GUIDELINES FOR THE CLINICAL MANAGEMENT OF HIV INFECTION IN MYANMAR FOURTH EDITION

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GUIDELINES
FOR THE CLINICAL MANAGEMENT OF HIV INFECTION IN MYANMAR

FOURTH EDITION

National AIDS Programme

Department of Health, Ministry of Health, Myanmar

2014

Contents

World Health Organization
Country Office for Myanmar

Introduction

- HIV prevalence in the adult population aged 15 years and older was estimated at 0.54% in 2014

- 212,000 people living with HIV (PLHIV) in Myanmar

- **106,000** PLHIV receiving ART in Dec 2015

Global AIDS Response Progress Report Myanmar 15 June 2015

- several meetings carried out in Naypyitaw and Yangon, with participation from all stakeholders to produce a local guidelins

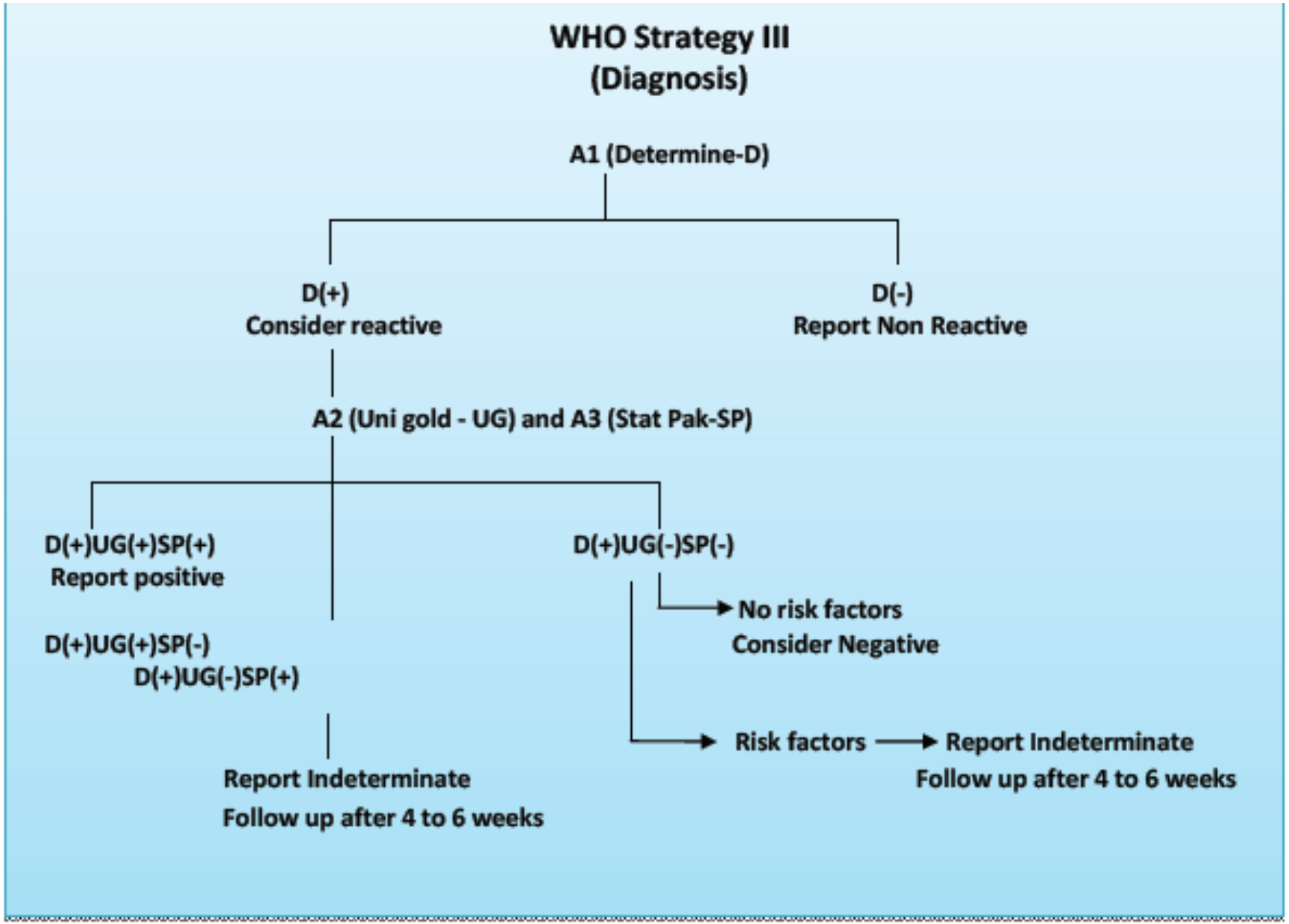
- the consensus reached was used to develop the Myanmar national guidelines 2014

- Based on
  - **WHO CONSOLIDATED GUIDELINES in June, 2013**

    and
  - March 2014 SUPPLEMENT TO THE 2013CONSOLIDATED GUIDELINES

1. Diagnosis of HIV infection

- Pre-test counseling
- Three testing strategy is used for clinical diagnosis
- Post-test counseling



