When to start antiretroviral treatment in a patient with a recent diagnosis of HIV infection?

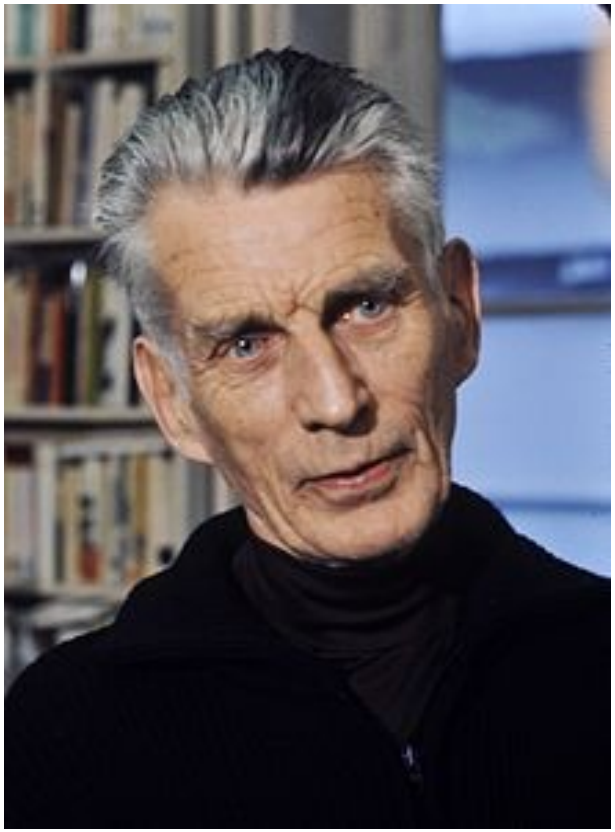
I would start the treatment immediately

Dr. Antonio Rivero
Hospital Universitario Reina Sofía

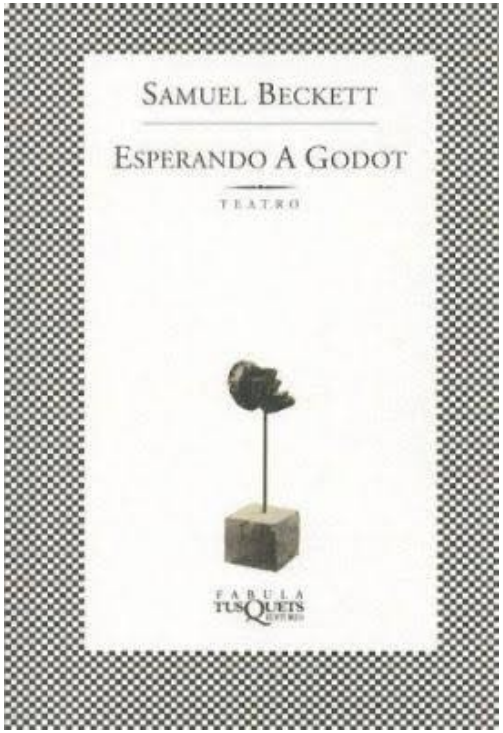
Conflictos de Interés

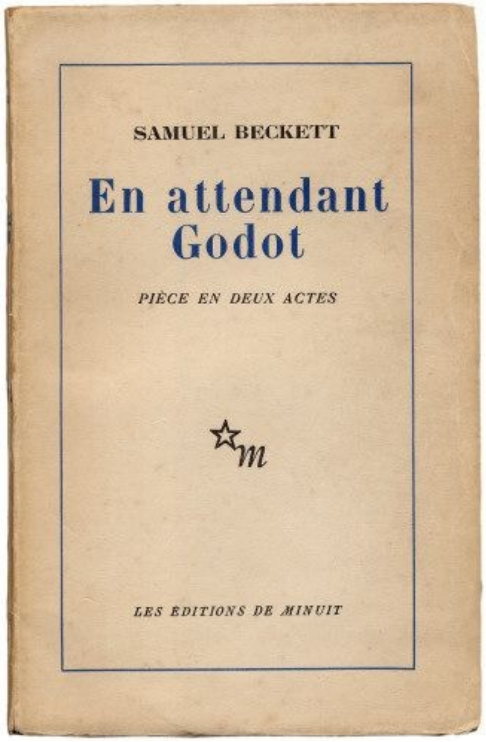
- ARR ha recibido honorarios por participar en actividades formativas y/o de asesoramiento de VIIV, Gilead, Janssen, Celgene, MSD y Abbvie.

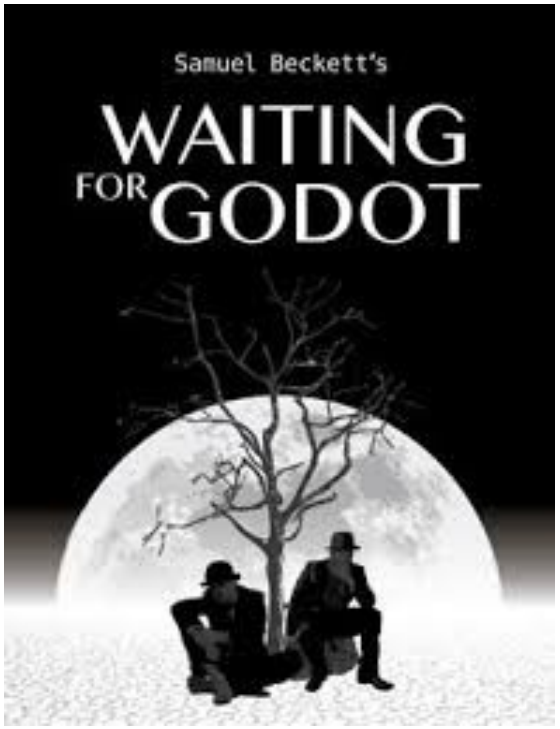
Samuel Beckett:
Premio Nobel de literatura 1969



“Esperando a Godot”







“Esperando a Godot”

“Esperando a Godot”

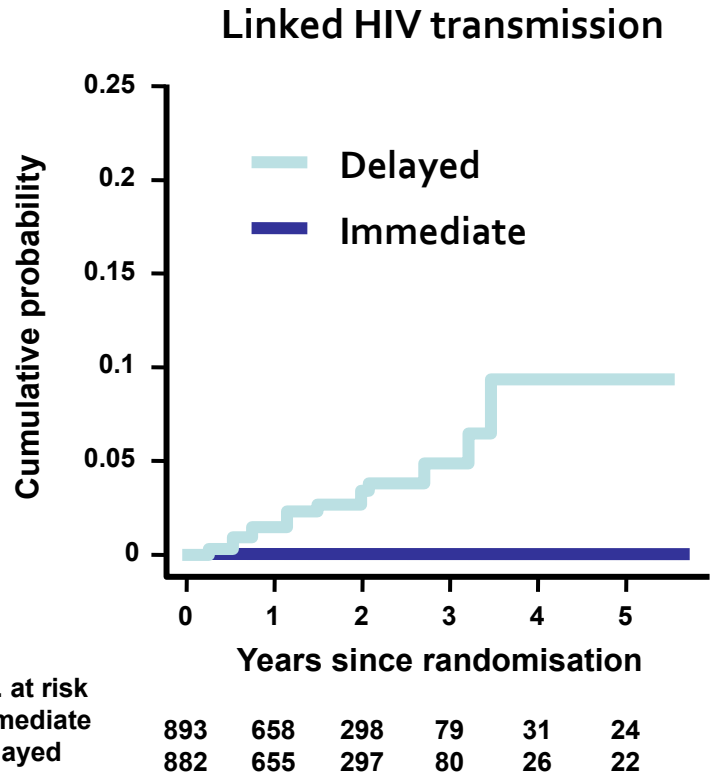
ESTRAGON: Vayámonos.
VLADIMIR: No podemos.
ESTRAGON: ¿Por qué?
VLADIMIR: Estamos esperando a Godot.

“Esperando a Godot”

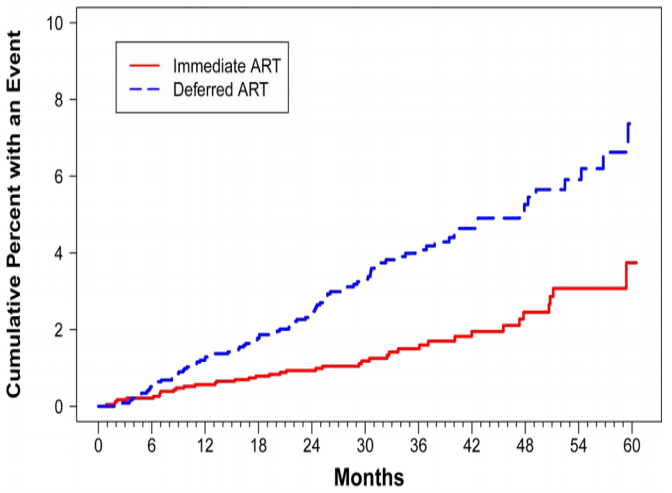
ESTRAGON: Vayámonos.
VLADIMIR: No podemos.
ESTRAGON: ¿Por qué?
VLADIMIR: Estamos esperando a Godot.

