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HIV: the search for a cure

[Image of a man speaking at a podium with the text "towards an HIV cure"]
Thanks to developments in HIV treatment and care over the 30 years since the virus was identified, many people with HIV will lead a long and healthy life. But this is dependent on medication which, for the moment, is a daily and lifelong commitment. The ultimate development in HIV treatment would be one that allows people to stop treatment – in effect, a cure.

Towards an HIV cure, a symposium held at the 7th International AIDS Society conference, has suggested that the search for a cure should become the latest phase in research into HIV treatment.

In recent years, there have been indications that we are closer to understanding possible routes to a cure. Individual case reports, such as the ‘Berlin patient’, Timothy Brown, and that of a baby in Mississippi, seem to show that it is possible to eradicate HIV from someone who has previously been infected with the virus. And there is some evidence that it may be possible, with the right combination and approach to HIV treatment, to achieve ‘remission’ or a ‘functional cure’ – control of HIV without the need for lifelong medication.

But these cases are based on a very specific set of circumstances and it is not currently possible or practicable to reproduce these as a widely applicable approach resulting in a cure.

Carl Dieffenbach, from the US National Institute of Allergy and Infectious Disease (NIAID), presenting at the symposium, called for researchers to approach the search for a cure through a detailed knowledge of the full – and complex – range of processes involved in HIV infection and replication in the body. These involve understanding both the virus’s processes and the human body’s immune system processes in response to these. Eradicating HIV from the body is likely to involve a combination of approaches, targeting different elements of these processes simultaneously.

As well as requiring the development of even more effective anti-HIV drugs, which can control HIV in every part of the body, any potential cure is likely to make new demands on the way HIV treatment and care are delivered. For example, there’s some evidence that treating people very soon after they acquire HIV is an important factor in controlling HIV without drugs.

There will also need to be changes in the way drug companies – and regulators – work together, to enable the necessary combinations of types of treatment to be developed and used together.

Some concern was expressed at the workshop about the potential safety of new approaches, and of not raising expectations unrealistically. It may be more accurate to describe some of the possible approaches as achieving ‘remission’ of HIV, even if the virus is not completely eradicated from the body.

Work towards a cure will clearly involve significant financial commitment and a call was made from the workshop to international bodies and governments to honour funding pledges.

Related links

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HIV treatment: when to start

Gottfried Hirnschall from the WHO at the press conference for the new HIV treatment guidelines, available online at www.who.int/hiv. Photo ©International AIDS Society/Steve Forrest/Workers' Photos.

The care needs of people living with HIV in some parts of the world are changing significantly.

The best time to start HIV treatment has been debated almost since HIV treatment has been available, with pros and cons for both starting treatment early and for waiting.

Guidance on when to start treatment is in large part based on CD4 cell count. International and national guidelines on HIV treatment have set CD4 cell levels that would normally trigger the recommendation to start treatment. Over the last few years, the threshold for the suggested starting point has risen from 200 cells/mm³ to 350 and – in the case of the most recent US Department of Health and Human Services’ guidelines – 500.

Now, the World Health Organization (WHO) has issued new HIV treatment guidelines that recommend offering treatment to anyone whose CD4 cell count is below 500 cells/mm³.

WHO predicts this shift could prevent 3 million deaths and 3.5 million new HIV infections between 2013 and 2025 if the new recommendations are put into action.

Since the last WHO guidelines were published, in 2010, evidence from the HPTN 052 study has
shown that starting treatment at a CD4 cell count of between 250 and 550 reduced HIV transmission between serodiscordant, heterosexual couples by 96%. The new guidelines recommend that anyone in a serodiscordant relationship (where one partner has HIV and the other does not) should start HIV treatment whatever their CD4 cell count.

Women who are pregnant or breastfeeding and children under five should also start treatment immediately, as should children over five years of age with a CD4 cell count under 500.

The anti-HIV drugs tenofovir (Viread), 3TC (lamivudine, Epivir) or FTC (emtricitabine, Emtriva) and efavirenz (Sustiva or Stocrin) are recommended as first-line treatment, ideally in a fixed-dose combination.

The 2013 guidelines recommend viral load testing as the preferred way of monitoring treatment efficacy – seen as the most reliable way of knowing whether someone needs to change treatment or can stay on first-line treatment – with accompanying CD4 cell count monitoring.

The new guidelines were broadly welcomed by groups representing people living with HIV, but concerns were expressed about their implementation. Although the last WHO guidelines recommended starting treatment with a CD4 cell count of about 350, around the world most people still start treatment when their CD4 cell count is under 100 – by which time they are at high risk of serious illness.

WHO estimates that an additional 25.9 million people will now be eligible for HIV treatment. UNAIDS has predicted that the costs can currently be met within the projected global budget for HIV treatment and care, as well as by reducing the costs of drugs and of delivery systems. There should also be lower healthcare costs with increased access to treatment reducing HIV-related illness.

There will, however, need to be financial investment made by individual governments as well as the international community, and advocates have pointed out that there are already large variations in access to treatment across the world. New guidelines alone may not be enough to address this problem.

Related links

- Read this news story in full on aidsmap
- Download the new guidelines from the WHO website
- Read the response from Médecins Sans Frontières
- Download the new report on global access to HIV treatment from UNAIDS, WHO and UNICEF

HIV treatment and care: age-related illnesses
The care needs of people living with HIV in some parts of the world are changing significantly.

While a cure might be the ultimate goal of developments in HIV treatment, highly effective anti-HIV drugs already in existence mean that those people who have access to them, and who have responded well, are now living long and healthy lives – many can expect to have a normal life expectancy.

As a result, delegates heard during the keynote address at the 7th International AIDS Society conference yesterday, illnesses other than those related to AIDS are becoming far more of an issue for many people with HIV.

Steven Deeks, from the University of California, San Francisco, explained that – as with many long-term conditions – well-controlled HIV still causes low-level activity in the immune system, with the resulting inflammation contributing to the development of other health conditions.

HIV has been shown to be a risk factor for heart disease, and for other health issues including bone problems, kidney disease, brain impairment and some cancers. Many of these health problems are also associated with ageing, but there’s some evidence that people with HIV can develop them earlier than their HIV-negative peers.

This situation has been recognised for some time in regions where HIV treatment has been widely available, such as the US and northern Europe, but a similar range of ‘co-morbidities’ are now being seen in the developing world too. An increase in age-related health problems will place another burden on healthcare systems that are already struggling, and increasingly health services will need to shift to dealing with HIV as a long-term, manageable condition.

It is possible to tackle these age-related conditions early, with drugs and lifestyle changes that can prevent, manage and reverse them. Starting HIV treatment earlier may help. But, Deeks says, the issues caused by chronic HIV infection – both for individuals and for healthcare systems – “could all be addressed by a cure”. Clinicians should aim to keep the people in their care well enough to benefit from a cure if and when it comes.

Related links

Read this news story in full on aidsmap
Clinical Care Options

The other official online science provider for IAS 2013 is Clinical Care Options (CCO).

CCO is providing scientific analysis for delegates and journalists, delivered through online continuing medical education (CME) activities.

Coverage from CCO will include capsule summaries of the most clinically relevant studies, selected by the CCO’s expert faculty; audio podcasts of the day’s highlights; downloadable PowerPoint slides summarising key data; and analysis of the clinical implications of the major studies from a panel of international experts.

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