Holiday From HIV Therapy Safe, Helpful

BY FRAN LOWRY
Orlando Bureau

GENEVA — Giving HIV-infected patients a holiday from their drugs may safely reduce the side effects and costs of treatment, according to results from the Staccato study, a prospective, open-label, randomized trial done in Thailand, Switzerland, and Australia.

Interruption of treatment with highly active antiretroviral therapy (HAART) according to a subject's CD4+ cell count led to substantial drug savings and reduced the side effects of treatment but did not raise the risk of increased immune suppression or emergence of resistance (Lancet 2006;368:459-65).

Lifelong treatment with HAART is extremely effective in controlling HIV and has significantly improved AIDS-free survival since its introduction in 1996. However, HAART is expensive and also can lead to troublesome side effects.

To evaluate the safety of interrupting HAART, the Staccato investigators randomized 430 patients who had CD4 counts greater than 350 cells/microliter and HIV RNA less than 50 copies /milliliter for at least 3 months prior to study entry to either continued therapy (n = 146) or scheduled treatment interruptions (n = 284) for a median of 21.9 months (range 16.4-25.3 months).

Initially, the Staccato trial attempted to assess the safety of interruption therapy of 1 week on/1 week off. However, an interim analysis of this strategy found an unacceptably high rate of failure, and this arm was discontinued, wrote senior author Dr. Bernard Hirschel, chief of the HIV/AIDS division, Geneva University Hospital, Geneva, and his associates.

All patients were monitored for CD4 count, viral load, adverse events, and HIV disease progression. Patients in the scheduled treatment interruption group began the trial by discontinuing HAART. If their CD4 count dropped below 350 cells/microliter on two consecutive measures, they resumed HAART for at least 12 weeks. They stopped again if their CD4 count rose above 350 cells/microliter.

Results at the end of the study showed that HIV control was similar in both groups, with 90.5% of patients in the interrupted group and 91.8% of patients in the continuous treatment group achieving HIV RNA less than 50 copies/milliliter.

Patients in the interruption group had more oral and genital candidiasis, but they also had a moderate decrease in such treatment-related adverse events as diarrhea and lipodystrophy, the researchers wrote.

"The results provide reassurance about the one risk that was feared—development of resistance and loss of efficacy of treatment," Dr. Hirschel said in a statement. "Scheduled treatment interruptions, lasting many months, with substantial drug savings, can be anticipated, particularly in patients whose immune systems were never damaged by HIV." ■

Serosorting May Decrease HIV Spread

BY HEIDI SPLETE
Senior Writer

WASHINGTON — Serosorting—the selection of sex practices based on a partner's known or perceived HIV status—is becoming more popular among men who have sex with men, Dr. Robert M. Grant said at the Ryan White CARE Act clinical meeting on HIV treatment.

Increased serosorting may reduce the spread of new HIV infections in this population. "This trend suggests that we need to think of sexual risk in a new way," said Dr. Grant of the University of California, San Francisco.

HIV patients' choices of partners with the same HIV status for high-risk sex may explain a plateau in HIV among men who have sex with men (MSM) in recent years, Dr. Grant said. He cited the 2003 HIV/AIDS Epidemiology Annual Report from the San Francisco Department of Public Health, which showed a tapering off of annual HIV incidence in MSM locally from 4% in 1999 to 2.9% in 2003.

The San Francisco report also noted that receptive unprotected anal intercourse (UAI) among MSM decreased from 1999 to 2003, which suggests that HIV-negative MSM are selectively using condoms or taking other precautions if they know their partners are HIV positive.

"We suspect it is a harm-reduction strategy that is better than not serosorting," Dr. Grant said.

Results from several studies of MSM in San Francisco presented at the Conference on Retroviruses and Opportunistic Infections earlier this year support an increase in serosorting behavior. A total of 32% of 310 MSM who were randomly surveyed reported no UAI, but 27% reported UAI with partners with the same HIV status. Another 21% reported no anal sex, while 19% reported UAI with partners who had a different HIV status. Data were not available for the remaining 1%.

In addition, the rate of newly diagnosed HIV-positive infections among MSM who were tested in an STD clinic between 2001 and 2005 was 2.6% among HIV-positive patients who reported serosorting, vs. 4.1% among those who reported no serosorting, based on data from more than 6,000 HIV tests.

Serosorting as a risk reduction strategy is probably more effective than not serosorting but less effective than adhering to other safe sex practices such as condom use, Dr. Grant said. Serosorting does not protect against other STDs, he added; additional data from the San Francisco clinic study showed that serosorters had about the same risk of developing STDs as those who were not serosorting (27% vs. 29%).

'This trend [serosorting] suggests that we need to think of sexual risk in a new way. ... We suspect it is a harm-reduction strategy.'

Although there is nothing wrong with serosorting, Dr. Grant recommends that clinicians continue to promote HIV testing to patients, as well as disclosure of HIV status to prospective sex partners.

Whether serosorting can increase the risk of infection with a second HIV strain (superinfection) remains to be seen. Data on superinfection are limited, but recently infected patients may be the most vulnerable. If there is a risk of superinfection, it may decline over time.

Of the 20 documented cases of HIV superinfection in the medical literature, 90% occurred during the first 3 years of infection, and no evidence of superinfection has been documented among HIV patients with long-term infections, Dr. Grant said.

That doesn't mean superinfection can't occur later on. But the possible risk of superinfection from serosorting should not be overstated, he added, and more research is needed to define the period of possible susceptibility to a second infection. ■

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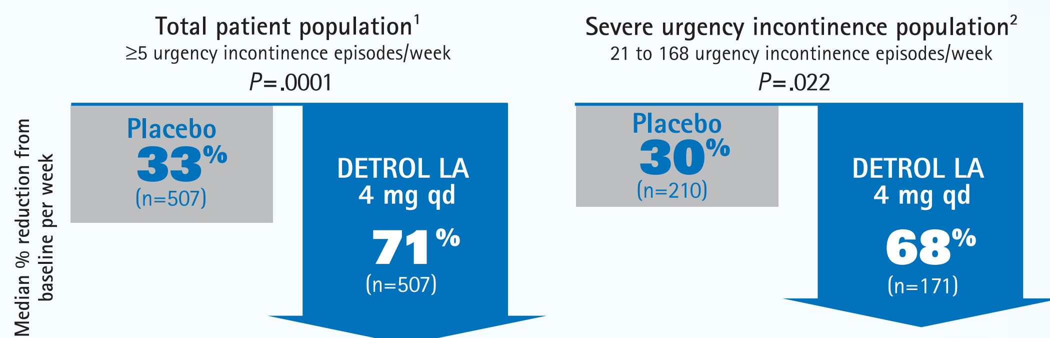

Van Kerrebroeck et al. *Urology.* 2001;57:414-421.[1]
A 12-week, placebo-controlled OAB study.
See full study description on next page.

Landis et al. *J Urol.* 2004;171:752-756.[2]
A post hoc subgroup analysis of Van Kerrebroeck et al.
See full study description on next page.

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*Source: IMS NPA, based on total US prescriptions of antimuscarinics for OAB from October 2001 to December 2005.
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