¿Por que no debemos diferir el TAR?

HPTN 052: TAR Inmediato disminuye el riesgo de transmisión



START: TAR Inmediato mejora pronóstico de pacientes



Type of event	Imm. ART	Def. ART
Serious AIDS	14	50
Serious non-AIDS	29	47
Total*	42	96

Cohen MS, *et al. N Engl J Med* 2011;365:493–505

N Engl J Med 2015; 373:795-

¿Que debatimos?

En la Primera visita clínica de un paciente con diagnostico de infección por VIH (diagnostico confirmado: Serología positiva + confirmación serológica o virológica)

Dr. Pineda

Diferir el TAR
"pero poquito"

Dr. Rivero

No Diferir el TAR

¿Que debatimos?

En la Primera visita clínica de un paciente con diagnostico de infección por VIH (diagnostico confirmado: Serología positiva + confirmación serológica o virológica)

Dr. Pineda

Dr. Rivero

Iniciemos TAR.

No podemos.

¿Por qué?

¡Porque hay que esperar a Godot!

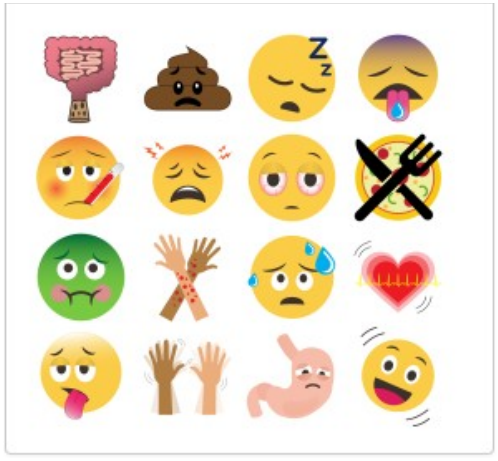
Documento de consenso del tratamiento antiretroviral en adultos infectados por el VIH (Version 2014)

- Se recomienda TAR **en todos los pacientes con infección por el VIH** para evitar la progresión de la enfermedad, disminuir la transmisión del virus y limitar el efecto nocivo sobre posibles morbilidades coexistentes (A-I).

- El inicio del TAR debe valorarse siempre individualmente. Antes de tomar la decisión de iniciarlo deben confirmarse las cifras de linfocitos CD4+ y CVP. Además, debe prepararse al paciente, ofertando las distintas opciones, adaptando el esquema terapéutico al estilo de vida, comorbilidades, posibles interacciones y valorando el riesgo de mala adherencia (A-III)

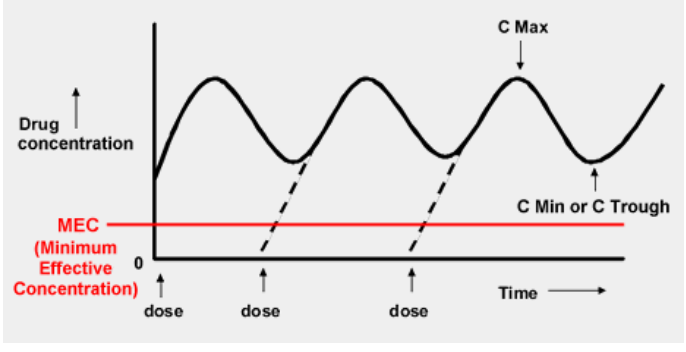
GeSIDA
GRUPO DE ESTUDIO DEL SIDA-SEIMC

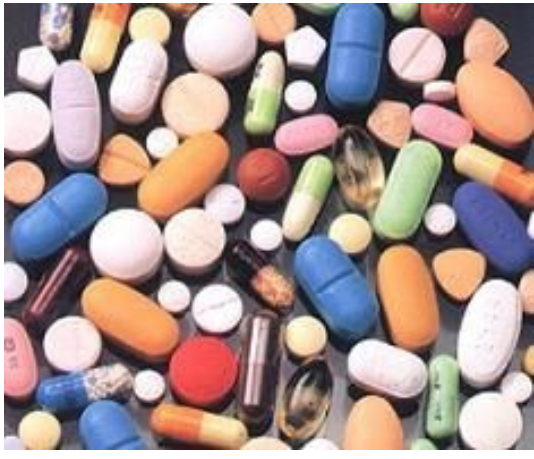
Recomendación inspirada en escenarios pasados de gran peso



Problema	Perfil
Efectos adversos	Altos/Graves
Nº Comprimidos	Muy alto
Conveniencia	Muy baja
Interacciones	Alto riesgo
Eficacia TAR (ITT)	<70%
TAR Universal	No
Inicio de TAR	Riesgo/beneficio

INTERACCIONES MEDICAMENTOSAS

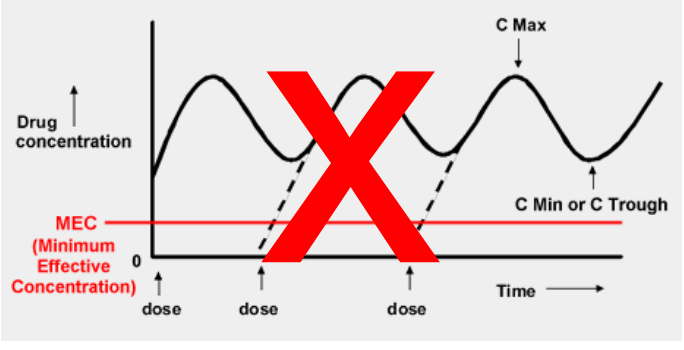


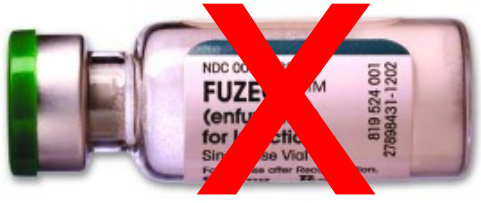


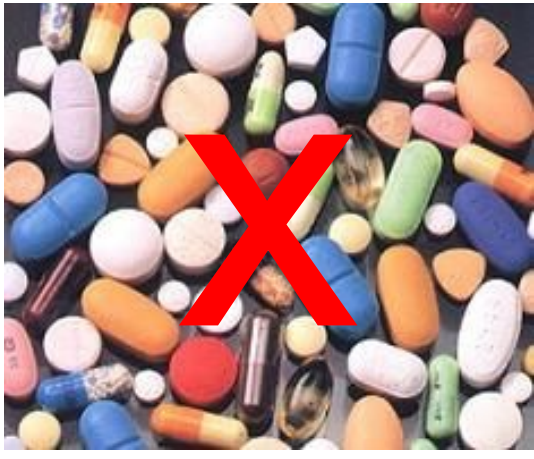
Recomendación inspirada en escenarios pasados de gran peso

Problema	Perfil
Efectos adversos	**Muy Bajo**
Nº Comprimidos	**Minimo (1)**
Conveniencia	**Muy alta (QD)**
Interacciones	**Baja**
Eficacia TAR (ITT)	**90%**
TAR Universal	**Si**
Inicio de TAR	**Siempre**

INTERACCIONES MEDICAMENTOSAS







Justificación para diferir el tratamiento tras diagnóstico

1. Esperar datos complementarios: Optimizar el TAR:
   - *Cifras de CD4 y Carga viral del VIH*
   - *Usar ABC en TAR (HLA-B 5701)*
   - *Poder disponer de Test VHB (FTC/TAF)*
   - *Poder disponer de Test TB (implicaciones TAR)*
   - *Poder disponer test Resistencia*
   - *Más opciones terapeuticas*
   - *Más tiempo para considerar las opciones.*
2. Mayor compromiso del paciente antes de iniciar el TAR
   - *Evitar presiones*
   - *Tiempo para asimilar el diagnóstico.*
   - *Construir una relación más fuerte para el futuro.*
3. Medida sin beneficio que incluso puede resultar negativa
4. Falta de evidencia

Justificación para diferir el tratamiento tras diagnóstico

1. **Esperar datos complementarios: Optimizar el TAR**
   - *Cifras de CD4 y CVP.*
   - *Usar ABC en TAR (HLA-B 5701)*
   - *Poder disponer de Test VHB (FTC/TAF)*
   - *Poder disponer de Test TB (implicaciones TAR)*
   - *Poder disponer test Resistencia*
   - *Más opciones terapeuticas*
   - *Más tiempo para considerar las opciones.*
2. Mayor compromiso del paciente antes de iniciar el TAR
   - *Evitar presiones*
   - *Tiempo para asimilar el diagnóstico.*
   - *Construir una relación más fuerte para el futuro.*
3. Medida sin beneficio que incluso puede resultar negativa

Realmente ¿que es imprescindible para iniciar TAR?

- Valoración Clínica
- Bioquímina

- Carga Viral VIH (?)
- CD4+
- Resistencias VIH
- HLAB5701
- Genotipo VIH
- VHA,VHB,VHC
- Serología (Toxo, ITS…)
- PPD/IGRA
- RxT
- ECG

No es imprescindible esperar los resultados de una prueba si se utiliza un régimen de TAR cuyo uso no esté condicionado a sus valores (incluyendo CV y CD4)

¿Con que regímenes de TAR no podríamos comenzar el mismo dia?

