ore 16.30 – 18.00

09|06
2025

science
eXpert
webinar
inHIV educazionale

Aspetti clinici dell'aumento di peso nell'HIV

G. Guaraldi

Paradigm shift

Choose the best approach for health assessment

BMI Centric

Focus on Obesity

VS

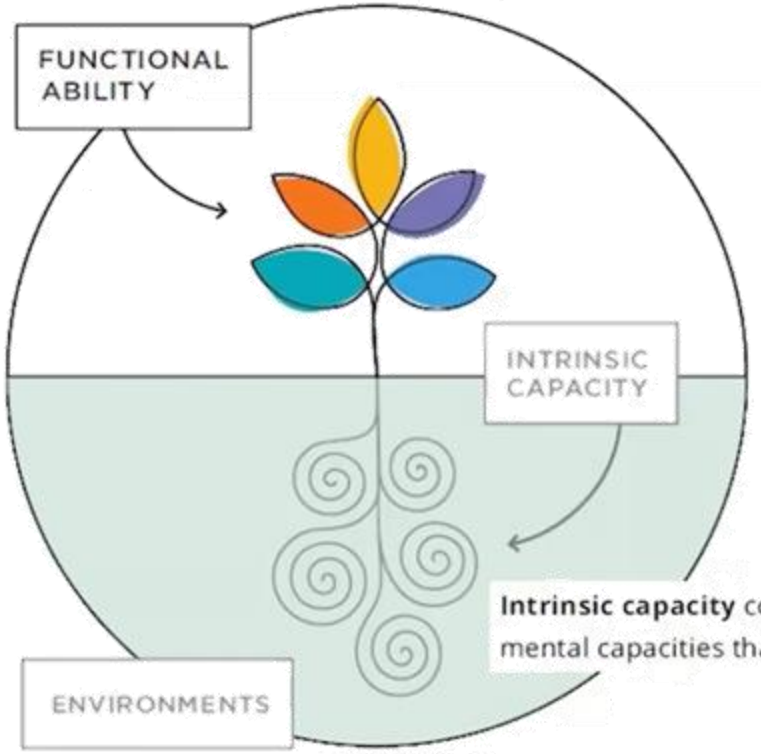
Person Centric

Focus on metabolic health

Healthy Living/ Healthy Ageing: a new paradigm focused on maintaining functional ability across the life course

Functional ability combines the intrinsic capacity of the individual, the environment a person lives in and how people interact with their environment.

The three components of healthy ageing



Healthy ageing is "the process of developing and maintaining the functional ability that enables well-being in older age".

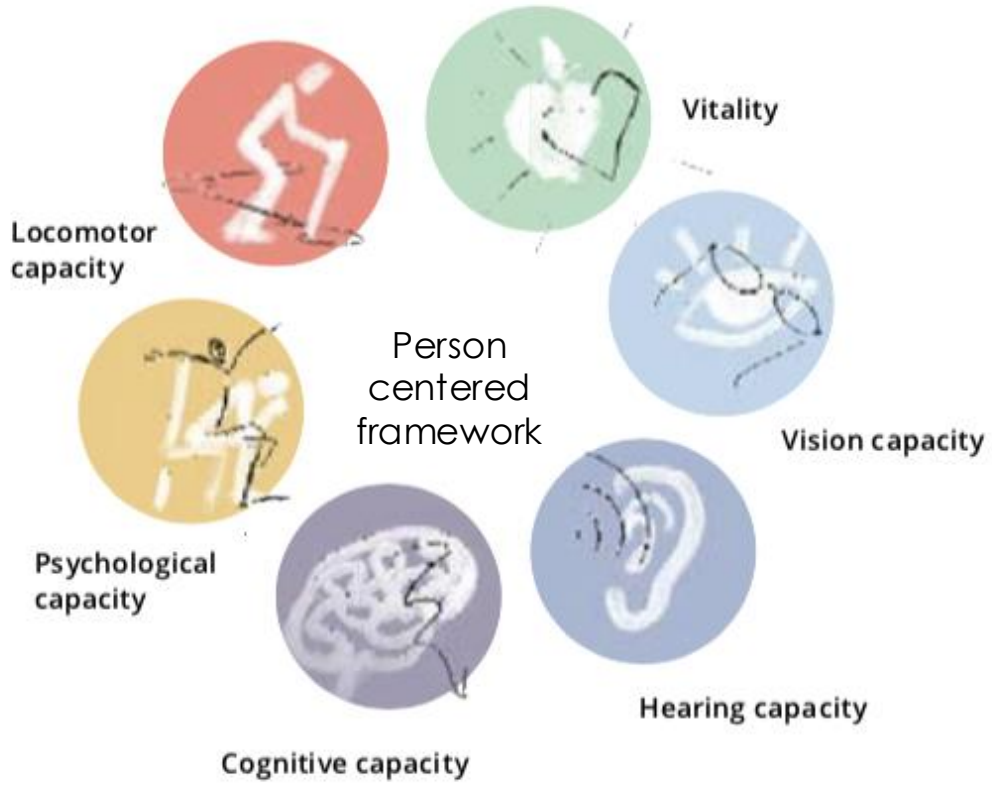
Intrinsic capacity comprises all the physical and mental capacities that a person can draw on.

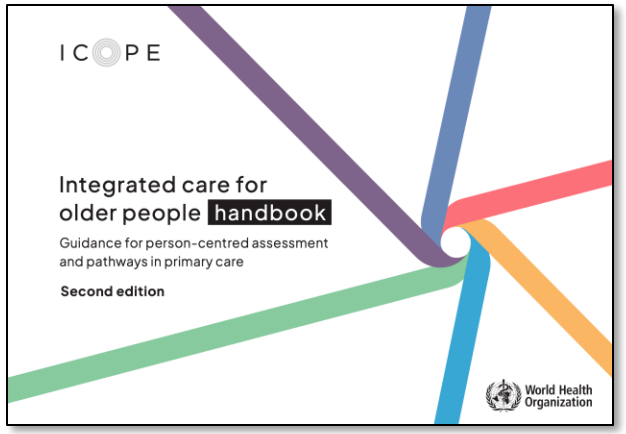
Environments are where people live and conduct their lives. Environments shape what older people with a given level of intrinsic capacity can be and do.

WHO Decade of Healthy Ageing: Baseline report
https://apps.who.int/iris/handle/10665/338677

The key to supporting healthy living for all is optimizing people's intrinsic capacity and functional ability throughout the life course.

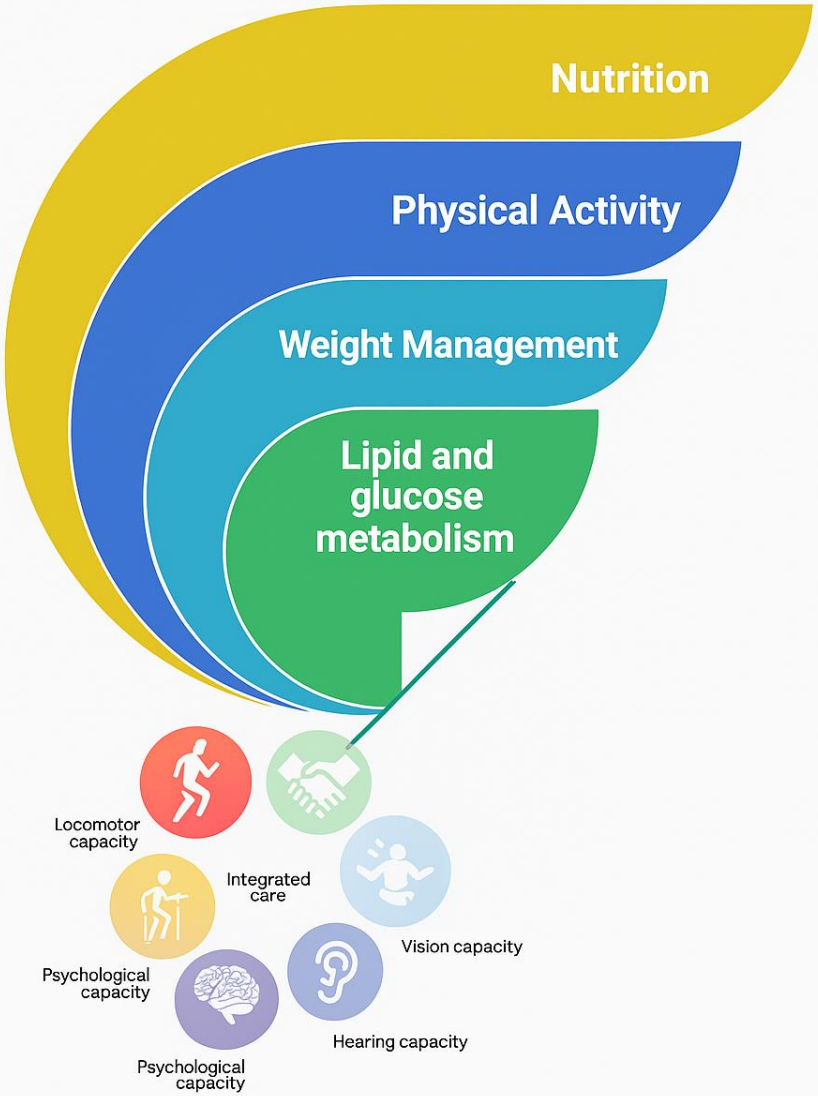
Intrinsic capacity = All physical and mental capacities of an individual





Adapted from World Health Organization. World Report on Ageing and Health. 2015. Available at: https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf;jsessionid=B4BB65FB12457BE99A9AC4AD19D770BB?sequence=1 [Accessed September 2019].

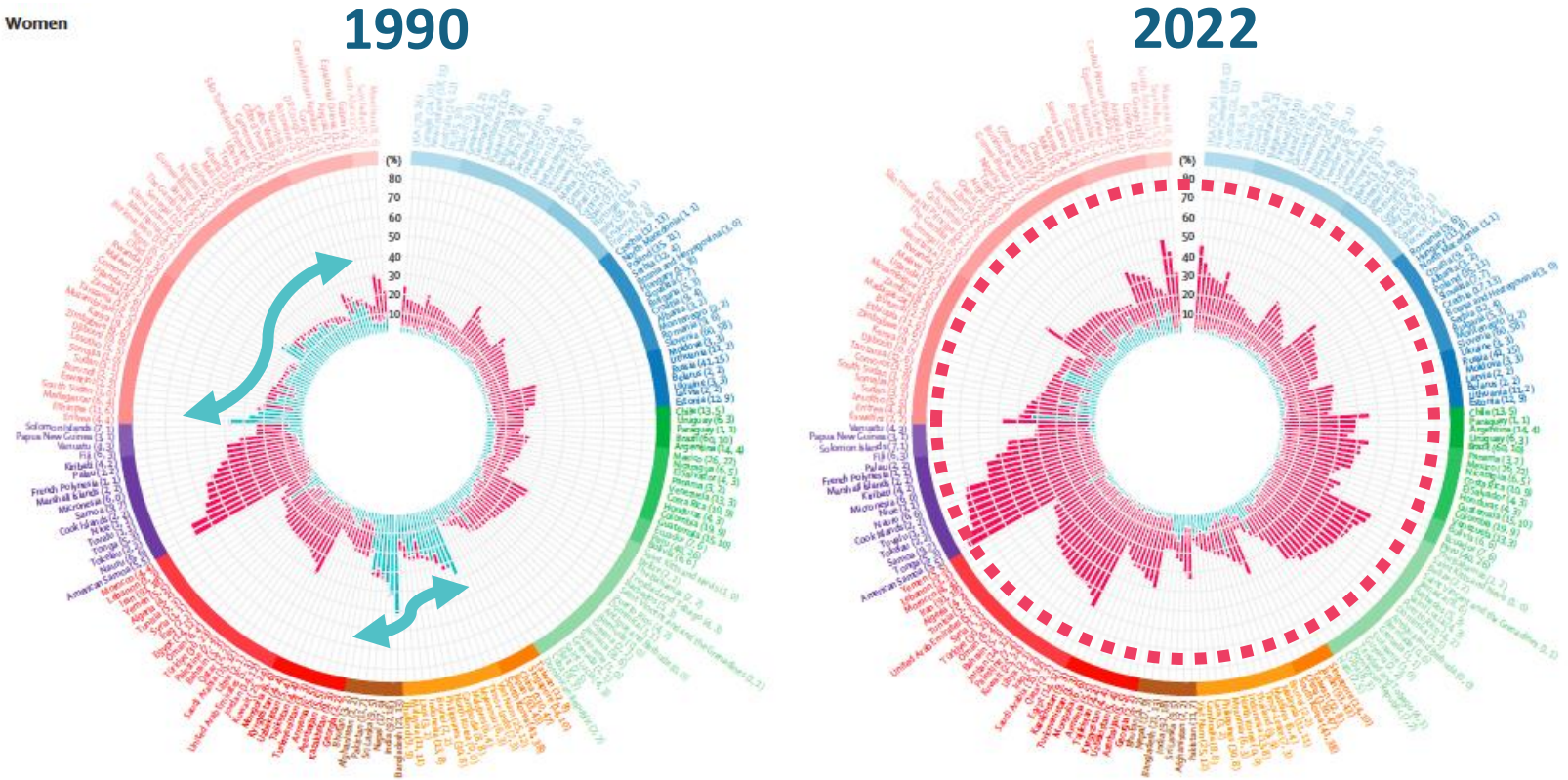
Vitality is Metabolic Health



Metabolic health in people with HIV (PWH) is defined as a patient-centered framework that addresses metabolic parameters influenced by chronic HIV infection, antiretroviral therapy exposure, individual characteristics, and environmental factors.

