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PATIENTS AWARENESS OF ANTIRETROVIRAL-RELATED CARDIOVASCULAR RISK AND THEIR PREFERENCES FOR MANAGING IT

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INTRODUCTION

During the HAART era, the prevalence of cardiovascular morbidity and mortality has increased continuously in patients infected by HIV/AIDS. In addition to factors directly related to Antiretroviral Therapy (ART) regimens, many other factors can increase the cardiovascular risk of HIV-infected patients. Knowledge of patients' preferences with regard to this problem and options for management would make it easier for them to collaborate and would maximize the success rate of preventive/palliative measures.

OBJECTIVE

To analyze the knowledge HIV-infected patients receiving ART have of the cardiovascular risk their therapy entails, and their attitudes and behavior towards risk prevention and willingness to change therapy in favor of another with a potentially lower cardiovascular risk.

METHODOLOGY

Questionnaire put to a sample of 858 HIV-infected patients. Error margin: ± 3.0 %. Confidence level: 95%. The questionnaire included questions on the extent of patients' knowledge of the cardiovascular risk therapy entails and the importance they give to this, as well as preferences towards changing to other, lower-risk therapies.

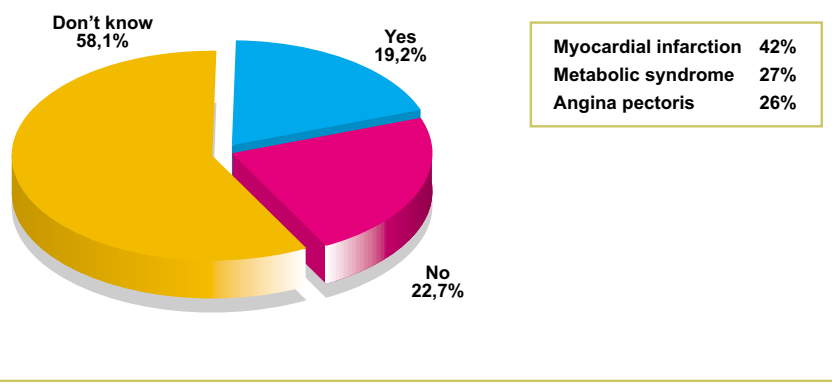
RESULTS

Table 1. Characteristics of the sample

DESCRIPTION OF THE SAMPLE	n	%
TOTAL	**858**	**100,0**
• Males	618	72
• Under 35 years of age	139	16
• Aged 35 to 50	644	75
• Over 50 years of age	75	9
• No school diplomas	142	17
• Primary level education	385	45
• Secondary school / NVQ	237	28
• University degree	94	11
• Working	314	37
• Once-daily dosing (QD)	212	25
• Two or more doses per day (≥ BID)	634	74
• Injecting drug user (IDU)	353	41
• AIDS	261	30
• Atazanavir-containing ART	79	9

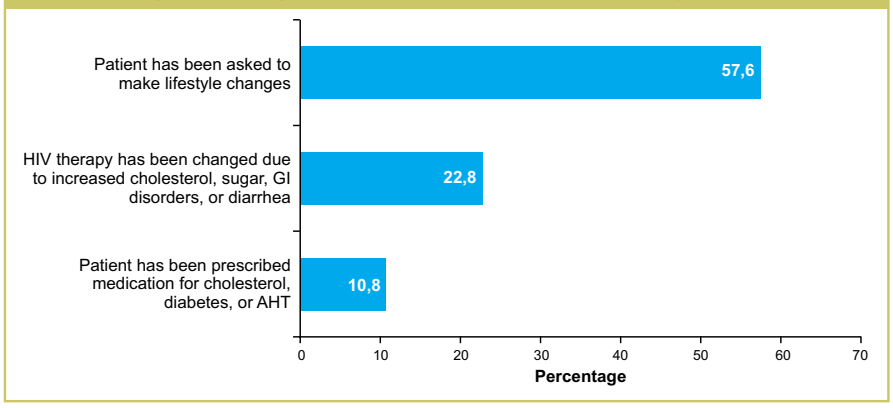
Only a fifth of those questioned claimed to know the relationship between their therapy and a potential increase in cardiovascular risk, which 37% class as *"very high"* or *"quite high"*. They were referring mainly to myocardial infarction, metabolic syndrome, and angina pectoris (Fig. 1).

Figure 1. Do you know if your HIV therapy has any cardiovascular effects?