Si no dispusieramos HLAB5701

ABC

ABC/3TC/DTG*

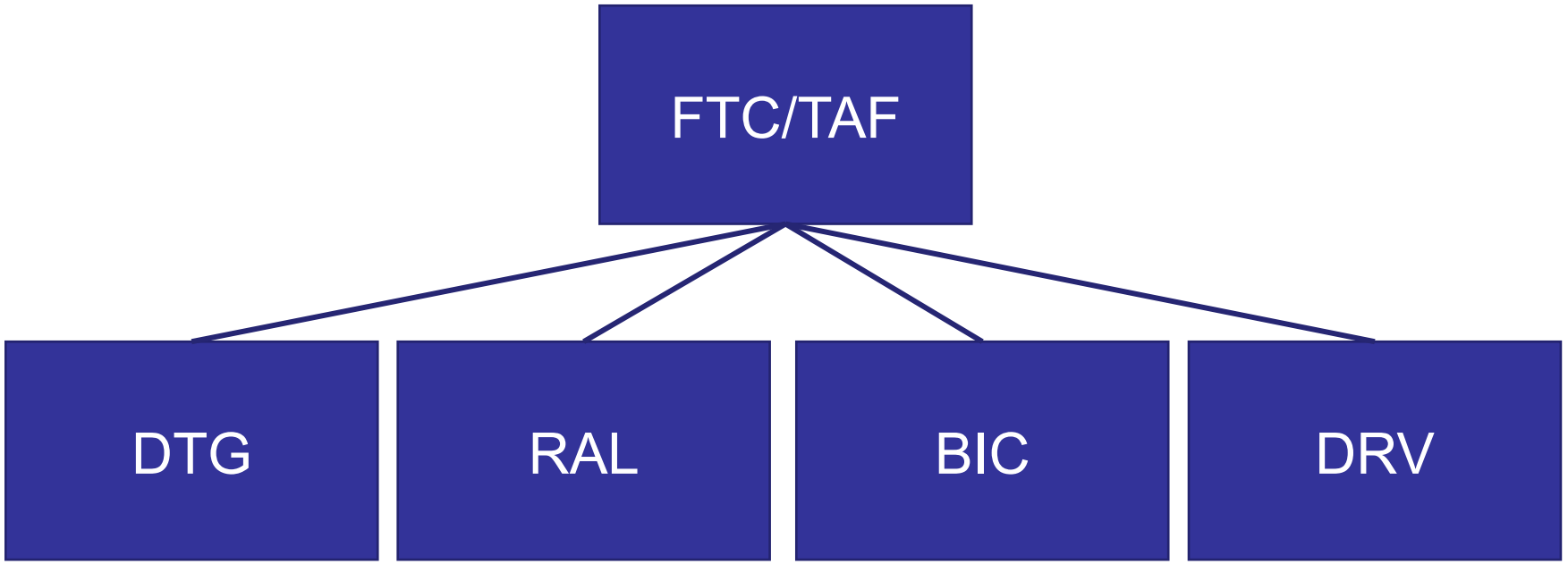
Si no dispusiéramos de CD4+

DTG/3TC

Si no dispusieramos de carga viral

RILPIVIRINA

¿Con que regimen podríamos comenzar el mismo dia?



Podríamos comenzar el mismo día con la mayoría de las pautas preferentes/alternativas

las exploraciones complementarias no condicionan el uso de la mayoría de regímenes…

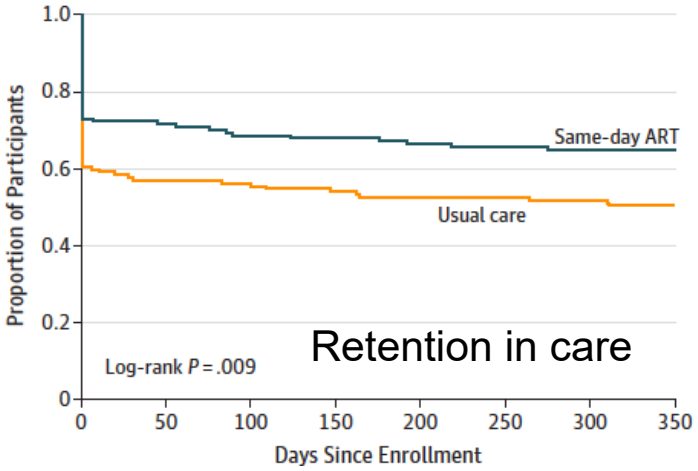
¿Tenemos que esperar a GODOT?

Justificación para diferir el tratamiento tras diagnóstico

1. **Esperar datos complementarios: Optimizar el TAR:**
   - *Cifras de CD4 y CVP.*
   - *Usar ABC en TAR (HLA-B 5701)*
   - *Poder disponer de Test VHB (FTC/TAF)*
   - *Poder disponer de Test TB (implicaciones TAR)*
   - *Poder disponer test Resistencia*
   - *Más opciones terapeuticas*
   - *Más tiempo para considerar las opciones.*
2. **Conseling: Mayor compromiso del paciente y adherencia**
   - *Evitar presiones*
   - *Tiempo para asimilar el diagnóstico.*
   - *Construir una relación más fuerte para el futuro.*
3. Medida sin beneficio que incluso puede resultar negativa

Cascade Clinical Trial

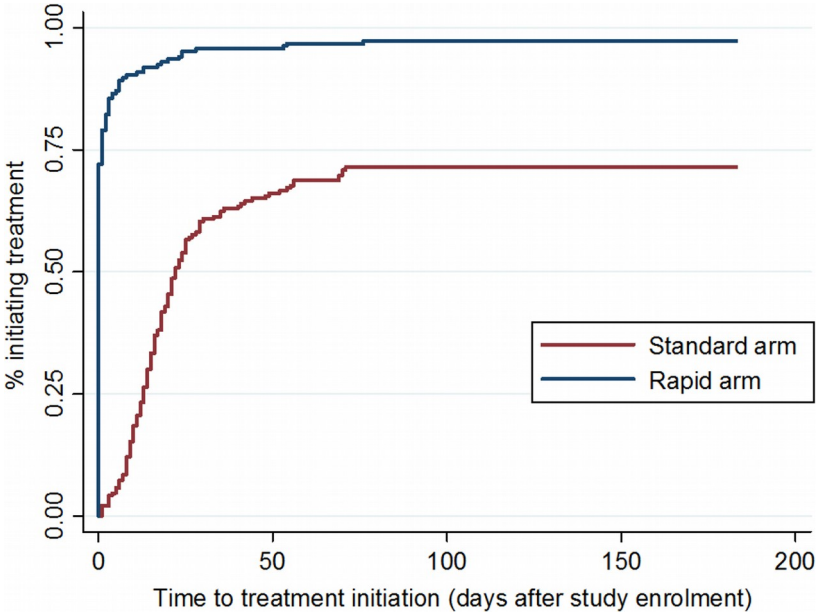
- **Diseño:** Randomizado, abierto
  - TAR inmediato (mismo dia)
  - TAR Standard (2ª visita con análisis y counseling)
- **Area:** Lesotho
- **End point primario:**
  - Linkage to care a los 3 meses
  - ARN-VIH < 100 cop a 12 meses
- **Numero:** 278 pacientes



Labhardt Nd et al. JAMA 2018

RAPIT: Inicio de TAR en primera visita

+ Sudafrica
+ EC aleatorizado a iniciar TAR:
  - En primera visita (RAPID)
  - Standard (3-5 visitas durante 2-4 w)
+ End point: ARN-VIH <400 a los 10 meses y adhesión al seguimiento