A1=Determine (D) ICT, A2=Uni-gold (UG) ICT, A3=Stat Pak (SP) ICT

Cotrimoxazole prophylaxis

- It is recommended for all symptomatic individuals (WHO clinical stages 2, 3 or 4) including pregnant women

- Where CD4 count is available, cotrimoxazole prophylaxis is recommended for individuals with CD4 count of < 350/mm3

Laboratory assessment

- Hb g/dl Baseline
- CD4 count Baseline
- Fasting blood sugar Baseline
- ALT, AST Baseline Desirable
- Creatinine Baseline Desirable
- HBs Ag, HCV Ab Baseline Desirable
- Urinalysis Baseline
- Chest X- rays Baseline if indicated

Drug Adherence Counseling

- Patients should understand
  - that ART is suppressive therapy
  - that ART is life-long
  - that near perfect adherence is necessary to prevent ART resistance
  - that there are possibilities of side effects
- ART should never be prescribed casually at the first visit

When to start anti retroviral therapy

- Initiate ART if CD4 count <500 cells/mm3
  - As a priority, initiate ART in everyone with severe/ advanced HIV disease (clinical stage 3 or 4) or CD4 count <350 cells/mm3

- WHO clinical stage 3 or 4 irrespective of CD4 cell count

Regardless of CD4 count and clinical stage

- Active TB disease
  - Start TB treatment first followed by ART as early as 2 weeks and not later than 8 weeks

- HBV co-infection with severe chronic liver disease

- HIV-positive individual in a serodiscordant couples

- Pregnant and breastfeeding women with HIV
  - Decide on when to stop (Option B) or Continue (Option B plus)

What ART combination to start

First-line ART	Preferred first -line regimens	Alternative first-line regimens
Adults and adolescents (including pregnant and breastfeeding women and adults with TB coinfection and HBV coinfection)	TDF+3TC (or FTC) +EFV	AZT + 3TC + EFV AZT + 3TC + NVP ABC + 3TC + EFV [a]

a ABC based combinations may be considered for pregnant women under special circumstances which may include situations where preferred or alternative regimens may not be available or suitable

Monitoring ARV toxicities and response to treatment

- 2wks after initiation of ART
  - Drug allergy, Adherence , side effects such as dizziness due to EFV

- 4wks after ART
  - Anaemia, renal function, liver function
  - In addition to above parameters

- 1 to 3 months after ART
  - IRIS
  - In addition to above parameters
- Timing of follow up may depends upon patient's condition after 3 months of ART
- Usually every 6 months in stable patients

Laboratory monitoring of ART	
Hb (For AZT)	Baseline and at 4, 8, 12 weeks ; every 6 months desirable
CD4 count	Baseline and every 6 months
Plasma viral load : targeted	At 12 months after the ART initiation and as needed only to confirm virological failure
Chest X- rays	When indicated
Urinalysis (proteinuria, glucosuria)	Baseline and Every 6 months if TDF used
Creatinine (for Cr clearance calculation)	Every 6 months if TDF used especially in high risk patients
ALT, AST	Every 6 months (if NVP used at 4,8 12 weeks) desirable but not compulsory
Fasting blood sugar	Every 6 months desirable
Lipid profile (at least cholesterol and triglyceride)	Every 12 months (desirable)

Management of Toxicities

- Find out the manageable causes of comorbidities such as ;
  - OTC use of drugs
  - HBV, HCV, syphilis
  - Acute kidney injury
  - Piles, worms infestations

- Intolerance to EFV ⟹ NVP or PI/r
- Intolerance to NVP ⟹ EFV or PI/r
- Intolerance to TDF ⟹ AZT or ABC
- Intolerance to AZT ⟹ TDF or ABC

When to switch to second line ART

- WHO definitions of **clinical, immunological and virological failure** for the decision to switch ART regimens

- New or recurrent clinical event indicating severe immunodeficiency (WHO clinical stage 4 condition) after 6 months of effective treatment

- **CD4 count** falls to the baseline (or below) or Persistent CD4 levels below 100 cells/mm3

- **Plasma viral load** above 1000 copies/ml based on two consecutive viral load measurements after 3 months with adherence support

Second-line ART regimens

- If d4T or AZT has been used in first line therapy, use TDF + 3TC (or FTC) plus a boosted PI (LPV/r)

- If TDF has been used in first line therapy, use AZT + 3TC plus a boosted PI (LPV/r)should be used as second line therapy
  - Keep TDF in second line if patient has HBV coinfection

- 3TC may remain useful in second line regimens even if there is resistance
- as such a strain may protect potential NRTI options and avoid PI monotherapy
- ABC and ddI are not recommended as preferred options

- If a patient on second line ART containing **LPV/r** have active TB use **RIFABUTIN** 150 mg 3times/wks instead of **RIFAMPICIN**

Third-line ART regimens

- Plans should be made for third-line therapy that consider costs, sustainability and equitable access to ART**???**

THANK YOU