

Summary of BHIVA guidelines HIV treatment for adults: Changing treatment

BHIVA (the British HIV Association) is an organisation that represents healthcare professionals working in HIV in the UK. Its [guidelines](#) set out the medical and other care people living with HIV can expect to receive in the UK. You can find out more about the process used to develop the guidelines here: [How BHIVA guidelines are developed](#).

BHIVA's guidelines, [Treatment of HIV-1 positive adults with antiretroviral therapy \(2012\)](#), set out evidence-based clinical practice for treating and managing HIV in adults through the use of antiretroviral therapy (ART, or HIV treatment). HIV clinic staff, following recommendations in these guidelines, will be providing the best possible treatment and care to their patients, taking into account individuals' situations as well as what is known about the most effective treatments.

- This symbol identifies a strong BHIVA recommendation for treatment or care.
- This symbol identifies treatment or care that BHIVA suggests is appropriate: a recommendation with weaker evidence or some conditions attached.

GPP identifies a 'good practice point' – a recommendation drawn from everyday clinical experience rather than research-based evidence.

This factsheet summarises the recommendations for people changing HIV treatment.

Why change HIV treatment?

There are a number of reasons why you might change HIV treatment:

- Because your treatment combination is not effectively suppressing HIV.
- Because you are having side-effects caused by one or more drugs in the treatment combination.
- Because one or more anti-HIV drugs in the treatment combination may interact with other drugs you need to take.
- Because there is a treatment combination that fits better with your lifestyle, helping you with [adherence](#).
- Because there is an equivalent regimen that is more cost effective.

Monitoring the effectiveness of treatment

Once you are on HIV treatment, you will be monitored regularly to see how well your treatment is working. The tests done are set out in the BHIVA guidelines on [Routine investigation and monitoring of adult HIV-1-infected individuals \(2011\)](#).

The aim of HIV treatment is to achieve an undetectable [viral load](#). The most important thing you can do to reach this goal is to take your treatment carefully, as prescribed. Taking HIV treatment every day, in the correct dose, gives you the best chance of keeping HIV under control.

Sometimes people have ‘blips’, where their viral load becomes detectable (though under 400 copies/ml) in one reading, and then drops back down to being undetectable in the next.

GPP There is no cause for concern in this situation.

- If you have a viral load result of over 400 copies/ml, when it has previously been undetectable, you will usually be given a [resistance test](#).

Changing treatment because of virological failure

If regular monitoring shows that the HIV treatment is not working, a doctor may suggest a change to the HIV treatment.

With no resistance

- If you are on your first treatment combination, and testing shows that your HIV isn't resistant to any anti-HIV drugs, it's recommended that you change to a [protease inhibitor](#)-based combination.

With little or limited resistance

- If your HIV has developed some resistance mutations, but not many, it's recommended that you change to a protease inhibitor-based regimen that includes at least one, and preferably two, new drugs that are active against the strain of HIV you have.
- If you have been on a regimen combining protease inhibitors with two nucleoside reverse transcriptase inhibitors (NRTIs), and you are resistant to one or more drugs in this combination, change to a new combination containing a new protease inhibitor that is active against your HIV. The new

combination should also contain at least one, and preferably two, other drugs active against this strain of HIV. One of these new drugs should be from a class you haven't taken before, so that the treatment works on HIV in a new way.

With extensive resistance

Some people will have limited options for effective treatment combinations; for example, people whose HIV is resistant to three [classes of anti-HIV drugs](#): NNRTIs, NRTIs and protease inhibitors.

GPP If you are in this situation, your doctor should seek expert advice and, if necessary, refer you to clinicians with more experience in this area.

- If you have triple-class resistance, your doctor will recommend that you switch to a new regimen containing at least two, and preferably three, drugs that are fully active against your HIV. At least one of these should be an active protease inhibitor, and another should be from a new drug class. This is likely to be a [CCR5 inhibitor](#) ([maraviroc](#), *Celsentri*, only suitable if you have a type of HIV called CCR5-tropic HIV), an [integrase inhibitor](#) ([raltegravir](#) [*Isentress*] or elvitegravir) or a [fusion inhibitor](#) ([T-20](#), *enfuvirtide*, *Fuzeon*), together with [etravirine](#) (*Intence*).

When an undetectable viral load is not achievable

Sometimes, someone will have such limited options that a treatment combination can't be put together that will achieve an undetectable viral load.

GPP Doctors should explore accessing new drugs through:

- [clinical trials](#).
- [expanded-access programmes](#).
- [named-patient programmes](#).

- You should not stop or interrupt treatment despite not having an undetectable viral load.

Changing treatment for other reasons

The BHIVA guidelines recognise that there will be situations where a treatment regimen is changed even if you have an undetectable viral load.

- This should not be at the risk of developing a detectable viral load.

GPP Doctors should compare possible side-effects, drug–drug interactions and drug resistance patterns before you change any single drug in an effective treatment combination.

Changing treatment because of side-effects

The BHIVA guidelines do not include recommendations on changing individual drugs in an effective regimen in order to deal with side-effects, although it's recognised that this situation may occur.

GPP The guidelines summarise existing evidence on the impact of possible switches and how these changes should be managed.

- Once you have started HIV treatment, you should usually stay on treatment. There are a few key exceptions to this advice. More information on these is available in [Factsheet 4: Stopping treatment](#).

More information from NAM

You can find out more about side-effects in NAM's booklets, [Anti-HIV drugs](#) and [Side-effects](#), as well as information on how to deal with common side-effects. If you are finding side-effects are affecting the quality of your life, talk to your doctor or another member of your healthcare team. There is likely to be something you can do to deal with the side-effect without stopping your treatment.

Changing treatment because of drug interactions

The guidelines recognise that, on occasion, an HIV treatment regimen will need to be changed because of a possible interaction between an anti-HIV drug and another medication.

GPP The guidelines summarise existing evidence on the impact of possible switches and how these changes should be managed.

Changing treatment to simplify a regimen

Some evidence suggests that regimens with simpler dosing (fewer pills in each dose, for example, or fewer doses per day) are easier to adhere to. The guidelines recognise that you may want to change treatment to a simpler regimen.

GPP Any benefit to adherence has to be weighed against effectiveness, possible side-effects or the risk of developing resistance.

● You should not switch from an effective triple-drug combination to protease inhibitor monotherapy.

Changing treatment because of cost

The 2012 BHIVA treatment guidelines have attracted some controversy because they are the first to discuss cost as one of the considerations when making a decision about treatment options.

The guidelines are clear that HIV treatment is very cost effective. However, they also recognise that the number of people on HIV treatment will continue to rise. Given this, and the economic situation in the UK, managing the cost of treatment is a challenge for health services. Local agreements for buying anti-HIV drugs – which drugs are bought and how – can allow services to make savings. The guidelines support this sort of arrangement when choosing between *drugs that have equivalent outcomes* for patients.

However, the guidelines are clear that drug choice should not be made on the grounds of cost at the risk of poorer treatment outcomes and quality of care.

Doctors taking cost into account when considering a choice of drug also need to weigh up factors such as side-effects, possible interactions and dosing requirements. Choosing a regimen that – although cheaper – doesn't work for you for any reason may result in poorer adherence. This is likely to result in greater costs in the long term.

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This patient-friendly version is based on information contained in the BHIVA guidelines *Treatment of HIV-1 positive adults with antiretroviral therapy (2012)*, 13 (Suppl. 2), 1–85, which were produced using the NICE-accredited process.

The full version of the guidelines is available to download from the BHIVA website at: www.bhiva.org/TreatmentofHIV1_2012.aspx

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