HIV complications: Treatment

Antiretroviral therapy (ART) should be initiated in nearly all HIV-infected individuals regardless of their CD4 count. Therapeutic options have expanded, and the available agents are more potent, better tolerated, and associated with less toxicity compared with earlier agents. The lower the CD4 count the worse the prognosis. Patients with comorbid conditions directly resulting from HIV infection or with non-AIDS-defining conditions should initiate ART as soon as possible regardless of CD4 cell count.

Examples of non-AIDS-defining conditions in early symptomatic HIV infection

Thrush
Vaginal candidiasis that is persistent, frequent, or difficult to manage
Oral hairy leukoplakia
Herpes zoster involving two episodes or more than one dermatome
Peripheral neuropathy
Bacillary angiomatosis
Cervical dysplasia
Cervical carcinoma in situ
Constitutional symptoms such as fever (38.5°C) or diarrhea for more than one month
Idiopathic thrombocytopenic purpura

These conditions can be seen with greater frequency and severity in the setting of HIV infection, even in the absence of severe immunosuppression (ie, CD4 cell count <200 cells/microL).

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Pearl: Cryptococcal meningitis is one exception to this approach, and initiation of ART should be delayed for such patients. It is likely that the benefits of early ART in cryptococcal meningitis are outweighed by induction of a potentially serious **immune reconstitution inflammatory syndrome (IRIS).**

IRIS describes a collection of inflammatory disorders associated with paradoxical worsening of a pre-existing infectious process following the initiation of potent antiretroviral therapy (ART) in HIV-infected individuals → **Headache, N/V and ↓alertness.** Most cases of cryptococcal IRIS occur one to six weeks after ART is initiated (median 29 to 33 days); however, late presentations (up to 10 months after ART is started) have also been reported.