This approach aims to maintain wellness and improve health-related quality of life through targeted pharmacologic and lifestyle interventions, serving as a guide across different stages of disease progression and aging.

The world is an obesogenic environment
Underweight and obesity in 1990 and 2022



Underweight

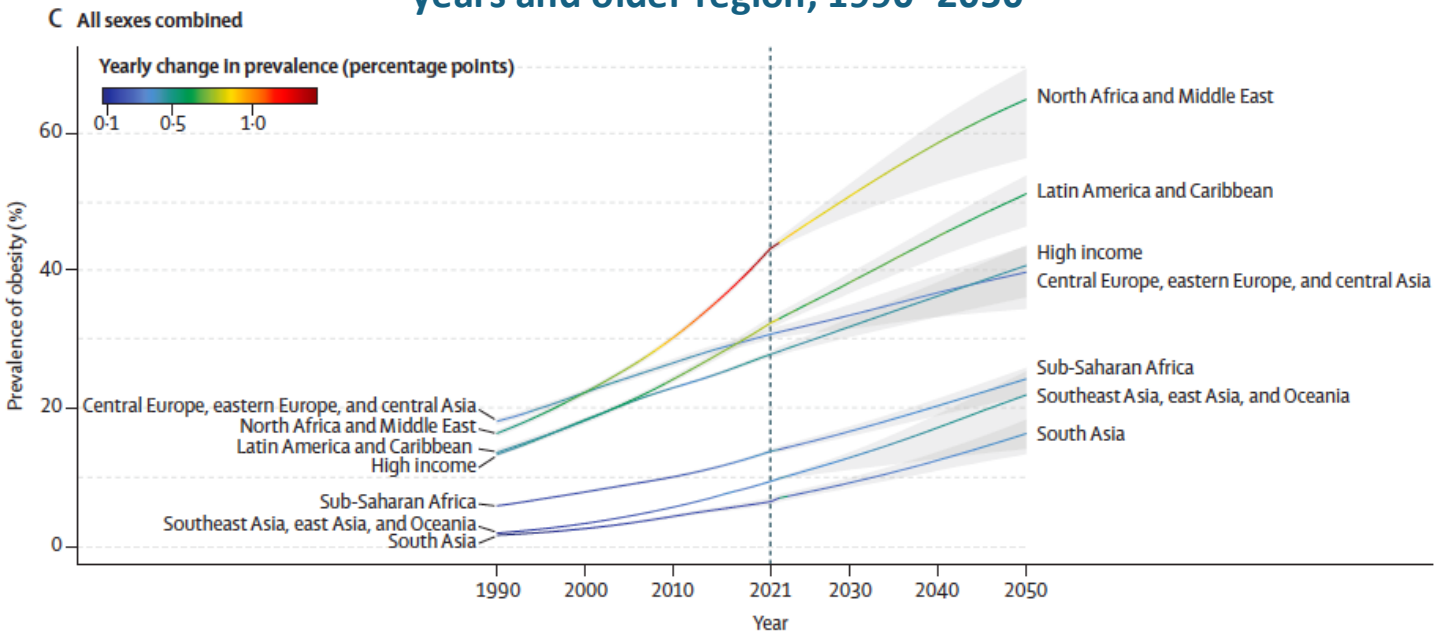
Obesity

- High-income English-speaking countries
- Northwestern Europe
- Southwestern Europe
- Central Europe
- Eastern Europe
- Southern Latin America
- Central Latin America
- Andean Latin America
- The Caribbean
- East Asia and the Pacific
- Southeast Asia
- South Asia
- Central Asia
- Middle East and north Africa
- Polynesia and Micronesia
- Melanesia
- East Africa
- West Africa
- Central and southern Africa
- Other sub-Saharan Africa

Data shown for women only; NCD Risk Factor Collaboration (NCD-RisC). The Lancet, 2024; 403(10431): 949–961

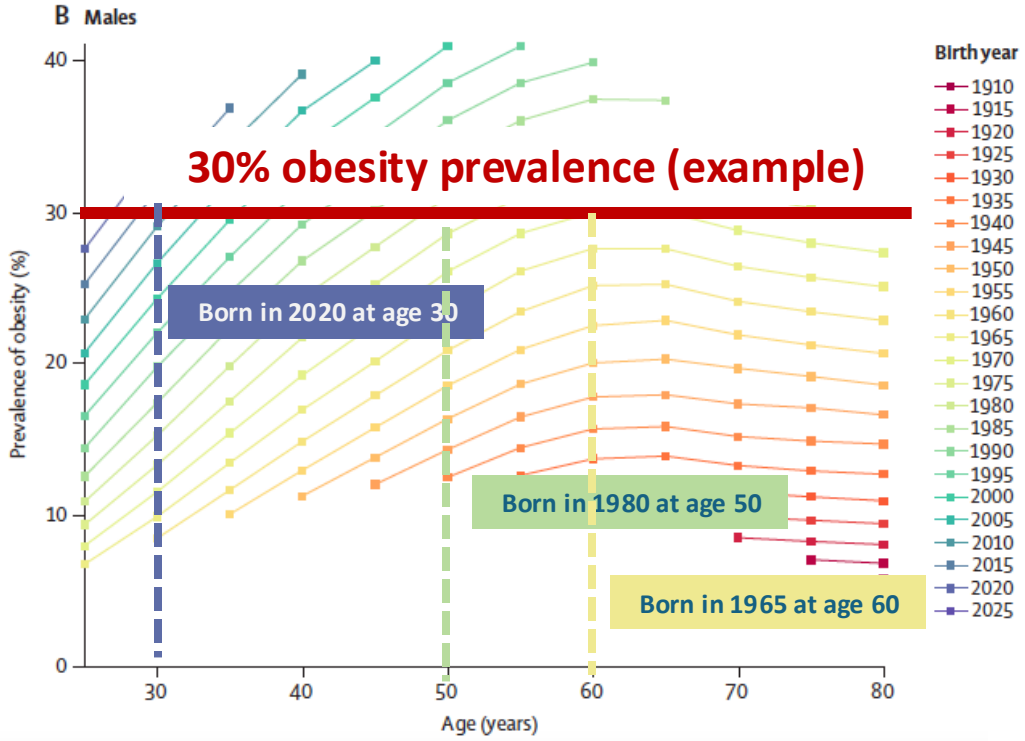
Obesity prevalence will continue to rise in the future and will reach peak prevalence at earlier age

Estimated age-standardised prevalence of obesity in adults aged 25 years and older region, 1990–2050



- North Africa and the Middle East had the sharpest increase: from 23.7% to 51.1% in women (1990 vs. 2021).
- A substantial rise was also observed in Latin America and the Caribbean.
- In the high-income countries, obesity increased from 14.7% to 29.8% in women (1990 vs. 2021).

Estimated prevalence of obesity by age across birth cohorts globally (males only)

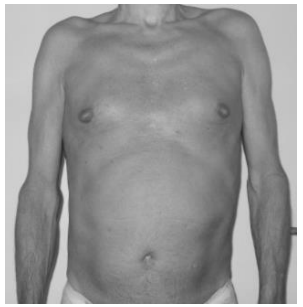


- In addition to the increase in age-specific prevalence over successive cohorts, each cohort also reached the peak prevalence of the previous cohort at an earlier age.

GBD 2021 Adult BMI Collaborators. Lancet. 2025;405(10481):813-838.

Anthropometric changes in people with HIV follow global trends in underweight and obesity

HIV



Global trends (prevalence, %)

