Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection

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### Table 15b. Antiretroviral-Therapy-Associated Adverse Effects and Management Recommendations—Dyslipidemia

(Updated May 22, 2018; reviewed May 22, 2018)

<table>
<thead>
<tr>
<th>Adverse Effects</th>
<th>Estimated Frequency</th>
<th>Risk Factors</th>
<th>Prevention/Monitoring</th>
<th>Management</th>
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</thead>
</table>
| Dyslipidemia    | Onset: 10% to 20% in young children receiving LPV/r. 40% to 75% of older children and adolescents with prolonged ART history will have lipid abnormalities. Higher abnormal fasting serum lipids in EVG/COBI/FTC/TAF vs. EVG/COBI/FTC/TDF regimen in studies of treatment-naive adults. Increase in serum lipids from baseline also noted in adolescents receiving EVG/COBI/FTC/TAF. | Advanced-stage HIV disease  High-fat, high-cholesterol diet  Lack of exercise  Obesity  Hypertension  Smoking  Family history of dyslipidemia or premature CVD  Metabolic syndrome  Fat maldistribution | Prevention:  
• Low-fat diet  
• Exercise  
• Smoking-prevention counseling  
• Do not use d4T | Assessment of additional CVD risk factors should be done in all patients. Patients living with HIV are considered to be at moderate risk of CVD.  
Counsel on lifestyle modification and dietary interventions (e.g., a diet low in saturated fat, cholesterol, and refined sugars, particularly in cases of ↑TG, elimination of trans fat in the diet, increase in physical activity, smoking cessation) for an adequate trial period (3–6 months). Consider consultation with dietician.  
ART regimen changes can be considered. Discontinue d4T or substitute a PI-sparing regimen or PI-based regimen with a more favorable lipid profile.  
Consider lipid-lowering therapy in consultation with a lipid specialist if ≥6-month trial of lifestyle modification fails.  
Some experts suggest treating children receiving ARV drugs according to NHLBI cardiovascular risk reduction guidelines for children aged ≥10 years: LDL-C ≥190 mg/dL, regardless of additional risk factors; LDL-C ≥160 mg/dL or LDL-C ≥130 mg/dL based on presence of additional risk factors and risk conditions.  
The minimal goal of therapy should be to achieve and maintain a LDL-C value below 130 mg/dL, while minimizing side effects and maintaining viral control. |

**Associated ARVs**

- PIs:
  - All PIs, especially RTV-boosted PIs; lower incidence reported with DRV/r and ATV with or without RTV.
  - NRTIs:
    - Especially d4T
  - Lower incidence reported with TDF than TAF
  - NNRTIs:
    - Lower incidence reported with NVP, RVP, and ETR than EFV

**Onset/Clinical Manifestations**

- PIs: As early as 2 weeks to months after beginning therapy
- NRTIs:
  - ↑LDL-C, TC, and TG
  - ↑LDL-C, TC, and HDL-C
- NNRTIs:
  - ↑LDL-C, TC, and TG

**Prevention/Monitoring**

- Adolescents and Adults: Monitor 12-hour FLP, which includes TC, HDL-C, non-HDL-C, LDL-C, and TG, every 6–12 months. Obtain FLPs twice (>2 weeks but ≤3 months apart, average results) before initiating or changing lipid-lowering therapy.
- Children (Aged ≥2 Years) without Lipid Abnormalities or Additional Risk Factors:
  - Obtain nonfasting screening lipid profiles at entry into care and then, if levels are normal, every 6–12 months. If TG or LDL-C is elevated, obtain fasting blood tests.
- Children with Lipid Abnormalities and/or Additional Risk Factors:
  - Obtain 12-hour FLP before initiating or changing therapy and every 6 months thereafter (more often if indicated).
  - Obtain 12-hour FLP, LFTs, and CK at 4 and 8 weeks, and 3 months after starting lipid therapy.

**Risk Factors**

- Advanced-stage HIV disease
- High-fat, high-cholesterol diet
- Lack of exercise
- Obesity
- Hypertension
- Smoking
- Family history of dyslipidemia or premature CVD
- Metabolic syndrome
- Fat maldistribution

**Management**

- Prevention:
  - Low-fat diet
  - Exercise
  - Smoking-prevention counseling
  - Do not use d4T

- Monitoring:
  - Adolescents and Adults:
    - Monitor 12-hour FLP, which includes TC, HDL-C, non-HDL-C, LDL-C, and TG, every 6–12 months. Obtain FLPs twice (>2 weeks but ≤3 months apart, average results) before initiating or changing lipid-lowering therapy.
  - Children (Aged ≥2 Years) without Lipid Abnormalities or Additional Risk Factors:
    - Obtain nonfasting screening lipid profiles at entry into care and then, if levels are normal, every 6–12 months. If TG or LDL-C is elevated, obtain fasting blood tests.
  - Children with Lipid Abnormalities and/or Additional Risk Factors:
    - Obtain 12-hour FLP before initiating or changing therapy and every 6 months thereafter (more often if indicated).
    - Obtain 12-hour FLP, LFTs, and CK at 4 and 8 weeks, and 3 months after starting lipid therapy.

