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## Letter to the Editor

# Immediate start of antiretroviral, why not?

Brazil has adopted universal antiretroviral treatment (ART) in 2013 as part of the strategy for the prevention of new infections.[1] In the following year UNAIDS launched the 90-90-90 goal aiming to end the AIDS epidemic by 2030.[2] In spite of evidence that prompt initiation of ART may benefit patients and the community,[3,4,5] access to ART in Brazil still faces different obstacles. This may be especially true for patients at acute phase of infections, a period of heightened transmission[4,5] and when treatment delay may impact future cure strategies.[6] Local difficulties to implement early treatment include referral services with limited first-time appointment or even closed for new cases, a scenario that results in long waiting periods. Moreover, some physicians at primary health units and even at specialized services opt to initiate ART only after lab exams results have turned out to rule out comorbidities, rather then initiating ART regimen and modifying it later as needed. Indeed, the same drugs are being used for post-exposure prophylaxis (PEP), prescribed without this information. Staging disease with CD4 T cell counts also does not justify waiting any longer,[1,7] except for patients with some clinical AIDS conditions associated to the risk of severe immune reconstitution syndrome, as when active tuberculosis or cryptococcosis are suspected.[7] All patients may benefit from treatment, in particular patients who report recent signs and symptoms compatible with Acute Retroviral Syndrome.[4,5] Even when elite controllers are considered (about 1% of the patients), ART may be subsequently suspended if necessary. Faced with the delays of our HIV treatment scenario, we report a curious and insightful way used by a patient to overcome the difficulties described above. One month after a negative HIV test with oral fluids purchased abroad, a 40-year-old Brazilian man who have sex with men presented with sore throat, cervical adenomegaly and asthenia. After medical consultation, he tested positive at chemiluminescence and rapid immunoblot, with a p31 negative band. With results obtained through the internet and aware through friends and other resources of the potential benefits of immediate treatment, but unable to have a same day consultation, he found out the same antiretroviral regimen is used for both initial treatment and PEP. He then sought an emergency room service, reporting recent risk exposure, but omitting the positive HIV test. No HIV testing was performed at this occasion and he started PEP on the same day, possibly still at Fiebig stage IV. As consultation after one month was not possible, he used this alternative once more. At the first regular visit he disclosed the situation and was prescribed therapy accordingly. This illustrates a creative way a patient used to circumvent administrative obstacles of some services. Simple changes based in scientific knowledge and common sense must be sought to improve current treatment access, particularly to a motivated patient, that is clearly recommended but still with limited application, albeit the potential benefit to patients and for controlling the HIV/AIDS epidemic.

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## Conflicts of interest

The author declares no conflicts of interest.

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