

Special considerations in patients presenting with an opportunistic disease.

The timing of when to start therapy in patients presenting with an opportunistic disease is controversial and is covered in detail in the [Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Patients \[28\]](#). The optimal time to start therapy varies, depending on the clinical scenarios. In patients with conditions for which there is no effective therapy except for improvement of immune function as a result of antiretroviral therapy (e.g., cryptosporidiosis, microsporidiosis, progressive multifocal leukoencephalopathy, and HIV-associated dementia), the early benefits of potent antiretroviral therapy outweigh any increased risk, and therefore therapy should be started as soon as possible (**AIII**). In the setting of *Mycobacterium avium* complex infection, *Pneumocystis jiroveci* pneumonia (PCP), and cryptococcal meningitis, in which immediate therapy may increase the risk of immune reconstitution inflammatory syndrome (IRIS), a short delay may be warranted before initiating antiretroviral treatment (**CIII**). With concomitant *M. tuberculosis* infection, delay of ART for 2 to 8 weeks after initiation of tuberculosis treatment is recommended in order to avoid confusion in the event of adverse drug reactions and to prevent or minimize IRIS (**BIII**). (See [TB/HIV Coinfection](#) section.)

Adherence Considerations. Concern about adherence to therapy is a major determinant for timing of initiation of therapy, with patient readiness to start treatment being a key factor in future adherence [29]. Depression and substance abuse may negatively affect adherence and response to therapy and should therefore be addressed, whenever possible, before therapy is initiated. However, no patient should automatically be excluded from consideration for antiretroviral therapy simply because the clinician judges that the patient exhibits behaviors or characteristics affecting adherence. Instead, the necessity for patient adherence to a long-term drug regimen should be discussed in detail by the patient and clinician before therapy is initiated. To achieve the level of adherence necessary for effective therapy, providers are encouraged to use strategies for assessing and assisting adherence. (See [Adherence](#) section.)

Table 5a. Indications for Initiating Antiretroviral Therapy for the Chronically HIV-1 Infected Patient (Updated December 1, 2007)

Clinical Condition and/or CD4 Count	Recommendations
<ul style="list-style-type: none"> History of AIDS-defining illness (AI) CD4 count <200 cells/mm³ (AI) CD4 count 200-350 cells/mm³ (AII) Pregnant women* (AI) Persons with HIV-associated nephropathy (AI) Persons coinfectd with hepatitis B virus (HBV), when HBV treatment is indicated (Treatment with fully suppressive antiviral drugs active against both HIV and HBV is recommended.) (BIII) 	Antiretroviral therapy should be initiated.
<ul style="list-style-type: none"> Patients with CD4 count >350 cells/mm³ who do not meet any of the specific conditions listed above. 	The optimal time to initiate therapy in asymptomatic patients with CD4 count >350 cells/mm ³ is not well defined. Patient scenarios and comorbidities should be taken into consideration. (See Table 5b and text regarding risks and benefits of therapy in patients with CD4 count >350 cells/mm ³).

* For women who do not require antiretroviral therapy for their own health, consideration can be given to discontinuing antiretroviral drugs postpartum. For more detailed discussion, please refer to the [Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women and Interventions to Reduce Perinatal HIV-1 Transmission in the United States](#) and the [HIV-Infected Women](#) section.