AIDS wasting syndrome

Pre-ART era

AZT

Before 1996

Lipodystrophy

Early-ART era

1ST generation PIs, NRTIs and NNRTIs

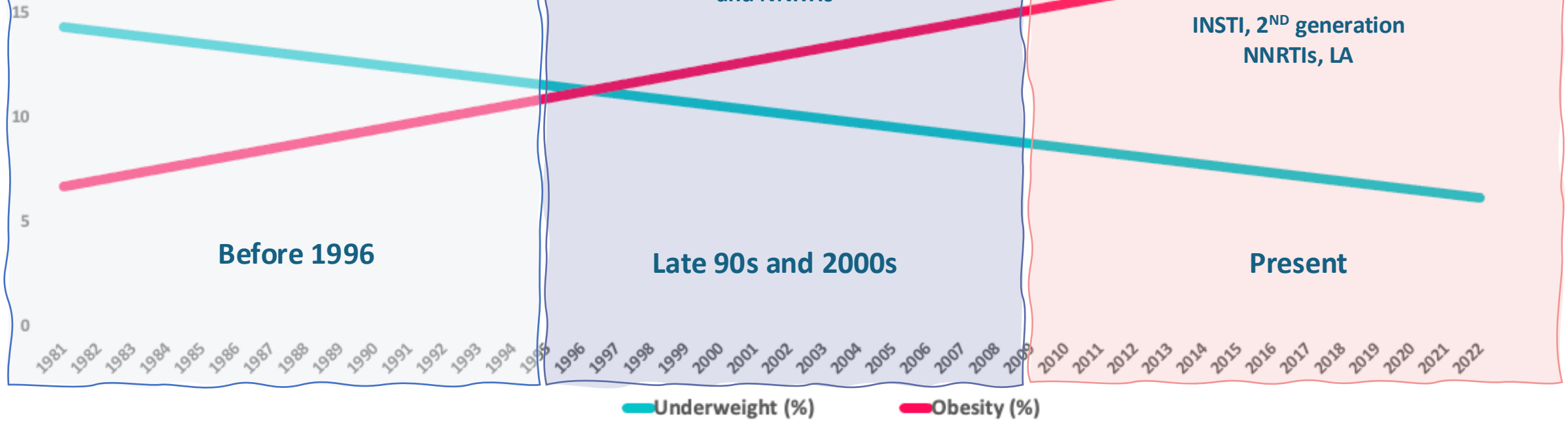
Late 90s and 2000s

Weight gain and obesity

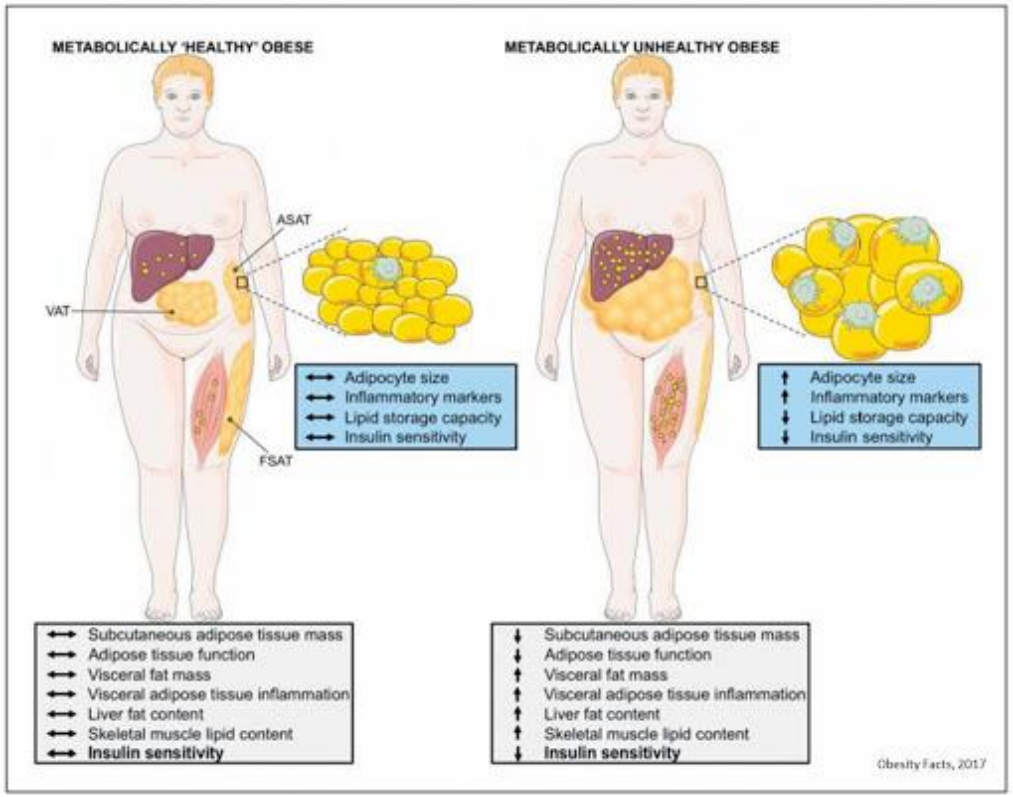
Modern-ART era

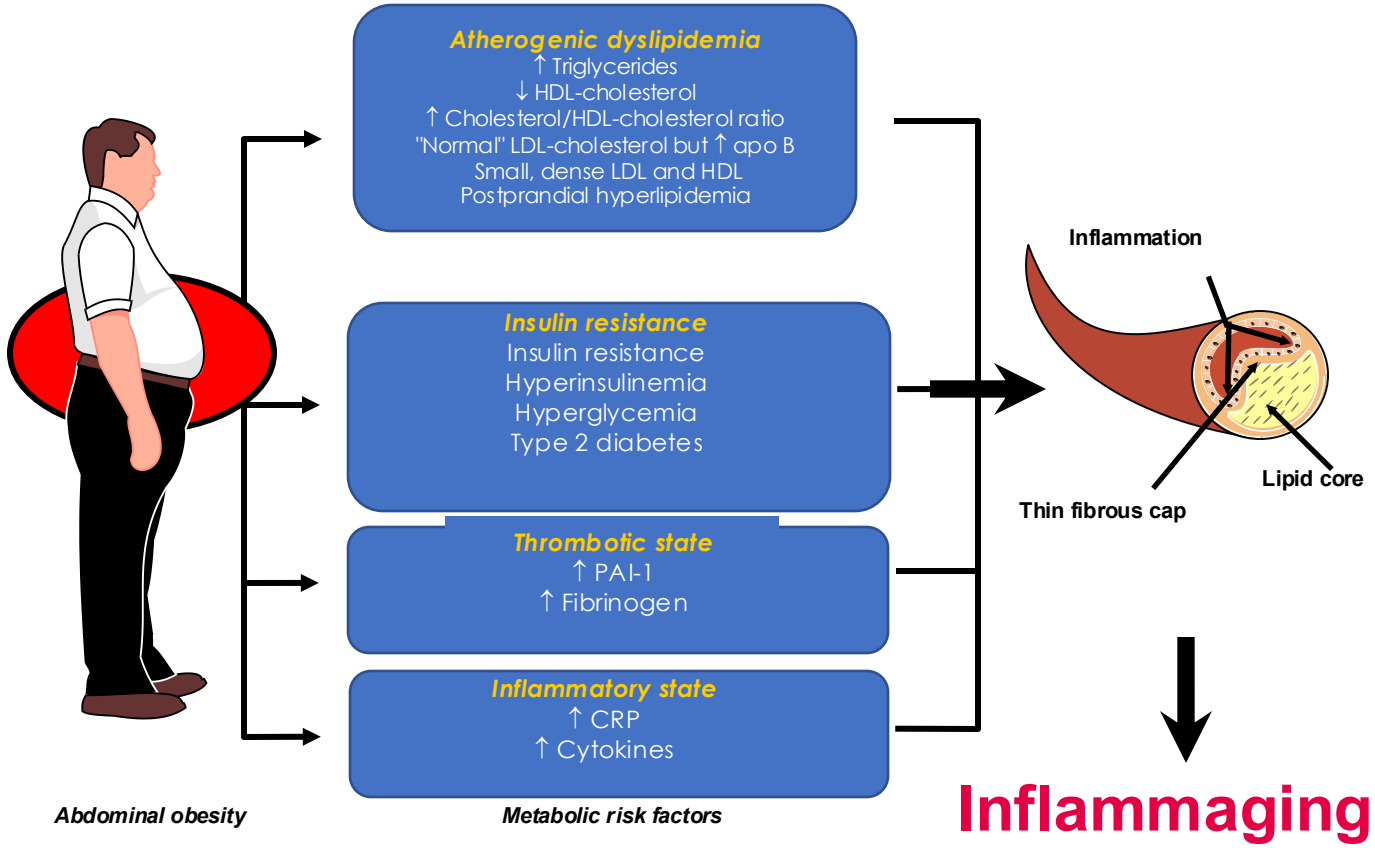
INSTI, 2ND generation NNRTIs, LA

Present



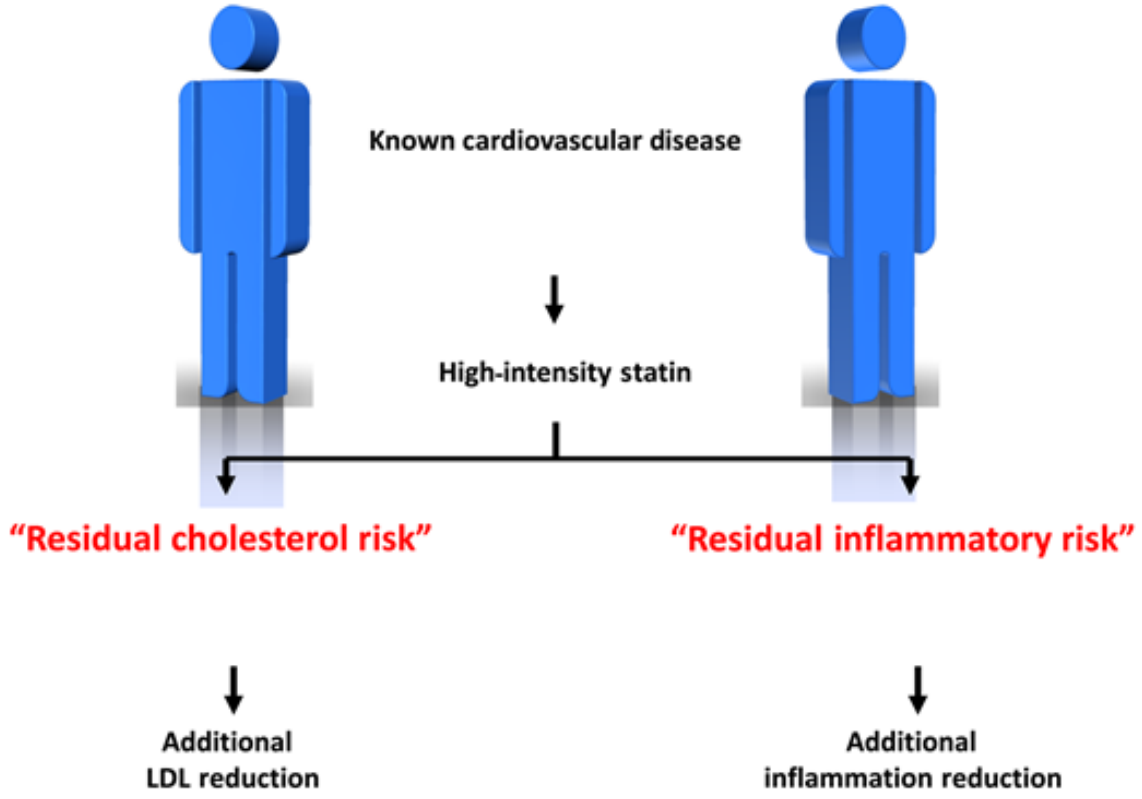
Fat quantity, quality and function





Modified from Lancet Diabetes Endocrinol **2019**
July 10, 2019 http://dx.doi.org/10.1016/ S2213-8587(19)30084-1

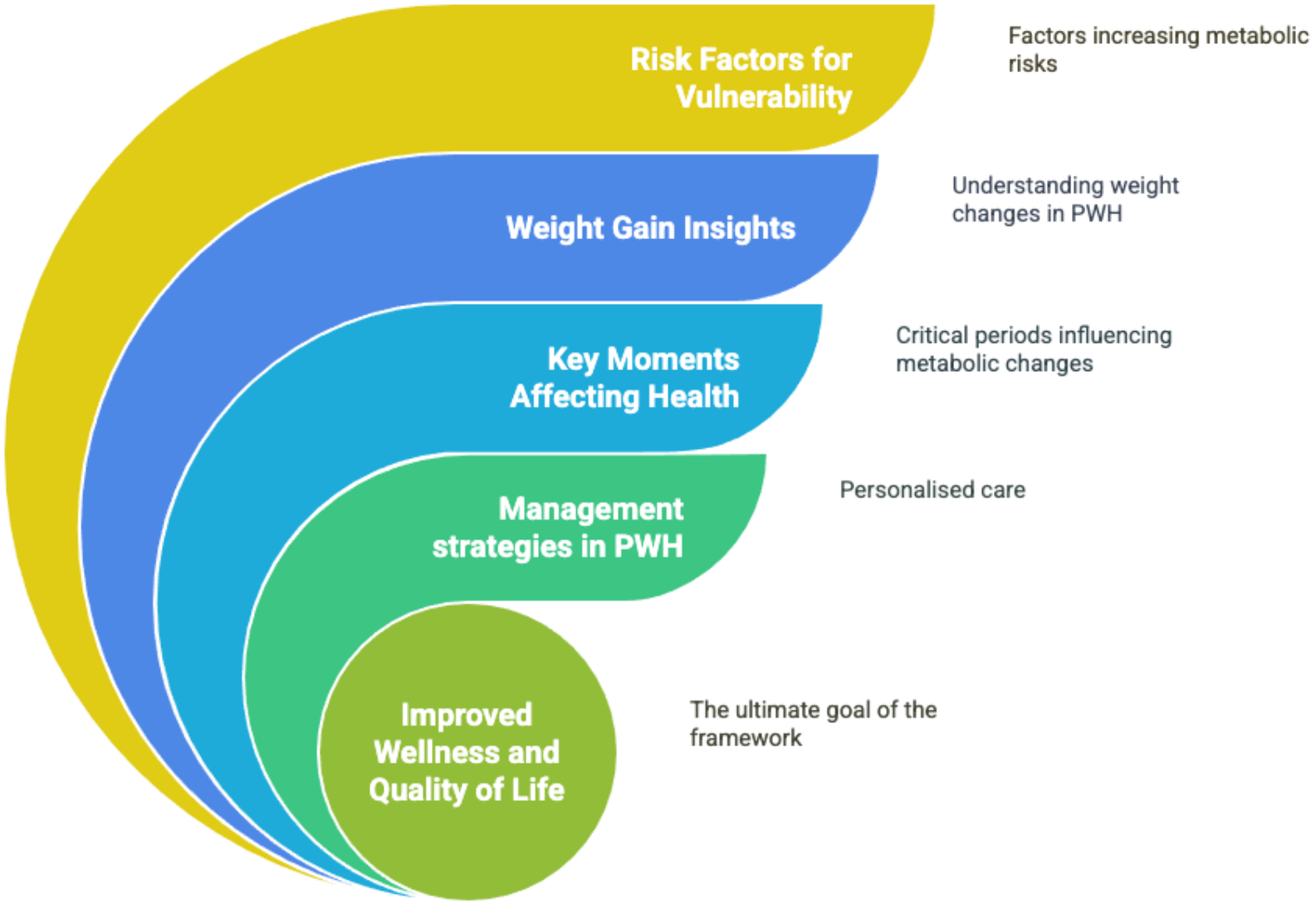
What drives Inflammaging: residual inflammatory risk



Modified from Ridker PM European Heart Journal 2016

Clinical Infectious Diseases
EDITORIAL COMMENTARY

A Metabolic Health Framework to Interpret Weight Gain Studies in People With Human Immunodeficiency Virus



Clinical Infectious Diseases
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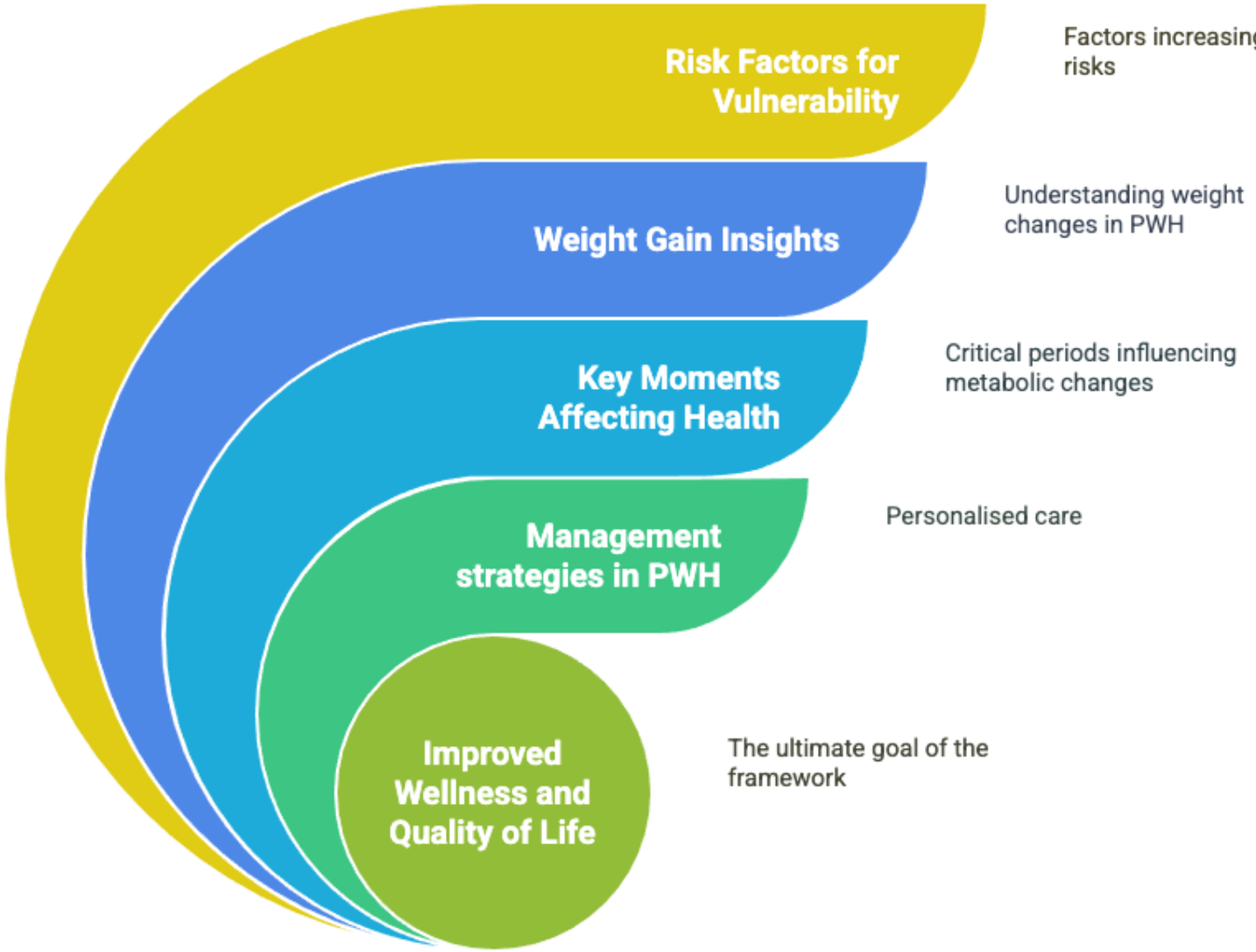


In a patient-centered approach, a **metabolic evaluation should always accompany the prescription of ART** to educate and consequently empower PWH to- ward healthy lifestyles.