- Assessment of additional CVD risk factors should be done in all patients. Patients living with HIV are considered to be at moderate risk of CVD.
- Counsel on lifestyle modification and dietary interventions (e.g., a diet low in saturated fat, cholesterol, and refined sugars, particularly in cases of ↑TG, elimination of trans fat in the diet, increase in physical activity, smoking cessation) for an adequate trial period (3–6 months). Consider consultation with dietician.
- ART regimen changes can be considered. Discontinue d4T or substitute a PI-sparing regimen or PI-based regimen with a more favorable lipid profile.
- Consider lipid-lowering therapy in consultation with a lipid specialist if ≥6-month trial of lifestyle modification fails.
- Some experts suggest treating children receiving ARV drugs according to NHLBI cardiovascular risk reduction guidelines for children aged ≥10 years: LDL-C ≥190 mg/dL, regardless of additional risk factors; LDL-C ≥160 mg/dL or LDL-C ≥130 mg/dL based on presence of additional risk factors and risk conditions.
- The minimal goal of therapy should be to achieve and maintain a LDL-C value below 130 mg/dL, while minimizing side effects and maintaining viral control.
### Table 15b. Antiretroviral-Therapy-Associated Adverse Effects and Management Recommendations—Dyslipidemia

(Last updated May 22, 2018; last reviewed May 22, 2018) (page 2 of 2)

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<td>Dyslipidemia</td>
<td></td>
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<td>Statins such as pravastatin, atorvastatin, or rosuvastatin&lt;sup&gt;d&lt;/sup&gt; can be considered.&lt;sup&gt;d&lt;/sup&gt; Pravastatin has lower lipid-lowering potency compared to other statins. Statin-induced lipid lowering effect appears more pronounced than ARV substitution. Statin-related toxicities include liver enzyme elevation and myopathy, and risk may be increased by drug interactions with ART, particularly PIs.&lt;sup&gt;c&lt;/sup&gt; Statins may also increase the risk of insulin resistance and type 2 diabetes mellitus, but data are conflicting. Risks must be weighed against potential benefits. Cholesterol absorption inhibitors (e.g., ezetimibe) can be considered as alternatives.</td>
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Statins may also increase the risk of insulin resistance and type 2 diabetes mellitus, but data are conflicting. Risks must be weighed against potential benefits. Cholesterol absorption inhibitors (e.g., ezetimibe) can be considered as alternatives.

Drug therapy for severe hypertriglyceridemia (TG ≥500 mg/dL) can be considered. Fibrates (gemfibrozil and fenofibrate) and N-3 PUFAs derived from fish oils may be used.

The long-term risks of lipid abnormalities in children receiving ART are unclear. However, persistent dyslipidemia in children may lead to premature CVD.

<sup>a</sup> Given the burden of collecting fasting blood samples, some practitioners routinely measure cholesterol and triglycerides from nonfasting blood samples and follow up abnormal values with a test done in the fasted state.

<sup>b</sup> Refer to NHLBI guidelines at [https://www.nhlbi.nih.gov/sites/default/files/media/docs/peds_guidelines_full.pdf](https://www.nhlbi.nih.gov/sites/default/files/media/docs/peds_guidelines_full.pdf).

<sup>c</sup> The risks of new treatment-related toxicities and virologic failure that could occur with changes in therapy must be weighed against the potential risk of drug interactions and toxicities associated with the use of lipid-lowering agents.

<sup>d</sup> Statins (HMG-CoA reductase inhibitors) are contraindicated in pregnancy (due to being potentially teratogenic) and should not be used in patients who may become pregnant. Multiple drug interactions exist between ARV drugs and statins (except for pravastatin, which is not dependent on CYP3A4 for metabolism). Pravastatin, atorvastatin, rosuvastatin (Crestor®), fluvasatinit, and ezetimibe (Zetia®) are approved for use in children aged ≥10 years. For additional information, see the PI, NNRTI, NRTI, and INSTI Drug Interactions Tables in the Adult and Adolescent Guidelines.

<sup>e</sup> d4T is no longer recommended for use in an ARV regimen
References


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K-14


33. Calza L, Colangeli V, Magistrelli E, et al. No correlation between statin exposure and incident diabetes mellitus in HIV-1-infected patients receiving combination
