharmacokinetic analysis suggests no dose adjustment required
vi Associated with nephrotoxicity; consider alternative PI if pre-existing CKD
vii Associated with nephrotoxicity; consider alternative ART if pre-existing CKD
viii See summary of product characteristics for specific recommendations; use with caution if eGFR < 30 mL/min

Work-up and Management of HIV-positive Persons with Increased ALT/AST

Identify potential cause of increased liver enzymes, using the following steps:



i Nonalcoholic steatohepatitis

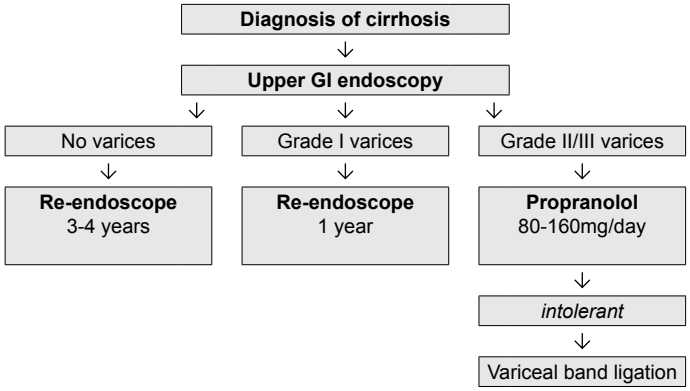
Liver Cirrhosis: Classification and Surveillance

Child-Pugh classification of the severity of cirrhosis

	Point*		
	1	2	3
Total bilirubin, mg/dL (µmol/L)	< 2 (< 34)	2-3 (34-50)	> 3 (> 50)
Serum albumin, g/L (µmol/L)	> 35 (> 507)	28-35 (406-507)	< 28 (< 406)
INR	< 1.7	1.71-2.20	> 2.20
Ascites	None	Mild/Moderate (diuretic responsive)	Severe (diuretic refractory)
Hepatic encephalopathy	None	Grade I-II (or suppressed with medicine)	Grade III-IV (or refractory)

* 5-6 points: Class A
7-9 points: Class B
10-15 points: Class C

Algorithm for surveillance for varices and primary prophylaxis



Liver Cirrhosis: Management

Management of HIV-positive persons with cirrhosis should be done in collaboration with experts in liver diseases. More general management guidance is described below.
For dosage adjustment of antiretrovirals, see Dose Adjustment of ARVs for Impaired Hepatic Function.
In end-stage liver disease (ESLD), use of EFV may increase risk of CNS symptoms.
ART, if otherwise indicated, also provides net benefit to cirrhotic persons.
See Diagnosis and Management of Hepatorenal Syndrome (HRS).

Management of hypervolaemic hyponatraemia	Management strategy of hepatic encephalopathy (HE)
1. Fluid restriction: 1000-1500 mL/day (consumption of bouillon allowed ad libitum) 2. If fluid restriction is ineffective, consider use of oral Tolvaptan a. To be started in hospital at 15 mg/day for 3-5 days, then titrated to 30-60 mg/day until normal s-Na; duration of treatment unknown (efficacy/safety only established in short-term studies (1 month)) b. S-Na should be monitored closely, particularly after initiation, dose modification or if clinical status changes. c. Rapid increases in s-Na concentration (> 8 mmol/day) should be avoided to prevent osmotic demyelisation syndrome d. Persons may be discharged after s-Na levels are stable and without need to further adjust dose	**General management** 1. Identify and treat precipitating factor (GI haemorrhage, infection, pre-renal azotaemia, constipation, sedatives) 2. Short-term (< 72 hours) protein restriction may be considered if HE is severe **Specific therapy** Lactulose 30 cm^3 orally every 1-2h until bowel evacuation, then adjust to a dosage resulting in 2-3 formed bowel movements per day (usually 15-30 cm^3 orally bd) Lactulose enemas (300 cm^3 in 1L of water) in persons who are unable to take it orally. Lactulose can be discontinued once the precipitating factor has resolved

Management strategy in uncomplicated ascites	
General management	• Treat ascites once other complications have been treated • Avoid NSAIDs • Norfloxacin prophylaxis (400 mg orally, qd) in persons with **1)** an ascites protein level of < 1.5 mg/dL, **2)** impaired renal function (serum creatinine level > 1.2 mg/dL, BUN > 25 mg/dL), **3)** s-Na level < 130mE g/L), or **4)** severe liver failure (Child Pugh score > 9 points with s-bilirubin level > 3 mg/dL)
Specific management	• Salt restriction: 1-2 g/day. Liberalise if restriction results in poor food intake • Large volume paracentesis as initial therapy only in persons with tense ascites • Administer intravenous albumin (= 6-8 g per litre ascites removed)
Follow-up and goals	• Adjust diuretic dosage every 4-7 days • Weigh the person at least weekly and BUN, s-creatinine, and electrolytes measured every 1-2 weeks while adjusting dosage • Double dosage of diuretics if: weight loss < 2 kg a week and BUN, creatinine and electrolytes are stable • Halve the dosage of diuretics or discontinue if: weight loss ≥ 0.5 kg/day or if there are abnormalities in BUN, creatinine or electrolytes • Maximum diuretic dosage: Spironolactone (400 mg qd) and Furosemide (160 mg qd)

Nutrition of cirrhotic persons	
Caloric requirements • 25-30 Kcal/Kg/day of normal body weight **Protein requirements** • Protein restriction is not recommended (see above for exception if HE)	• Type: rich in branched chain (non-aromatic) amino acids • Some studies support that parental proteins carry less risk of encephalopathy since not converted by colonic bacteria into NH_3 **Micronutrients** • Mg and Zn

Analgesia in persons with hepatic failure	
• **Acetaminophen** can be used; caution on daily dose (max 2 g/day). • **NSAIDs generally avoided,** predispose persons with cirrhosis to develop GI bleeding. Persons with decompensated cirrhosis are at risk for NSAID-induced renal insufficiency.	• **Opiate** analgesics are not contraindicated but must be used with caution in persons with pre-existing hepatic encephalopathy.

Screening for hepatocellular carcinoma

- Ultrasound (US) every 6 months
  Alpha-foetoprotein is a suboptimal surveillance tool because of low sensitivity and specificity
- In case of suspicious lesions on US, perform CT scan (+arterial phase) or dynamic contrast-enhanced MRI
- Confirm diagnosis by fine needle aspiration or biopsy should CT scan or MRI be inconclusive.

When to refer for liver transplantation
Best to refer early as disease progresses rapidly

= MELD[ii] score 10-12 (listing at 15)
Decompensated cirrhosis (at least one of the following complications)

- Ascites
- Hepatic encephalopathy
- Variceal bleeding
- Spontaneous bacterial peritonitis
- Hepatorenal syndrome
- Hepatopulmonary syndrome
- Hepatocellular carcinoma

i Alpha-foetoprotein may also be expressed in µg/L (cut-off value of 400 is the same)
ii Unit for both S-creatinine and S-bilirubin is mg/dL.
MELD score = 10 {0,957 Ln (serum creatinine (mg/dL)) + 0.378 Ln (total bilirubin (mg/dL)) + 1.12 Ln (INR) + 0.643}. See www.mdcalc.com/meld-score-model-for-end-stage-liver-disease-12-and-older/

Diagnosis and Management of Hepatorenal Syndrome (HRS)

Diagnosis	Consider HRS in a person with cirrhosis and ascites and a creatinine level of > 1.5 mg/dL. It is a diagnosis of exclusion - before making the diagnosis, the following need to be ruled out and treated: • Sepsis (person needs to be pancultured) • Volume depletion (haemorrhage, diarrhoea, overdiuresis) • Vasodilatators • Organic renal failure (urine sediment; kidney ultrasound) Diuretics should be discontinued and intravascular volume expanded with iv albumin. If renal dysfunction persists despite above, diagnose HRS		
Recommended therapy	Liver transplant (priority dependent on MELD score). If person is on transplant list, MELD score should be updated daily and communicated to transplant centre.		
Alternative (bridging therapy)	Vasoconstrictors	Octreotide	100-200 mcg subcutaneously td
			→ Goal to increase mean arterial pressure by 15 mm HG
		+ Midodrine	5-15 mg orally td
		or Terlipressin(i)	0.5-2.0 mg iv every 4-6 hours
	and iv albumin (both for at least 7 days)		50-100 g iv qd

i Tesamorelin (growth hormone releasing factor) was shown to reduce visceral adipose tissue volume but this effect was lost on discontinuation; the drug is not currently licensed in Europe

Dose Adjustment of ARVs for Impaired Hepatic Function

NRTIs	
ABC	**Child-Pugh Score** 5–6: 200 mg bd (use oral solution)
	Child-Pugh Score > 6: Contraindicated
ddI	Contraindicated
	If used no dosage adjustment
d4T	Contraindicated
	If used no dosage adjustment
FTC	No dosage adjustment
3TC	No dosage adjustment
TDF	No dosage adjustment
TDF/FTC	No dosage adjustment
ZDV	Reduce dose by 50% or double the interval between doses if Child-Pugh > 9
NNRTIs	
DLV	No dosage recommendation; use with caution in persons with hepatic impairment
EFV	No dosage adjustment; use with caution in persons with hepatic impairment
TDF/FTC/EFV	
ETV	**Child-Pugh score** < 10: no dosage adjustment
NVP	**Child-Pugh score** > 6: contraindicated

PIs	
ATV	Child-Pugh Score 7–9: 300 mg once daily
	Child-Pugh Score > 9: not recommended
	RTV boosting is not recommended in persons with hepatic impairment (Child-Pugh Score > 7)
DRV	Mild to moderate hepatic impairment: no dosage adjustment
	Severe hepatic impairment: not recommended
FPV	**PI-naive persons only:**
	Child-Pugh Score 5–9: 700 mg bd
	Child-Pugh Score 10–15: 350 mg bd
	PI-experienced persons:
	Child-Pugh Score 5–6: 700 mg bd + RTV 100 mg qd
	Child-Pugh Score 7–9: 450 mg bd + RTV 100 mg qd
	Child-Pugh Score 10–15: 300 mg bd + RTV 100 mg qd
IDV	Mild to moderate hepatic insufficiency: 600 mg q8h
LPV/r	No dosage recommendation; use with caution in persons with hepatic impairment
NFV	Mild hepatic impairment: no dosage adjustment
	Moderate to severe hepatic impairment: not recommended
RTV	Refer to recommendations for the primary PI
SQV	Mild to moderate hepatic impairment: use with caution
	Severe hepatic impairment: contraindicated
TPV	Child-Pugh score < 7: use with caution
	Child-Pugh score > 6: contraindicated
FI	
ENF	No dosage adjustment
CCR5 Inhibitor	
MVC	No dosage recommendations. Concentrations will likely be increased in persons with hepatic impairment
INSTI	
RAL	No dosage adjustment

Note: Hepatic dysfunction is a good indication for TDM as clinical experience with these dose adjustments is very limited

Lipodystrophy: Prevention and Management

LIPOATROPHY	LIPOHYPERTROPHY
Prevention • Avoid d4T and ZDV or pre-emptively switch away from them • Regimens containing ritonavir-boosted PIs lead to more limb fat gain than regimens containing NNRTIs • Regimens not containing NRTIs lead to more fat gain than regimens containing NRTIs • CCR5 and INSTI have not been associated with lipoatrophy in registrational studies, although not in formal comparative studies	**Prevention** • No proven strategy. • ATV/r has been associated with more central fat gain than EFV • Weight gain expected with effective ART reflecting "return to health" type of response • Weight reduction or avoidance of weight gain may decrease visceral adiposity • Avoid inhaled Fluticasone (and potentially other inhaled corticosteroids) with RTV-boosted PI as it may cause Cushing syndrome or adrenal insufficiency
Management • Modification of ART – Switch d4T or ZDV to ABC or TDF: – Only ART modification proven to partially restore subcutaneous fat; increase in total limb fat ~400-500 g/year – Risk of toxicity from new drug, see Adverse Effects of ARVs & Drug Classes – Switch to regimen not including NRTIs – Increase in total limb fat ~400-500 g/year – May increase risk of dyslipidaemia • Surgical intervention – Offered for relief of facial lipoatrophy only	**Management** • Diet and exercise may reduce visceral adiposity; – Limited data, but possible reduction in visceral adipose tissue and improvement in insulin sensitivity and blood lipids, especially in obesity associated with lipohypertrophy – No prospective trials in HIV-positive persons to definitely indicate degree of diet and/or exercise needed to maintain reduction in visceral fat – May worsen subcutaneous lipoatrophy • Pharmacological interventions to treat lipohypertrophy have not been proven to provide long-term effects and may introduce new complications; • Growth hormone – Decreases visceral adipose tissue – May worsen subcutaneous lipoatrophy and insulin resistance • Tesamorelin(i) • Metformin – Decreases visceral adipose tissue in insulin resistant persons – May worsen subcutaneous lipoatrophy • Surgical therapy can be considered for localised lipomas/buffalo humps – Duration of effect variable

i See Diagnosis and Management of Heptatorenal Syndrome (HRS)

Hyperlactataemia and Lactic Acidosis: Diagnosis, Prevention and Management

Risk factors	Prevention/Diagnosis	Symptoms
• Use of ddI > d4T > ZDV • HCV/HBV co-infection • Use of ribavirin • Liver disease • Low CD4 cell count • Pregnancy • Female sex • Obesity	• Avoid d4T + ddI combination • Routine monitoring of serum lactate levels not recommended - does not predict risk of lactic acidosis. • Measurement of serum lactate, bicarbonate & arterial blood gases + pH indicated in case of symptoms suggestive of hyperlactataemia • Close monitoring for symptoms if > 1 risk factor	• Hyperlactataemia: unexplained nausea, abdominal pain, hepatomegaly, elevated ALT and/or AST, weight loss • Acidaemia: asthenia, dyspnoea, arrhythmias • Guillain-Barré-like syndrome

Management

Serum Lactate (mmol/L)	Symptoms	Action
> 5(i)	Yes/No	• Repeat test under standardised conditions to confirm & obtain arterial pH and bicarbonate(i) • If confirmed, exclude other causes – Arterial pH ↓ and/or bicarbonate ↓(i): Stop NRTIs – Arterial pH and/or bicarbonate normal: Consider switch from high to low-risk NRTI & monitor carefully OR stop NRTIs
2-5	Yes	Exclude other causes; if none found: watchfully follow up OR consider switch from high to low-risk NRTI, OR stop NRTI
2-5	No	Repeat test If confirmed, watchfully follow up
< 2		None

i Lactic acidosis is a rare but life-threatening situation usually associated with symptoms; high risk if serum lactate > 5 and especially > 10 mmol/L.