WG control is a shared goal for both clinicians and patients, and it represents an opportunity to increase **comorbidity-free life expectancy and quality of life in PWH**

Re-Examining InSTI Effects on Weight Gain Among Treatment-Naïve People With HIV in North America

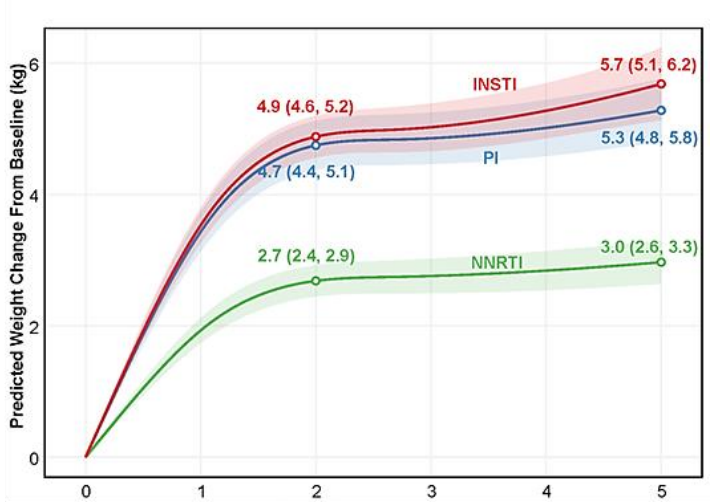
- **Background:**
  - Re-assessment of weight gain among ART-naïve PWH in NA-ACCORD, accounting for weight-suppressive agents and incorporating data on TAF and newer INSTIs

- **Results:**
  - Adult, TN PWH initiating INSTI, PI, or NNRTI-based ART with a dual-NRTI backbone from Jan 2007-Dec 2021 were included
  - N=32,514 median baseline values: age 41 years, BMI 25.4 kg/m^2, CD4 329 cells/uL, HIV RNA 4.6 log10 c/mL, 84% male, 45% Black
  - 10,406 started an INSTI-based ART, 13,500 an NNRTI, and 9,056 a PI
  - 72% started TDF/FTC, 12% ABC/3TC, and 11% TAF/FTC
  - 5-year predicted weight change from baseline was lower for NNRTI-based regimens vs. PIs and INSTIs overall, when including only TDF containing regimens, and when including or excluding EFV from the analysis
  - Among INSTIs, BIC (6.9 kg) was associated with the highest predicted weight change after 2 years, followed by DTG (5.3 kg), RAL (4.5 kg), and ELV/c (4.0 kg)
  - Black females experienced the most pronounced weight gain after starting DTG or BIC with TAF/FTC

- **Conclusions:**
  - Treatment-naïve PWH who initiated INSTI- or PI-based regimens in NA-ACCORD gained more weight than those starting NNRTIs, even after adjusting for NRTI backbone and excluding EFV
  - These results suggest that previously reported differences in weight gain between ART regimens may not be entirely explained by the weight suppressive effects of EFV and TDF

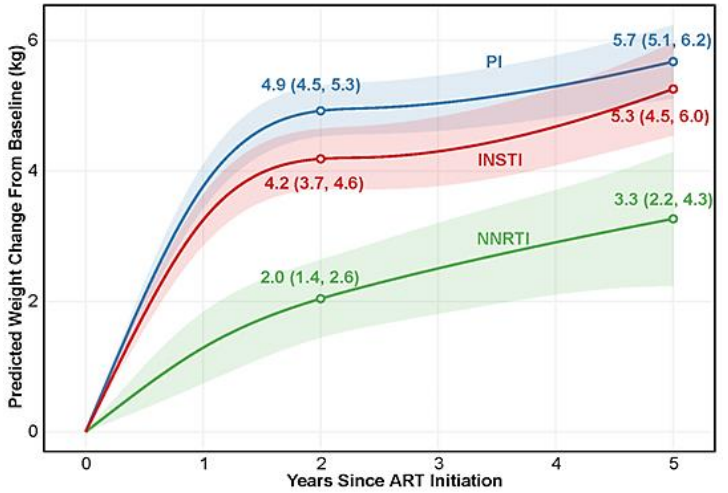
Change in Predicted Weight Over 5 years by ART Regimen

NNRTI: n=13,344
PI: n=8,876
INSTI: n=10,294



Change in Predicted Weight Over 5 Years By ART Regimen in Participants **Starting TDF and Excluding EFV**.

non-EFV NNRTI: n=1,792
PI: n=6,723
INSTI: n=4,457



KEY POINTS: Previously reported differences in weight gain between ART regimens may not be entirely explained by the weight-suppressive effects of EFV and TDF, suggesting an independent association between INSTI-based regimens and excessive weight gain in ART-naïve PWH

INSTI : integrase strand transfer Inhibitor ; HIV : human immunodeficiency virus ; ART : antiretroviral therapy ; PWH : people with HIV ;
NA-ACCORD : North American AIDS Cohort Collaboration on Research and Design ; TAF : tenofovir alafenamide ; TN : treatment naïve; PI : protease inhibitor ;
NNRTI : non-nucleoside reverse transcriptase inhibitors ; NRTI : nucleos(t)ide reverse transcriptase inhibitors ; BMI : body mass index ;
CD4 : cluster of differentiation 4 ; uL : microliter ; RNA : ribonucleic acid ; TDF : tenofovir disoproxil fumarate ; FTC : emtricitabine ; ABC : abacavir ;
3TC : lamivudine ; EFV : efavirenz ; BIC : bictegravir ; DTG : dolutegravir ; RAL : raltegravir ; ELV/c : elvitegravir/cobicistat,

Bourgi K, et al. Re-Examining InSTI Effects on Weight Gain Among Treatment-Naive People With HIV in North America
Poster presentation at CROI 2025. Abstract 891

Weight Gain After Initiating ART Close to HIV Seroconversion

Pantazis et al_**Lancet 2024**

CASCADE Collaboration

- **Objective**: examine **bodyweight trends** and **associated factors** among individuals with well estimated dates of **HIV-1 seroconversion**
- Inclusion: **stable (≥30 days) use of INSTI, NNRTI or PI** regimen initiated as **first-line therapy** ≥2007 within 12 months of seroconversion
- Of **5698 eligible individuals**, 48.8% initiated INSTI, 31.7% PI and 19.5% NNRTI. 76% originated from **Europe** or North America (***CASCADE*** Collaboration)

Conclusions

- **Our findings suggest a direct effect of INSTIs and tenofovir alafenamide on bodyweight gain, rather than a return to health effect.**
- **Given the known risk for cardiometabolic disease, bodyweight management needs to be part of the overall care of individuals prescribed these drugs**

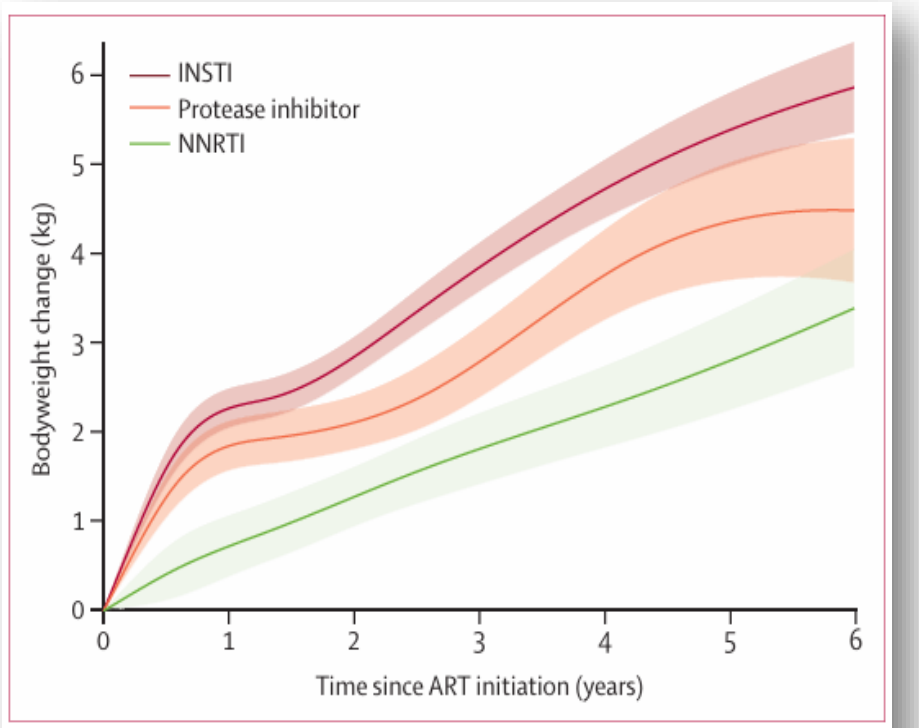


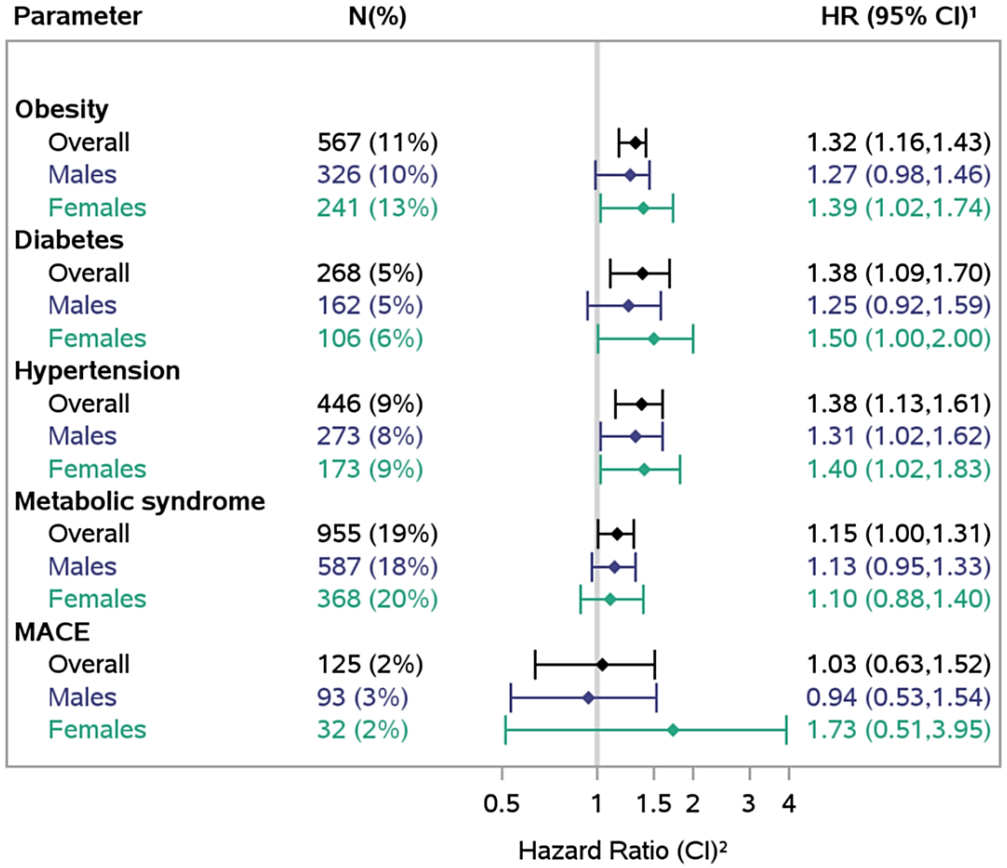
Figure 1: **Estimated bodyweight changes after ART initiation by ART class**
Estimates derived from a mixed model using restricted cubic splines of time since ART initiation to model mean bodyweight changes and shown for up to 6 years after baseline. Shaded areas represent 95% CIs. ART=antiretroviral therapy. INSTI=integrase strand transfer inhibitor. NNRTI=non-nucleoside reverse transcriptase inhibitor.