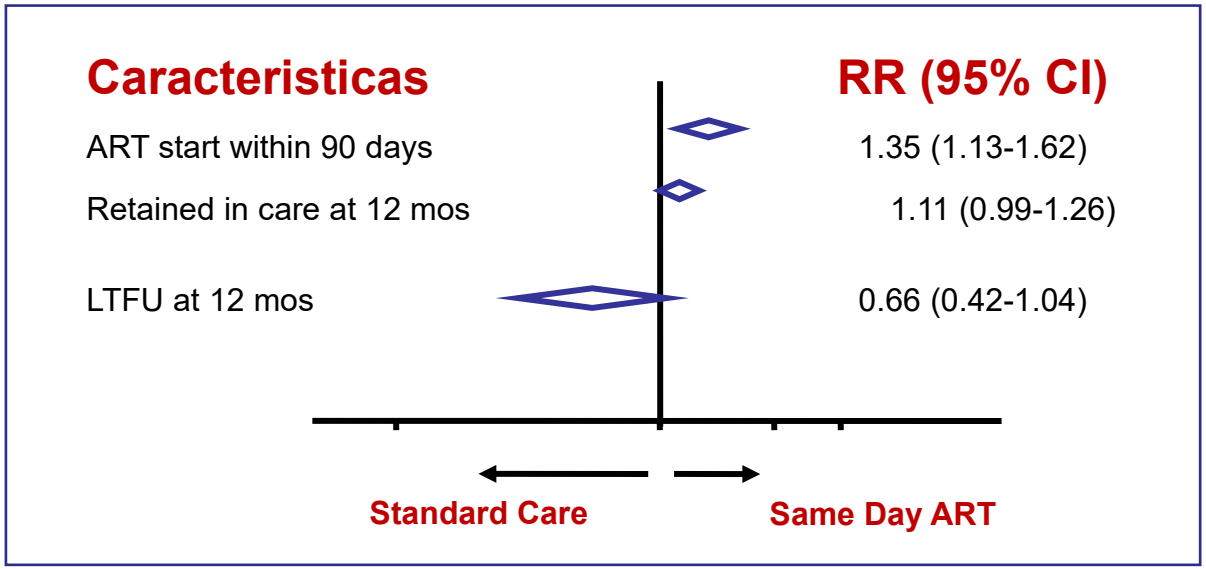


Outcome	Standard arm(%) *n* = 190	Rapid arm(%) *n* = 187	Crude risk difference (95% CI)	Crude relative risk (95% CI)
Initiated ≤ 90 d and suppressed by 10 mo (primary outcome)	96 (51%)	119 (64%)	13% (3%–23%)	1.26 (1.05–1.50)

Rosen S. PLOS Medicine, 2016

Metanálisis de 4 EECC

- Origen: Africa, Haiti
- Standard of care vs Inicio en el mismo dia del diagnostico



Ford N, et al. AIDS. 2018;32

Si diferir el TAR para conseling no mejora la adhesión al tratamiento/seguimiento (evidencias de lo contrario)…

¿Tenemos que esperar a GODOT?

Justificación para diferir el tratamiento tras diagnóstico

1. Esperar datos complementarios: Optimizar el TAR:
   - *Cifras de CD4 y CVP.*
   - *Usar ABC en TAR (HLA-B 5701)*
   - *Poder disponer de Test VHB (FTC/TAF)*
   - *Poder disponer de Test TB (implicaciones TAR)*
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   - *Más opciones terapeuticas*
   - *Más tiempo para considerar las opciones.*
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   - *Evitar presiones*
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   - *Construir una relación más fuerte para el futuro.*

3. **Medida sin beneficio que incluso puede resultar negativa**

Cascade Clinical Trial

- **Diseño:** Randomizado, abierto
  - TAR inmediato (mismo dia)
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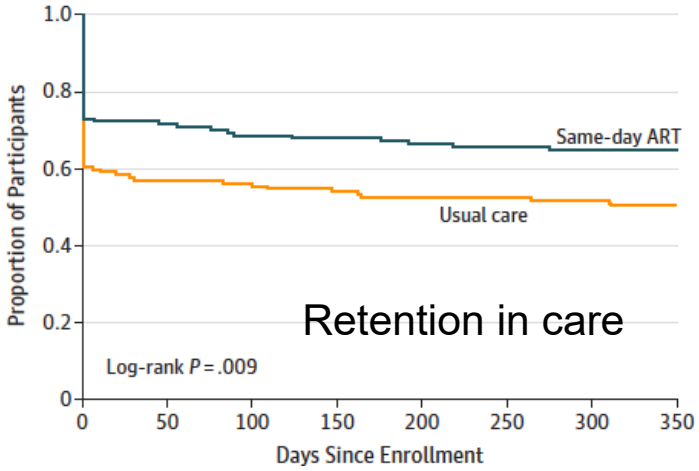
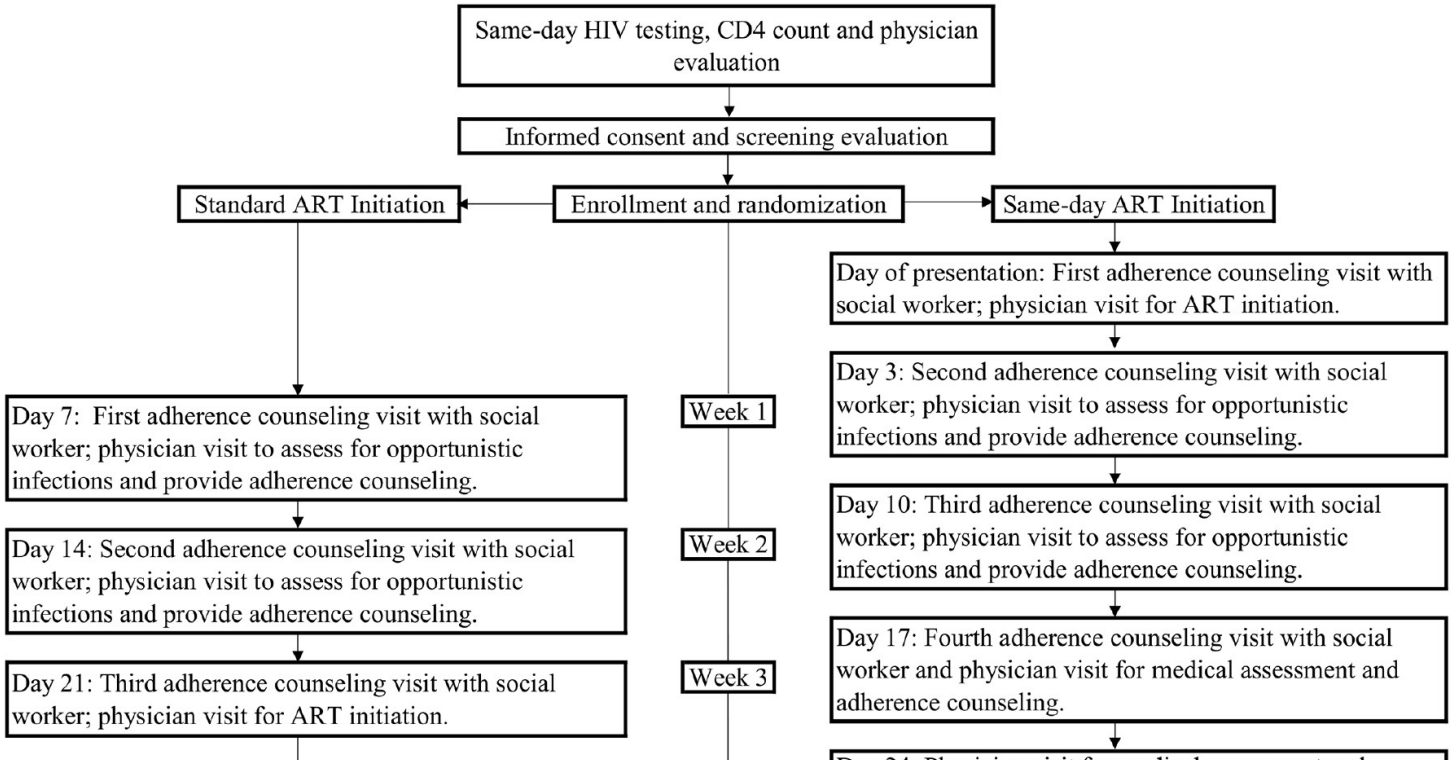


