# É tempo di ripensare l'approccio al rischio cardiovascolare nelle persone con HIV.

## It is time to rethink the approach to cardiovascular risk in people with HIV.

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For several years, people living with HIV infection (PWH) have had a life expectancy very close to that of the general population.

Among the causes of mortality, AIDS-related events are not the most frequent but rather non-infectious co-morbidities related to HIV infection. Of these, cardiovascular diseases are among the most frequent.

This stems from the fact that there is considerable evidence that PWH have twice the risk of developing cardiovascular events compared to the general population [1].

This fact depends on, and this has always been the most widespread assumption, that PWH have a higher prevalence of the classic risk factors associated with cardiovascular disease.

The results of the REPRIEVE study [2], very well commented on in this issue of JHA by the "minority report" of Tommasi et al [3], force this assumption to be partially revised.

The fact that pitavastatin treatment reduces the risk of events even in young, identified PWH at low risk for cardiovascular events, suggests that there is a factor at play that is at least as relevant as the common cardiovascular risk factors.

This factor is likely to be the persistent state of inflammation that endures even in PWH on suppressive antiretroviral treatment.

Even a major study in the general population showed, in a completely different setting of high-risk patients, that in those who were receiving statins, residual inflammatory risk (as measured by high-sensitivity C-reactive protein) was a stronger predictor of cardiovascular events, cardiovascular death, and death from all causes than the risk associated with high LDL-cholesterol levels [4].

As if to say that inflammation matters as much as dyslipidemia.

Taken together, these results indicate that perhaps the time has come to change the approach in research objectives as well, by investigating the role of drugs with an anti-inflammatory action.

Furthermore, it is increasingly crucial that there be a multidisciplinary approach, in which infectivologist and cardiologist work together, for the management of cardiovascular risk in PWH. ■

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