ART : antiretroviral therapy ; HIV : human immunodeficiency virus ; INSTI : integrase strand transfer Inhibitor ; NNRTI : non-nucleoside reverse transcriptase inhibitors ; PI : protease inhibitor

Risk of Obesity, Cardiometabolic Disease, and MACE after Switch to Integrase Inhibitors in **REPRIEVE**

- **Background:**
  - Target trial emulation to estimate the effect of switching to INSTI-based ART on incident obesity, DM, HTN, metabolic syndrome and MACE in ART-experienced PWH adjusted for age, sex, race, region, ASCVD, statin use, and BMI changes
- **Results:**
  - Of 5162 participants eligible for at least one trial; **2708 (52%) switched to an INSTI-based regimen (82% dolutegravir)**
  - 11% developed obesity, 5% diabetes, 9% HTN, 19% metabolic syndrome, and 2% experienced MACE
  - F/U was similar between groups; average time to event following INSTI switch ranged from 3.5 – 4 years depending on the outcome
  - In the INSTI group, increased hazards were observed for obesity (HR: 1.32), DM (HR: 1.38), HTN (HR: 1.38), and metabolic syndrome (HR: 1.15) but not MACE (HR: 1.03)
  - Results were similar when accounting for choice of NRTI and time-updated percent change in BMI
- **Conclusions:**
  - In this analysis from the REPRIEVE study, an increased risk of cardiometabolic complications was observed after accounting for BMI changes following a switch to INSTI-based ART over 5 years of follow-up

Estimated hazard of obesity, DM, HTN, metabolic syndrome, and MACE, among participants who switch to an INSTI-based regimen compared to non-switchers



Kileel EM, et al. Risk of Obesity, Cardiometabolic Disease, and MACE after Switch to Integrase Inhibitors in REPRIEVE Poster presentation at CROI 2025. Abstract 838

MACE: major adverse cardiovascular events; INSTI: integrase strand transfer Inhibitor; ART: antiretroviral therapy; DM: Diabetes Mellitus; HTN: hypertension; PWH: people with HIV; ASCVD: Atherosclerotic cardiovascular disease; BMI: body mass index; F/U: follow up; HR: hazard ratio; CI: confidence interval

Phase IV, open-label, multicentre, randomised clinical trial[1]

30 sites across Spain | Collaborative study between **Fundación SEIMC-GeSIDA** and ViiV Healthcare

Screening

- HIV-1 RNA <50 c/mL for ≥24 weeks
- Current ART containing >1 pill/day, cobi booster, EFV or TDF
- No prior VF or known/suspected resistance
- No prior DTG or BIC
- No chronic hepatitis B

Randomised 1:1

Stratified by BL TAF use and sex at birth

- **DTG/3TC (n=277)**
- **BIC/FTC/TAF (n=276)**

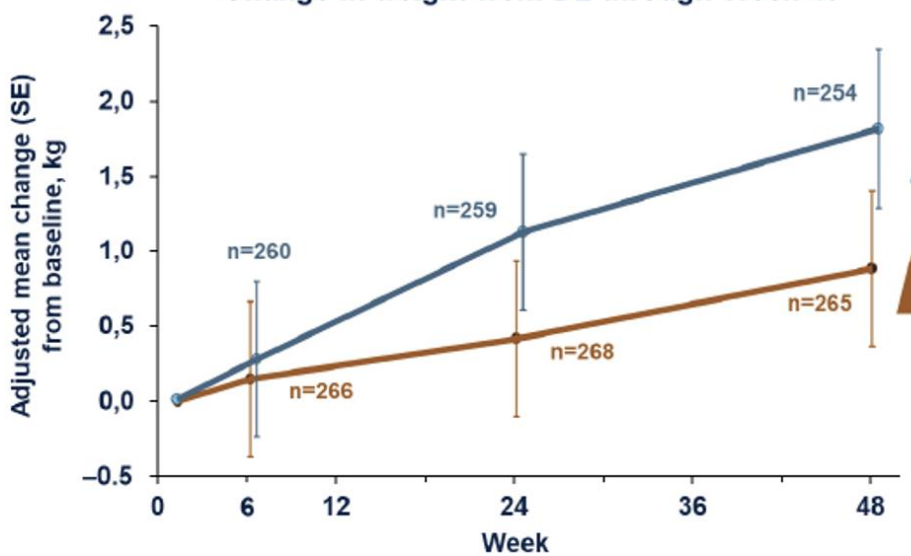
BL | Week 6 | Week 24 | Week 48 | Week 96

Primary endpoint: Participants with plasma HIV-1 RNA ≥50 c/mL (FDA Snapshot; non-inferiority margin 4%)
Key secondary endpoint: Weight change (study was powered to assess differences)

Other secondary endpoints include efficacy, safety, tolerability, immune recovery, metabolic parameters, kidney function, blood pressure, body composition and bone mineral density, PROs, and genotypic resistance analysis in case of virological failure

1. Switching to DTG/3TC demonstrated non-inferior efficacy than switching to BIC/FTC/TAF at 48 weeks.
2. DTG/3TC and BIC/FTC/TAF showed similarly high barrier to resistance.
3. DTG/3TC and BIC/FTC/TAF were both well tolerated, with exceptional discontinuations due to adverse effects.
4. Switching to BIC/FTC/TAF led to more weight gain than switching to DTG/3TC at 48 weeks.
5. Weight gain with BIC/FTC/TAF, but not with DTG/3TC, depended on the NRTI 1 in the ART regimen discontinued.

Change in weight from BL through Week 48

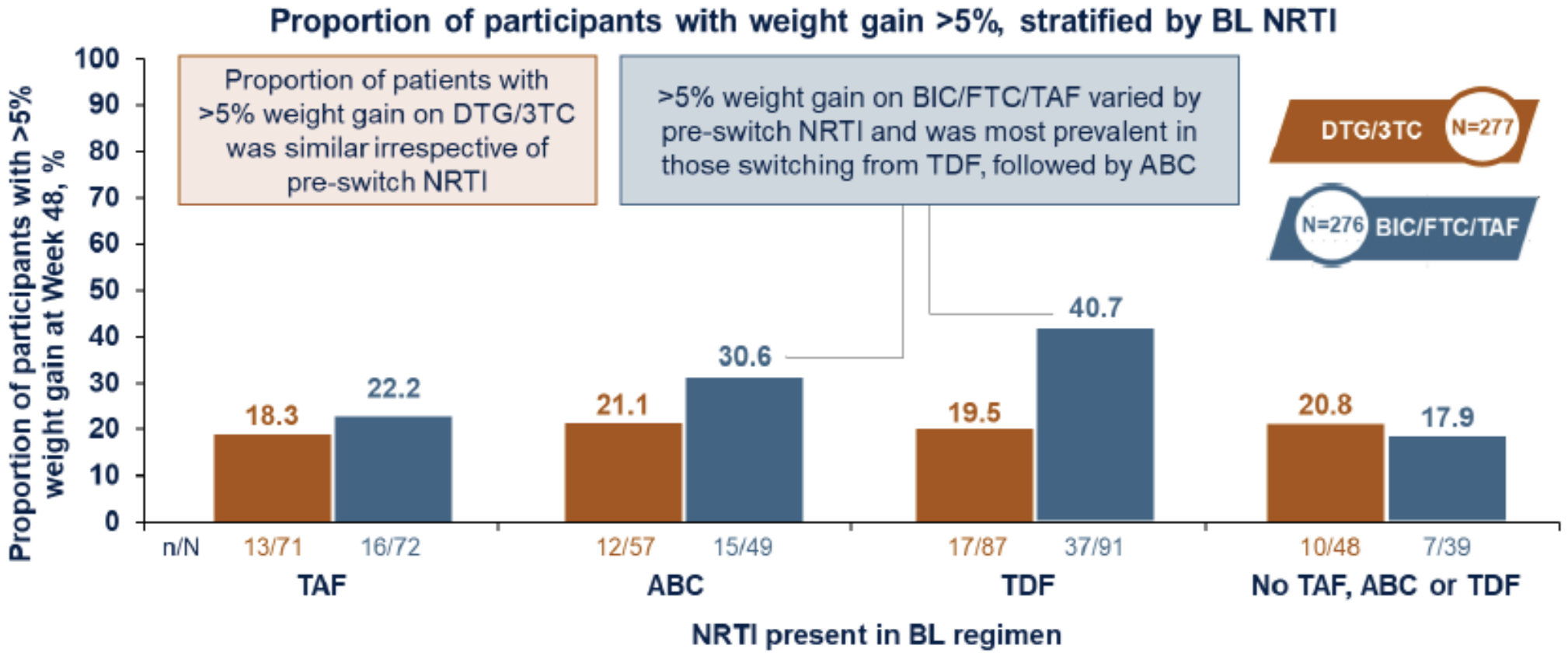


+1.81 kg on BIC/FTC/TAF

+0.89 kg on DTG/3TC

Mean adjusted difference:
+0.92 kg
(95% CI: 0.17, 1.66)
P=0.016

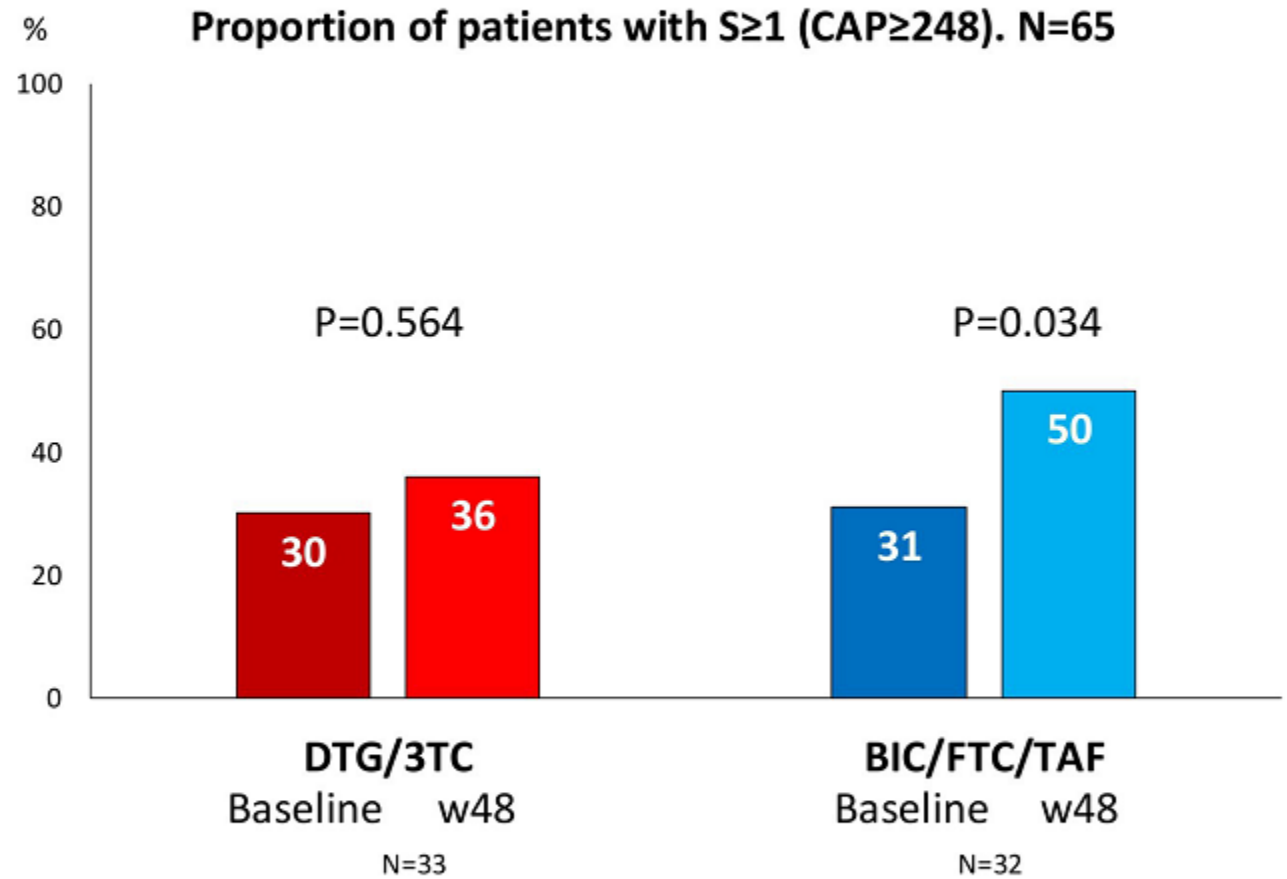
PASO-DOBLE Study: Weight Gain >5% by Pre-switch NRTI 1



25th International AIDS Conference; July 22-26, 2024; Munich, Germany

Ryan et al. AIDS 2024; Munich, Germany. Oral presentation OAB3606LB

Changes in the Proportion of PLWH With SLD According to Assigned Treatment. PLWH With Any Weight Gain



