Discussão de caso clinico

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Conflito de Interesse

- Coordenador do Comitê de AIDS da SBI e Representante da SBI no PCDT
- Funcionário público estadual
- Membro do câmara técnica de AIDS da Coordenação Estadual de AIDS São Paulo

- Atividades de pesquisa clínica: Abbvie, BMS, Boehringer, GSK, Gilead, Janssen, MSD, Roche

- Palestrante: Abbvie, BMS, Gilead, Janssen, MSD

- Apoio para atividades de educação médica: Abbvie, BMS, Gilead, Janssen, MSD

- Advisory board: Abbvie, BMS, GSK, Gilead, Janssen, MSD

Caso clínico

- Sexo masculino, 53 anos, branco, natural de São Paulo.
- Obesidade (IMC =40,5)
- Hipertensão arterial há mais de 10 anos, em uso de tenoretic (atenolol + clortalidona), sem controle.
- Diabetes mellitus tipo 2 há cerca de 1 ano, em uso de metformina 750mg/3 vezes ao dia, sitagliptina 50mg 2 vezes ao dia e Insulina NPH e Humalog
- HIV positivo em 27/01/2017, exame realizado para investigar lesões de pele (sifilis secundária)

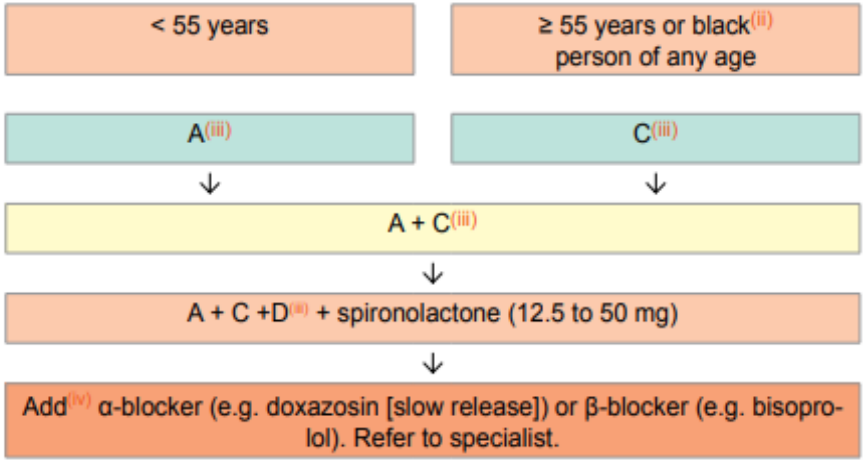
Caso clínico

- CD4= 366, CD8= 1553 e carga viral HIV= 85.000 cópias/ml
- Genotipagem do HIV, subtipo B, sem resistências.
- O tenoretic foi trocado por Losartana 50 mg 2 vezes ao dia e Amlodipina 5mg/dia e foi prescrito atorvastatina 10mg/dia
- Outros exames:
  - Colesterol total: 270, HDL= 30, LDL= 210, triglicérides = 230,
  - Glicose= 114, HbA1c = 7,8%,
  - AST= 31 e ALT=64
  - Uréia=34 e creatinina= 0,8
  - TSH= 2,02 e T4livre=1,21
  - Vitamina D= 14
  - Urina I: proteinúria +

EACS Guideline 9.0

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

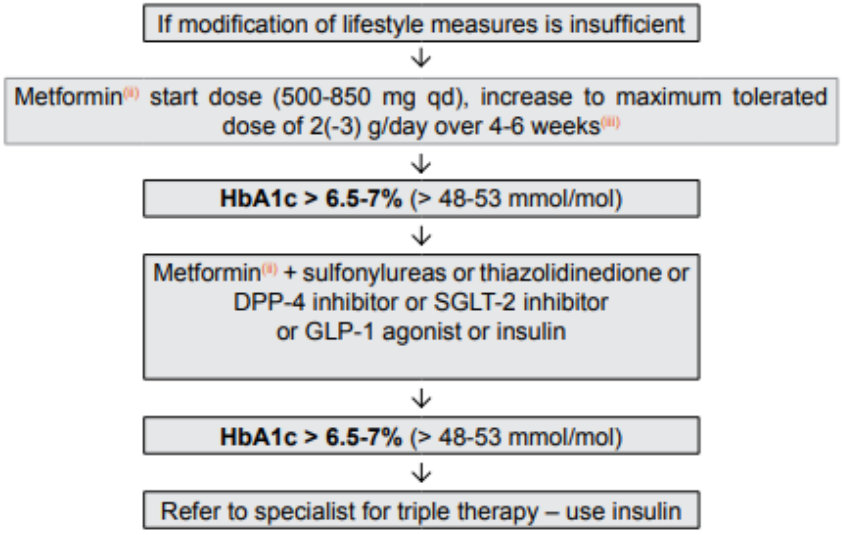
iii Wait 4-6 weeks to assess whether target, see page 40, is achieved; if not, go to next step

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

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

EACS Guideline 9.0

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 40, and blood pressure < 130/80 mmHg, see page 41.
- Acetylsalicylic acid (75-150 mg qd) considered in diabetics with elevated underlying CVD risk, see page 40.
- 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 Metformin may worsen lipoatrophy.
No data for any oral antidiabetic agents in terms of CVD prevention in HIV-positive persons. Incretins (DDP-4 inhibitors [e.g. linagliptin, saxagliptin (reduce dose when given with a booster), sitagliptin and vildagliptin], GLP-1 agonists [liraglutide, exenatide], and SGLT-2 inhibitors [e.g. dapagliflozin, canagliflozin, empagliflozin] have not been evaluated in HIV-positive persons, but some (e.g empagliflozin, liraglutide) have shown to reduce mortality from CVD; choice of drugs dependent on a variety of individual- & disease-specific factors; no clinically significant drug-drug-interaction or adverse effects on CD4 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.

iii Consider lower dose in individuals with mild to moderate CKD or individuals receiving DTG.

Que regime antirretroviral escolher?

- TDF/3TC + DTG
- TDF/3TC/EFV
- ABC + 3TC + DTG
- AZT/3TC + DTG
- ATV/RTV + DTG
- DRV/RTV + DTG
- DTG + 3TC
- Outro regime? Qual?

ASCVD Risco cardiovascular = 32,1% em 10 anos

Discussão

Muito obrigado

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Dolutegravir + Lamivudine

- ACTG A5353
  - Pilot study on DTG/3TC in ART-naïve
  - 120 participants enrolled
  - 31% with HIV RNA >100,000 cpm
  - At 34 weeks, 96% achieved viral suppression (HIV RNA

<50 cpm)

Two large trials currently enrolling to evaluate this regimen vs first line triple therapy regimens in treatment-naïve patients (GEMINI-1 and GEMINI-2)

Taiwo BO, et al. ACTG A5353: A pilot study of dolutegravir (DTG) + lamivudine (3TC) for initial treatment of HIV- 1-infected participants with HIV-1 RNA <500,000 copies/ml. IAS 2017: Conference on HIV Pathogenesis
Treatment and Prevention, Paris, France
July 23-26 2017

Dolutegravir + Lamivudine

- LAMIDOL
  - 104 treatment-experienced participants switched to dolutegravir + lamivudine
  - 101 maintained viral suppression at 40 weeks

Joly V et al. *Promising results of dolutegravir + lamivudine maintenance in ANRS 167 Lamidol trial*. Conference on Retroviruses and Opportunistic Infections (CROI 2017), Seattle, abstract 458, 2017.