Diabetes in the time of HIV

Sir,
It is indeed a welcome endeavor that "HIV and diabetes" is being projected in the October 2011 issue of the IJEM.[1]

In India, as per National Aids Control Organization (NACO) guidelines, protease inhibitors are considered when clinical, virological, or immunological failure occurs on first-line anti-retroviral therapy (ART).[2] Therefore, the statement "PI based regimens should be avoided in patients with a high risk of diabetes" (page 248, para 7) should be reviewed and revised. If a patient develops diabetes or glucose intolerance, this has to be dealt with appropriate measures as protease inhibitors form the backbone of second-line ART.

With reference to the choice of therapy, most of our patients with HIV are below the poverty line, and hence both insulin and Glucagon like peptide-1 (GLP-1) analogs will not be easily affordable options. Moreover, liraglutide (or exenatide) with concurrent usage of non-nucleoside reverse transcriptase inhibitors may pose a risk of pancreatitis.[2]

Dyslipidemia in HIV is well established and this has similarities with diabetic dyslipidemia. In diabetic patients with HIV, NCEP ATPI III recommendations to reduce total cholesterol levels to less than 160 mg/ dl, low density lipoprotein (LDL) to less than 100 mg/ dl, high density lipoprotein (HDL) to above 40 mg/dl in men and 50 mg/ dl in women should be advised and not the higher targets suggested by the authors.[3] While using statins, it is important to be aware of the risk of hepatic dysfunction and consequent death in HIV-infected individuals.[4] Physicians should also know that the occurrence of myopathy/rhabdomyolysis is high when protease inhibitors are used in conjunction with certain statins like simvastatin and lovastatin.

The authors have not alluded to the International Aids Society's guidelines on metabolic complications published in 2002 in the *Journal of Acquired Immune Deficiency Syndromes* for diabetes and lipid-related issues other than in the context of megestrol acetate usage.[5] The Asian guidelines should state issues of concern in our subset of HIV-infected patients, considering their propensity for metabolic syndrome and the ART regimes in use here. A summary sheet with screening intervals, indications, and criteria, therapeutic options, and red flags for immediate action (both for dysglycemia and dyslipidemia and associated conditions like hypertension and ischemic heart disease (IHD)) would be of immense help to primary care physicians.

Physicians and endocrinologists need to accept the chronicity of HIV infection as well as diabetes, and consider consequent social, economic, physical, and psychological implications while treating these patients. There is a paucity of ethically and systematically conducted longitudinal research work focusing on the risks of disease and the benefits and side effects of therapies. We need these to make precise and concise guidelines for these patients, constantly bearing in mind that a vast majority of them struggle to make a living and are unable to afford costly drugs which claim high benefits.

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