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Interview by
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Prof. Jose' R. Arribas
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Stefano Rusconi:
We have here Prof. Arribas from Madrid. Where going to ask him three questions about today's ART- STR strategy. The first is: long-term data are derived from cohort studies. What's ongoing and what's the future?

Prof Arribas:
Okay, I think those studies are going to be important. So far I don't think we have enough patients exposed to less than 3-drug therapy will have definitive proof that, you know, that these have some benefits or some negative consequences derived from cohort data. But I think that as time goes by we will have enough patients exposed to less than 3-drugs; and it's going to be very interesting in the cohorts if, these drawbacks of, for example, monotherapy, low-level virological rebound, perhaps more inflammation, have any meaningful clinical impact in cohort studies.

Stefano Rusconi:
Thank you. And the second: how much time do we need to be convinced about the safety and the efficacy of this strategy as physicians? For example, registration randomised clinical trials versus therapeutic strategies?

Prof Arribas:
So, I think what really convinces clinicians is a well performed randomised clinical trial, and it's true that for these less than 3-drug regimens, we don't have trials with a sample size large enough for a registered clinical trial. With two important exceptions, I think: NEAT, an 800-(?) patient trial, and the Modern with Darunavir and Maraviroc is going to be also an 800 patient trial. And we have also a very important trial in rescue therapy, the second-line trial with

Lopinavir, Ritonavir and Raltegravir. So I think that the reasons clinicians are not convinced is because we didn't have enough trials like these. With monotherapy, if we don't have a large trial, but if we add up Monaid, Monoi, Protea, probably, you know, people will have a meta-analysis, and we can have, you know, really evidence for clinicians to decide if they want to use monotherapy or not.

Stefano Rusconi:
And the third one: do you think there is standard at least for recommending simplification drugs?

Prof Arribas:
Yeah, there is a lot of active research in… The word 'simplification' is difficult because some of these combinations, despite having less than 3 drugs, don't have just one single pill. So I tend not to use 'simplification'; even if it's true that for example, with the new 800 pill of Danuravir, monotherapy with Danuravir is going to be two pills, once-a-day, and that's going to be very close to simplification. But we are really looking here at trials with Danuravir, Ritonavir plus an intergrase inhibitor, Lopinavir, Ritonavir plus an intergase inhibitor and a very important boosted PI plus 3TC. I think that the dual therapy with 3TC, I think, are trials that could become very important in HIV therapy because we may learn that we use a boosted PI with 3TC is going to be all that I need to go with a boosted PI.

Stefano Rusconi:
So, to this extent, a PI boosted therapy will always be considered a cornerstone in this new approach?

Prof Arribas:
I think so because the data that we have with Nuc/aspirin and PI/ aspirin (?) are quite experimental. There are small pilot trials, and to me, really, playing with the number of drugs if there is not a boosted PI included, to me it sounds very risky.

Stefano Rusconi:
Thank you, Professor.