Weight Gain and Health-Related Quality of Life in PWH On ARV Therapy

- Retrospective observational study using data from the **Adelphi HIV Disease Specific Program (DSP)** – US database
- **225 PWH** were included in the analyses for comparison of HRQoL scores between ≥5% weight gain (N=54) and <5% weight gain (N=171) groups

✓ **PWH with ≥5% weight gain had lower Physical, Physical Function, and Psychosocial composite scores** as well as Total score indicating a **negative impact of adverse weight gain on HRQoL**

✓ The study findings highlight the **humanistic impact of adverse weight gain in PWH**, emphasizing the need to **monitor and consider weight gain in HIV management including selection of ART**

Metabolic health is a driver of the 4° 90% goal

HRQoL was assessed using the Impact of **Weight on Quality of Life-Lite-Clinical Trials (IWQoL-Lite-CT) questionnaire**

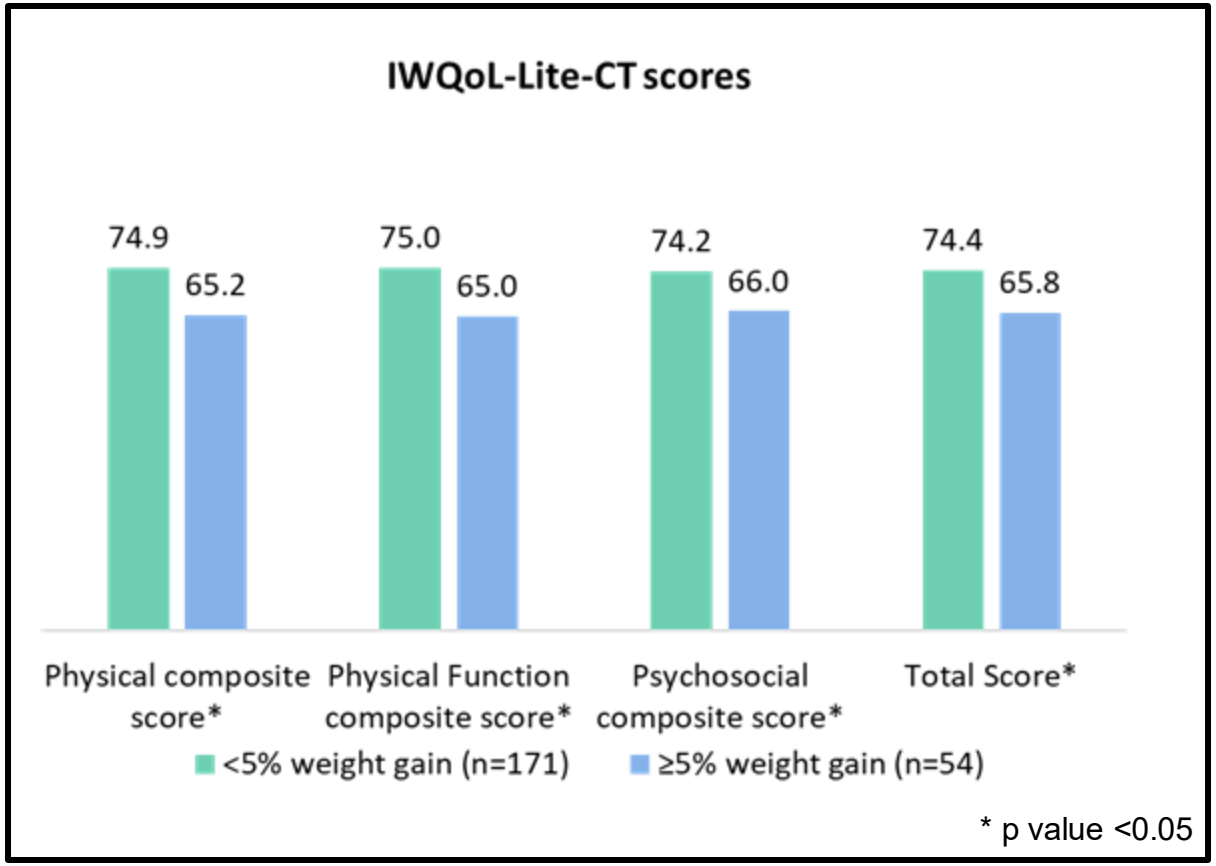
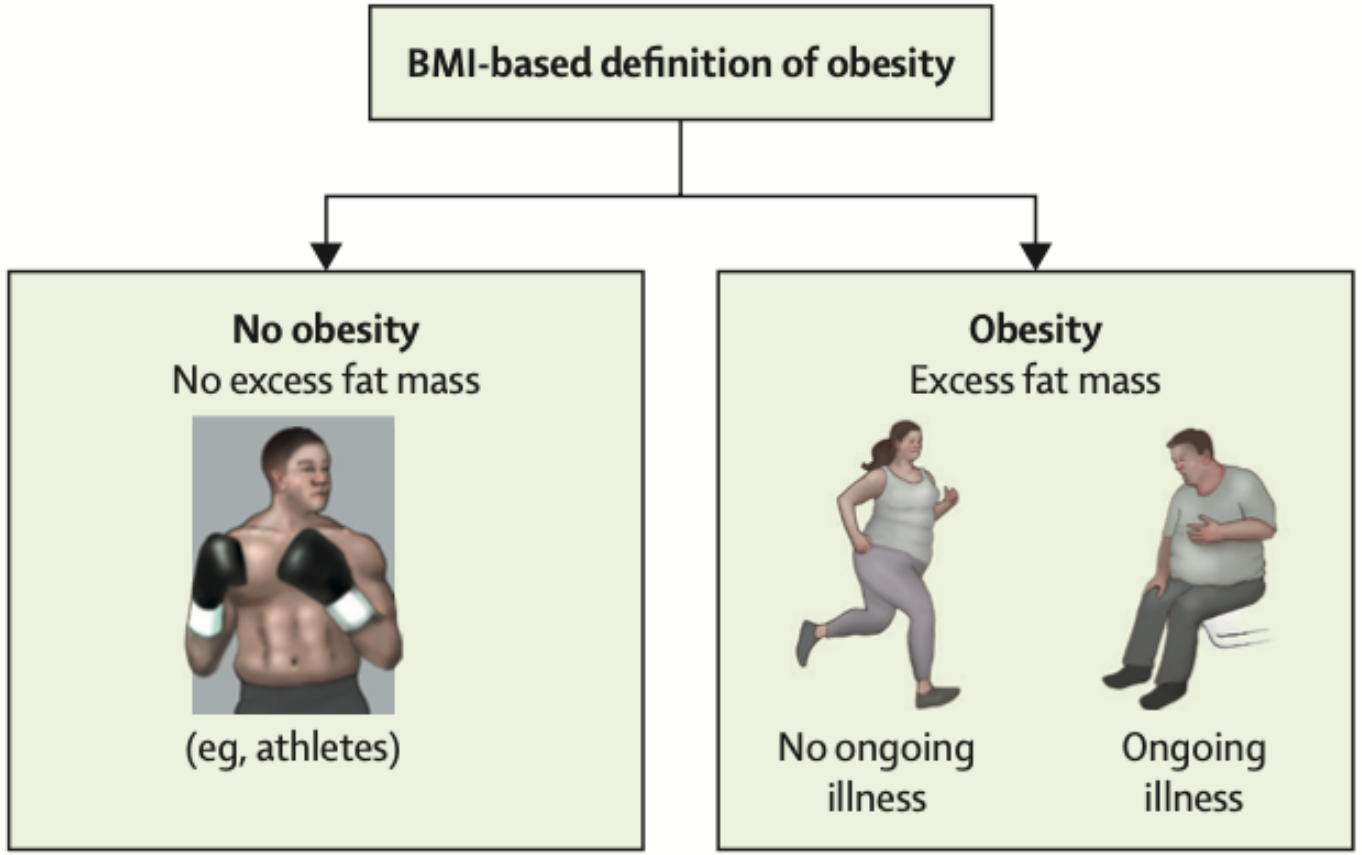


Figure 3a: HRQoL scores in PWH with ≥5% and <5% weight gain over 12 months

PWH: People with HIV; ARV: antiretroviral; HIV: human immunodeficiency virus; HRQoL: health-related quality of life; ART: Antiretroviral therapy

Tadese Weight Gain & QoL ***IAS 2024***

Limitations of the BMI-based definition of obesity



The current BMI-based definition of obesity (eg, BMI >30 kg/m2) can both underestimate and overestimate adiposity and underdiagnose and overdiagnose illness.

BMI does not differentiate between fat and lean mass and does not account for differences in fat distribution.

www.thelancet.com/diabetes-endocrinology
Published online January 14, 2025 https://doi.org/10.1016/S2213-8587(24)00316-4

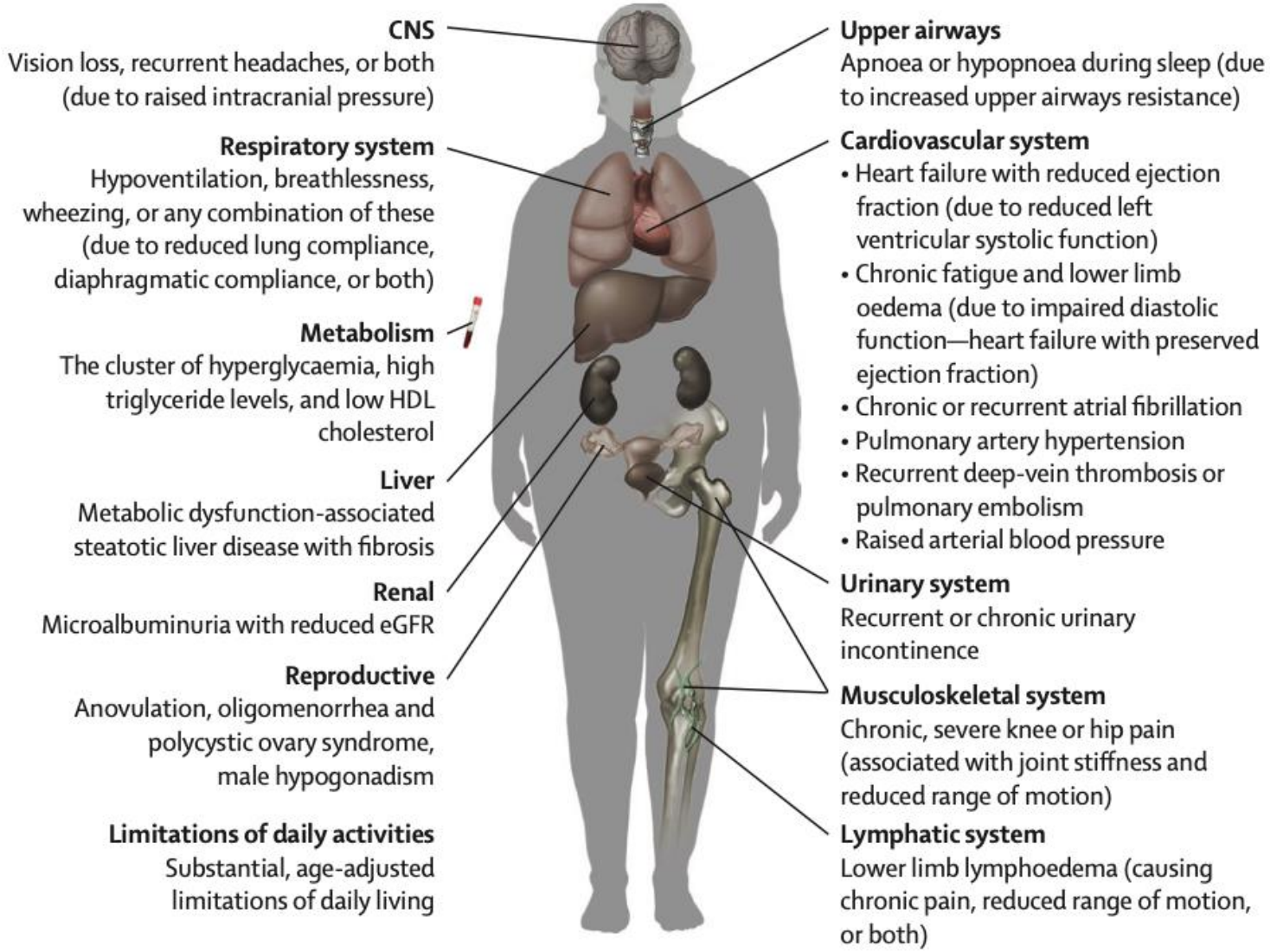
Diagnostic criteria for clinical obesity in adults

The diagnosis of **Clinical Obesity** requires:

a. **Clinical confirmation of obesity status by anthropometric criteria** or by direct body fat measurement, Plus one or both of the following criteria:

b. **Evidence of reduced organ/tissue function** due to obesity (ie, signs, symptoms and/or diagnostic tests showing abnormalities in the function of one or more tissue/organ system),

c. **Significant, age-adjusted limitations of day-to-day activities** reflecting the specific impact of obesity on mobility and/or other basic Activities of Daily Living (ADL=bathing, dressing, toileting, continence, eating)



CNS: central nervous system; HDL: High-Density Lipoprotein; eGFR: estimated glomerular filtration rate

www.thelancet.com/diabetes-endocrinology **Published online January 14, 2025 https://doi.org/10.1016/S2213-8587(24)00316-4**

Overweight and obesity management: Principles of care

1 Respect me

- **Ask** my permission to discuss topics around overweight and obesity.
- **Respect** my choices, even if you do not agree with them.
- **Do not assume** all my symptoms are caused by my weight or obesity.
- **Explore** my decisions sensitively, or delay discussions to another time, if I do not wish to talk about any issue you have raised.