In 23% of the sample, the physician changed ART because of increased levels of cholesterol, glucose, or due to of gastrointestinal disorders / diarrhea. In 58% of the sample, the physician asked the patient to consider lifestyle changes (smoking, diet, exercise) and prescribed concomitant treatment to 11% (Fig. 2).

Figure 2. Strategies followed after onset of the metabolic syndrome



RESULTS

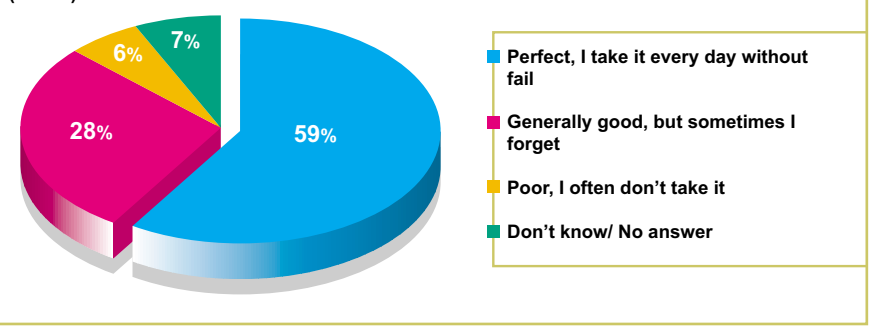
Nevertheless, most of the patients questioned preferred to switch therapy for one with a lower risk, rather than consider lifestyle changes or taking concomitant medication (Table 2). The latter option negatively affected adherence to ART in 10% of cases, while 34% of the sample admit an incompleto adherence to the concomitant therapy (Fig. 3).

Table 2

IF NECESSARY, WHICH OF THE FOLLOWING MEASURES WOULD YOU PREFER TO TRY?	(n=858)
	%
1 - Change HIV therapy for a lower cardiovascular risk therapy	**74,0**
2 - Do whatever my doctor says	69,0
3 - Change lifestyle (smoking, diet, exercise)	65,6
4 - Take medication for lipids (triglycerides, cholesterol)	45,8
5 - Don't know	24,1

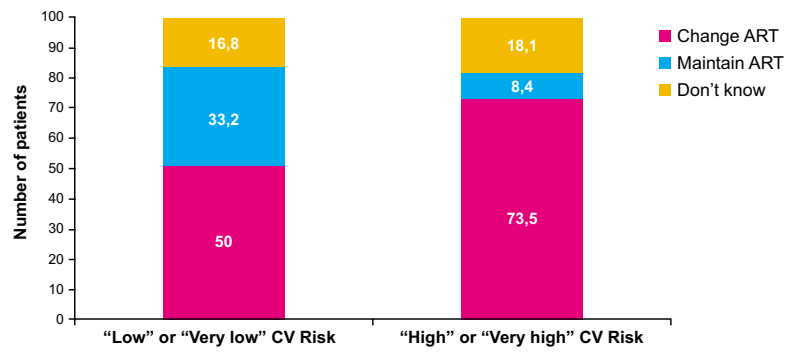
Figure 3. Adherence to therapy for triglycerides/cholesterol

(n = 68)



In the case of a *"low"* or *"very low"* cardiovascular risk, 50% would prefer to switch to another, lower cardiovascular risk treatment (once the preference was ruled out following medical advice). This percentage increased to 74% when the supposed risk was *"high"* or *"very high"*. (Fig. 4).

Figure 4. Preferences for change of therapy (when faced with probable CV risk)



DISCUSSION

- The results of this survey reveal a marked lack of knowledge by patients of the potential impact of ART on cardiovascular risk. This is clearly one area which could be improved with the successful implementation of measures to prevent the growing prevalence of cardiovascular events in the HIV-infected population. It is also interesting to see how, in such a controversial area for the scientific community, patients clearly state their preference for a change in the ART responsible for the increased cardiovascular risk rather than maintain it and opt for other palliative measures. Furthermore, the adherence of patients who have started lipid-lowering therapy is far from negligible in a third of cases, neither is its negative impact on adherence to ART in up to 10% of patients receiving both treatments concomitantly. This could explain, at least in part, the low efficacy of lipid-lowering therapy in the HIV population.

CONCLUSION

- **Patients' preferences and declared adherence reinforce the importance of switching strategy in HIV therapy to more convenient and potentially less toxic ARV regimens. Educational programs might improve patients' attitudes towards prevention of CV.**