We are glad that HIV/AIDS as public health issue remains high up on the political agenda and that the new communication demonstrates a very positive sign of continuity. It was mentioned in the past many times by the Commissioners for health that there’s no room for complacency and that we all need to stay active and engaged in combating HIV/AIDS across Europe and beyond.

The current Commission communication focused very much on promoting prevention as a most important cor-
nerstone of any comprehensive HIV policy. Political leadership, partnership and the involvement of civil society were identified as additional essential elements that need realisation if one really intends to turn down the epidemics. The HIV/AIDS epidemic has changed its face and its speed across Europe over the last couple of years. The epidemic has shown its social dimension and it has become more and more evident that a co-operation across politics and societies is indispensable for a meaningful response.

Several of these elements are under discussion for the design of the next strategy on combating HIV/AIDS in the EU and the neighbourhood. Prevention remains the key priority and we have to promote better that successful prevention strategies need resources but that effective prevention strategies are always cost-effective and finally save resources and lives. A second key priority will be a focus on priority groups, and a third priority is the focus on those geographical areas where HIV/AIDS pose the biggest burden now and potentially over the next five years. This of course does implement that the policy will keep its general aspects and addresses basically all aspects that comprise a meaningful response.

It is without doubt, that only a strong cooperation helps to bring down the numbers of new HIV infections over the next years, helps to improve the lives of PLWHA and helps to overcome different expressions of stigma and discrimination that particularly people belonging to most at risk groups face. Another important aspect for a future development towards the better is that the knowledge and awareness around HIV/AIDS needs urgently improvement across all layers of society and in particular among young people.

It sounds simple, but it seems to be a long way to go forward. Surveillance needs to be strengthened to deliver even more meaningful data that serve as basis for policy development and implementation. The right investment of scarce resource needs more attention and solidarity needs to be strengthened among all societal groups, politics and industry. All need to deliver in order to reverse the trend and the speed of the epidemic.

We have always seen the Portuguese HIV/AIDS policy as exemplarily. It shows that determination and cooperation among stakeholders leads to results and admirable achievements, of course without creating “un monde parfait”. But organising a meaningful and effective response is very much linked to the determination of many people, including the national coordinators, civil society, politics and all citizens that care.

When to Start
Anton Pozniak
Chelsea and Westminster Hospital NHS, UK

Until recently HIV treatment guidelines suggested starting treatment in patients with symptomatic HIV disease or if asymptomatic when the CD4 count declined to between 200 and 350 cells/mm³. In reality many started with CD4 counts of approximately 200 cells/mm³ or lower mainly because of presenting late with advanced immunosuppression. Recently guidelines have been recommending earlier treatment when the CD4 falls below 350 rather than allow patients to wait and let the CD4 approach the 200 level. In some patients it may be appropriate to start even earlier if risk factors for progression or non-HIV related morbidities are present. The recommendation for earlier treatment has evolved as several studies have shown a higher risk of clinical disease at higher CD4 counts than previously thought.

In the SMART study of treatment interruption those individuals, all with CD4 counts greater than 350 cells/mm³, and including both not on treatment and those randomised to treatment interruption, had more disease events than those who remained on treatment throughout. Interestingly the excess of clinical disease was not only due to HIV related conditions but also non-HIV related such as cardiovascular, renal and hepatic disease.

The North American AIDS Cohort Collaboration identified 2620 patients who had started treatment at a CD4 count above 500 cells/mm³, and compared their risk of death to those who started treatment later. They found a 60% higher risk of death for those who deferred treatment (relative hazard 1.60, p<0.001, after controlling for potential confounding factors such as age and baseline viral load.

After six years 10% of those who deferred treatment had died, and 15% by eight years, indicating that although the absolute risk of death was small, it was not negligible. A second analysis, using data from 21,247 patients in seven cohorts, yielding 68,256 person-years of follow-up was carried out by the When to Start Consortium. They compared the effects of deferring treatment across a range of CD4 cell bands below 550 cells/mm³, and found that there was no significant difference in the risk of AIDS or death between those who started in the range 451-550 cells/mm³ and those who started in the range 351 to 450 cells/mm³ (HR 0.99, 95% CI 0.76 – 1.29). As expected there was a significant difference in the range 351-450 cells/mm³ when compared to 251-350 cells/mm³ (HR 1.28, 95% CI 1.04 – 1.57).

A large study called START has commenced and is looking at this question of starting early or deferring treatment in a randomised fashion.

As a consequence of all this data from cohorts the European AIDS Clinical Society (EACS) recommend treating...