2 Support me

- **Talk to me** in a sensitive, person-centred, developmentally appropriate and non-judgemental way.
- **Identify and explore** the terms I would prefer you to use.
- **Focus** on improvements in my health and wellbeing rather than simply talking about weight and obesity.
- **Stay positive**, supportive and solution based.
- **Take into account** my thoughts, views and cultural, religious or spiritual beliefs during our conversations.
- **Be mindful** of factors that apply to me that prevent or restrict weight loss (such as some medicines or comorbid conditions).
- **Ensure** my notes are up to date so other healthcare professionals know my views, what we have covered and agreed before, and why.

3 Know about my life

- **Think about** my family history and weight-related complications.
- **Be aware** of my weight history (and for children and young people, growth history), and previous experiences of related problems (such as eating disorders).
- **Take into account** my experiences of weight stigma, bullying and adverse experiences.
- **Think about** my family and personal context: daily life, ethnicity, culture, money worries, special needs and disabilities, mental health factors and stage in life.
- **Be aware** of my current medicine use and medical history.
- **Find out** if I am ready and able to engage with change. If not, how can you help me?
- **Talk about** how my friends and family can help (this is especially important for children and young people).

4 Help me when we talk

- **Use** non-stigmatising language and images.
- **Ensure** anything you give me to read or watch is suitable and tailored to my particular needs, such as Easy Read literature.
- **Ensure** conversations and communications are appropriate for my age, maturity and level of understanding. For children and young people make sure information is accurate for age (for example, BMI centile).
- **Give me time** to understand and process the information I have been given.
- **Ask me** if I have any questions, and make it clear you are happy for me to ask them either now or later on.

5 Understand how I feel

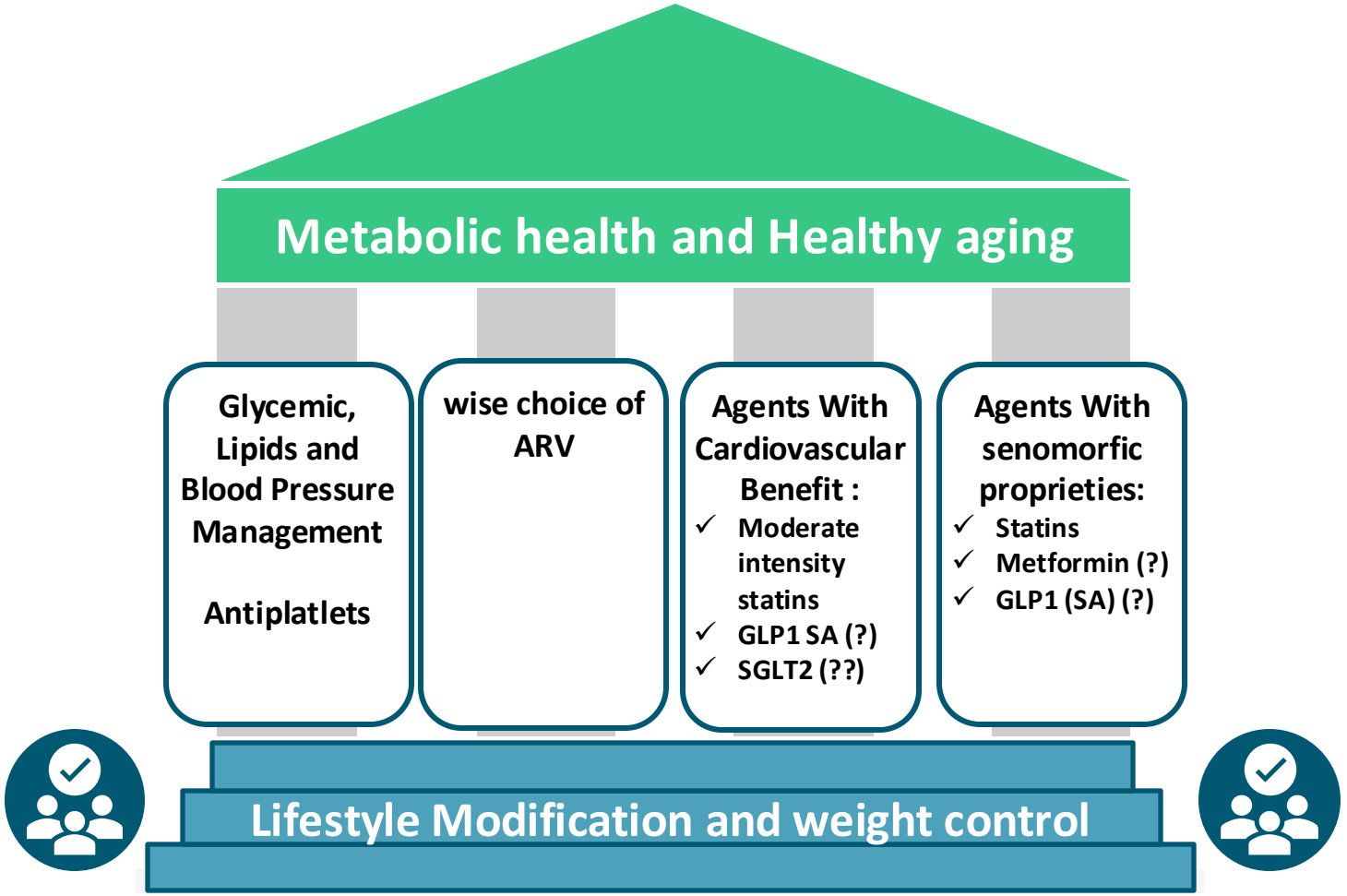
- **Think about** whether it is appropriate or important to discuss weight or obesity, or take measurements right now.
- **Think about** the impact on my body image or self esteem of taking measurements or the way they are done.
- **Understand** my weight may have been raised many times before.
- **Understand** that I might be affected by an eating disorder at any weight, and I might be vulnerable to disordered eating.
- **Be aware** of your own feelings, sensitivities and bias about weight and obesity.

NICE National Institute for Health and Care Excellence

This diagram covers only part of the guideline content. For full details, see NG246 Overweight and obesity management.

 Last updated January 2025. ISBN 978-1-4731-6741-4.

Multifactorial Approach to Metabolic Health in PWH



Impact of Geroscience on Therapeutic Strategies for Older Adults With Cardiovascular Disease

JACC Scientific Statement Vol.82, n.7, 2023

The Problem

Aging drives CVD via molecular damage, cellular senescence, inflammation ("inflammaging"), and decline of resilience mechanisms.

🧬 The Geroscience Hypothesis

Targeting aging biology can delay or prevent CVD, frailty, and multimorbidity.

🧪 Emerging Therapeutic Strategies

- **Non-pharmacologic**: Exercise, caloric restriction, healthy diet (Mediterranean).
- **Pharmacologic ("gerotherapeutics")**:
  - **Senolytics**: Remove senescent cells (dasatinib, quercetin, fisetin).
  - **Senomorphics**: Suppress harmful SASP signals (rapamycin, metformin).
  - **Metabolic drugs**: SGLT2 inhibitors, GLP-1 receptor agonists (including semaglutide, tirzepatide).
  - **NAD+ boosters**: Enhance DNA repair and mitochondrial function.

Statins reduce frailty in people with HIV

Jovana Milic[1], Alessandra Carobbio[2], Marianna Menozzi[1], Giuseppe Mancini[1], Gianluca Cuomo[1], Federico Motta[1], Chiara Mussi[3], Cristina Mussini[1], Paolo Raggi[4], Giada Sebastiani[5,6], *Giovanni Guaraldi[1]*

[1]Modena HIV Metabolic Clinic, UNIMORE, Italy; [2]Department of Medical and Surgical Sciences for Children and Adults, UNIMORE, Italy; [3] Department of Biomedical, Metabolic and Neural Sciences, UNIMORE, Italy; [4] Department of Medicine and Division of Cardiology, University of Alberta,, Canada; [5] Division of Gastroenterology and Hepatology and Chronic Viral Illness Service, McGill University Health Centre, Canada; [6] Division of Experimental Medicine, McGill University, Canada

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CROI Conference on Retroviruses and Opportunistic Infections

2025

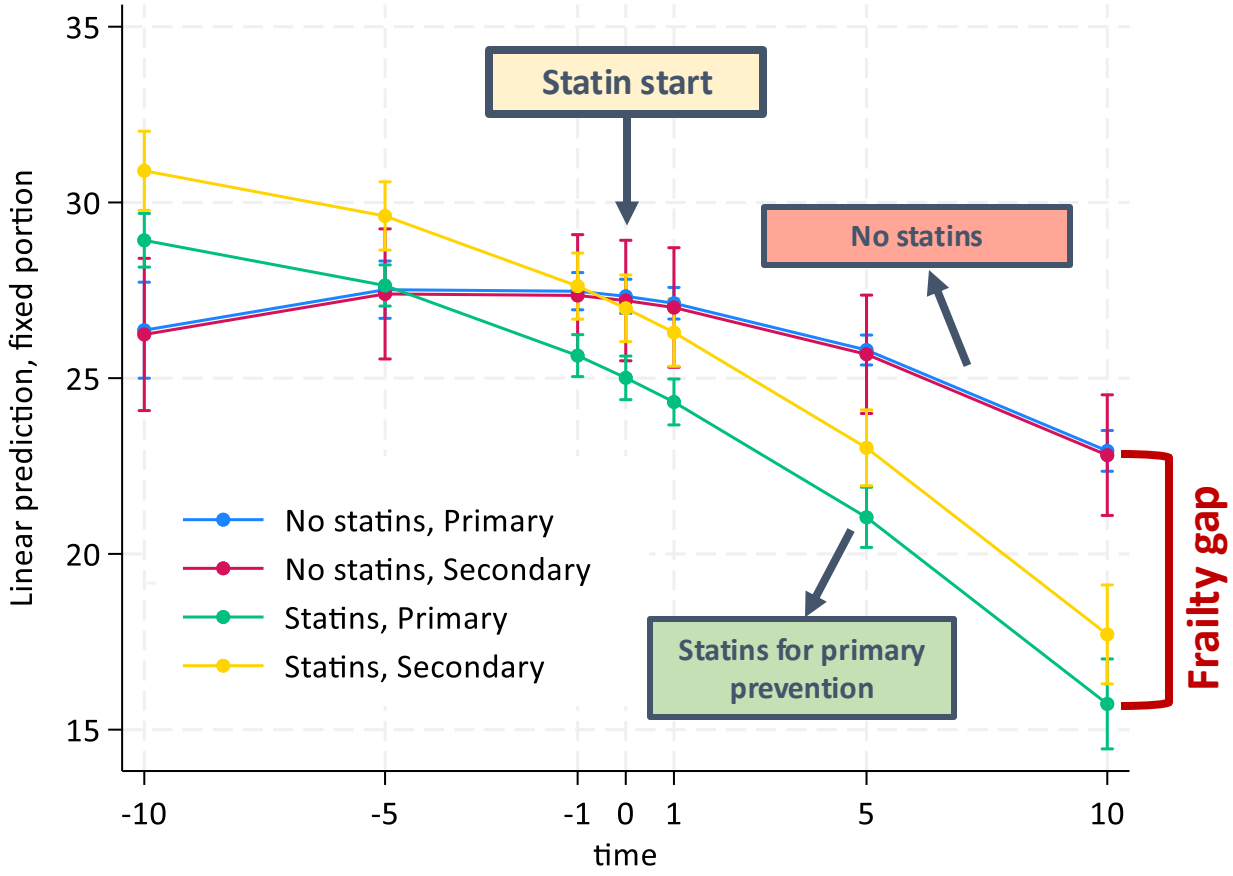
Objective

- to compare frailty trajectories, in people with HIV (PWH) who used statins for primary and secondary cardiovascular prevention with those who did not.

Summary

- Frailty trajectories were analyzed in **3,544 PWH** who used statins for primary and secondary cardiovascular prevention
- Follow-up: **7.5 years.**
- Statin use for **primary** prevention **reduces frailty by 2.33%** per year, suggesting **geroprotective effect** in PWH.
- Statin use for **secondary** prevention **increased frailty by 2.8%** per year.
- These effects were independent of cholesterol levels, achievement of LDL cholesterol targets, or cardiovascular risk stratification, suggesting **pleiotropic effect of statins.**

Linear predictions of frailty index with predictive margin of statins according to its use for primary and secondary prevention



*Milic J. Oral presentation #4, session **The statins breakthrough in HIV management,** 22 May, 11.10-12.10, Sala Antenore*

Epigenetic Clocks — What Are They?

- Epigenetic clocks estimate a person's **biological age** based on patterns of **DNA methylation** (chemical tags on DNA that regulate gene expression).
- They don't just count years - they try to measure *how fast* your body is aging at the molecular level.

