

The LipoWatch program from Visionary Health Concepts is designed to support providers and patients with education that integrates a "real world" focus with scientific data. This issue of LipoWatch is the second part of a report on cardiovascular risk associated with HIV disease and treatment, and focuses on clinical implications. Next month's LipoWatch will focus on the cardiovascular risk associated with various antiviral drugs in patients with HIV. NOTE: LipoWatch faxes are archived on the web at http://www.vhconcepts.com/edu_progs.cfm

Studies of cardiovascular (CV) events in patients with HIV have produced varying results, as discussed in last month's LipoWatch. How should clinicians approach the management of CV risk in treating their patients?

CV risk management has undoubtedly been underemphasized among patients with HIV. As antiviral treatments increase the life span of people with HIV, CV risk and various other general health issues deserve the same attention as the general public. This implies a much higher level of attention to CV risk than was applied when HIV infection was generally fatal within a few years. Patients usually receive better HIV care when it is delivered by an experienced, HIV specialist. However, CV risk management is more likely to occur in a family physician or general internist setting. Consequently, some HIV specialists may need to review their assessment strategies or refer HIV patients out for cardiovascular risk assessment and collaborate in its management.

The identification of specific CV risk factors has been a major advance in CV medicine. Reduction of these risk factors lowers rates of CV disease. The basis for most projections remains the Framingham study, a 50-year examination of a Massachusetts community⁽¹⁾. A simple on-line calculator based on this study is available⁽²⁾. Increasingly, the intensity

of CV risk interventions is being made proportional to the risk of CV disease⁽³⁾. This underscores the need for careful risk assessment, including the contributions of HIV treatments.

However, CV risk assessment can be problematic. The impact of a specific risk factor varies substantially depending on other factors. For example, Dr. Donald Kotler noted in a recent talk⁽⁴⁾ that a 45-year-old male smoker with total cholesterol of 290 mg/dL, HDL cholesterol of 36 mg/dL and systolic blood pressure of 134 mm/Hg has a 10-year CV disease risk of 28%. Smoking cessation could drop that risk to 9%, a much more effective risk reduction than lowering cholesterol.

There is a growing body of research on CV event rates and risk management in people with HIV. Two summaries were published recently^{(5),(6)}. However, clinicians must rely predominantly on guidelines developed for the general population, such as the NCEP guidelines. Ideally, CV risk management begins before an HIV patient begins antiviral therapy, especially if baseline risk is elevated. It may be much easier to initiate risk reduction activities, especially lifestyle changes, without the complicating issues associated with taking antiviral therapy.

CV risk management should begin with lifestyle changes (smoking cessation, increased physical activity, and dietary changes). These may be extremely difficult to achieve but may be the most effective interventions. The next interventions are pharmacologic, to reduce serum lipid levels and possible to improve insulin sensitivity. In patients with HIV, these become more problematic due to drug-drug interactions, pill burden, adherence issues, and side effects.

Therefore, clinicians will increasingly be

evaluating the CV risk profiles of various antiviral regimens. Considered selection of certain regimens may defer or eliminate the need for lipid-lowering drugs and their concomitant interactions and other problems. Recent studies^{(7),(8)} have documented a more favorable lipid profile for protease-sparing regimens compared to protease-containing, and a reduction of serum lipids when switching from a protease-containing to non-nucleoside analog based regimens. There are also differences among protease inhibitors, and next month's LipoWatch fax will focus on individual medications and their contributions to cardiovascular risk.

Of note: At a May 13, 2003 hearing, an FDA Advisory Committee unanimously recommended the approval of atazanavir, a protease inhibitor in Phase III clinical development which has demonstrated a benign impact on lipid levels; final action is anticipated in June 2003.

¹Grundy SM, Pasternak R, Greenland P, Smith S, Fuster V. Assessment of Cardiovascular Risk by Use of Multiple-Risk-Factor Assessment Equations: A Statement for Healthcare Professionals From the American Heart Association and the American College of Cardiology. *J Am Coll Cardiol* 1999;34:1348-59 or <http://www.acc.org/clinical/consensus/risk/dirindex.htm>, last accessed May 6, 2003.
²Risk Assessment Tool for Estimating 10-year Risk of Developing Hard CHD (Myocardial Infarction and Coronary Death), National Cholesterol Education Program Adult Treatment Panel III. Last accessed May 6, 2003 at <http://hin.nhlbi.nih.gov/atpii/calculator.asp?usertype=prof>
³Grundy SM, D'Agostino RG, Mosca L et al. Summary of National Heart, Lung and Blood Institute Workshop on Cardiovascular Risk Assessment, <http://www.nhlbi.nih.gov/resources/docs/cvrisks.pdf> Last accessed May 6, 2003. Original version appeared in *Circulation*, 2001;104:491-496.
⁴Mulligan K, Kotler D. Metabolic and Morphologic Complications in HIV Disease: What's New? PRN Notebook 2003; 8(1):11-20.
⁵AACTG Metabolic Complications Guides at <http://aactg.s-3.com/metabolic/> Last accessed May 6, 2003.
⁶Schambelan M, Benson C, Carr A et al. Management of Metabolic Complications Associated With Antiretroviral Therapy for HIV-1 Infection: Recommendations of an International AIDS Society-USA Panel. *JAIDS* 2002; 31(3):257-275. Available on line at <http://www.iasusa.org/pub/metcomp.html>; last accessed May 6, 2003.
⁷Keiser P, Senson M, DeJesus E, et al. Simplification of protease inhibitor (PI)-based highly active antiretroviral regimens with abacavir (ABC) improves hyperlipidemia and maintains viral suppression in HIV-1 infected adults (ESS40003). Program and abstracts of the XIV International AIDS Conference; July 7-12, 2002; Barcelona, Spain. Abstract WePc6267.
⁸Van Leth F, Hassink E, Phanuphak P et al. Results of the 2NN study: a randomized comparative trial of first-line antiretroviral therapy with regimens containing either nevirapine alone, efavirenz alone, or both drugs combined, together with stavudine and lamivudine. Abstracts, 10th Conference on Retroviruses and Opportunistic Infections; February 10-14, 2003, Boston MA, Abstract 176.

Next month's LipoWatch will discuss cardiovascular risk associated with various antivirals in HIV. Order now upcoming FREE Visionary Health programs and fax 800-407-2505, or register at www.freehivinfo.com. Please print clearly

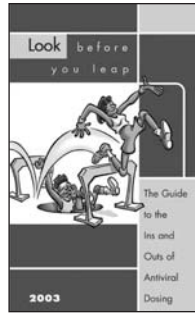
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Approx. Total # of clients _____		# HIV+ _____	# HCV+ _____
Population served: African-American _____ %		Hispanic _____ %	Asian _____ %
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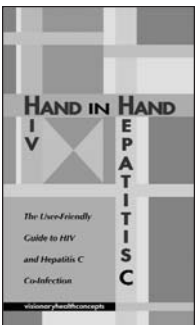
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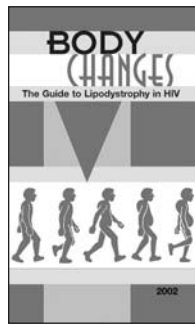


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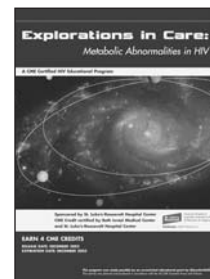


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