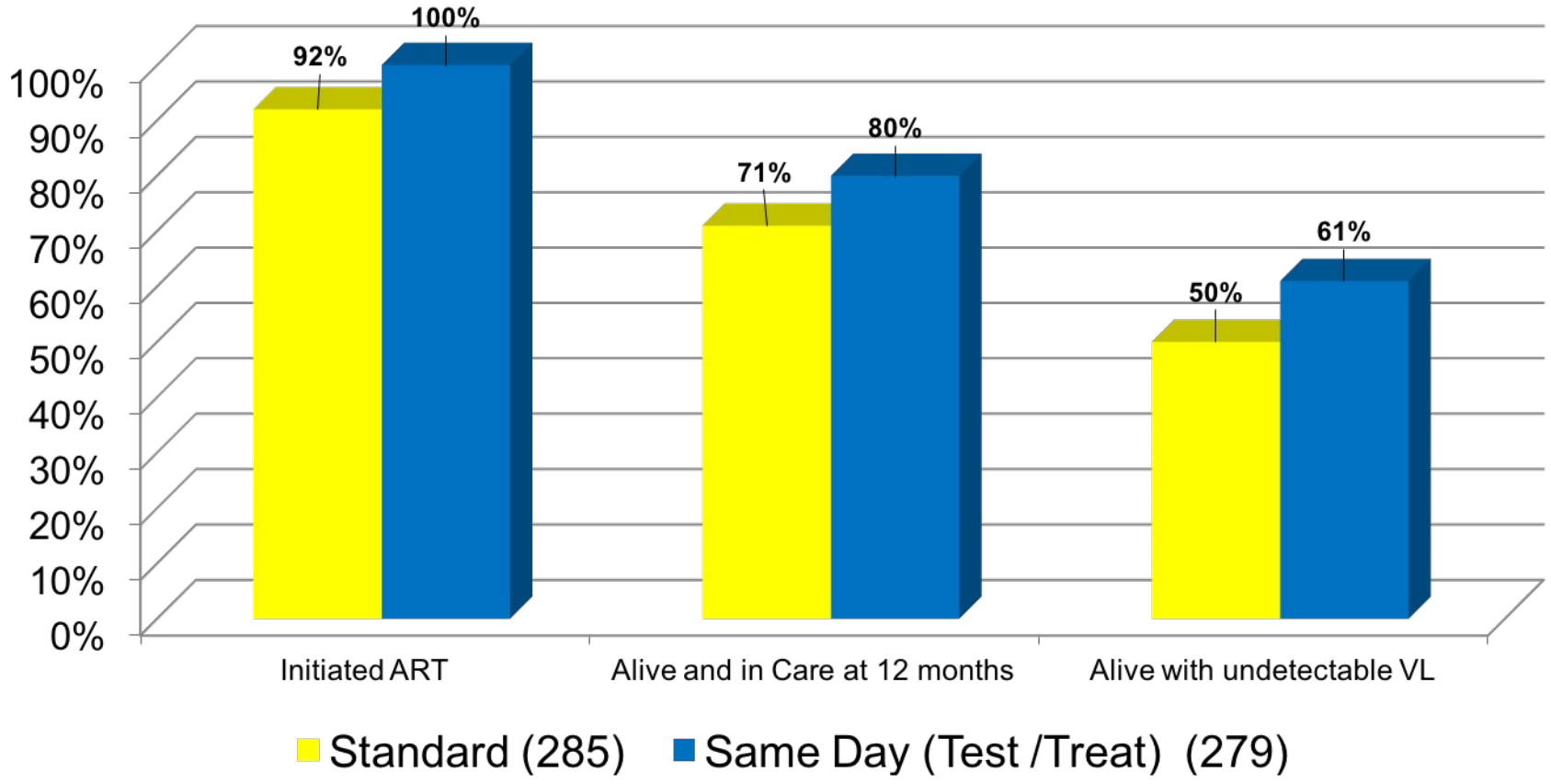
Labhardt Nd et al. JAMA 2018

GHESKIO/HARVARD: Inicio TAR standard ART versus Inmediato (mismo dia del diagnóstico).



Koenig SP, et al. Plos Medicine 2017

GHESKIO/HARVARD: Standard vs. Inmediato Situación a lod 12 meses



Koenig SP, et al. Plos Medicine 2017

Metanálisis de 4 EECC

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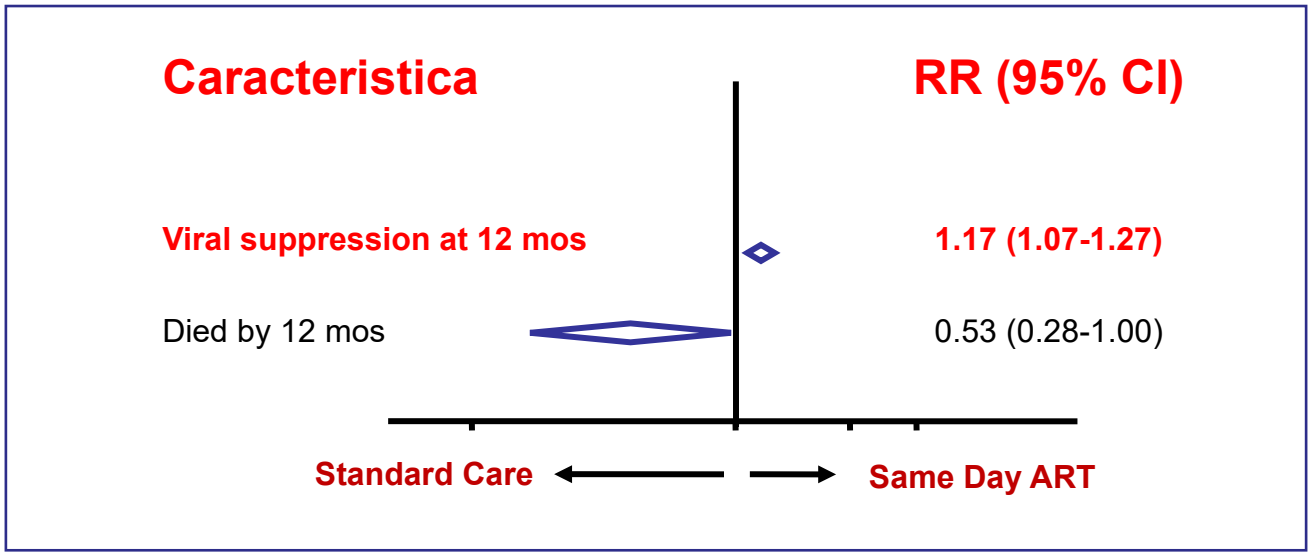


Ford N, et al. AIDS. 2018;32

Si las evidencias sugieren que el TAR inmediato como estratagia es mas eficaz en conseguir ARN-VIH indetectable a largo plazo…

¿Tenemos que esperar a GODOT?

Justificación para diferir el tratamiento tras diagnóstico

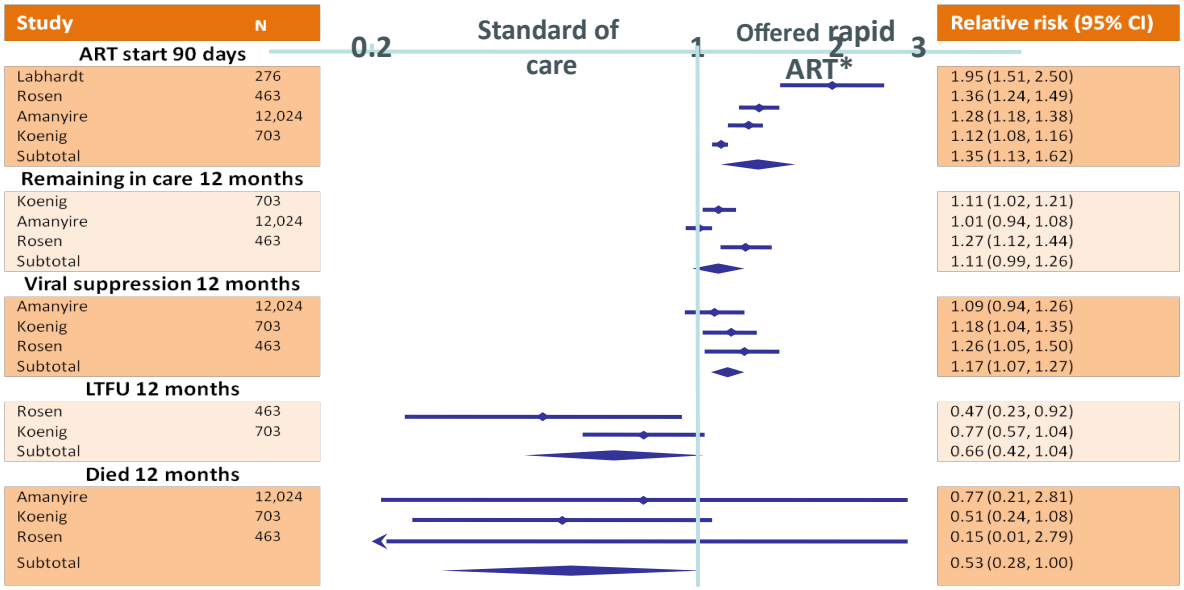
1. Esperar datos complementarios: Optimizar el TAR:

2. Mayor compromiso del paciente antes de iniciar el TAR

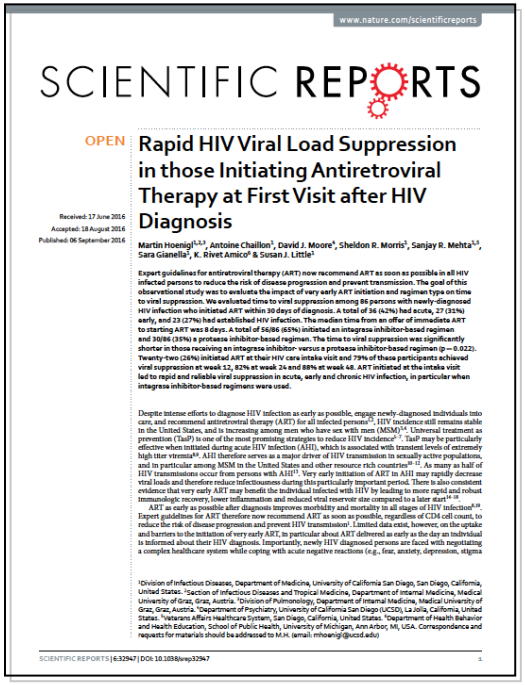
3. Medida sin beneficio que incluso puede resultar negativa

4. **No hay evidencia. Y la que hay procede de paises en desarrollo**

Evidencias: 4 Ensayos clínicos randomizados + 1 metanálisis



Evidencias en países desarrollados: 3 estudios observacionales y un Ensayo clínico



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SCIENTIFIC REPORTS

OPEN

Rapid HIV Viral Load Suppression in those Initiating Antiretroviral Therapy at First Visit after HIV Diagnosis