Clock Generation	Example	Measures	Clinical Application
1st (Chronological)	Horvath, Hannum	Chronological age	Limited, research use
2nd (Mortality)	PhenoAge, GrimAge	Mortality, disease risk	Emerging, clinical trials
3rd (Pace of aging)	DunedinPACE	Current rate of biological aging	Research and trials, potential future clinical biomarker

Semaglutide stabilizes epigenetic aging in PWH-associated lipohypertrophy

CROI Conference on Retroviruses and Opportunistic Infections 2025

Rationale

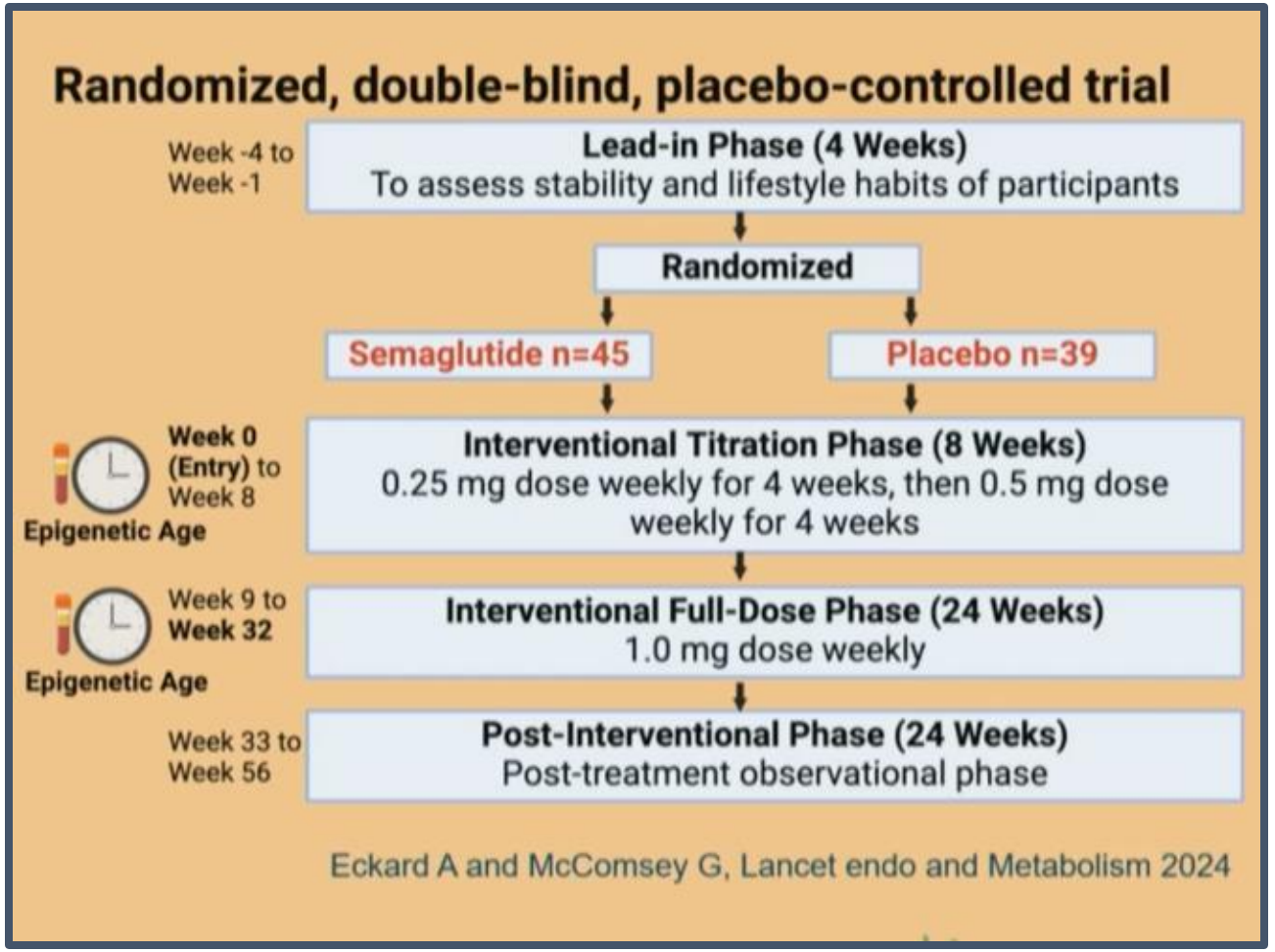
- 32-week double blind RCT showed significant effects of semaglutide on total and visceral adipose tissue quantity in HIV-associated lipohypertrophy.

Hypothesis

- Pleiotropic effects of semaglutide on biological aging may exist.

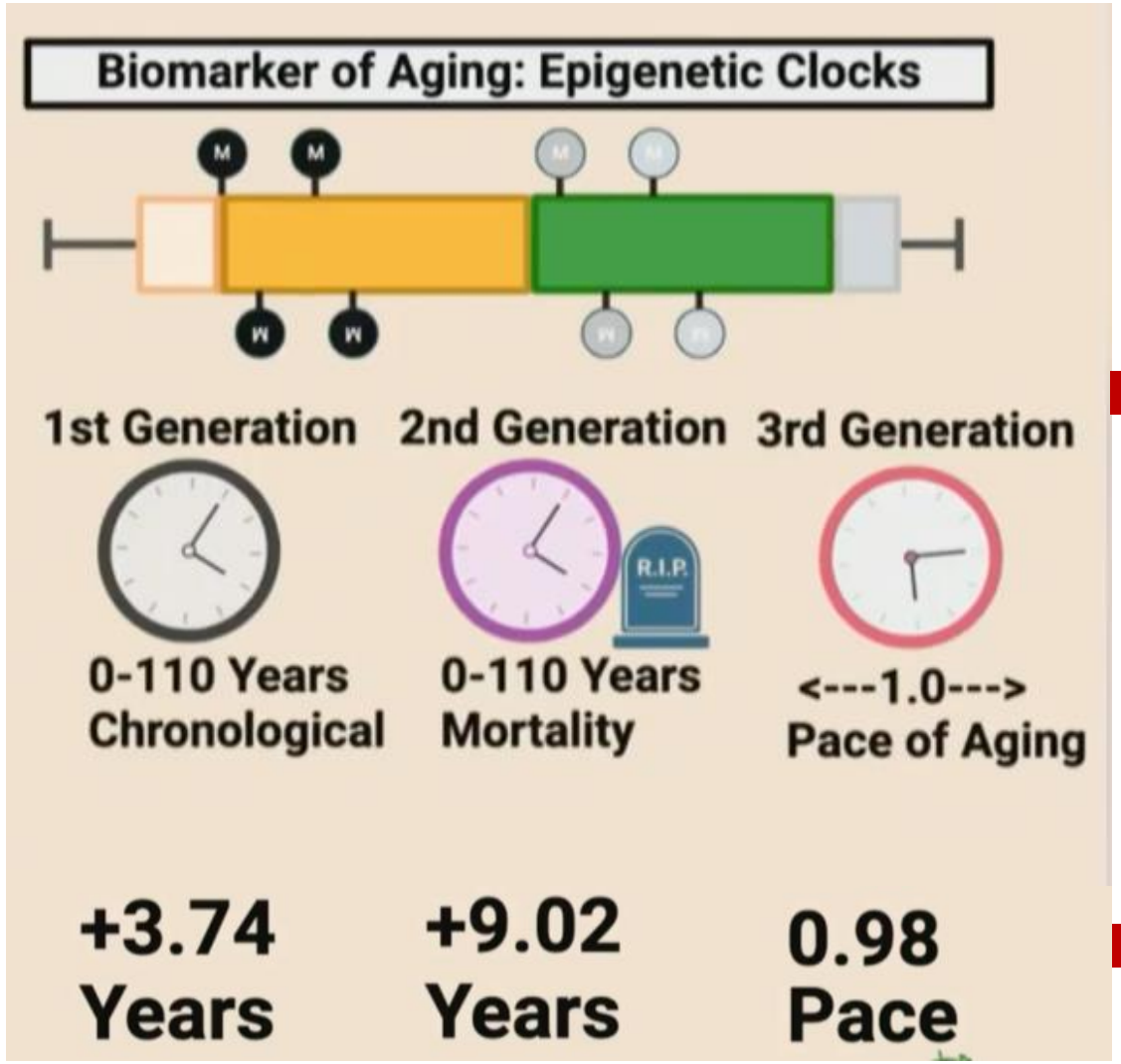
Objective

- To evaluate semaglutide's effects on epigenetic aging biomarkers in PWH



Corley MJ. OC-181, CROI 2025

Semaglutide stabilizes epigenetic aging in PWH-associated lipohypertrophy



32-week double blind RCT showed significant effects of semaglutide on total and visceral adipose tissue quantity in HIV-associated lipohypertrophy.

Outcome (Baseline -> 32 weeks)

1st, 2nd and 3rd generation epigenetic clock DNA methylation algorithms with a principal component-based approach were used to calculate epigenetic ages for participants at entry and 32 weeks

Main result

PWH showed an increased mean epigenetic age using both 1st and 2nd generation epigenetic clocks and stable pace of aging.

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Semaglutide stabilizes epigenetic aging in PWH-associated lipohypertrophy

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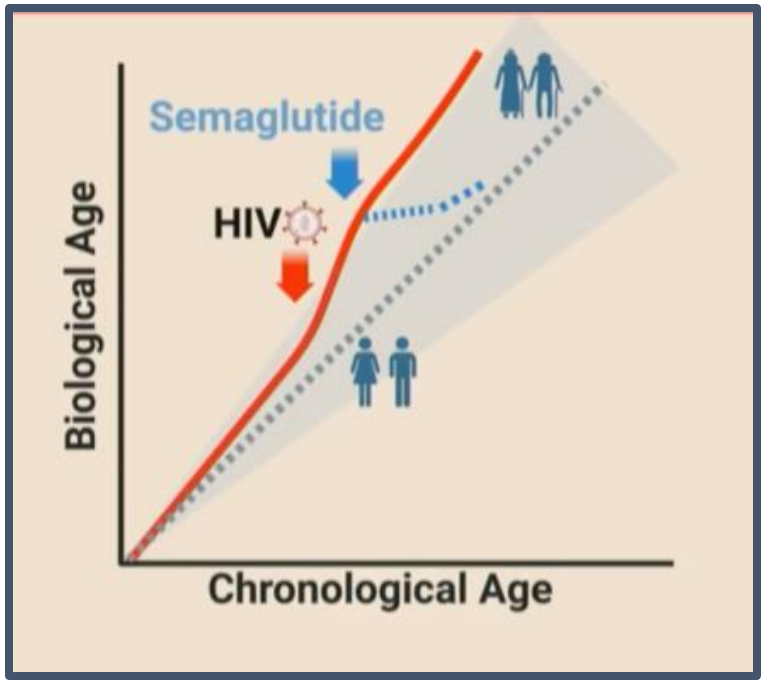
Semaglutide ~3 years ↓ in Annual Rate of Epigenetic Aging Mortality Risk

Predictor	Estimate	P-value	95% CI (Lower, Upper)
(Intercept)	5.6	0.11	[-1.36, 12.60]
Randomization	**-3.08**	**0.007**	**[-5.2876, -0.86]**
Sex	1.19	0.34	[-1.23, 3.48]
BMI	0.08	0.25	[-0.06, 0.25]
HsCRP	-0.0002	0.16	[-0.0004, 0.0001]
sCD163	0.002	0.029	[-0.008, -0.0005]

Semaglutide ~9% ↓ in Pace of Aging Compared to Placebo

Predictor	Estimate	P-value	95% CI (Lower, Upper)
(Intercept)	0.23	0.04	[0.005, 0.45]
Randomization	**-0.09**	**0.01**	**[-0.17, -0.02]**
Sex	0.03	0.45	[-0.05, 0.105]
BMI	-0.001	0.66	[-0.006, 0.004]
HsCRP	0.000006	0.09	[-0.000001, 0.000001]
sCD163	0.00003	0.63	[-0.0001, -0.00009]



Semaglutide stabilized epigenetic aging in PWH-associated lipohypertrophy over 32 weeks on treatment.

Corley MJ. OC-181, CROI 2025

Take home message

- **La salute metabolica è centrale per un invecchiamento sano** nelle persone con HIV e dovrebbe rappresentare un obiettivo prioritario nella cura a lungo termine.
- **L'aumento di peso associato alla terapia antiretrovirale (ART) è multifattoriale,** influenzato dalla classe farmacologica (in particolare INSTI e TAF), da caratteristiche individuali e dai determinanti sociali di salute.
- **Un aumento di peso non controllato ha un impatto negativo sulla qualità della vita** e aumenta il rischio di complicanze cardiometaboliche come diabete, ipertensione e sindrome metabolica.
- **Monitorare peso corporeo e composizione corporea,** soprattutto nella fase iniziale della ART, è fondamentale per guidare interventi tempestivi.
- Scelte terapeutiche personalizzate, interventi sullo stile di vita e terapie aggiuntive (es. agonisti del recettore GLP-1, statine) possono supportare la salute metabolica e migliorare gli esiti a lungo termine.
- Affrontare il rischio metabolico non è solo una necessità clinica: è una responsabilità condivisa tra operatori sanitari e pazienti per promuovere una **vita sana e una speranza di vita libera da comorbidità.**