Management of lactic acidosis (irrespective of serum-lactate level)

Admit the person. Stop NRTIs. Provide iv fluids. Vitamin supplementation can be used (vitamin B complex forte 4 mL bd, riboflavin 20 mg bd, thiamine 100 mg bd; L-carnitine 1000 mg bd), although benefit is unproven.

Travel

General precautions	• Delay travel until clinically stable and treatment established • Provide drug prescription and referral letter for emergencies • Provide medical certificate for import of personal medicines/syringes • Carry antiretrovirals split between suitcase and hand luggage • Beware of fake drugs
ART	• Maintain hours of medicines (e.g. 23.00 local time) when switching time zones, shortening the interval to the next dose when flying east
Acknowledge increased susceptibility[i] of HIV-positive	**1. Observe food hygiene** • Bacterial enterocolitis e.g. Salmonella, Shigella, Campylobacter • Intestinal parasitosis Cyclospora, Cryptosporidium, Isospora, Microsporidia **2. Prevent insect bites** • Repellents (DEET ≥ 30%, Permethrin) • Malaria Chemoprophylaxis/emergency treatment[ii] • Yellow fever, see page 55 • Leishmaniasis Beware of sand flies (dogs)

Advice on travel restrictions – see www.hivtravel.org

i Higher susceptibility due to HIV-associated GALT destruction, low CD4

ii According to malaria risk at travel destination and national guidelines; adherence counselling is particularly important in persons visiting friends and relatives. See Drug-drug Interactions between Antimalarial Drugs and ARVs

Drug-drug Interactions between Antimalarial Drugs and ARVs

Effect of ARVs on antimalarial drugs and key metabolite

Legend:
Arrows indicate effect of antiretrovirals on antimalarial drug/key metabolite
Green no clinically significant interaction expected
Orange potential interaction (consider treatment ahead of travel and therapeutic drug monitoring)
Red clinically relevant interaction, do not use or use with caution

Mefloquine (M)		
Key Metabolite **Indication**	**CYP 3A4** **Prophylaxis** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	↓	No
RPV, RAL, MVC, DTG	→	No
PI, COBI	↑ M may reduce PI/COBI (RTV ca 35%)	Potential

Artemisinins (A)		
Artemisinins and its key metabolite, dihydroartemisinin, are active compounds		
Key Metabolite **Indication**	**CYP 2B6, 3A4, 2C19** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	↓ A & dihydroartemisinin; A & metabolites reduce NVP, but not EFV/ETR	do not use or use with caution
RPV, RAL, MVC, DTG	→ A may reduce RPV, MVC	Potential
PI, COBI	↑ Increase A: monitor toxicity (liver)	Potential

Lumefantrin (L)		
Key Metabolite **Indication**	**CYP 3A4** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	↓	Potential
RPV, RAL, MVC, DTG	→	No
PI, COBI	↑ LPV increases L 2-3x	do not use or **use with caution**

Atovaquone (A), Proguanil		
• •Atovaquone increases ZDV levels by 35% • •Synergy with atovaquone is related to proguanil, not its active metabolite; therefore presumably no net effect of induction/inhibition		
Key Metabolite **Indication**	**CYP 2C19** **Prophylaxis** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	↓ ETV is increased	Potential
RPV, RAL, MVC, DTG	→	No
PI, COBI	↓ At & P take with fat meal, consider dose increase	Potential

Doxycycline		
Key Metabolite **Indication**	**N/A** **Prophylaxis**	**Significance**
NNRTI (EFV, NVP, ETV)	possibly ↓	Potential
RPV, RAL, MVC, DTG	→	No
PI, COBI	→	No

Chloroquine		
Key Metabolite **Indication**	**CYP 3A4, 2D6** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	→	No
RPV, RAL, MVC, DTG	→	No
PI, COBI	→	No

Quinine (Q)		
Key Metabolite **Indication**	**CYP 3A4, 2D6** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	↓ Consider dose increase	Potential
RPV, RAL, MVC, DTG	→	No
PI, COBI	↑ RTV increases Q 4x: consider dose reduction, monitor toxicity (tinnitus). CAVE: PI & Q prolong QT	Potential

Primaquine		
Key Metabolite **Indication**	**CYP 1A2, 2D6, 3A4** **(Prophylaxis)** **Treatment**	**Significance**
NNRTI (EFV, NVP, ETV)	N/A	Potential
RPV, RAL, MVC, DTG	→	No
PI, COBI	N/A	

Vaccination

• Vaccinate according to national guidelines for healthy population • Delay polysaccharide vaccination until CD4 ≥ 200 cells/µL • Consider repeating vaccinations performed at CD4 < 200 cells/µL (CD4% < 14) following adequate immune reconstitution • As vaccine responses may be significantly lower in HIV-positive persons, consider antibody titres to assess their effectiveness	• For attenuated live vaccines[i] (in addition to restrictions for general population): • ***Varicella, measles, mumps, rubella, yellow fever*** contraindicated if CD4 < 200 cells/µL (14%) and/or AIDS • **Oral typhoid, oral polio (OPV)** contraindicated as inactivated vaccines are available

Infection	Vaccination rationale in HIV+ persons	Comment
Influenza Virus	Higher rate of pneumonia	Yearly
Human Papilloma Virus (HPV)	Shared risk with HIV of contracting infection. Higher rate of cervical and anal cancer	If HPV infection is established, efficacy of vaccine is questionable
Hepatitis B Virus (HBV)	Shared risk with HIV of contracting infection. HIV accelerates liver disease progression	Vaccinate if seronegative. Consider double dose (40 µg) and intradermal vaccination in non-responders, in particular with low CD4 and high viraemia. Repeat doses until HBs antibodies ≥ 10 IU/L / ≥ 100 IU/L according to national guidelines. See page 64
Hepatitis A Virus (HAV)	According to risk profile (travel, MSM, IVDU, active hepatitis B or C infection)	Vaccinate if seronegative. Check antibody titres in individuals with risk profile See page 64
Neisseria meningitidis	As general population	Use conjugated vaccine (2 doses) if available, then continue with polysaccharide vaccine
Streptococcus pneumoniae	Higher rate and severity of invasive disease	Consider conjugated 13-valent vaccine instead of PPV-23 polysaccharide vaccine if available[ii] Consider one single booster with PPV-23 after 5 years[iii]
Varicella Zoster Virus (VZV)	Higher rate and severity of both chickenpox and zoster	Vaccinate if seronegative For contraindications, see*
Yellow Fever Virus	Mandatory for travel to selected countries (provide exemption letter if no true risk of exposure)	Contraindicated if past or current haematological neoplasia or thymus resection/radiation Relatively contraindicated at age > 60 years For other contraindications, see*

i Administer live vaccines simultaneously or with an interval of 4 weeks
ii 13-valent conjugated vaccine may replace 23-valent polysaccharide vaccine as more immunogenic
iii Repetitive boosting may attenuate immune response

Sexual and Reproductive Health of HIV-positive Women and Men

Screening questions about sexual and reproductive health and sexual functioning should be routinely asked in every HIV consultation.

Sexual transmission of HIV

Effective measures to reduce sexual transmission of HIV include:

Measure	Comment
Male condom or female condom use	• Effective in treated and untreated HIV-positive persons
Post-exposure prophylaxis (PEP)	• Consider after situations of unprotected anal or vaginal intercourse, if one partner has detectable HIV-VL and the other partner is seronegative • Start as soon as possible and within 72 hours post sexual exposure
ART for HIV-positive partner	• Considered effective from 6 months of fully suppressive ART if no active STIs • Consider in e.g. serodifferent couples(i)

i See page 7

STI screening and treatment

STI screening should be offered to all sexually active HIV-positive persons at the time of HIV diagnosis, annually thereafter or at any time STI symptoms are reported. Diagnosis procedures should follow local or national guidelines. More comprehensive advice can be found at www.iusti.org/regions/Europe/euroguidelines.htm

The following STIs should be universally considered in HIV-positive persons and their sexual partner(s):

	Therapy	Comment
Chlamydia infection	Consider Doxycycline (100 mg bd for 7-10 days) or Ofloxacin (200 mg bd), Erythromycin (500 mg qd for 7 days) or Azithromycin (1 g once). For *Lymphogranuloma venereum* consider Doxycycline (100 mg bd for at least 3 weeks)	• May cause therapy-resistant proctitis in HIV-positive MSM • Consider co-infections with *Neisseria gonorrhoeae*
Gonorrhoea	Therapy recommended according to geographical resistance profiles. Ceftriaxone 500 mg im as a single dose together with Azithromycin 2 g as a single dose po.	• Can cause proctitis, prostatitis and epididymitis • In women often asymptomatic • Fluroquinolone resistance is extensive
HBV infection **HCV infection**	See table on HIV/HCV or HIV/HBV co-infections, page 64, 66-79	• Interruption of TDF, 3TC or FTC can lead to HBV reactivation • Clusters of acute HCV infection in HIV-positive MSM across Europe
HPV infection	Treatment of genital warts is challenging. Consider operative removal by laser surgery, infrared coagulation, cryotherapy etc. Management of both pre-invasive cervical lesions as well as peri- and intra-anal lesions should follow local or national guidelines	• Infection is mostly asymptomatic; relapse of genital warts is frequent • Cervical PAP smear test recommended in all HIV-positive women • Anal HPV screening and PAP smear should be considered in all HIV-positive persons practising anal sex • Consider high resolution anoscopy in case of suspicious cytological findings (rectal palpation or external inspection is not sufficient)
HSV2 infection	Primary infection: Acyclovir (400–800 mg po td) or Valacyclovir (500 mg bd) for 5 days	• Treatment of HSV2 alone does not prevent HIV-transmission and only modestly prevents HIV disease progression.
Syphilis	**Primary/secondary syphilis:** Benzathine Penicillin G (2.4 million IU im as single dose). **Late latent syphilis and syphilis of unknown duration:** Benzathine Penicillin (2.4 mio IU im weekly on days 1, 8 and 15); alternatives such as Doxycycline (100 mg bd), or Erythromycin (2 g/day) for 2 weeks are considered less effective. **Neurosyphilis:** Penicillin G (6 x 3 - 4 million IU iv for at least 2 weeks)	• Expect atypical serology and clinical courses • Consider cerebral spinal fluid (CSF) testing in persons with neurological symptoms (evidence for intrathecally-produced specific antibodies, pleocytosis etc.) • Successful therapy clears clinical symptoms and/or decreases VDRL test by at least 2 titre levels • Serology cannot distinguish re-infection from re-activation

Reproductive health

Reproductive health issues should be preferentially discussed with both partners, particularly in serodifferent couples. RAL, RPV and NRTIs have been shown to have no interaction with oral contraceptives.

Approaches for serodifferent couples who want to have children
Screening for STIs (and treatment, if required) of both partners is mandatory. For HIV-positive women wishing to conceive: (1) avoid using ddI, d4T or triple NRTI, avoid EFV in first trimester; among PI/r, prefer LPV/r, SQV/r or ATV/r, already started NVP, RAL or DRV/r can be continued, see page 12; (2) consider treating the HIV-positive partner to reduce risk of HIV transmission to the HIV-negative partner

No single method is fully protective against transmission of HIV; the following list represents selected measures with increasing safety for serodifferent couples without active STIs:
- Unprotected intercourse during times of maximum fertility (determined by ovulation monitoring), if the HIV-positive partner has undetectable HIV-VL
- Vaginal syringe injection of seminal fluid during times of maximum fertility, if the male partner is HIV-negative
- Sperm washing, with or without intra-cytoplasmic sperm injection, if the male partner is HIV-positive

Sexual dysfunction

Guidelines for treatment of sexual dysfunction in the general population are available for men but not women. Refer to specialist where appropriate. See Sexual Dysfunction and Treatment of Sexual Dysfunction in HIV-positive Men

Sexual Dysfunction

When sexual complaints exist:	What is the exact nature of the problem? In which phase(s) of the sexual response cycle does the problem occur?	**1. Desire** (lack of sexual desire or libido; desire discrepancy with partner; aversion to sexual activity) **2. Arousal** (difficulties with physical and/or subjective sexual arousal; difficulties or inability to achieve or sustain an erection of sufficient rigidity for sexual intercourse (M)–i.e. erectile dysfunction; lack or impaired nocturnal erections (M); difficulties lubricating (W); difficulties sustaining arousal) **3. Orgasm** (difficulties experiencing orgasm) **4. Pain** (pain with sexual activity; difficulties with vaginal/anal penetration–anxiety, muscle tension; lack of sexual satisfaction and pleasure)	
Identify the causes:	Psychological or sociological problems?	Stigma, body image alteration, depression, fear of infecting an HIV-negative partner?	*Refer to clinical psychologist*
	Relevant co-morbidity?	CVD (note: if complete sexual response possible - e.g. with another partner, with masturbation or nocturnal - then no major somatic factors are involved)	*Refer to urologist, andrologist, cardiologist*
	Relevant medicines, drugs, lifestyle factors?	Drugs associated with sexual dysfunction: 1) psychotropics (antidepressants, antiepileptics, antipsychotics, Benzodiazepines), 2) lipid-lowering drugs (Statins, Fibrates), 3) antihypertensives (ACE-inhibitors, betablockers, alfablockers), 4) others (Omeprazole, Spironolactone, Metoclopramide, Finasteride, Cimetidine); 5) contribution from ARVs is controversial and benefit from switching studies is not proven.	*Refer to clinical pharmacologist*
	Signs of hypogonadism in men?	Signs of testosterone insufficiency (reduced sexual arousal and libido; decreased frequency of sexual thoughts and fantasies; decreased or absent nocturnal erections; decreased genital sensitivity; loss of vitality; fatigue; loss of muscle mass and muscle strength and decreased body hair)	*Refer to endocrinologist*

Treatment of Sexual Dysfunction in HIV-positive Men

Treatment of Erectile dysfunction	Treatment of Premature ejaculation
Primarily oral PDE5-Is (Sildenafil, Tadalafil, Vardenafil). • All at least 30 minutes before initiation of sexual activity • Use lower dose if on PI/r – Sildenafil (25 mg every 48 hours) – Tadalafil 5 mg initial dose with maximum dose 10 mg in 72 hours – Vardenafil 2.5 mg maximum dose in 72 hours • Tadalafil also licensed for use as an everyday ongoing therapy	Consider behavioural interventions and/or psychosexual counselling, SSRIs, tricylclic antidepressants, Clomipramine and topical anaesthetics. • Use lower dose of Clomipramine and other tricyclic antidepressants if on PI/r • Dapoxetine, a short-acting SSRI, is the only drug approved for on-demand treatment of premature ejaculation in Europe. • Treatment must be maintained as recurrence is highly likely following withdrawal of medicine

