

# HIV/AIDS – Treatment Overview

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# HIV/AIDS IN JAMAICA

Sero-prevalence among adults

1.5%

Estimated No. with HIV/AIDS

22,000

No. of persons in need of ARV

8,000

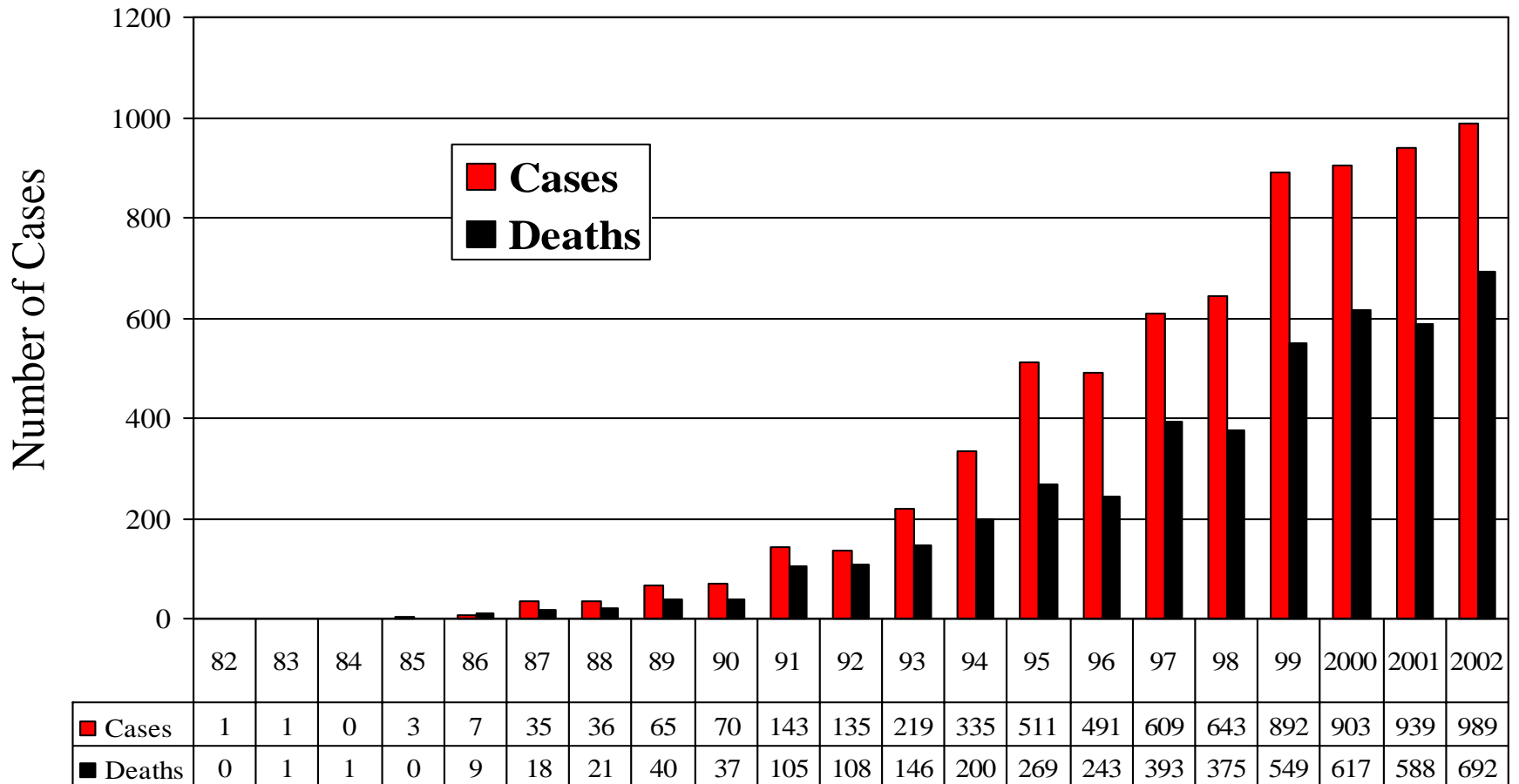
No. of persons currently on ARV

500

# Jamaica

## AIDS Cases & Deaths

### Reported Annually in Jamaica (1982 to 2002)



# Improving Access to Antiretroviral Drugs

## Global fund proposal accepted

- Operational plan developed
- Rapid scale up of AIDS treatment is on the way
- 15 treatment sites identified islandwide all but two currently managing patients with ARVs