Received: 17 June 2016
Accepted: 18 August 2016
Published: 06 September 2016

Martin Hoenigl[1,2,3], Antoine Chaillon[1], David J. Moore[4], Sheldon R. Morris[5], Sanjay R. Mehta[3,6], Sara Gianella[3], K. Rivet Amico[5] & Susan J. Little[1]

Expert guidelines for antiretroviral therapy (ART) now recommend ART as soon as possible in all HIV infected persons to reduce the risk of disease progression and prevent transmission. The goal of this observational study was to evaluate the impact of very early ART initiation and regimen type on time to viral suppression. We evaluated time to viral suppression among 86 persons with newly-diagnosed HIV infection who initiated ART within 30 days of diagnosis. A total of 36 (42%) had acute, 27 (31%) early, and 23 (27%) had established HIV infection. The median time from an offer of immediate ART to starting ART was 8 days. A total of 56/86 (65%) initiated an integrase inhibitor-based regimen and 30/86 (35%) a protease inhibitor-based regimen. The time to viral suppression was significantly shorter in those receiving an integrase inhibitor- versus a protease inhibitor-based regimen (p = 0.022). Twenty-two (26%) initiated ART at their HIV care intake visit and 79% of these participants achieved viral suppression at week 12, 82% at week 24 and 88% at week 48. ART initiated at the intake visit led to rapid and reliable viral suppression in acute, early and chronic HIV infection, in particular when integrase inhibitor-based regimens were used.

Despite intense efforts to diagnose HIV infection as early as possible, engage newly-diagnosed individuals into care, and recommend antiretroviral therapy (ART) for all infected persons[1,2], HIV incidence still remains stable in the United States, and is increasing among men who have sex with men (MSM)[3,4]. Universal treatment as prevention (TasP) is one of the most promising strategies to reduce HIV incidence[5–7]. TasP may be particularly effective when initiated during acute HIV infection (AHI), which is associated with transient levels of extremely high titer viremia[8,9]. AHI therefore serves as a major driver of HIV transmission in sexually active populations, and in particular among MSM in the United States and other resource rich countries[10–12]. As many as half of HIV transmissions occur from persons with AHI[13]. Very early initiation of ART in AHI may rapidly decrease viral loads and therefore reduce infectiousness during this particularly important period. There is also consistent evidence that very early ART may benefit the individual infected with HIV by leading to more rapid and robust immunologic recovery, lower inflammation and reduced viral reservoir size compared to a later start[14–18].

ART as early as possible after diagnosis improves morbidity and mortality in all stages of HIV infection[8,19]. Expert guidelines for ART therefore now recommend ART as soon as possible, regardless of CD4 cell count, to reduce the risk of disease progression and prevent HIV transmission[1]. Limited data exist, however, on the uptake and barriers to the initiation of very early ART, in particular about ART delivered as early as the day an individual is informed about their HIV diagnosis. Importantly, newly HIV diagnosed persons are faced with negotiating a complex healthcare system while coping with acute negative reactions (e.g., fear, anxiety, depression, stigma

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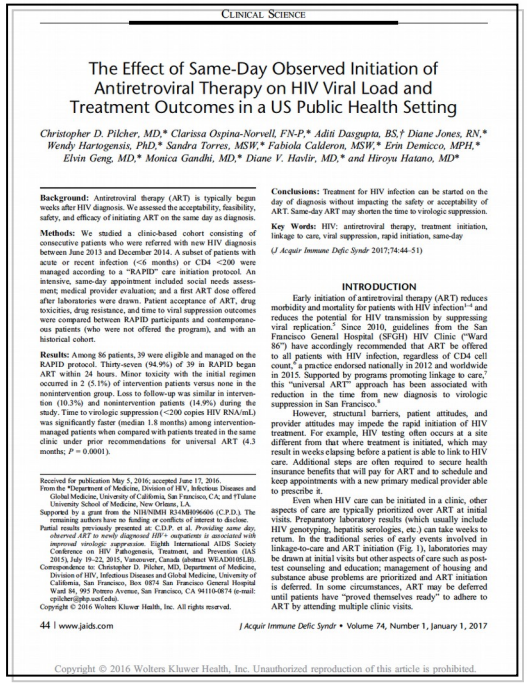
SAN DIEGO
Hoenig M et al,
Sci Rep, 2016



CLINICAL SCIENCE

The Effect of Same-Day Observed Initiation of Antiretroviral Therapy on HIV Viral Load and Treatment Outcomes in a US Public Health Setting

Christopher D. Pilcher, MD, Clarissa Ospina-Norvell, FN-P,* Aditi Dasgupta, BS,† Diane Jones, RN,* Wendy Hartogensis, PhD,* Sandra Torres, MSW,* Fabiola Calderon, MSW,* Erin Demicco, MPH,* Elvin Geng, MD,* Monica Gandhi, MD,* Diane V. Havlir, MD,* and Hiroyu Hatano, MD**

Background: Antiretroviral therapy (ART) is typically begun weeks after HIV diagnosis. We assessed the acceptability, feasibility, safety, and efficacy of initiating ART on the same day as diagnosis.

Methods: We studied a clinic-based cohort consisting of consecutive patients who were referred with new HIV diagnosis between June 2013 and December 2014. A subset of patients with acute or recent infection (<6 months) or CD4 <200 were managed according to a "RAPID" care initiation protocol. An intensive, same-day appointment included social needs assessment; medical provider evaluation; and a first ART dose offered after laboratories were drawn. Patient acceptance of ART, drug toxicities, drug resistance, and time to viral suppression outcomes were compared between RAPID participants and contemporaneous patients (who were not offered the program), and with an historical cohort.

Results: Among 86 patients, 39 were eligible and managed on the RAPID protocol. Thirty-seven (94.9%) of 39 in RAPID began ART within 24 hours. Minor toxicity with the initial regimen occurred in 2 (5.1%) of intervention patients versus none in the nonintervention group. Loss to follow-up was similar in intervention (10.3%) and nonintervention patients (14.9%) during the study. Time to virologic suppression (<200 copies HIV RNA/mL) was significantly faster (median 1.8 months) among intervention-managed patients when compared with patients treated in the same clinic under prior recommendations for universal ART (4.3 months; $P = 0.0001$).

Conclusions: Treatment for HIV infection can be started on the day of diagnosis without impacting the safety or acceptability of ART. Same-day ART may shorten the time to virologic suppression.

Key Words: HIV: antiretroviral therapy, treatment initiation, linkage to care, viral suppression, rapid initiation, same-day

(*J Acquir Immune Defic Syndr* 2017;74:44–51)

INTRODUCTION

Early initiation of antiretroviral therapy (ART) reduces morbidity and mortality for patients with HIV infection[1,2] and reduces the potential for HIV transmission by suppressing viral replication.[3] Since 2010, guidelines from the San Francisco General Hospital (SFGH) HIV Clinic ("Ward 86") have accordingly recommended that ART be offered to all patients with HIV infection, regardless of CD4 cell count,[4] a practice endorsed nationally in 2012 and worldwide in 2015. Supported by programs promoting linkage to care,[5] this "universal ART" approach has been associated with reduction in the time from new diagnosis to virologic suppression in San Francisco.[6]

However, structural barriers, patient attitudes, and provider attitudes may impede the rapid initiation of HIV treatment. For example, HIV testing often occurs at a site different from that where treatment is initiated, which may result in weeks elapsing before a patient is able to link to HIV care. Additional steps are often required to secure health insurance benefits that will pay for ART and to schedule and keep appointments with a new primary medical provider able to prescribe it.

Even when HIV care can be initiated in a clinic, other aspects of care are typically prioritized over ART at initial visits. Preparatory laboratory results (which usually include HIV genotyping, hepatitis serologies, etc.) can take weeks to return. In the traditional series of early events involved in linkage-to-care and ART initiation (Fig. 1), laboratories may be drawn at initial visits but other aspects of care such as post-test counseling and education; management of housing and substance abuse problems are prioritized and ART initiation is deferred. In some circumstances, ART may be deferred until patients have "proved themselves ready" to adhere to ART by attending multiple clinic visits.