Depression: Screening and Diagnosis

Significance

- Higher prevalence of depression reported in HIV-positive persons (20-40% versus 7% in general population)
- Significant disability and poorer treatment outcomes associated with depression

Screening and diagnosis

Who?	How to screen	How to diagnose
Risk population • Positive history of depression in family • Depressive episode in personal history • Older age • Adolescence • Persons with history of drug addiction, psychiatric, neurologic or severe somatic co-morbidity • Use of EFV and other neurotropic - incl. recreational - drugs • As part of investigation of neurocognitive impairment if any of the 3 initial screening questions are positive, see page 61	• Screen every 1-2 years • Two main questions: 1. Have you often felt depressed, sad or without hope in the last few months? 2. Have you lost interest in activities that you usually enjoy? • Specific symptoms in men: – Stressed, burn out, angry outbursts, coping through work or alcohol • Rule out organic cause (such as hypothyroidism, hypogonadism, Addison's disease, non-HIV drugs, vit B12 deficiency)	**Symptoms – evaluate regularly** **A.** At least 2 weeks of depressed mood OR **B.** Loss of interest OR **C.** Diminished sense of pleasure **PLUS 4 out of 7 of the following:** 1. Weight change of ≥ 5% in one month or a persistent change of appetite 2. Insomnia or hypersomnia on most days 3. Changes in speed of thought and movement 4. Fatigue 5. Feelings of guilt and worthlessness 6. Diminished concentration and decisiveness 7. Suicidal ideation or a suicide attempt

Depression: Management

Degree of depression	Number of symptoms (see page 59: A,B or C + 4/7)	Treatment	Consultation with expert
No	< 4	No	
Mild	4	• Problem-focused consultation • Consider antidepressant treatment(i) • Recommend physical activity	• Always if treating physician is unfamiliar with use of antidepressants • If depression not responding to treatment • If person has suicidal ideation • In case of complex situations such as drug addiction, anxiety disorders, personality disorders, dementia, acute severe life events
Intermediate	5-6	Start antidepressant treatment(i)	
Severe	> 6	Refer to expert (essential)	

i See Drug-drug Interactions between Antidepressants and ARVs

If a person is diagnosed with depression switching off EFV to another third ARV drug according to switch rules is recommended

Classification, Doses, Safety and Adverse Effects of Antidepressants

Mechanisms & classification	Start dose	Standard dose	Lethality in overdose	Insomnia and agitation	Sedation	Nausea or GI effects	Sexual dysfunction	Weight gain
	mg/day							
Selective serotonin-reuptake inhibitors (SSRIs)[i]								
Paroxetine	10-20	20-40	Low	+	- / +	+	++	++
Sertraline	25-50	50-150	Low	+	- / +	+	+	+
Citalopram	10-20	20-40	Low	+	- / +	+	+	+
Escitalopram	5-10	10-20	Low	+	- / +	+	+	+
Mixed or dual-action reuptake inhibitors								
Venlafaxine	37.5-75	75-225	Moderate	++	- / +	+	+	- / +
Mixed-action newer agents								
Mirtazapine	30	30-60	Low	- / +	++	- / +	- / +	++

- none
\+ moderate
++ severe

i For many persons, SSRI induction may be associated with adverse effects (GI tract, dizziness, anxiety, panic attacks). Commencing at lower doses (i.e. 10, 25 & 10 mg for Paroxetine, Sertraline and Citalopram, respectively) and increasing to the above starting doses after 4 to 7 days if tolerated may reduce such effects.

Drug-drug Interactions between Antidepressants and ARVs

antidepressants		ATV/r	DRV/r	LPV/r	SQV/r	EFV	ETV	NVP	RPV	MVC	DTG	EVG/c	RAL
SSRI	citalopram	↑ [a]	↑	↑ [a]	↑ [a]	↓	↓	↓	↔	↔	↔	↑	↔
	escitalopram	↑ [a]	↑	↑ [a]	↑ [a]	↓	↓	↓	↔	↔	↔	↑	↔
	fluvoxamine	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔
	fluoxetine	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔
	paroxetine	↑↓?	↓39%	↑↓?	↑↓?	↔	↔	↔	↔	↔	↔	↑↓?	↔
	sertraline	↓	↓49%	↓	↓	↓39%	↓	↓	↔	↔	↔	↑	↔
SNRI	duloxetine	↑↓	↑↓	↑↓	↑↓	↔	↔	↔	↔	↔	↔	↑	↔
	venlafaxine	↑	↑	↑	↑	↓	↓	↓	↔	D	↔	↑	↔
TCA	amitriptyline	↑	↑	↑	↑ [b]	↔	↔	↔	↔	↔	↔	↑	↔
	clomipramine	↑	↑	↑	↑ [b]	↓	↓	↓	↔	↔	↔	↑	↔
	desipramine	↑	↑	↑5%	↑	↔	↔	↔	↔	↔	↔	↑	↔
	doxepin	↑	↑	↑	↑ [b]	↔	↔	↔	↔	↔	↔	↑	↔
	imipramine	↑ [a]	↑	↑ [a]	↑ [a]	↓	↓	↓	↔	↔	↔	↑	↔
	nortriptyline	↑ [a]	↑	↑ [a]	↑ [a,b]	↔	↔	↔	↔	↔	↔	↑	↔
	trimipramine	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔
TeCA	maprotiline	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔
	mianserine	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔
	mirtazapine	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔
Others	bupropion	↓	↓	↓57%	↓	↓55%	↔	↓	↔	↔	↔	↑?	↔
	lamotrigine	↓32%	↓	↓50%	↓	↔	↔	↔	↔	↔	↔	↔	↔
	nefazodone	↑	↑	↑	↑	↓	↓ E	↓	E	E	↔	↑	↔
	St John's wort	D	D	D	D	D	D	D	D	D	D [c]	D	↔
	trazodone	↑	↑	↑	↑ [b]	↓	↓	↓	↔	↔	↔	↑	↔

Legend

↑ potential elevated exposure of the antidepressant
↓ potential decreased exposure of the antidepressant
↔ no significant effect
D potential decreased exposure of ARV drug
E potential elevated exposure of ARV drug
a ECG monitoring is recommended
b coadministration contraindicated in the European SPC. However, US prescribing information recommends TDM for antidepressants. The charts reflect the more cautious option. Numbers refer to decreased AUC of the antidepressant as observed in drug-drug interactions studies.
SSRI selective serotonin reuptake inhibitors
SNRI serotonin and norepinephrine reuptake inhibitors
TCA tricyclic antidepressants
TeCA tetracyclic antidepressants

Colour legend

no clinically significant interaction expected.
these drugs should not be coadministered.
potential interaction which may require a dosage adjustment or close monitoring.
potential interaction predicted to be of weak intensity (< 2 fold ↑AUC or < 50% ↓AUC). A dosage adjustment is *a priori* not recommended.

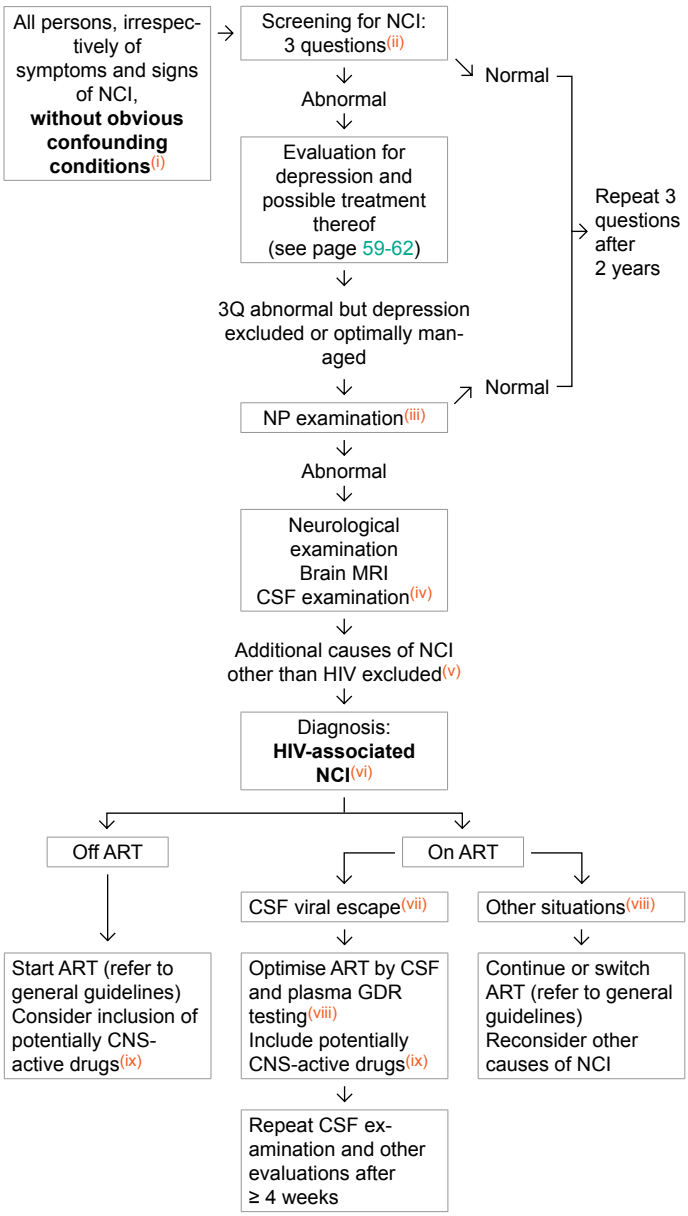
Comment

The symbol (red, amber, green) used to rank the clinical significance of the drug interaction is based on www.hiv-druginteractions.org (University of Liverpool). For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, refer to the above-mentioned website.

Algorithm for Diagnosis and Management of HIV-Associated Neurocognitive Impairment (NCI) in Persons without Obvious Confounding Conditions

Abbreviations

CSF	cerebrospinal fluid
GDR	genotypic drug resistance test
HAD	HIV-associated dementia
MND	mild neurocognitive disorder
MRI	brain magnetic resonance imaging
NP	neuropsychological



i Persons with obvious confounding conditions are not to be considered in this algorithm.

Obvious confounding conditions include:

1. Severe psychiatric conditions
2. Abuse of psychotropic drugs
3. Alcohol abuse
4. Sequelae from previous CNS-OIs or other neurological diseases
5. Current CNS-OIs or other neurological diseases

ii **3 questions** [3]

1. Do you experience frequent memory loss (e.g. do you forget the occurrence of special events even the more recent ones, appointments, etc.)?
2. Do you feel that you are slower when reasoning, planning activities, or solving problems?
3. Do you have difficulties paying attention (e.g. to a conversation, book or movie)?

For each question, answers could be: **a)** never, **b)** hardly ever, or **c)** yes, definitely. HIV-positive persons are considered to have an "abnormal" result when answering "yes, definitely" on at least one question.

iii NP examination will have to include tests exploring the following cognitive domains: fluency, executive functions, speed of information processing, attention/working memory, verbal and visual learning, verbal and visual memory, motor skills [4] plus assessment of daily functioning.

iv **Brain MRI and CSF examination**
These are required to further exclude other pathologies and to further characterise HIV-associated NCI, by including assessment of CSF HIV-RNA level and, where appropriate, evidence for genotypic drug resistance (GDR) in a paired CSF and plasma sample.

v For differential diagnosis, see www.aidsetc.org/aidsetc?page=cg-802_dementia

vi Includes **HAD and MND definitions** [4].
- HAD is defined in the presence of:
1) marked acquired impairment in cognitive functioning involving at least 2 cognitive domains, as documented by performance of at least 2 SD below the mean for age-education appropriate norms on NP tests
2) marked interference in daily functioning;
3) no evidence of another pre-existing cause for the dementia
- MND is defined in the presence of:
1) acquired impairment in cognitive functioning involving at least 2 cognitive domains, as documented by performance of at least 1 SD below the mean for age-education appropriate norms on NP tests
2) mild interference in daily functioning
3) no evidence of another pre-existing cause for the MND

vii CSF escape definition: either CSF VL > 50 and plasma VL < 50 c/mL- or both CSF and plasma VL > 50 c/mL, with CSF VL > 1 $\log_{10}$ higher than plasma VL

viii Including all situations that do not fulfil the CSF escape definition

ix **Definition of 'potentially CNS-active' drugs:**
ARV drugs with either demonstrated clear CSF penetration when studied in healthy HIV-positive populations (concentration above the IC_{90} in > 90% examined persons) or with proven short-term (3-6 months) efficacy on cognitive function or CSF VL decay when evaluated as single agents or in controlled studies in peer-reviewed papers.
- Agents with demonstrated clear CSF penetration:
  - NRTIs: ZDV, ABC*
  - NNRTIs: EFV, NVP
  - Boosted PIs: IDV/r, LPV/r, DRV/r*
  - Other classes: MVC
- Drugs with proven clinical efficacy:
  - NRTIs: ZDV, d4T, ABC
  - Boosted PIs: LPV/r

* When administered twice daily. Once-daily administration of these drugs, although common in clinical practice, has not been studied extensively with regard to CNS effects/CSF penetration and may have different CNS activity.

Part IV Clinical Management and Treatment of HBV and HCV Co-infection in HIV-positive Persons

General Recommendations for Persons with Viral Hepatitis/HIV Co-infection

Screening

1. All HIV-positive persons should be screened for HCV at time of HIV diagnosis and annually hereafter. Screening should use an anti-HCV antibody test. A positive result should be followed by HCV-RNA and genotype determination. Persons with risk factors (ongoing IVDU, mucosal traumatic sex, ongoing unprotected anal intercourse, recent sexually transmitted infection) with unexplained increase in hepatic transaminases and a negative anti-HCV antibody test should be tested for HCV-RNA for early detection of a recent infection.
2. HIV-positive persons should be screened for HAV and HBV. Persons who are anti-HBc positive and HBsAg negative, in particular those with elevated liver transaminases, should be screened for HBV-DNA in addition to HBsAg to rule out occult HBV infection.
3. Hepatitis delta antibodies should be screened for in all HBsAg positive persons.
4. Persons with liver cirrhosis Child Pugh class A or B and Child Pugh class C awaiting liver transplantation and persons with HBV irrespectively of fibrosis stage should be screened at 6-monthly intervals with hepatic ultrasound (CT in case of nodules– alpha-foetoprotein may also be used, but value controversial) for the occurrence of hepatocellular carcinoma (HCC). Routine screening is also advised for oesophageal varices at the time of diagnosis mainly when there is evidence of portal hypertension and at 3-4-year intervals thereafter if not present initially, see page 46. Regarding HCC screening, see page 47. In the presence of a liver nodule or a liver mass, recall policy of EASL/EORTC guidelines should be followed. Management of HCC should be defined for each case with a multidisciplinary team including transplant surgeon, interventional radiologist and hepatologist. In persons treated with Sorafenib, toxicity of ARVs and Sorafenib should be strictly monitored.