# Initial Management

- 1. History-including past medical problems, travel, pets, occupational exposures, drug and alcohol use, sexual history (past and current, including contraceptive use), social service needs etc.
- Use of supplements and alternative therapies should be obtained
- For all clients, status of HIV or AIDS reporting should be checked and reporting done as required

## Vaccines

Review history of vaccines measles, rubella,  
tetanus

Refer for dental cleaning every 3-6 months,  
and oral exam at least q 6 months. More  
frequently

# Initial Management

## **Counseling/education**

Safer sex and other secondary prevention

- Diet (ex. No unpasteurized milk products, raw eggs, etc)
- Nutritional consult
- If active substance abuse, encourage entry into counseling and/or treatment
- Screen for depression

# Initial Management

- Physical examination- with particular attention to the skin, eyes, oral cavity, lymph nodes, liver and spleen
- For women, PAP smear every 6-12 months

# Laboratory Evaluation

- CBC, chem and liver function tests, urinalysis, lipid profile (repeat yearly)
- Hepatitis B test (HBSAg, HBSAb and HBCAb)-
- VDRL
- TB screen
- Chest X- ray
- CD4 count as baseline
- Viral load (optional)

# Follow up

## **CD4 > 350**

CD4 counts every 6-12 months

## **CD4 ≤ 350**

- CD4 counts 3-6 months depending on level and clinical status
  - PCP prophylaxis
- TMP/SMX (Bactrim) if possible, otherwise dapsone

# Follow up

## **Cd4 $\leq$ 200**

- CD4 counts initially every 3 months depending on level and clinical status
- Discuss and recommend antiviral therapy
- PCP prophylaxis

# *When to Start*

## **Adults**

- All patients with clinical AIDS
- All patients with CD4 200 or less
- Patients with a total lymphocyte count 1200 to 1400/mm<sup>3</sup> (where CD4 counts not available)
- Patients with CD 4 levels between 200 and 350/mm<sup>3</sup>, the doctor should assess when to start therapy, by looking at clinical features

# Highly Active Antiretroviral Therapy (HAART)

Combination of at least 3 drugs, usually:

- NNRTI - based regimens (2 NRTIs + 1 NNRTI)
- NRTI - based regimens (3 NRTIs)
- PI - based regimens (2 NRTIs + 1-2 PIs)
- Therapy with only one or two ARV drugs allows HIV to overcome therapy through resistance mutations and should not be used