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Partial results previously presented at: C.D.P. et al. *Providing same day, observed ART to newly diagnosed HIV+ outpatients is associated with improved virologic suppression.* Eighth International AIDS Society Conference on HIV Pathogenesis, Treatment, and Prevention (IAS 2015), July 19–22, 2015, Vancouver, Canada (abstract WEAD0105LB).
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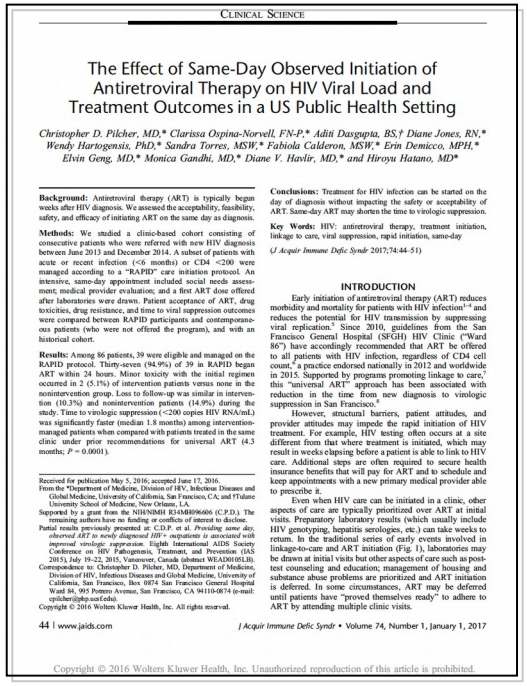
SAN FRANCISCO
Pilcher et al,
Antivir Ther, 2017



CLINICAL SCIENCE

The Effect of Same-Day Observed Initiation of Antiretroviral Therapy on HIV Viral Load and Treatment Outcomes in a US Public Health Setting

Christopher D. Pilcher, MD, Clarissa Ospina-Norvell, FN-P,* Aditi Dasgupta, BS,† Diane Jones, RN,* Wendy Hartogensis, PhD,* Sandra Torres, MSW,* Fabiola Calderon, MSW,* Erin Demicco, MPH,* Elvin Geng, MD,* Monica Gandhi, MD,* Diane V. Havlir, MD,* and Hiroyu Hatano, MD**

Background: Antiretroviral therapy (ART) is typically begun weeks after HIV diagnosis. We assessed the acceptability, feasibility, safety, and efficacy of initiating ART on the same day as diagnosis.

Methods: We studied a clinic-based cohort consisting of consecutive patients who were referred with new HIV diagnosis between June 2013 and December 2014. A subset of patients with acute or recent infection (<6 months) or CD4 <200 were managed according to a "RAPID" care initiation protocol. An intensive, same-day appointment included social needs assessment; medical provider evaluation; and a first ART dose offered after laboratories were drawn. Patient acceptance of ART, drug toxicities, drug resistance, and time to viral suppression outcomes were compared between RAPID participants and contemporaneous patients (who were not offered the program), and with an historical cohort.

Results: Among 86 patients, 39 were eligible and managed on the RAPID protocol. Thirty-seven (94.9%) of 39 in RAPID began ART within 24 hours. Minor toxicity with the initial regimen occurred in 2 (5.1%) of intervention patients versus none in the nonintervention group. Loss to follow-up was similar in intervention (10.3%) and nonintervention patients (14.9%) during the study. Time to virologic suppression (<200 copies HIV RNA/mL) was significantly faster (median 1.8 months) among intervention-managed patients when compared with patients treated in the same clinic under prior recommendations for universal ART (4.3 months; $P = 0.0001$).

Conclusions: Treatment for HIV infection can be started on the day of diagnosis without impacting the safety or acceptability of ART. Same-day ART may shorten the time to virologic suppression.

Key Words: HIV: antiretroviral therapy, treatment initiation, linkage to care, viral suppression, rapid initiation, same-day

(*J Acquir Immune Defic Syndr* 2017;74:44–51)

INTRODUCTION

Early initiation of antiretroviral therapy (ART) reduces morbidity and mortality for patients with HIV infection[1,2] and reduces the potential for HIV transmission by suppressing viral replication.[3] Since 2010, guidelines from the San Francisco General Hospital (SFGH) HIV Clinic ("Ward 86") have accordingly recommended that ART be offered to all patients with HIV infection, regardless of CD4 cell count,[4] a practice endorsed nationally in 2012 and worldwide in 2015. Supported by programs promoting linkage to care,[5] this "universal ART" approach has been associated with reduction in the time from new diagnosis to virologic suppression in San Francisco.[6]

However, structural barriers, patient attitudes, and provider attitudes may impede the rapid initiation of HIV treatment. For example, HIV testing often occurs at a site different from that where treatment is initiated, which may result in weeks elapsing before a patient is able to link to HIV care. Additional steps are often required to secure health insurance benefits that will pay for ART and to schedule and keep appointments with a new primary medical provider able to prescribe it.

Even when HIV care can be initiated in a clinic, other aspects of care are typically prioritized over ART at initial visits. Preparatory laboratory results (which usually include HIV genotyping, hepatitis serologies, etc.) can take weeks to return. In the traditional series of early events involved in linkage-to-care and ART initiation (Fig. 1), laboratories may be drawn at initial visits but other aspects of care such as post-test counseling and education; management of housing and substance abuse problems are prioritized and ART initiation is deferred. In some circumstances, ART may be deferred until patients have "proved themselves ready" to adhere to ART by attending multiple clinic visits.

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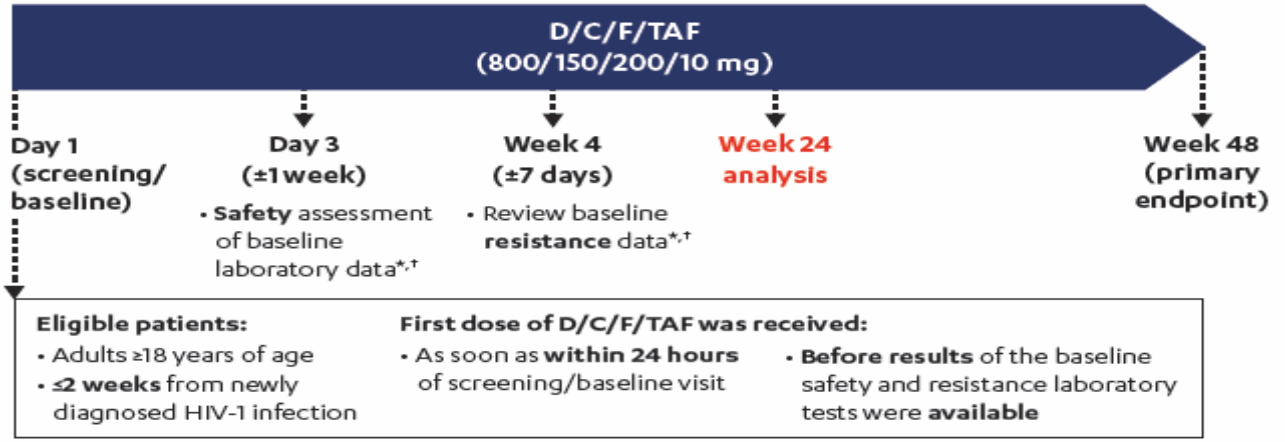
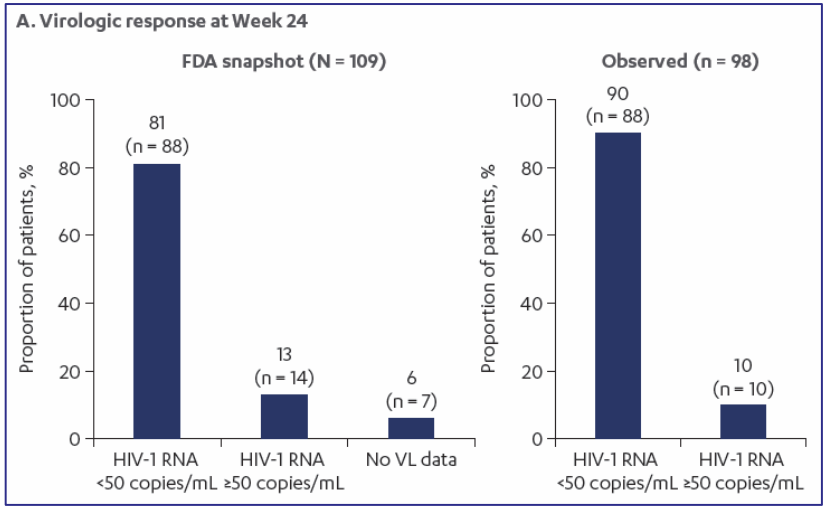
LONDRES
Girometti el al.
Antivir Ther, 2016

DIAMOND: DRV/c/FTC/TAF modelo de Test-and-Treat con DRV/c/FTC/TAF (análisis interino)

EC Fase 3, un solo brazo, abierto: D/C/F/TAF como TAR de inicio rápido





Huhn G, et al. IAS 2018; Abstract WEPEC200.

Documento de consenso del tratamiento antiretroviral en adultos infectados por el VIH (Version 2014)

- El inicio del TAR debe valorarse siempre individualmente. Antes de tomar la decisión de iniciarlo deben confirmarse las cifras de linfocitos CD4+ y CVP. Además, debe prepararse al paciente, ofertando las distintas opciones, adaptando el esquema terapéutico al estilo de vida, comorbilidades, posibles interacciones y valorando el riesgo de mala adherencia **(A-III)**

GeSIDA
GRUPO DE ESTUDIO DEL SIDA-SEIMC

Si las evidencias disponibles demuestran mayor eficacia TAR inmediato y recomendaciones en sentido contrario no estan avaladas por evidencias…

¿Tenemos que esperar a GODOT?