Vaccination see page 55

5. Persons lacking anti-HAV IgG antibodies or anti-HBs antibodies should be offered vaccination for the respective virus to prevent infection regardless of their CD4 cell count. The response to the HBV vaccine is influenced by the CD4 cell count and level of HIV-VL. In persons with low CD4 cell count (< 200 cells/µL) and ongoing HIV replication, ART should be initiated first prior to respective vaccination. Because of the lack of data on the impact of immunization in isolated anti-HBc IgG positive persons (HBsAg negative, anti-HBc positive and anti-HBs negative profile), vaccination is not presently recommended in this population. This guideline might be revised when more data is available from current trials. Occult HBV (HBsAg negative and HBV-DNA positive) should be ruled out in all persons with isolated anti-HBc.
6. In HIV-positive persons vaccinated for HBV with insufficient response (anti-HBs < 10 IU/L), re-vaccination should be considered. Double-dose (40 µg) at 3-4 time points (months 0, 1, 6 and 12) may help to improve response rates to the HBV vaccine. Persons who fail to seroconvert after HBV vaccination and remain at risk for HBV should have annual serological tests for evidence of HBV infection. TDF based cART has been associated with prevention of HBV infection in these persons.

ART

7. HIV-positive persons with HBV and/or HCV co-infection benefit from early ART because liver fibrosis progression is reduced with immune reconstitution and suppression of HIV-VL. Thus, ART initiation with a TDF-based regimen is recommended in all persons with HBV co-infection needing anti-HBV therapy irrespective of CD4 cell count, and in all HBsAg positive persons with less than 500 CD4 cells irrespective of HBV disease status to prevent transition to a more active HBV disease state due to immune suppression.
8. In persons with chronic HCV, ART initiation is recommended when CD4 cell counts drop below 500 cells/µL. Stopping ART has been associated with enhanced risk for AIDS and non-AIDS related events; indeed, the risk for non-AIDS events was particularly enhanced for persons with hepatitis co-infection. Stopping anti-HBV containing ART should be avoided in persons with HIV/HBV co-infection because of the high risk of severe hepatitis flares and decompensation following HBV reactivation hepatitis.

End Stage Liver Disease (ESLD)

9. HIV-positive persons require the same measures for the treatment of oesophageal varices, hepatorenal syndrome, hepatic encephalopathy or ascites as HIV-negative persons, see page 46-48 and Diagnosis and Management of Hepatorenal Syndrome (HRS).
10. Persons with viral hepatitis/HIV co-infection suffering from ESLD warrant particular attention in the management of liver insufficiency; see Dose Adjustment of ARVs for Impaired Hepatic Function. Nevertheless, it is important to highlight that ART initiation in cirrhotic persons generally improves overall survival and is therefore strongly recommended in these persons when indicated.
11. Renal complications are frequent, see page 47 and Diagnosis and Management of Hepatorenal Syndrome (HRS)
12. Persons with HCC or a MELD-score > 15*, CD4 cell count > 100 cells/µL and options for efficacious and durable ART should be evaluated for liver transplantation (OLTX). OLTX outcomes in persons with HIV/HBV co-infection are particularly promising, whereas post-transplant survival in persons with HIV/HCV co-infection has been somewhat lower than in persons with HCV mono-infection mainly due to the complicated course of HCV re-infection after transplantation.

* MELD calculation, see page 47.

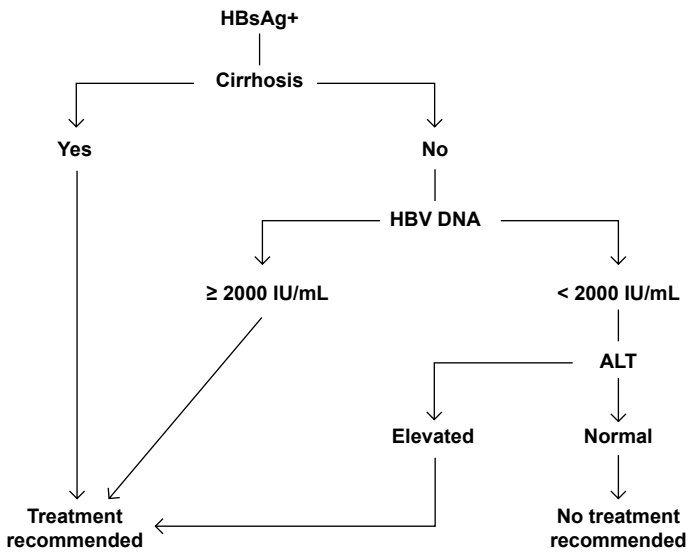
Prevention/Support

13. Psychiatric, psychological, social and medical support should be made available to persons with alcohol intake to stop drinking.
14. Substitution therapy (opioid replacement therapy) in persons with active drug abuse as a step towards cessation of active drug use should be encouraged. Help provided (e.g. through needle and syringe exchange programme) reduces the risk of re-infection including parenteral viral transmission (harm reduction strategy). See Drug Dependency and Drug Addiction
15. Since HBV and HIV, and occasionally HCV, are transmitted sexually, adequate counselling including the use of condoms is advisable. Information on the risk of HCV transmission due to mucosal traumatic sexual practices associated with a high likelihood of blood contact should be provided and risk reduction should be discussed.

Delta Virus

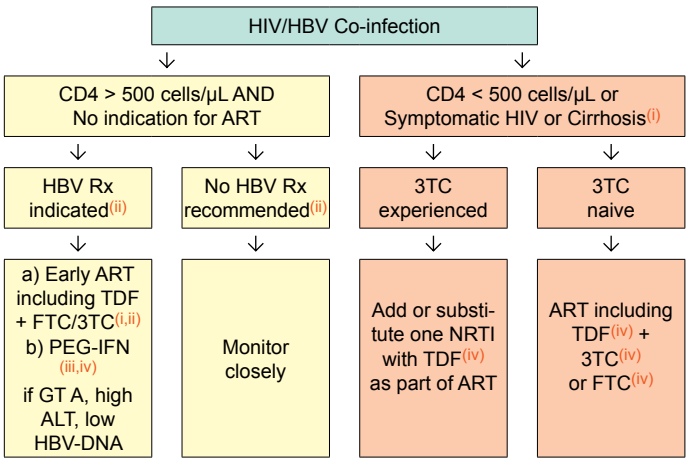
16. In persons with Delta virus co-infection and significant liver fibrosis (≥ F2), long-term (> 18 months) treatment with PEG-IFN might be considered in association with TDF-based ART. Because of its anti-HBV activity, TDF should be added to PEG-IFN in order to reduce HBV-DNA load. Treatment efficacy should be monitored with HBV-DNA and HDV-RNA measurements, when available, and with follow-up of biochemical and liver fibrosis estimates.
    Persons with anti-HCV antibodies and detectable HCV-RNA should be offered anti-HCV treatment in order to induce a sustained virologic response for HCV co-infection. Persistent off-treatment HDV-RNA negativity and anti-HBs seroconversion are the ideal goals of antiviral treatment for hepatitis Delta even if they can only be obtained in a minority of persons. Histological remission of liver disease is a less ambitious but more likely to be achieved goal. In persons with Delta virus and ESLD or HCC, liver transplantation from HBsAg negative donor should be strongly considered especially in the absence of active HCV co-infection. Transplant with anti-HBV post-OLTX prophylaxis cures HBV and Delta virus infection.

Assessment of Treatment Indications for HBV in Persons with HBV/HIV Co-infection



Note: In persons with significant liver fibrosis (F2-F4), anti-HBV treatment might be considered even when serum HBV-DNA is below 2000 IU/mL and liver enzymes are not elevated.

Treatment of Chronic HBV in Persons with HBV/HIV Co-infection



i For management of cirrhotic persons, see page 46-49. Persons with liver cirrhosis and low CD4 cell count require careful surveillance in the first months after starting ART in order not to overlook immune reconstitution syndrome and subsequent liver decompensation due to flares of liver enzymes.

ii See page 65 for assessment of HBV Rx indication. Some experts strongly believe that any person with HBV infection requiring ART should receive TDF + 3TC or FTC unless history of TDF intolerance, particularly with advanced liver fibrosis (F3/F4). TDF administration should be adapted to eGFR if necessary. In persons with no history of treatment with 3TC and strict contraindication of TDF use, Entecavir can be used in addition to fully suppressive cART without FTC or 3TC.

iii ART-naive Asian, HBeAg positive, HIV-co-infected persons initiating ART with TDF or TDF+FTC reached unexpectedly high rates of HBe (and even HBs) seroconversion, strengthening the rationale for early ART. In persons with HBV GT A, high ALT and low HBV-DNA, PEG-IFN might be used for a total length of 48 weeks. The addition of an NRTI-based anti-HBV regimen has not been proved to increase PEG-IFN efficacy. Recent data obtained in HBV mono-infected persons suggests that on-treatment quantification of HBsAg in persons with HBeAg-negative chronic HBV treated with PEG-IFN may help identify those likely to be cured by this therapy and optimise treatment strategies. This was also observed for NRTI-based strategies even if the rate of HBs seroconversion in this setting was very low. The optimal treatment duration for nucleos(t)ide analogues with anti-HBV activity has not yet been determined and experts recommend life-long therapy if anti-HBV nucleos(t)ides are given as part of ART. With persons not requiring ART and on treatment with Telbivudine +/- Adefovir, or those on ART where the nucleoside backbone needs changing, anti-HBV therapy may be stopped cautiously in HBeAg positive persons who have achieved HBe-seroconversion for at least six months or after confirmed HBs-seroconversion in those who are HBeAg negative. In persons with liver cirrhosis, stopping of effective anti-HBV treatment is not recommended in order to avoid liver decompensation due to flares of liver enzymes.

iv In some cases of TDF intolerance (i.e. renal disease, see page 42), TDF in doses adjusted to renal clearance in combination with effective ART may be advisable (see page, 44). If TDF is strictly contra-indicated, Entecavir + Adefovir may be tried. However, efficacy and renal toxicity need to be closely monitored, because of the proven renal toxicity of Adefovir. In persons with no prior 3TC exposure, Entecavir may be used alone. NRTI substitution should only be performed if feasible and appropriate from the perspective of maintaining HIV suppression. Caution is warranted to switch from a TDF-based regimen to drugs with a lower genetic barrier, e.g. FTC or 3TC, in particular in 3TC-pretreated cirrhotic persons as viral breakthrough due to archived YMDD mutations is likely to happen. This has also been described in individuals with previous 3TC HBV-resistance who have been switched from TDF to Entecavir. The addition of Entecavir to TDF in persons with low persistent HBV-replication has not statistically proved to be efficient and should therefore be avoided. Results of trials are awaited.

Diagnostic Procedures for HCV in Persons with HCV/HIV Co-infection

Diagnosis of HCV
HCV-Ab (turn positive 1-6 months after infection as late seroconversions have been described, may rarely be lost due to immunosuppression)
HCV-RNA levels[(i)] (in particular important for the prediction of response to IFN treatment)
Status of Liver Damage
Staging of fibrosis (e.g. FibroScan, liver biopsy, serum fibrosis markers[(ii)])
Hepatic synthetic function (e.g. coagulation, albumin, cholinesterase)
Ultrasound every 6 months if cirrhosis (gastroscopy upon diagnosis of cirrhosis and every 1-2 years thereafter), see page 46
Before HCV Treatment
HCV GT and HCV-RNA
Autoantibodies (ANA, LKM1)[(iii)]
TSH, thyroid autoantibodies (risk of hyperthyroidism under IFN-based therapy)
Monitoring of HCV Treatment
Differential blood count and liver enzymes every 2-4 weeks
HCV-RNA at week 4 (to evaluate rapid virological response (RVR) under IFN-based HCV regimens and to ensure compliance), at end-of-treatment and at week 12 and 24 after treatment cessation (to assess SVR).
CD4 cell count and HIV-VL every 12 weeks
TSH every 12 weeks under IFN-based therapy

i Low HCV-RNA defined as <400,000-600,000 IU/mL when using PEG-IFN+RBV. There is no standard conversion formula for converting the amount of HCV-RNA reported in copies/mL to the amount reported in IU/mL. The conversion factor ranges from about one to five HCV-RNA copies per IU/mL.

ii Serum fibrosis markers include APRI, FIB-4, Hyaluronic acid, Fibrometer, Fibrotest, Forns, Hepascore and other indices; recently more complex tests such as Fibrometer, Fibrotest and Hepascore have shown to more accurately predict liver fibrosis than simple biochemical tests such as APRI, FIB-4 or Forns.

iii Persons with positive anti LKM or ANA with homogeneous pattern should be evaluated for concurrent autoimmune hepatitis especially in the presence of ALT elevation during INF-based treatment.

Treatment of HCV in Persons with HCV/HIV Co-infection

Treatment indication

1. HCV treatment offers the possibility of eradicating HCV within a defined treatment period which translates into HCV cure. This is potentially advantageous for the subsequent management of the person with HIV, and every person with co-infection should therefore be considered for treatment when the benefits of therapy outweigh the risks. This also needs to be seen in the context of faster liver fibrosis progression in persons with HCV/HIV co-infection and with better HCV-treatment outcome with the use of direct acting antivirals (DAAs) in these persons. Furthermore, achieving SVR has also been associated with an improved survival even in lower fibrosis stages (F2) suggesting benefits of HCV therapy beyond cure of HCV and prevention of further liver disease progression. Similar HCV cure rates in HCV/HIV co-infected persons as in HCV mono-infected persons under DAA therapy have further questioned the separation of HIV co-infected persons as a separate patient group and have claimed treatment indication and regimens to be the same as in HCV mono-infection.
2. If chronic HCV is detected early in the course of HIV infection (before ART initiation), treatment for chronic HCV is advised n presence of immediate HCV treatment indication (≥F2).
   For persons with a CD4 cell count < 500 cells/µL, early ART initiation is recommended to optimise HCV treatment outcome.
3. Information on liver fibrosis staging is important for making therapeutic decisions in persons with co-infection. However, a liver biopsy is no longer mandatory for considering treatment of chronic HCV.
4. In case of the availability of a liver biopsy or FibroScan® demonstrating lack of or minimal liver fibrosis (F0-1), regardless of HCV GT, treatment can be deferred. This may be especially important in countries where no or only limited DAAs have become available so far or where cost reimbursement issues still have not been clarified. In these cases, fibrosis assessment should be carried out periodically to monitor for fibrosis progression (see page 70).

