

# GUEST EDITORIAL

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At the outset, I would like to thank Professor Des Martin, outgoing President of the Southern African HIV Clinicians Society, for all he has done for our Society and in particular for the trust he has placed in the Paediatric Subcommittee. We wish him success in all his endeavours for the future.

This edition sees the publication of the 3rd version of the SAHIVS Paediatric Antiretroviral Therapy Guidelines (p. 18). Since the first version was published in November 2000, major changes have taken place in the arena of paediatric ART in South Africa. The Department of Health paediatric antiretroviral rollout is well under way, and although it had rather a slow start, it is our fervent wish that the rollout will go from strength to strength and that many, many more children will be placed on ART. To this end we have included a summary of the DOH Paediatric Antiretroviral Guidelines in this edition (p. 33), so that members of our society who are treating patients in the state sector can consult these as a ready reference. It should be stressed that people should consult the latest version of the DOH Guidelines, as previous editions are still in circulation.

Because of the existence of the excellent DOH Paediatric ART Guidelines for the state sector, our Committee experienced a dilemma as to what to include in our SAHIVS Paediatric ART Guidelines. We decided to direct our guidelines primarily at the private sector, where there are still a considerable number of patients on ART and where there is access to more resources than may be available in the State sector.

Anybody who peruses the numerous paediatric ART guidelines available worldwide will invariably find that each one uses a different paediatric HIV classification. Some use the CDC criteria and some the WHO criteria. The previous DOH guidelines used modified WHO criteria, and the WHO is in the process of preparing a new classification. This is

very confusing for people treating paediatric HIV and also makes it difficult to extrapolate between guidelines. Professor Mark Cotton's excellent article on the different HIV classification systems on p. 14 will bring some clarity to this really confusing subject.

Paediatric ART has always lagged behind adult ART in terms of the number of drugs available, dosages and pharmacokinetic studies. For this reason the excellent article discussing paediatric antiretroviral pharmacokinetics by Dr Edmund Capparelli and colleagues from the University of California, San Diego, is most welcome. As more and more data become available this topic is becoming less cloudy, and Dr Capparelli and colleagues have gone a long way towards clarifying this field for us.

Treating paediatric patients with ART is probably one of the most rewarding activities a doctor can become involved in. These children literally go from being critically ill to lovely healthy children. As one of the members of a workshop at which I was presenting said to me, 'There are only two side-effects from antiretroviral therapy in children – they get fat and they get naughty!' The beauty of treating children with ART is that they seem to get better clinically no matter how they respond in terms of viral load suppression. Professor Clive Gray of the National Institute for Communicable Disease (NICD) discusses the paediatric response to ART in his article on p. 42. However, adolescence is frequently a time when previously well controlled patients start to experience virological rebound. The usual reason for this is the poor adherence that typically occurs at this time as teenage patients establish their identities by rebelling against the status quo. Obviously this is very detrimental to their virological control. Disclosure of their HIV diagnosis is an essential component of maintaining good adherence in adolescence, and Aneesa Naeem-Sheik and Glenda Gray discuss this topic on p. 46.

One of the overseas reviewers of the SAHIVS Paediatric ART Guidelines commented on the fact that we don't discuss change of therapy much in our guideline. This is because we felt that changing therapy is a very complex issue and best left to people who are experts in this matter. We therefore encourage anybody who needs to change a patient's ART to consult with the SAHIVS, who will be able to refer you to the relevant experts in the field. It is hoped that the article on p. 38 shows the complexity of this issue and the reasons why we recommend consulting an expert.

Please remember that the guidelines in this journal must be seen as a guide. There is no substitute for expert advice, and the reader is encouraged to consult with the SAHIVS for a range of experts who will be able to help them in treating patients with ART. Paediatric patients are very rewarding to treat and respond dramatically to therapy. I would like to encourage everybody to go out and treat a child today!

**LEON LEVIN**  
*Guest Editor*

