Case Study # 2

41 y/o male diagnosed with HIV & Hepatitis C, 2001 when entered into care, CD4 nadir 3 no h/o OI Started in care with NP 2004: Cd4 150 Vl <50 } Viral Load always <50 - Cd4 fluctuates between 200 – 300. Never > 350.

- **HIV & Hepatitis C Risk Factors:** IDU heroin, last 1996, MSM
- **PMH:** Chronic Alcohol Abuse age 12 – 33 stopped all alcohol use 2005, Tobacco use d/o (15 pack year) Cirrhosis (scoped and no varices), Peripheral Neuropathy (feet), Bipolar d/o, Seizure d/o
- **SH:** lives with mother who accompanies him to appointments – good relationship/support – male partner died 10 years ago - patient reports no other relationships and not sexually active since 2003
  Co-managed by psychiatrist at HIV Center } 2004 to present – no acute psychiatric events
- **Meds:** Neurontin, Pamelor, Zyprexa, Celexa, Kerrpa
- **HIV Treatment History: No medication intolerance**
  2001: Viramune/Combivir
  2005: switched to Viramune/Truvada
  2007: 2° increasing creatinine Truvada stopped and Epzicom started/ Viramune continued
  Hepatitis C: Type 1, 2004 viral load > 7 million IU

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- **Hepatitis C Treatment:** 2007 Echo, H/H, bili, INR, AST/ALT wnl - Treated Peg/Riba 8/2007 – 12/2008 } Hep C viral load undetectable throughout treatment - moderate anemia after several months of treatment – riba adjusted, no transfusion/epo, otherwise tolerated treatment / no missed treatment} Hep C viral load rebounded when treatment stopped

- The patient has continued on HIV and other meds and mostly feeling well. Continues surveillance for HCC - intermit MRI negative. Hep C viral load remains > 7 million IU, recent repeat echo & h/h wnl, INR 1.5, bili 1.8, Cr 1.3 (MELD 16) ast/alt wnl.

- Should retreatment for hepatitis C be considered with new agent?

- If so what agent should be used?

- How should HIV regimen be adjusted?

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