Treatment of chronic HCV in persons with HCV/HIV-co-infection

5. With first pilot studies in HCV treatment-naive and treatment experienced persons with HCV/HIV co-infection demonstrating significant higher SVR 12-24 rates with DAA based therapy, IFN-free DAA combinations should be considered standard of care for chronic HCV, in particular in advanced fibrosis.
   The combination of Sofosbuvir 400 mg qd and a weight-adapted dose of RBV of 1000 (wt<75 Kg) -1200 (wt>75Kg) mg/day (administered bd) for 12 weeks has become the new gold standard therapy for all HCV GT2 persons promising HCV cure in >90% of persons. Persons with cirrhosis can be treated for an extended duration of 16 weeks. In countries where no Sofosbuvir is available PEG-IFN and RBV combination treatment for 24 weeks (if RVR i.e. negative HCV-RNA at week 4 after starting HCV therapy) or 48 weeks represents an alternative treatment choice for HCV GT2. The standard dose for PEG-IFN 2a is 180 µg once weekly, and for PEG-IFN 2b 1.5 µg/kg body weight once weekly.
6. The approval of further DAA have offered the opportunity of IFN- and RBV-free DAA combination regimens which because of significantly improved tolerability and higher HCV cure rates should be considered as preferred option where available and reimbursable.
   In particular combination of Sofosbuvir (all GT1-4) and Simeprevir (only GT1 or 4) or Sofosbuvir and Daclatasvir (all GT1-4) are recommended, see IFN-free HCV Treatment Options.
   In case of limited DAA availability or reimbursement issues Sofosbuvir in combination with PEG-IFN and RBV would be the next best treatment option (for GT1, 3-6), see IFN-containing HCV Treatment Options For Fibrosis Stages up to CHILD A. Simeprevir in combination with PEG-INF and RBV can also be an alternative (for GT1 or 4; but with longer treatmenmt duration for IFN), but absence of the Q80K mutation should be demonstrated prior to treatment initiation.
   Use of older, first generation HCV PIs (Boceprevir and Telaprevir; only indicated in GT1) are only recommended where other DAAs are not currently available and for some future time.
7. Use of HCV PIs is associated with additional toxicities: Boceprevir causes anaemia, Teleprevir skin rash and Simeprevir hyperbilirubinaemia and skin reactions/photosensibility.
8. Please keep in mind that the field of DAAs is evolving rapidly with an expected European approval of IFN- and RBV-free fix-dose combination of Sofosbuvir/Ledipasvir in November 2014 as well as IFN-free combination of Paritaprevir/RTV/Ombitasvir, 150mg/100mg/25mg qd and Dasabuvir early 2015 which will add additionally treatment options into the HCV treatment armamentarium. Clearly these IFN-free treatment options together with the ones already available will be preferred treatment choices, and should encourage to no longer use IFN-based HCV therapies.
9. Due to drug-drug interactions in particular HIV and HCV PIs careful checking for interactions is urgently recommended prior to starting HCV therapy, see www.hep-druginteractions.org or Drug-drug Interactions Between ARVs and DAAs. During PEG-IFN-RBV therapy, ddI is contraindicated in persons with cirrhosis and should be avoided in persons with less severe liver disease. D4T and ZDV should also be avoided if possible.

Treatment goal

10. The primary aim of HCV treatment is SVR defined as undetectable HCV-RNA 12-24 weeks after the end of therapy, evaluated using sensitive molecular tests.

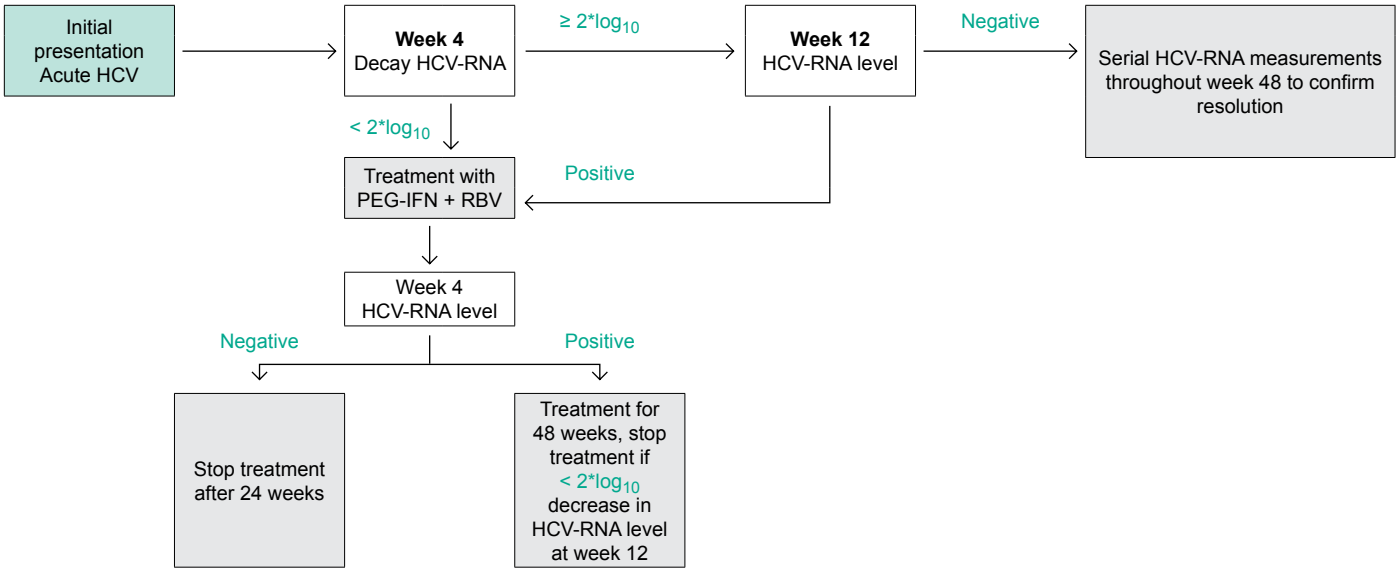
Stopping rules

11. If an early virological response (decline of at least $2*\log_{10}$ reduction in HCV-RNA at week 12 compared to baseline) is not achieved when treating HCV infection with PEG-IFN and RBV, treatment should be stopped, see page 73. Different stopping rules apply when DAAs are being used in combination with PEG-IFN and RBV and are summarised, see page 74. Futility rules with Simeprevir in combination with PEG-IFN and RBV are that HCV-RNA> 25 IU/mL after 4,12 or 24 weeks of HCV therapy should be discontinued. In case of successful Telaprevir-based HCV therapy at week 4 (HCV-RNA < 1000 IU/mL), Telaprevir should be continued until week 12, see page 74. If HCV-RNA at week 12 is still < 1000 IU/mL, dual therapy with PEG-IFN-RBV should be continued until week 24. If HCV-RNA is undetectable at week 24, dual therapy with PEG-IFN-RBV should be continued for another 24 weeks resulting in total treatment duration of 48 weeks. Futility rules for Boceprevir-containing HCV therapy are that in case of HCV-RNA > 100 IU/mL at week 12 or detectable HCV-RNA at week 24, all HCV therapy needs to be discontinued and interpreted as lack of response and high risk for Boceprevir resistance selection. In PEG-IFN and Sofosbuvir or IFN-free based therapies reasons to stop treatment may be non-adherence or toxicities on an individual basis.

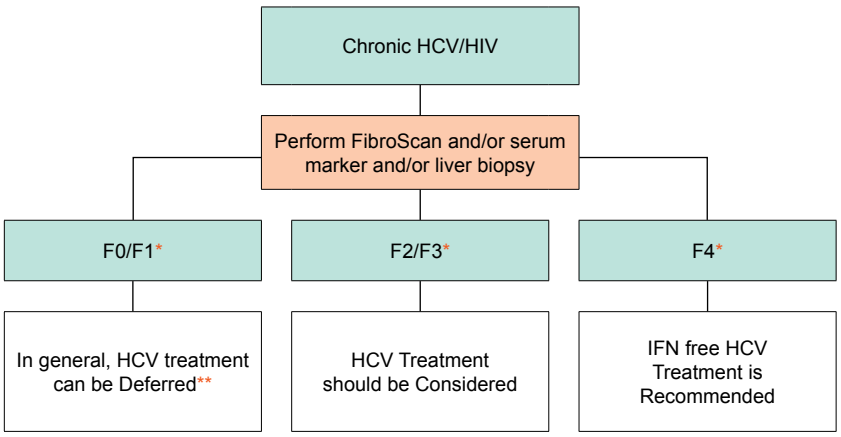
Treatment of Acute HCV

12. Identification of persons with acute HCV is important since treatment in the acute phase leads to higher SVR rates than for treatment of chronic HCV. In persons with acute HCV, HCV-RNA should be measured at initial presentation and 4 weeks later. Treatment should be offered in persons without a decrease of $2*\log_{10}$ of HCV-RNA at 4 weeks compared with initial HCV-RNA and to persons with persistent serum HCV-RNA 12 weeks after diagnosis of acute HCV. Duration of treatment should be based on RVR regardless of GT. Persons who do not achieve a $\geq 2*\log_{10}$ decrease in HCV-RNA level at week 12 should discontinue therapy. Unfortunately, results from randomized prospective treatment trials are not available so far to allow a more precise recommendation on treatment duration or the role of RBV in treatment of acute HCV at this point. Also only uncontrolled data in 19 HIV-positive persons receiving 12 weeks of Telaprevir, PEG-IFN and RBV is available as yet. Therefore, considering the high cure rates with PEG-IFN-RBV alone in acute HCV, DAAs are currently not recommended unless there is a lack of virological response (at week 12 < $2*\log_{10}$ decrease in HCV-RNA), a situation in which treatment intensification with DAAs can be discussed on an individual basis.

Algorithm for Management of Acute HCV in Persons with HCV/HIV Co-infection



Management of Persons with Chronic HCV/HIV Co-infection



* Metavir fibrosis score: F0=no fibrosis; F1= portal fibrosis, no septae; F2= portal fibrosis, few septae, F3=bridging fibrosis, F4=cirrhosis.

** Monitor fibrosis stage annually, preferably with two established methods. Consider Treatment, if rapid progression.

HCV Treatment Options in HCV/HIV Co-infected Persons

IFN-free HCV Treatment Options		
HCV GT	**Treatment**	**Treatment duration**
1 & 4	SOF + RBV	24 weeks*
	SOF + SMP	12 weeks**
	SOF + DCV	12 weeks in non-cirrhotics, 24 weeks in compensated cirrhotics
2	SOF + RBV	12 weeks***
3	SOF + RBV	24 weeks
	SOF + DCV + RBV	24 weeks in compensated cirrhotics and/or treatment-experienced
5 & 6	In the absence of clinical data on DAAs in HCV GT 5 and 6 infection persons should be treated similar to HCV GT 1 and 4 infection	

RBV Ribavirin
SOF Sofosbuvir
SMP Simeprevir
DCV Daclatasvir
* Licensed only for persons who are not eligible for IFN-containing therapy
** Possible extension up to 24 weeks in treatment-experienced cirrhotics and/or addition of RBV
*** Possible extension up to 16 weeks in treatment-naïve cirrhotics or relapsers; up to 24 weeks in treatment-experienced

IFN-containing HCV Treatment Options (For Fibrosis Stages up to CHILD A)		
HCV GT	**Treatment**	**Treatment duration**
1 & 4	SOF + PEG-IFN/RBV	12 weeks (possible extension up to 24 weeks in cirrhotics)
	SMP* + PEG-IFN/RBV	24 weeks** (48 weeks in cirrhotics and treatment-experienced)
	DCV + PEG-IFN/RBV***	24 weeks if RVR, 48 weeks if non-RVR
2	PEG-IFN/RBV	IFN-free treatment recommended. If SOF not available: PR 24 weeks if RVR, 48 weeks if non-RVR
3	SOF + PEG-IFN/RBV	12 weeks (possible extension up to 24 weeks in cirrhotics)
5 & 6	In the absence of clinical data on DAAs in HCV GT 5 and 6 infection persons should be treated similar to HCV GT 1 and 4 infection	

PEG-IFN/RBV Pegylated-Interferon + Ribavirin
RBV Ribavirin
SOF Sofosbuvir
SMP Simeprevir
DCV Daclatasvir
* SMP for 12 weeks only
** also in relapsers
*** GT4 only, DCV for 24 weeks only

Drug-drug Interactions between DAAs and ARVs

HCV drugs		ATV/r	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	DTG	EVG/c	RAL	ABC	FTC	3TC	TDF	ZDV
DAAs	Boceprevir	D35%	↓32%D44%	↓45%D34%	↓19%E20%	↑10%D23%	↓E	E	E	↔	↓D	↔	↔	↔	↔	↔	↔[i]
	Daclatasvir	↑110%[ii]	↑[iii]	↑[iii]	↓32%[iv]	↓[iv]	↓[iv]	↔	↔	↔	↑[iii]	↔	↔	↔	↔	↑10%E10%	↔
	Simeprevir	↑	↑	↑	↓71%D10%	↓	↓	↑6%E12%	↔	↔	↑	↓11%E8%	↔	↔	↔	↓14%E18%	↔
	Sofosbuvir	↔	↑34%	↔	↓6%D4%	↔	↔	↑9%E6%	↔	↔	↔	↓13%D27%	↔	↓6%	↔	↓6%	↔
	Telaprevir	↓20%E17%	↓35%D40%	↓54%	↓26%D7%	↓16%	↓?	↓5%E	E	E25%	↑13%D16%	E31%	↔	↔	↔	E30%	↔[i]

Legend

↑ potential elevated exposure of DAA
↓ potential decreased exposure of DAA
↔ no significant effect
D potential decreased exposure of ARV
E potential elevated exposure of ARV

Numbers refer to decreased/increased AUC of DAAs and ARVs as observed in drug interactions studies