# What To Start

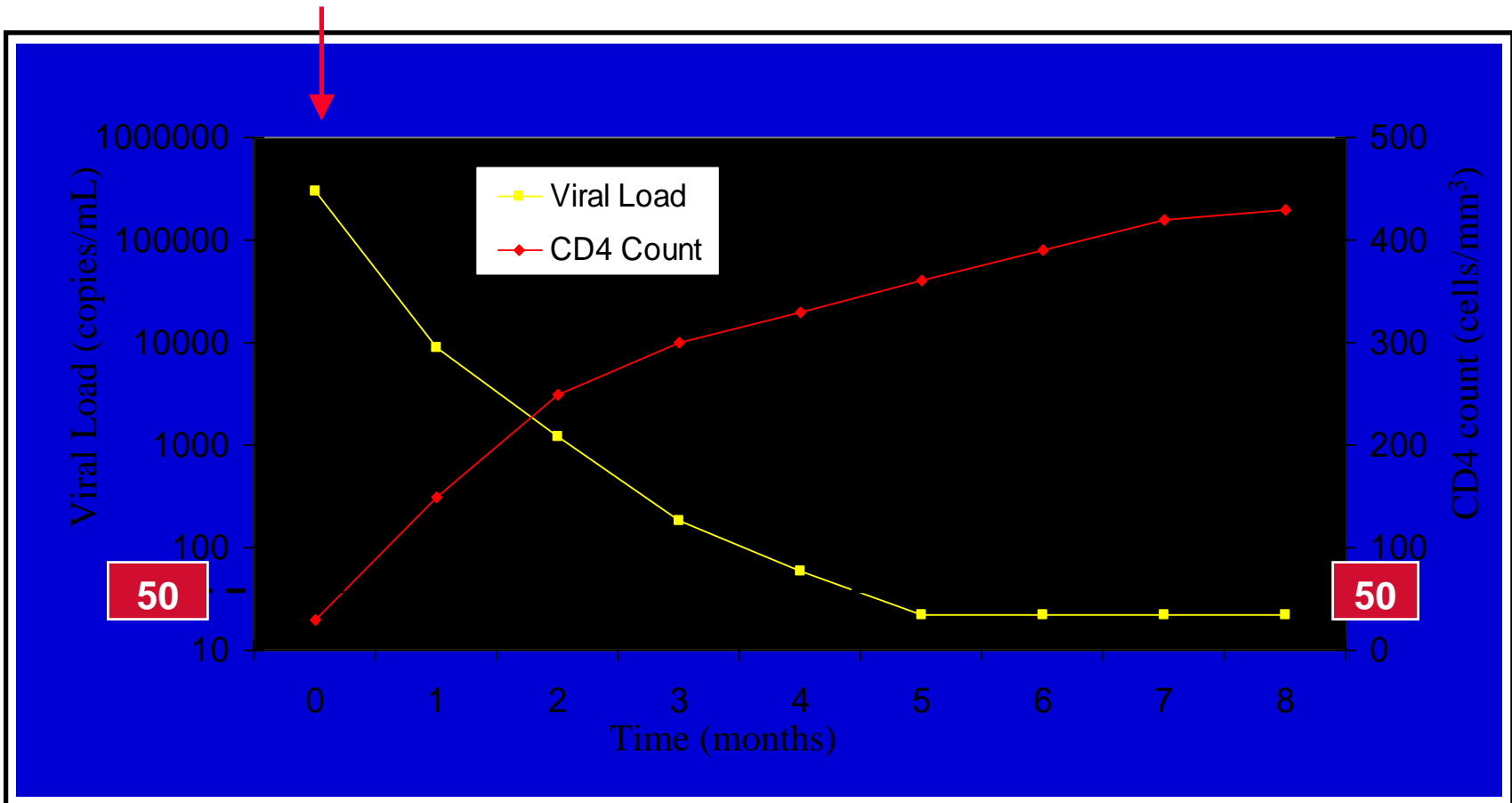
Choose one from A plus one from B

<b>Column A</b>	<b>Column B</b>
Zidovudine+ Lamivudine	Efavirenz
Lamivudine + Stavudine	Nevirapine
	Indinavir

# Optimal Response to Initial HAART

- Clinical improvement
- Rise in CD4 count
- Immune restoration
- Steep drop in viral load to undetectable levels (< 50 copies/ml) after 4-6 months treatment

# Antiretroviral Therapy: Optimal Response



# ADHERENCE

## Rationale

Failure with <78-95% adherence

Resistance with 50-95% adherence

## Caution: Patients with

Low literacy

Low income

High anxiety

Poor support

# ADHERENCE

## Caution: Patients with

**Low literacy** – They don't understand why they must adhere, take pill breaks, try other remedies

**Low income** – run out of money, wait too long to buy the next bottle, may not fill other prescriptions

**High anxiety** – don't hear what you say

**Poor support** – encourage family or friend to see you with the patient & explain issues carefully to all

**Probe adherence at every visit** – patient must bring their medication and show you how they take it

# AIDS/STD Helpline

## Patient

- Source of HIV information
- Confidential counseling

## Provider

- Source of useful information
- Resources available

Telephone: 967-3764

967-3830

1-888-991-4444

# TREATMENT FAILURE

- Clinical disease progression with the reemergence, recurrence or development of an opportunistic infection or malignancy when the drugs have been given sufficient time to induce a protective degree of immune restoration

# Treatment Failure

- **Treatment failure will be defined as:**
- A) presence of: (if viral load testing unavailable):
- Persistently declining CD4 of over 30% on two occasions measured 3-6 months apart **AND ONE OF THE FOLLOWING**
  - Significant weight loss
  - Popular prurigo, oral candidia or chronic diarrhoea
- Or**
- Worsening symptoms or onset of new HIV-related illness

# Treatment Failure

- **Treatment failure will be defined as:**
- B). Significant (grade 3 or 4) adverse drug reaction (ADR) necessitating therapy discontinuation

# SWITCHES FOR VIROLOGIC FAILURE

Column A	Column B
Didanosine + Zidovudine	Nelfinavir
Didanosine + Lamivudine	Indinavir
	Lopinavir + Ritonavir

# Conclusion

- We need to significantly increase the response to HIV – prevention as well as comprehensive treatment and care
- There are still no permanent solutions
- We need a vaccine

# Conclusion

- Stigma and discrimination particularly among health care workers must be eliminated allowing comfortable access to care and support services

Thank You