Suprimir la replicación del VIH es la mejor estrategia para prevenir su transmisión

- 1.110 parejas serodiscordantes homo/heterosexuales
- Análisis interino a los 2 años: Ningun caso de transmisión con **ARN-VIH <200 cop/ml**

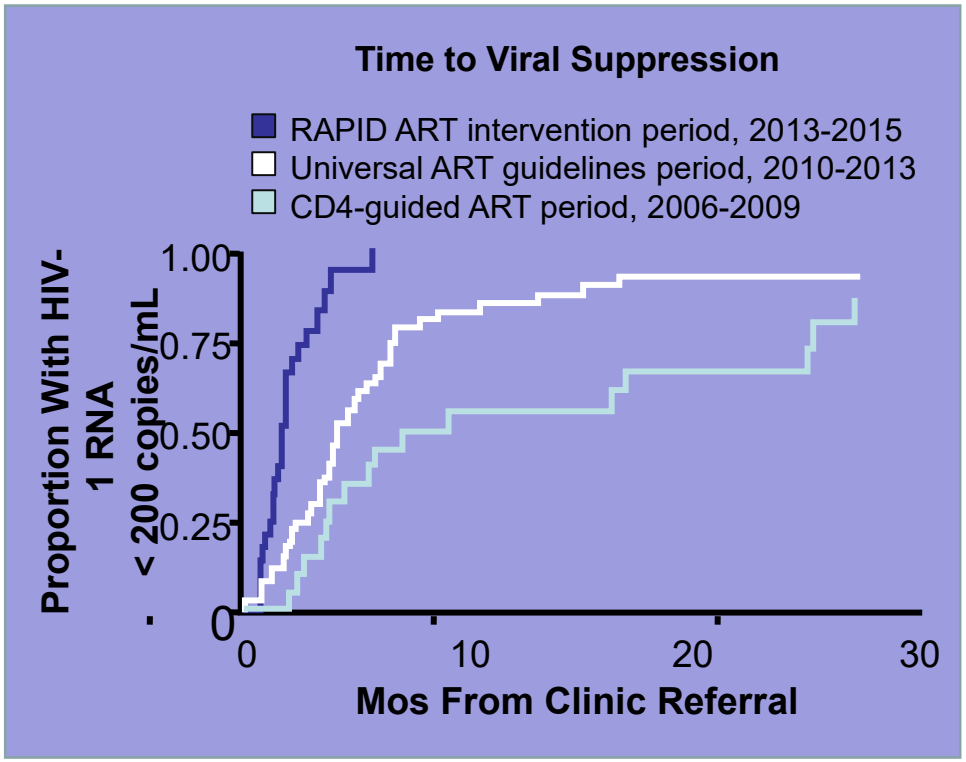
Suprimir VIH es la mejor estrategia para prevenir la transmisión sexual

Study	Nº	Parejas 4w	Riesgo
Ipergay	400	10	HSH
Partner PrEp	2499	4	HTX
IPREX	4747	18*	HSH
FEM-PrEp	2120	1-11**	Mujeres

*12 semanas
** Ultima semana

RAPID (Rapid ART Program Initiative for HIV Diagnoses): estudio Piloto en San Francisco

Inicio de TAR mismo dia del diagnostico (RAPID ART). Including access to labs and counseling. Including vulnerable populations (racial/ethnic minorities and homeless patients).



Time Diagnosis to first virologic suppression decreased 54% (from 134 days to 61 days)

Pilcher CD, et al. J Acquir Immune Defic Syndr. 2017;74:44-51.

Si el TAR inmediato contribuye a reducir la carga viral poblacional y adelanta la supresión de ARN-VIH…

¿Tenemos que esperar a GODOT?

Recomendaciones de las Guias

Guidelines[1–4]	Recommendation
WHO[1]	• ART initiation within **7 days** for all people living with HIV following confirmed diagnosis and clinical assessment • **ART initiation offered on the same day to people who are ready to start**
DHHS[2]	• ART for all individuals with HIV, regardless of CD4 T lymphocyte cell count • ART initiation **as soon as** possible (may be deferred because of clinical and/or psychosocial factors)
IAS-USA[3]	• **ART initiation as soon as possible after diagnosis, including immediately after diagnosis**, unless patient is not ready to commit to starting therapy
EACS[4]	• ART irrespective of the CD4 count (lower the CD4 count = **greater urgency** to start ART **immediately**) • **Accumulating evidence that ART initiation the day after establishing diagnosis is feasible and acceptable to HIV-positive persons**

ART, antiretroviral therapy.

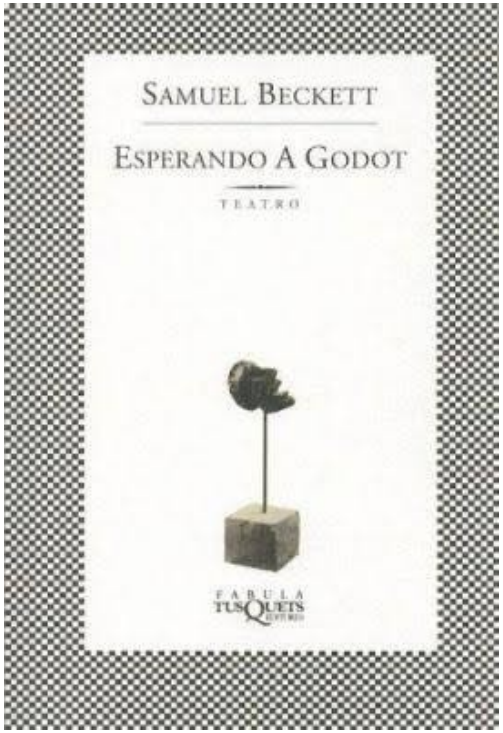
1. WHO. Jul 2017. http://www.who.int/hiv/pub/guidelines/advanced-HIV-disease/en/;
2. Panel on Antiretroviral Guidelines for Adults and Adolescents. Oct 2018. http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf;
3. Saag MS, et al. JAMA 2018;320:379–396; 4. EACS. Oct 2018. http://www.eacsociety.org/files/2018_guidelines-9.1-english.pdf.

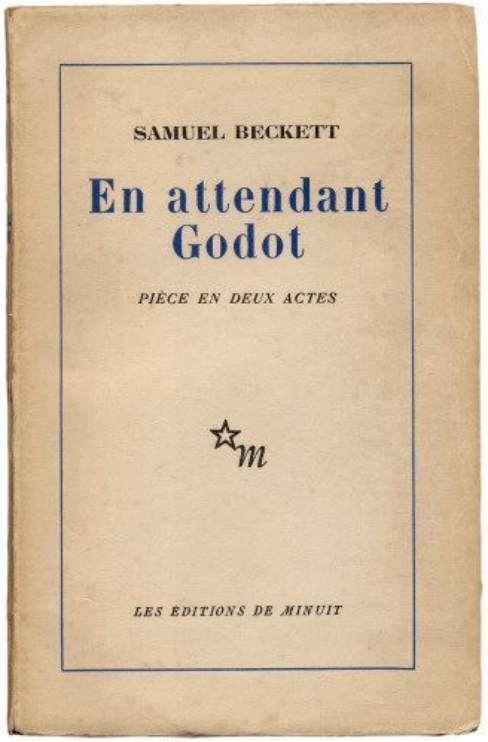
Documento de consenso del tratamiento antiretroviral en adultos infectados por el VIH (Versión Enero 2019)

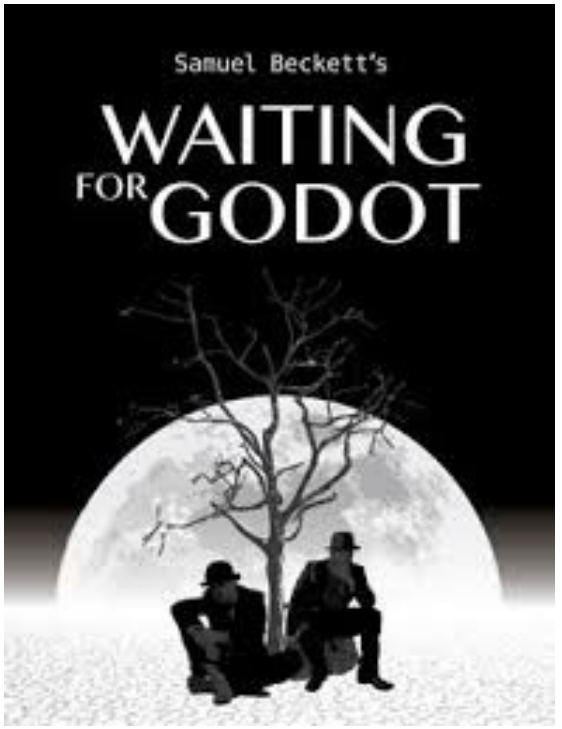
- El TAR debe instaurarse lo más rápidamente posible una vez confirmado el diagnóstico (A-III)
- Se debe realizar siempre una determinación de linfocitos CD4+ y CVP previa al inicio del tratamiento, aunque no es imprescindible esperar hasta disponer de los resultados

GeSIDA
GRUPO DE ESTUDIO DEL SIDA-SEIMC

Recomendación







Recomendaciones

¡ No esperen a GODOT !

Ni para decidir iniciar TAR

Ni como estrategia de vida