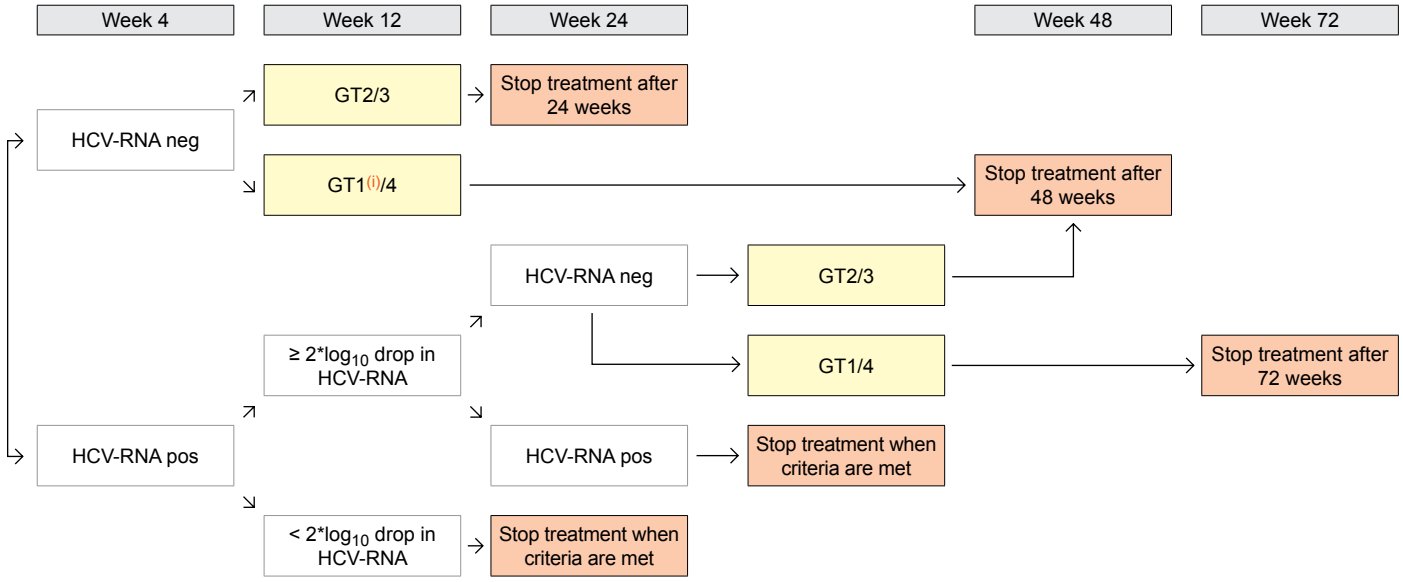
i potential haematological toxicity
ii Daclatasvir should be reduced to 30 mg once daily with ATV/r. No dose reduction with unboosted ATV
iii Daclatasvir should be reduced to 30 mg once daily
iv Daclatasvir should be increased to 90 mg once daily.

Colour legend

no clinically significant interaction expected.
these drugs should not be coadministered.
potential interaction which may require a dosage adjustment or close monitoring.

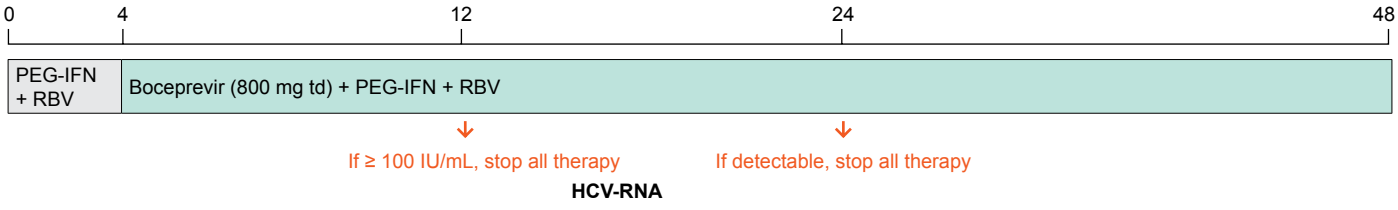
Note: the symbol (green, amber, red) used to rank the clinical significance of the drug interaction is based on www.hep-druginteractions.org.

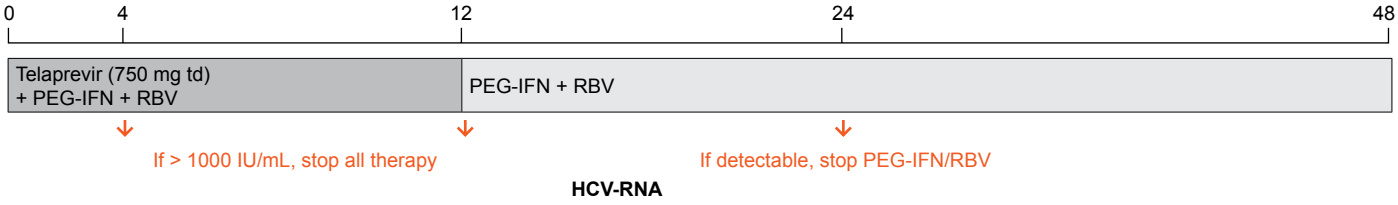
Proposed Optimal Duration of Dual HCV Therapy in Persons with Chronic HCV/HIV Co-infection Not Eligible for Triple Therapy Including DAAs against HCV

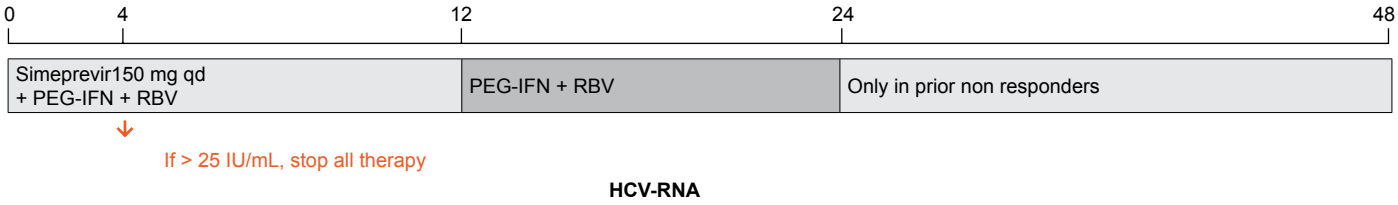


i Where no access to DAAs available or high chances of cure even with dual therapy (favourable IL28B GT, low HCV-RNA and no advanced fibrosis)

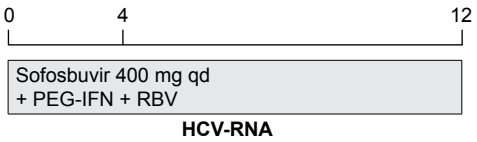
Use of Boceprevir, Telaprevir, Simeprevir or Sofosbuvir with PEG-IFN + RBV in Persons with HIV/HCV Co-infection







Therapy should be stopped if there is a confirmed increase in HCV-RNA by 1*$\log_{10}$ following a decline at any stage.



No stopping rules apply: Fixed duration of 12 weeks regardless of HCV-RNA decline.

Definition of Treatment Response of PEG-IFN and RBV

	Time	HCV-RNA
Rapid Virological Response (RVR)	Week 4 on treatment	Undetectable (< 50 IU/mL)
Early Virological Response (EVR)	Week 12 on treatment	Undetectable (< 50 IU/mL)
Delayed Virological Response (DVR)	Week 12 on treatment	> 2*$\log_{10}$ decrease from baseline but not undetectable
Null Response (NR)	Week 12 on treatment	< 2*$\log_{10}$ decrease from baseline
Partial Non-Response (PR)	Week 12 and week 24 on treatment	> 2*$\log_{10}$ decrease at week 12 but detectable at week 12 and 24
Sustained Virological Response (SVR)	24 weeks post treatment	Undetectable (< 50 IU/mL)
Breakthrough	Any time during treatment	Reappearance of HCV-RNA at any time during treatment after virological response
Relapse (RR)	End of treatment and week 24 post treatment	Undetectable HCV-RNA at end of therapy, detectable by week 24 post treatment

Adapted from [3]
See www.easl.eu/assets/application/files/4a7bd873f9cccbf_file.pdf

Part V Opportunistic Infections

Prevention and Treatment of Opportunistic Infections in HIV-positive Persons

Primary Prophylaxis

Disease	Drug	Dose	Comments
Pneumocystis jirovecii (PcP) & Toxoplasma gondii			**Indication:** CD4 < 200 cells/µL, CD4 percentage < 14%, or oral thrush **Stop:** if CD4 > 200 cells/µL over 3 months or CD4 100-200 cells/µL and HIV-VL undetectable for 3 months
Positive or Negative Serology for Toxoplasmosis	**TMP-SMX**	1 double-strength tablet (ds) (800/160 mg) 3 x /week po or 1 single-strength tablet (ss) (400/80 mg)/day po or 1 ds tablet/day po	
Negative Serology for Toxoplasmosis	**Pentamidine**	300 mg in 6 mL Aqua 1 x Inhalation/month	
Negative Serology for Toxoplasmosis	**Dapsone**	1 x 100 mg/day po	Check for G6PD-deficiency
Positive or Negative Serology for Toxoplasmosis	**Atovaquone suspension**	1 x 1500 mg/day po (with food)	
Positive Serology for Toxoplasmosis	**Dapsone** **+ Pyrimethamine** **+ Folinic Acid**	200 mg 1x/week po 75 mg 1x/week po 25 mg 1x/week po	Check for G6PD-deficiency
Positive Serology for toxoplasmosis	**Atovaquone suspension** **+ Pyrimethamine** **+ Folinic acid**	1 x1500 mg/day po (with food) 75 mg/week po 25 mg/week po	
Non-Tuberculous Mycobacteria (M. avium complex, M. genavense, M. kansasii)			**Indication:** CD4 < 50 cells/µL **Stop:** if CD4 > 100 cells/µL over 3 months
Regimens listed are alternatives	**Azithromycin**	1 x 1200-1250 mg/week po	
	or **Clarithromycin**	2 x 500 mg/day po	
	or **Rifabutin**	300 mg/day po	Check for interactions with ARVs

Secondary Prophylaxis, Maintenance Therapy

Disease	Drug	Dose	Comments
Pneumocystis jirovecii (PcP)			**Stop:** if CD4 > 200 cells/µL over 3 months
Negative or Positive Serology for Toxoplasmosis	**TMP-SMX**	1 ds tablet 800/160 mg 3x/week po or 1 ds tablet 400/80 mg 1x/day po or 1 ds tablet 1x/day po	
Negative Serology for Toxoplasmosis	**Pentamidine**	300 mg in 6 mL Aqua 1 x Inhalation/month	
Negative Serology for Toxoplasmosis	**Dapsone**	1 x 100 mg/day po	Check for G6PD-deficiency
Negative or Positive Serology for Toxoplasmosis	**Atovaquone suspension**	1 x 1500 mg/day po (with food)	
Positive Serology for Toxoplasmosis	**Dapsone** **+ Pyrimethamine** **+ Folinic Acid**	1 x 200 mg/week po 75 mg/week po 25 mg/week po	Check for G6PD-deficiency
Positive Serology for Toxoplasmosis	**Atovaquone suspension** **+ Pyrimethamine** **+ Folinic Acid**	1 x 1500 mg/day po (with food) 75 mg/week po 25 mg/week po	

Secondary Prophylaxis, Maintenance Therapy

Disease	Drug	Dose	Comments
Toxoplasma gondii Encephalitis			**Stop:** if CD4 > 200 cells/µL over 6 months
Regimens listed are alternatives	**Sulfadiazine** **+ Pyrimethamine** **+ Folinic Acid**	2-3 g/day po (in 2-4 doses) 1 x 25-50 mg/day po 1 x 10 mg/day po	
	or **Clindamycin** **+ Pyrimethamine** **+ Folinic Acid**	 3 x 600 mg//day po 1 x 25-50 mg//day po 1 x 10 mg//day po	Additional PCP prophylaxis is necessary
	or **Atovaquone suspension** **+ Pyrimethamine** **+ Folinic Acid**	 2 x 750-1500 mg/day po (with food) 1 x 25-50 mg/day po 1 x 10 mg/day po	
	or **Atovaquone suspension**	2 x 750-1500 mg/day po (with food)	
	or **TMP-SMX**	 2 x 800/160mg/day po	
Cryptococcal Meningitis			At least 12 months. Consider stopping, if CD4 >100 cells/µL for at least 3 months
	Fluconazole	1 x 200 mg/day po	
Cytomegalovirus (CMV) Retinitis			**Stop:** if CD4 > 200 cells/µL over 3 months
Regimens listed are alternatives	**Valganciclovir**	1 x 900 mg/day po (with food)	
	or **Ganciclovir**	 5 x 5 mg/kg/week iv	
	or **Foscarnet**	 5 x 100 mg/kg/week iv	
	or **Cidofovir** **+ NaCl + Probenecid**	 5 mg/kg every 2 weeks iv	Cidofovir may not be available in all European countries
Mycobacterium avium (MAC) Infection			**Stop:** if CD4 > 100 cells/µL over 6 months and after MAC treatment at least 12 months
Regimens listed are alternatives	**Clarithromycin** **+ Ethambutol**	2 x 500 mg/day po 1 x 15 mg/kg/day po	
	or **Azithromycin** **+ Ethambutol**	 1 x 500 mg/day po 1 x 15 mg/kg/day po	
Leishmaniasis			**Consider stopping:** if CD4>200-350 cells/µL over 3 months, no relapse for at least 6 months and negative PCR in blood or negative urinary antigen
	Liposomal Amphotericin B	4 mg/kg every 2-4 weeks iv	
	or **Lipidcomplex Amphotericin B**	 3 mg/kg every 3 weeks iv	

Secondary Prophylaxis, Maintenance Therapy

Disease	Drug	Dose	Comments
Alternative Therapies	**Pentavalent Antimonium Salts (Glucantine®)**	20 mg/kg every 4 weeks iv/im	
	or **Miltefosine**	1 x 100 mg/day po	
	or **Pentamidine**	300 mg every 3 to 4 weeks iv	

