



## **Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV**

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## **Treatment Goals (Last updated January 28, 2016; last reviewed January 28, 2016)**

Antiretroviral therapy (ART) has reduced HIV-related morbidity and mortality at all stages of HIV infection<sup>1-4</sup> and has reduced HIV transmission.<sup>5-8</sup> Maximal and durable suppression of plasma viremia delays or prevents the selection of drug-resistance mutations, preserves or improves CD4 T lymphocyte (CD4) cell numbers, and confers substantial clinical benefits, all of which are important treatment goals.<sup>9,10</sup> HIV suppression with ART may also decrease inflammation and immune activation thought to contribute to higher rates of cardiovascular and other end-organ damage reported in cohorts with HIV (see [Initiating Antiretroviral Therapy](#)). Despite these benefits, eradication of HIV infection cannot be achieved with available antiretrovirals (ARVs). Treatment interruption has been associated with rebound viremia, worsening of immune function, and increased morbidity and mortality.<sup>11</sup> Thus, once initiated, ART should be continued, with the following key treatment goals:

- Maximally and durably suppress plasma HIV RNA;
- Restore and preserve immunologic function;
- Reduce HIV-associated morbidity and prolong the duration and quality of survival; and
- Prevent HIV transmission.

Achieving viral suppression currently requires the use of combination ARV regimens that generally include three active drugs from two or more drug classes. Baseline patient characteristics and results from drug resistance testing should guide design of the specific regimen (see [What to Start: Initial Combination Regimens for the Antiretroviral-Naive Patient](#)). When initial HIV suppression is not achieved or not maintained, changing to a new regimen with at least two active drugs is often required (see [Virologic Failure](#)). The increasing number of ARV drugs and drug classes makes viral suppression below detection limits an achievable goal in most patients.

After initiation of effective ART, viral load reduction to below limits of assay detection usually occurs within the first 12 to 24 weeks of therapy. Predictors of virologic success include the following:

- Low baseline viremia;
- High potency of the ARV regimen;
- Tolerability of the regimen;
- Convenience of the regimen; and
- Excellent adherence to the regimen.

### **Strategies to Achieve Treatment Goals**

#### ***Selection of Initial Combination Regimen***

Several ARV regimens are recommended for use in ART-naive patients (see [What to Start](#)). Most of the recommended regimens have comparable efficacy but vary in pill burden, potential for drug interactions and/or side effects, and propensity to select for resistance mutations if ART adherence is suboptimal. Regimens should be tailored for the individual patient to enhance adherence and support long-term treatment success. Considerations when selecting an ARV regimen for an individual patient include potential side effects, patient comorbidities, possible interactions with concomitant medications, results of pretreatment genotypic drug-resistance testing, and regimen convenience (see [Table 7](#)).

#### ***Improving Adherence***

Suboptimal adherence may result in reduced treatment response. Incomplete adherence can result from complex medication regimens; patient-related factors, such as active substance abuse, depression, or

the experience of adverse effects; and health system issues, including interruptions in patient access to medication and inadequate treatment education and support. Conditions that promote adherence should be maximized before and after initiation of ART (see [Adherence to the Continuum of Care](#)).

## References

1. Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=20647201](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201).
2. INSIGHT START Study Group. Initiation of antiretroviral therapy in early asymptomatic HIV infection. *N Engl J Med*. Jul 20 2015. Available at <http://www.ncbi.nlm.nih.gov/pubmed/26192873>.
3. TEMPRANO ANRS Study Group, Danel C, Moh R, et al. A trial of early antiretrovirals and isoniazid preventive therapy in africa. *N Engl J Med*. Aug 27 2015;373(9):808-822. Available at <http://www.ncbi.nlm.nih.gov/pubmed/26193126>.
4. Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med*. Apr 30 2009;360(18):1815-1826. Available at [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=19339714](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19339714).
5. Mofenson LM, Lambert JS, Stiehm ER, et al. Risk factors for perinatal transmission of human immunodeficiency virus type 1 in women treated with zidovudine. Pediatric AIDS Clinical Trials Group Study 185 Team. *N Engl J Med*. Aug 5 1999;341(6):385-393. Available at [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=10432323](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=10432323).
6. Wood E, Kerr T, Marshall BD, et al. Longitudinal community plasma HIV-1 RNA concentrations and incidence of HIV-1 among injecting drug users: prospective cohort study. *BMJ*. 2009;338:b1649. Available at [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=19406887](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19406887).
7. Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med*. Aug 11 2011;365(6):493-505. Available at [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=21767103](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=21767103).
8. Reynolds SJ, Makumbi F, Nakigozi G, et al. HIV-1 transmission among HIV-1 discordant couples before and after the introduction of antiretroviral therapy. *AIDS*. Feb 20 2011;25(4):473-477. Available at <http://www.ncbi.nlm.nih.gov/pubmed/21160416>.
9. O'Brien WA, Hartigan PM, Martin D, et al. Changes in plasma HIV-1 RNA and CD4+ lymphocyte counts and the risk of progression to AIDS. Veterans Affairs Cooperative Study Group on AIDS. *N Engl J Med*. Feb 15 1996;334(7):426-431. Available at [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=8552144](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=8552144).
10. Garcia F, de Lazzari E, Plana M, et al. Long-term CD4+ T-cell response to highly active antiretroviral therapy according to baseline CD4+ T-cell count. *J Acquir Immune Defic Syndr*. Jun 1 2004;36(2):702-713. Available at [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=15167289](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=15167289).
11. El-Sadr WM, Lundgren JD, Neaton JD, et al. CD4+ count-guided interruption of antiretroviral treatment. *N Engl J Med*. Nov 30 2006;355(22):2283-2296. Available at [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=17135583](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=17135583).