Treatment of Opportunistic Infections

Pneumocystis jirovecii Pneumonia (PcP)			
Preferred Therapy	**TMP-SMX**	3 x 5 mg/kg/day TMP iv/po + 3 x 25 mg/kg/day SMX iv/po	**21 days, then secondary prophylaxis** until CD4 cell counts > 200 cells/µL for > 3 months
	+ Prednisone if PaO2 <10 kPa or <70 mmHg or alveolar/arterial O_2 gradient > 35 mmHg. Start Prednisone 15-30 min before TMP/SMX	2 x 40 mg/day po 5 days 1 x 40 mg/day po 5 days 1 x 20 mg/day po 10 days	Benefit of corticosteroids if started before 72 hours
Alternative Therapy for *Moderate to Severe PcP*	**Primaquine** **+ Clindamycin** or	1 x 30 mg (base)/day po 1 x 600-900 mg iv/po	
	Pentamidine or	1 x 4 mg/kg/day iv (infused over 60 min.)	Check for G6PD deficiency
	Caspofungin For each regimen + **Prednisone**, if PaO_2 <10 kPa or <70 mmHg, or alveolar/arterial O_2 gradient > 35 mmHg. Start Prednisone 15-30 min before TMP/SMX	70 mg/1st day followed by 50 mg/day iv	Can be added to the therapy in severe cases
Alternative Therapy for *Mild to Moderate PcP*	**Primaquine** **+ Clindamycin**	1 x 30 mg (base)/day po 1 x 600-900 mg/day po	Check for G6PD deficiency
	or **Atovaquone suspension**	2 x 750 mg/day po (with food)	
	or **Dapsone** **+ Trimethoprim**	1 x 100 mg/day po 3 x 5 mg/kg/day po	Check for G6PD deficiency In case of rash: reduce dose of TMP (50%), antihistamines
Toxoplasma gondii Encephalitis			
Preferred Therapy	**Pyrimethamine** **+ Sulfadiazine** **+ Folinic Acid**	Day 1: 200 mg po, **then** • If ≥ 60 kg; 1 x 75 mg/day po • If < 60 kg: 1 x 50 mg/day po • If ≥ 60 kg: 2x 3000 mg/day po/iv • If < 60 kg: 2 x 2000 mg/day po/iv 1 x 10 mg/day po	**6 weeks, then secondary prophylaxis** until CD4 cell counts > 200 cells/µL for > 6 months

Disease	Drug	Dose	Comments
Treatment of Opportunistic Infections			
Alternative Therapy	**Pyrimethamine** **+ Clindamycin** **+ Folinic Acid**	Day 1: 200 mg/day po, **then** • If ≥ 60 kg: 1 x 75 mg/day po • If < 60 kg: 1 x 50 mg/day po 4 x 600-900 mg/day po/iv 1x 10 mg/day po	Additional PcP prophylaxis is necessary
	or **TMP-SMX**	 2 x 5 mg TMP/kg/day po/iv 2 x 25 mg SMX/kg/day po	
	or **Pyrimethamine** **+ Atovaquone** **+ Folinic Acid**	 Day 1: 200 mg po, **then** If ≥ 60 kg; 1 x 75 mg/day po If < 60 kg: 1 x 50 mg/day po 2 x 1500 mg/day po (with food) 1 x 10 mg/day po	
	or **Sulfadiazine** **+ Atovaquone**	 • If ≥ 60 kg: 4 x 1500 mg/day po/iv • If < 60 kg: 4 x 1000 mg/day po/iv 2 x 1500 mg/day po (with food)	
	or **Pyrimethamine** **+ Azithromycin** **+ Folinic Acid**	 Day 1: 200 mg po, **then** • If ≥ 60 kg; 1 x 75 mg/day po • If < 60 kg: 1 x 50 mg/day po 1 x 900-1200 mg/day po 1 x 10 mg/day po	
Cryptococcal Meningitis			
Induction Therapy	**Liposomal Amphotericin B** **+ Flucytosine**	3 mg/kg/day iv 4 x 25 mg/kg/day po	**14 days** Then perform LP: if CSF culture sterile → switch to oral regimen. • Liposomal Amphotericin B is accompanied by significantly fewer adverse effects. • Opening pressure should always be measured when an LP is performed. Repeated LPs or CSF shunting are essential to effectively manage increased intracranial pressure which is associated with better survival. • Flucytosine dosage must be adapted to renal function. • Treat for at least 14 days, then perform LP: if CSF culture sterile → switch to oral consolidation therapy. • Defer start of ART for at least 4 weeks.
	or **Amphotericin B Deoxycholate** **+ Flucytosine**	 0,7 mg/kg/day iv 4 x 25mg/kg/day po	
Consolidation Therapy	**Fluconazole**	1 x 400 mg/day po (loading dose 1 x 800 mg 1st day)	**8 Weeks**, **then secondary prophylaxis.** Repeated LP until opening pressure < 20 cm H_2O or 50% of initial value
Candidiasis			
Oropharyngeal	**Fluconazole**	1x 150-200 mg/day po	Once or until improvement (5-7 days)
	or **Itraconazole**	 1-2 x 100-200 mg/day po (oral solution fasting)	 7-14 days. Be aware of interactions with ARVs, see Drug-drug Interactions Between ARVs and Non-ARVs
	or **Amphotericin B**	 3-6 lozenges at 10 mg/day or oral suspension 1-2g/day (in 2-4 doses)	 7-14 days

Disease	Drug	Dose	Comments
Treatment of Opportunistic Infections			
Esophagitis	**Fluconazole**	1 x 400 mg/day po or 400 mg loading dose, then 200 mg/day po	3 days 10-14 days. Be aware of interactions with ARV's, see Drug-drug Interactions Between ARVs and Non-ARVs
	or **Itraconazole**	1-2 x 200 mg/day po (oral solution fasting)	10-14 days
Severe cases/azole resistance	**Caspofungin**	1 x 70 mg 1st day, then 50mg/day iv	14 days
Herpes simplex virus (HSV) Infections			
Initial Genital / Mucocutaneous HSV	**Valacyclovir**	2 x 1000 mg/day po	7-10 days or until lesions healed
	or **Famciclovir**	2 x 500 mg/day po	7-10 days or until lesions healed
	or **Acyclovir**	3 x 400 mg/day po	7-10 days or until lesions healed
Recurrent Genital / Mucocutaneous HSV (> 6 episodes/year)	**Valacyclovir**	2 x 500 mg/day po	Chronic suppressive therapy. Alternatively start early treatment of recurrences as above.
Severe Mucocutaneous Lesions	**Acyclovir**	3 x 5 mg/kg/day iv	After lesions begin to regress switch to oral treatment or until lesions healed
Encephalitis	**Acyclovir**	3 x 10 mg/kg/day iv	14-21 days
Acyclovir resistant Mucocutaneous HSV infection	**Foscarnet**	80-120 mg/kg/day iv in 2-3 divided doses	Until clinical response
	or **Cidofovir + Probenecid + Hydration**	1 x 5 mg/kg/week iv	Cidofovir may not be available in all European countries
Varicella zoster virus (VZV) Infections			
Primary Varicella Infection (Chickenpox)	**Valaciclovir**	3 x 1000 mg/day po	5-7 days
Herpes Zoster (Shingles): Not Disseminated	**Valaciclovir**	3 x 1000 mg/day po	10 days
	or **Famciclovir**	3 x 500 mg/day po	10 days
	or **Acyclovir**	3 x 5 mg/kg/day iv	10 days
Herpes Zoster: Disseminated	**Acyclovir**	3 x 10 mg/kg/day iv	10-14 days
Cytomegalovirus (CMV) Infections			
Retinitis, Immediate Sight-threatening Lesions	**Ganciclovir**	2 x 5 mg/kg/day iv	3 weeks, then secondary prophylaxis
	or **Foscarnet**	2 x 90 mg/day iv	3 weeks, then secondary prophylaxis
Retinitis, Small Peripheral Retinal Lesions	**Valganciclovir**	2 x 900 mg/day po (with food)	
	or **Foscarnet**	2 x 90 mg/kg/day iv	
	or **Cidofovir + Probenecid + Hydration**	1 x 5mg/kg/week iv	Cidofovir may not be available in all European countries
Esophagitis/Colitis	**Ganciclovir**	2 x 5 mg/kg/day iv	
	or **Foscarnet**	2 x 90 mg/kg/day iv	
	or **Valganciclovir**	2 x 900 mg/day po (with food)	In milder disease if oral treatment tolerated

Treatment of Opportunistic Infections

Encephalitis/Myelitis	**Ganciclovir**	2 x 5 mg/kg/day iv	Consider combination of Ganciclovir and Foscarnet in severe cases
	or **Foscarnet**	2 x 90 mg/kg/day iv	
Disease	**Drug**	**Dose**	**Comments**
Bacillary angiomatosis (Bartonella henselae, Bartonella quintana)			
	Doxycycline	2 x 100 mg/day po	Until improvement (until 2 months)
	or **Clarithromycin**	2 x 500 mg/day po	Until improvement (until 2 months)
Mycobacterium avium-intracellulare complex (MAC)			
	Clarithromycin **+ Ethambutol**	2 x 500 mg/day po 1 x 15 mg/kg/day po	12 months, then secondary prophylaxis
	Ev. + Rifabutin	1 x 300 mg/day po	Consider Rifabutin if resistance to Macrolides or Ethambutol is suspected, severe immunodeficiency (CD4 < 50 cells/µL), high bacterial load (> 2 L of CFU/mL of blood), no cART
	Ev. + Levofloxacin	1 x 500 mg/day po	4th drug to consider for disseminated disease
	Ev. + Amikacin	1 x 10-15 mg/kg/day iv	4th drug to consider for disseminated disease
	or **Azithromycin** **+ Ethambutol**	 1 x 500 mg/day po 1 x 15 mg/kg/day po	Consider additional drugs as above
Mycobacterium kansasii			
	Rifampicin **+ Isoniazid** **+ Ethambutol** or	1 x 600 mg/day po (or Rifabutin 300mg/day po) 1 x 300 mg/day po 1 x 20 mg/kg/day po	15-18 months
	Rifampicin **+ Clarithromycin** **+ Ethambuthol**	1 x 600 mg/day po (or Rifabutin 300 mg/day po) 2 x 500 mg po 1 x 15-20 mg/day po	15-18 months
Leishmaniasis			
Preferred treatment	**Liposomal Amphotericin B**	1 x 2-4 mg/kg/day iv for 10 consecutive days	Then secondary prophylaxis
	or **Liposomal Amphotericin B**	1 x 4 mg/kg/day iv on day 1-5, 10, 17, 24, 31 and 38	
Alternative therapy	**Lipidcomplex Amphotericin B**	1 x 3 mg/kg/day iv	10 days
	or **Amphotericin B Deoxycholate**	1 x 0.5-1 mg/kg/day iv (total dose 1.5-2 g)	Amphotericin B Deoxylate may not be available in all European countries
	or **Pentavalent antimonium salt (Glucantine®)**	1 x 20 mg/kg/day iv or im	4 weeks
	or **Miltefosine**	1 x 100 mg/kg/day po	4 weeks

Diagnosis and Treatment of TB in HIV-positive Persons

Treatment of TB in HIV-positive persons
For standard treatment of TB in HIV-positive persons, including appropriate choice of ARVs, see below table and ART in TB/HIV Co-infection

Disease	Drug	Dose	Comments
Susceptible *Mycobacterium tuberculosis*			
Initial Phase	**Rifampicin** **+ Isoniazid** **+ Pyrizinamide** **+ Ethambutol**	Weight based	**Initial phase** (Rifampicin+Isoniazid+Pyrizinamide+Ethambutol) for 2 months, then **Continuation phase** (Rifampicin+Isoniazid) according to TB type
Alternative	**Rifabutin** **+ Isoniazid** **+ Pyrizinamide** **+ Ethambutol**	Weight based	**Initial phase** (Rifabutin+Isoniazid+Pyrizinamide+Ethambutol) for 2 months, then **Continuation phase** (Rifabutin + Isoniazid) according to TB type
Continuation phase	**Rifampicin/Rifabutin** **+ Isoniazid** according to TB type		Total duration of therapy: 1. Pulmonary, drug susceptible TB: 6 months 2. Pulmonary TB & positive culture at 8 weeks of TB treatment: 9 months 3. Extrapulmonary TB with CNS involvement or disseminated TB: 9-12 months 4. Extrapulmonary TB with bone/joint involvement : 9 months 5. Extrapulmonary TB in other sites: 6-9 months

Diagnosis of Multi-drug Resistant TB (MDRTB) / Extended-Drug Resistant TB (XDRTB)

MDRTB/XDRTB should be suspected in case of:
- Previous TB treatment
- Contact with MDR/XDR TB index case
- Birth, travel or work in an area endemic for MDRTB
- History of poor adherence
- No clinical improvement on standard therapy and/or sputum smear positive after 2 months of TB therapy or culture positive at 3 months
- Homelessness/hostel living and in some countries recent/current incarceration
- In areas with very high MDRTB/XDRTB prevalence

MDRTB: Resistance to Isoniazid and Rifampicin.
XDRTB: Resistance to Isoniazid and Rifampicin and Quinolones and at last one at the following injectable drugs: Kanamycin, Capreomycin or Amikacin

Rapid Detection

Gene Xpert or similar technology has the advantage of rapid detection of drug resistance. Drug susceptibility testing is important in optimizing treatment.
Some countries/regions have neither of the above and have to use an empirical approach.

Treatment of Resistant TB

INH-resistant TB
- RIF or RFB + EMB + PZA for 7 months

Each dose of MDR/XDR TB regimen should be given as DOT throughout the whole treatment.

Treatment regimens should consist of at least four active drugs based on:
- Susceptibility testing for Isoniazid, Rifampicin, Rifabutin, Floroquinolones, injectable agents and other drugs if available
- Treatment history
- Local surveillance data
- Drug not been part of regimens used in the area

More than four drugs should be started if the susceptibility pattern is unknown or the effectiveness of one or more agents is questionable.

Drug Choices

Regimens often contain five to seven drugs

Include drugs from groups 1-5 (see below) in hierarchical order based on potency

1. Use any of the first-line oral agents (group 1) that are likely to be effective
2. Use an effective aminoglycoside or polypeptide by injection (group 2)
3. Use a fluoroquinolone (group 3)
4. Use the remaining group 4 drugs to complete a regimen of at least four effective drugs
5. For regimens with fewer than four effective drugs, consider adding two group 5 drugs

The regimen should be reassessed and modified if needed once drug sensitivity results become available.

Group 1: First-line oral agents	• Pyrazinamide (Z) • Ethambutol (E) • Rifabutin (RFB)
Group 2: Injectable agents	• Kanamycin (Km) • Amikacin (Am) • Capreomycin (CM) • Streptomycin (S)
Group 3: Fluoroquinolones	• Levofloxacin (LFX) • Moxifloxacin (MFX) • Ofloxacin (OFX) • Gatifloxacin (G)
Group 4: Oral bacteriostatic second-line agents	• Para-aminosalicylic acid (PAS) • Cycloserine (CS) • Terizidone (TRD) • Ethionamide (ETO) • Protionamide (PTO)
Group 5: Agents with unclear role in treatment of drug resistant-TB	• Clofazimine (CFZ) • Linezolid (LZD) /Tedizolid (TZD) • Amoxicillin/Clavulanate (Amx/CLV) • Thioacetazone (THZ) • Imipenem/Cilastatin (IPM/CLN) • High-dose Isoniazid (high-dose H-16–20 mg/kg/day) • Clarithromycin (CLR) • Consider, Bedaquiline, Delamanid and new anti-TB agents for MDR/XDR TB

Duration of MDR/XDR Treatment

8 months of intensive phase using 5 or more drugs,
followed by 12 months of 3 drugs depending on response.
E.g . 8 months of Z, Km, OFX, PTO and CS, followed by 12 months of OFX, PTO and CS.

Drug interactions with ART and MDR/XDR regimens

Unless RBT is being used, use normal doses but with caution as few data available on potential drug interactions, see ART in TB/HIV Co-infection

Latent Tuberculosis	
Indication: TST > 5 mm or positive IGRA or close contacts to open tuberculosis	
Regimen	**Comments**
Isoniazid (INH) 5 mg/kg/day (max. 300 mg) po + **Pyridoxin** (Vit B6) 25 mg/day po	6-9 months
Rifampicin 600 mg/day po or **Rifabutin** po (dose according to current cART)	4 months, check interactions with cART
Rifampicin 600 mg/day po or **Rifabutin** po (dose according to current cART) + **Isoniazid** (INH) 5 mg/kg/day (max 300 mg) po + **Pyridoxin** (Vit B6) 25 mg/day po	3 months, check interactions with cART
Rifampicin 600mg 2x/week po + **INH 900** mg 2x/week po + **Pyridoxin** (Vit B6) 300mg 1x/week po	3 months, check interactions with cART

References

Green colour refers to specific references used in each section
Black colour refers to general references used in each section

Part I Assessment of HIV-positive Persons at Initial & Subsequent Visits

Please see references for Part III

Part II ARV Treatment of HIV-positive Persons

1 Langewitz W et al. Spontaneous talking time at start of consultation in outpatient clinic: cohort study. BMJ 2002;325: 682-683.
2 Glass TR et al. Antiviral Therapy 13(1):77-85. 2008.
3 WHO 2003 p.95-107.
4 Arroll B et al. BMJ 327:1144-1146. 2003.
5 Simioni S, Cavassini M, Annoni JM, et al. Cognitive dysfunction in HIV patients despite long-standing suppression of viremia. AIDS. 2010 Jun 1;24(9):1243-50.
6 The Fast Alcohol Screening Test, Alcohol and Alcoholism (2002) 37 (1): 61-66.7. Castle, Lancet 2008;372:646-55.
7 J. Fehr, D. Nicca, W. Langewitz, D. Haerry, M.Battegay, revision 2013
8 Artemis, AIDS 2008, Vol 22 No 12: 1389 – 1397.
9 ACTG 5142 study, N Engl J Med 2008;358:2095-106.
10 Brogly S. Pediatrics Inf Dis journal 2010.
11 French Perinatal Cohort, 20th CROI2013, Atlanta, abstract 81.

Part III Prevention and Management of Co-morbidities in HIV-positive Persons

1 EHS 2013 Guidelines, J.Hypertens; 2013:7:1281-1357
2 International Diabetes Federation. The IDF consensus worldwide definition of the metabolic syndrome. 2005.
3 Simioni S, Cavassini M, Annoni JM, Rimbault AA, Bourquin I, Schiffer V, et al. Cognitive dysfunction in HIV patients despite long-standing suppression of viremia. AIDS 2010 Jun 1;24(9):1243-50.
4 Antinori A, Arendt G, Becker JT, Brew BJ, Byrd DA, Cherner M, et al. Updated research nosology for HIV-associated neurocognitive disorders. Neurology 2007 Oct 30;69(18):1789-99.

Peters B, Post F, Wierzbicki AS et al. Screening for chronic comorbid disease in people with HIV: the need for a strategic approach. HIV Med. 2013 Jan;14 Suppl 1:1-11.

El-Sadr WM, Lundgren JD, Neaton JD et al. CD4+ count-guided interruption of antiretroviral treatment. N Engl J Med 2006,355:2283-2296.

Silverberg MJ, Chao C, Leyden WA et al. HIV infection and the risk of cancers with and without a known infectious cause. AIDS. 2009 Nov 13;23(17):2337-45.

Clifford GM, Polesel J, Rickenbach M et al. Cancer risk in the Swiss HIV Cohort Study: associations with immunodeficiency, smoking, and highly active antiretroviral therapy. J Natl Cancer Inst. 2005 Mar 16;97(6):425-32.

De Wit S, Sabin CA, Weber R et al. Incidence and risk factors for new onset diabetes mellitus in HIV infected patients: the D:A:D study. Diabetes care 2008 Jun;31(6):1224-9.

Tien PC, Schneider MF, Cox C et al. Association of HIV infection with incident diabetes mellitus: impact of using hemoglobin A1C as a criterion for diabetes. J Acquir Immune Defic Syndr. 2012 Nov 1;61(3):334-40.

Freiberg MS, Chang CC, Kuller LH et al. HIV infection and the risk of acute myocardial infarction. JAMA Intern Med. 2013 Apr 22;173(8):614-22.

Worm SW, Sabin S, Weber R et al. Risk of Myocardial Infarction in Patients with HIV Infection Exposed to Specific Individual Antiretroviral Drugs from the 3 Major Drug classes: The Data Collection on Adverse Events of Anti-HIV Drugs (D:A:D) Study. J Infect Dis. 2010 Feb 1;201(3):318-30.

Triant VA, Lee H, Hadigan C et al. Increased acute myocardial infarction rates and cardiovascular risk factors among patients with human immunodeficiency virus disease. J Clin Endocrinol Metab 2007,92:2506-2512.

Islam FM, Wu J, Jansson et al. Relative risk of cardiovascular disease among people living with HIV: a systematic review and meta-analysis. HIV Med. 2012 Sep;13(8):453-68.

Grunfeld C, Delaney JA, Wanke C et al. Preclinical atherosclerosis due to HIV infection: carotid intima-medial thickness measurement from the FRAM study. AIDS. 2009 Sep 10;23(14):1841-9

Friis-Moeller N, Thibébaut R, Reiss P et al. for the D:A:D study group. Predicting the risk of cardiovascular disease in HIV-infected patients: the Data Collection on Adverse Effects of Anti-HIV Drugs Study.
Eur J Cardiovasc Prev Rehabil. 2010 Oct;17(5):491-501

Rothman MS, Bessesen MT. HIV infection and osteoporosis: pathophysiology, diagnosis and treatment options. Curr Osteoporos Rep. 2012 Dec;10(4):270-7.

Ryom L, Mocroft A, Kirk O et al. on behalf of the D:A:D study group. Association Between Antiretroviral Exposure and Renal Impairment Among HIV-positive Persons with Normal Baseline Renal Function: the D:A:D study. J Infect Dis. 2013 May;207(9):1359-1369.

Alsauskas ZC, Medapalli RK, Ross MJ. Expert opinion on pharmacotherapy of kidney disease in HIV-infected patients. Expert Opin Pharmacother 2011,12:691-704.

Mocroft A, Kirk O, Reiss P et al. for the EuroSIDA Study Group. Estimated glomerular filtration rate, chronic kidney disease and antiretroviral drug use in HIV-positive patients. AIDS 2010 Jul 17;24(11):1667-78.

Bonjoch A, Bayes B, Riba J, et al. Validation of estimated renal function measurements compared with the isotopic glomerular filtration rate in an HIV-infected cohort. Antiviral Res 2010,88:347-354.

Chang HR, Pella PM. Atazanavir urolithiasis. N Engl J Med 2006,355:2158-2159.

Gaspar G, Monereo A, Garcia-Reyne A et al. Fanconi syndrome and acute renal failure in a patient treated with tenofovir: a call for caution. AIDS 2004,18:351-352.

Gupta SK, Eustace JA, Winston JA, et al. Guidelines for the management of chronic kidney disease in HIV-infected patients: recommendations of the HIV Medicine Association of the Infectious Diseases Society of America.
Clin Infect Dis 2005,40:1559-1585.

Benhamou Y, Di Martino V, Bochet M et al. Factors affecting liver fibrosis in human immunodeficiency virus-and hepatitis C virus-coinfected patients: impact of protease inhibitor therapy. Hepatology 2001,34:283-287.

Kovari H, Ledergerber B, Peter U et al. Association of noncirrhotic portal hypertension in HIV-infected persons and antiretroviral therapy with didanosine: a nested case-control study. Clin Infect Dis 2009,49:626-635.

Weber R, Sabin CA, Friis-Moeller N et al. Liver related deaths in persons infected with the human immunodeficiency virus: The D:A:D study. Arch Intern Med 2006 Aug 14-28;166(15):1632-1641.

Qurishi N, Kreutzberg C, Lüchters G et al. Effect of antiretroviral therapy on liver-related mortality in patients with HIV and hepatitis C virus coinfection. Lancet 2003 Nov 22;362(9397):1708-13.

Part IV Clinical Management and Treatment of Chronic HBV and HCV Co-infection in HIV-positive Persons

1 Acute hepatitis C in HIV-infected individuals: recommendations from the European AIDS Treatment Network (NEAT) consensus conference. AIDS 2011 Feb 20;25(4):399-409.
2 Ingiliz P, Rockstroh JK. HIV-HCV co-infection facing HCV protease inhibitor licensing: implications for clinicians. Liver Int 2012 Sep;32(8): 1194-9.
3 EASL Clinical Practice Guidelines: management of hepatitis C virus infection. J Hepatol 2011 Aug;55(2):245-64.

Thomson EC, Nastouli E, Main J, et al. Delayed anti-HCV antibody response in HIV-positive men acutely infected with HCV. AIDS. 2009;23:89-93.

Lacombe K, Rockstroh J. HIV and viral hepatitis coinfections: advances and challenges. Gut 2012;61(Suppl 1):i47-i58.

Qurishi N, Kreuzberg C, Lüchters G, et al. Effect of antiretroviral therapy on liver-related mortality in patients with HIV and hepatitis C virus coinfection. Lancet. 2003;362:1708-13.

Torriani FJ, Rodriguez-Torres M, Rockstroh JK, et al. Peginterferon alfa-2a plus ribavirin for chronic hepatitis C virus infection in HIV infected patients. N Engl J Med 2004;351:438–50.

Núñez M, Miralles C, Berdún MA, et al. PRESCO Study Group. Role of weight-based ribavirin dosing and extended duration of therapy in chronic hepatitis C in HIV-infected patients: the PRESCO trial. AIDS Res Hum Retroviruses. 2007;23:972-82.

Rodriguez-Torres M, Slim J, Bhatti L, et al. Peginterferon alfa-2a plus ribavirin for HIV-HCV genotype 1 coinfected patients: a randomized international trial. HIV Clin Trials 2012;13:142–52.

Sulkowski MS, Sherman KE, Dieterich DT, et al. Combination Therapy With Telaprevir for Chronic Hepatitis C Virus Genotype 1 Infection in Patients With HIV: A Randomized Trial. Ann Intern Med. 2013;159:86-96.

Sulkowski M, Pol S, Mallolas J et al. P05411 study investigators. Boceprevir versus placebo with pegylated interferon alfa-2b and ribavirin for treatment of hepatitis C virus genotype 1 in patients with HIV: a randomised, double-blind, controlled phase 2 trial. Lancet Infect Dis. 2013;13:597-605.

Cotte L, Braun J, Lascoux-Combe C, et al. ANRS HC26 Study Group. High Early Virological Response with Telaprevir-Pegylated-Interferon-Ribavirin in Treatment-experienced Hepatitis C Virus Genotype 1/HIV Co-infected Patients: ANRS HC26 TelapreVIH Study. 20th Conference on Retroviruses and Opportunistic Infections, March 3-6, 2013;abstract 36.

Poizot-Martin I, Bellissant E, Piroth L, et al. ANRS-HC27 BOCEPREVIH Study Group. ANRS-HC27 BocepreVIH Interim Analysis: High Early Virologic Response with Boceprevir + Pegylated Interferon + Ribivirin in Hepatitis C Virus/HIV Co-infected Patients with Previous Failure to Pegylated Interferon + Ribivirin. 20th Conference on Retroviruses and Opportunistic Infections, March 3-6, 2013

Berenguer J, Alvarez-Pellicer J, et al. GESIDA 3603/5607 Study Group. Sustained virological response to interferon plus ribavirin reduces liver-related complications and mortality in patients coinfected with human immunodeficiency virus and hepatitis C virus. Hepatology. 2009 Aug;50(2):407-13.

Berenguer J, Rodríguez E, Miralles P, et al. GESIDA HIV/HCV Cohort Study Group. Sustained virological response to interferon plus ribavirin reduces non-liver-related mortality in patients coinfected with HIV and Hepatitis C virus. Clin Infect Dis. 2012 Sep;55(5):728-36.

Hézode C, Fontaine H, Dorival C, et al. CUPIC Study Group. Triple therapy in treatment-experienced patients with HCV-cirrhosis in a multicentre cohort of the French Early Access Programme (ANRS CO20-CUPIC) - NCT01514890. J Hepatol. 2013 May 10. doi:pii: S0168-8278(13)00290-0. 10.1016/j.jhep.2013.04.035. [Epub ahead of print]

Miro JM, Montejo M, Castells L, et al. Spanish OLT in HIV-Infected Patients Working Group investigators. Outcome of HCV/HIV-coinfected liver transplant recipients: a prospective and multicenter cohort study. Am J Transplant. 2012;12:1866-76.

Terrault NA, Roland ME, Schiano T, et al. Solid Organ Transplantation in HIV: Multi-Site Study Investigators. Outcomes of liver transplant recipients with hepatitis C and human immunodeficiency virus coinfection. Liver Transpl. 2012;18:716-26.

Sonneveld MJ, Rijckborst V, Boucher CA, et al. Prediction of sustained response to peginterferon alfa-2b for hepatitis B e antigen-positive chronic hepatitis B using on-treatment hepatitis B surface antigen decline. Hepatology. 2010;52:1251-1257.

Neukam K, Camacho A, Caruz A, et al. Prediction of response to pegylated interferon plus ribavirin in HIV/hepatitis C virus (HCV)-coinfected patients using HCV genotype, IL28B variations, and HCV-RNA load. J Hepatol. 2012;56:788-794.

Part V Opportunistic Infections

DHHS: Guidelines for prevention and treatment of opportunistic infections in HIV-infected adults and adolescents. July 2013. www.aidsinfo.nih.gov