Lopinavir/Ritonavir (LPV/r, Kaletra)

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Formulations

Oral Solution

- [Kaletra] Lopinavir 80 mg/mL and ritonavir 20 mg/mL (contains 42.4% alcohol by volume and 15.3% propylene glycol by weight/volume)

Film-Coated Tablets

- [Kaletra] Lopinavir 100 mg/ritonavir 25 mg
- [Kaletra] Lopinavir 200 mg/ritonavir 50 mg

Generic Formulations

- Lopinavir 80 mg/mL and ritonavir 20 mg/mL oral solution (contains 42.4% alcohol by volume and 15.3% propylene glycol by weight/volume)
- Lopinavir 100 mg/ritonavir 25 mg oral tablet
- Lopinavir 200 mg/ritonavir 50 mg oral tablet

When using fixed-dose combination (FDC) tablets, refer to other sections of the Drug Appendix for information about the individual components of the FDC. See also Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents.

For additional information, see Drugs@FDA or DailyMed.

Dosing Recommendations

Neonate (Aged <14 Days) Dose

- Lopinavir/ritonavir (LPV/r) is not approved by the U.S. Food and Drug Administration (FDA) for use in neonates before a postmenstrual age of 42 weeks and a postnatal age of at least 14 days.

Dosing for Individuals Who Are Not Receiving Concomitant Nevirapine (NVP) or Efavirenz (EFV)

Infant (Aged 14 Days to 12 Months) Dose

- Once-daily dosing **is not recommended.**
- LPV/r 300 mg/75 mg per m^2 of body surface area per dose twice daily. This approximates LPV/r 16 mg/4 mg (both per kg body weight) twice daily. Use of this dose in infants aged <12 months is associated with lower lopinavir (LPV) trough levels than those found in adults; LPV dosing should be adjusted for growth at frequent intervals (see Pharmacokinetics and Dosing below).

Selected Adverse Events

- Gastrointestinal (GI) intolerance, nausea, vomiting, diarrhea, alteration of taste
- Hyperlipidemia, especially hypertriglyceridemia
- Elevated transaminases
- Hyperglycemia
- PR interval prolongation
- QT interval prolongation and Torsades de Pointes
- Risk of toxicity—including life-threatening cardiotoxicity—is increased in premature infants (see Major Toxicities below).

Special Instructions

- LPV/r tablets can be administered without regard to food; administration with or after meals may enhance GI tolerability.

Child and Adolescent (Aged >12 Months to ≤18 Years) Dose

- Once-daily dosing **is not recommended.**
- LPV/r 300 mg/75 mg per m^2 of body surface area per dose twice daily (maximum dose LPV/r 400 mg/100 mg twice daily, except as noted below). For patients weighing <15 kg, this dose approximates LPV/r 13 mg/3.25 mg (both per kg body weight) twice daily. For patients weighing ≥15 kg to 45 kg, this dose approximates LPV/r 11 mg/2.75 mg (both per kg body weight) twice daily. This dose is routinely used by many clinicians and is the preferred dose for antiretroviral therapy–experienced patients who could harbor virus with decreased LPV susceptibility (see Pharmacokinetics and Dosing below).
- LPV/r 230 mg/57.5 mg per m^2 of body surface area per dose twice daily can be used in antiretroviral (ARV)-naive patients aged >12 months. For patients weighing <15 kg, this dose approximates LPV/r 12 mg/3 mg per kg body weight given twice daily. For patients weighing ≥15 kg to 40 kg, this dose approximates LPV/r 10 mg/2.5 mg per kg body weight given twice daily. This lower dose **should not be used** in treatment-experienced patients who could harbor virus with decreased LPV susceptibility.
- See the table below for weight-band dosing when using tablets.

Adult (Aged ≥18 Years) Dose

- LPV/r 800 mg/200 mg once daily; *or*
- LPV/r 400 mg/100 mg twice daily
- **Do not use** once-daily dosing in patients receiving concomitant therapy with NVP or EFV, or patients with three or more LPV-associated mutations (see Special Instructions for a list of mutations).

Dosing for Individuals Receiving Concomitant NVP or EFV

- These drugs induce LPV metabolism and reduce LPV plasma levels. Increased LPV/r dosing is required with concomitant administration of these drugs. Once-daily dosing **should not be used** in these patients.

Infant (Aged 14 Days to 12 Months) Dose

- Once-daily dosing **is not recommended.**
- LPV/r 300 mg/75 mg per m^2 of body surface area per dose twice daily. This approximates LPV/r 16 mg/4 mg (both per kg body weight) twice daily. Use of this dose in infants aged <12 months is associated with lower lopinavir (LPV) trough levels than those found in adults; LPV dosing should be adjusted for growth at frequent intervals (see Pharmacokinetics and Dosing below).
- LPV/r tablets must be swallowed whole. **Do not crush or split tablets.**
- LPV/r oral solution should be administered with food because a high-fat meal increases absorption.
- The poor palatability of LPV/r oral solution is difficult to mask with flavorings or foods (see Formulations below).
- LPV/r oral solution can be kept at room temperature (up to 77ºF or 25ºC) if used within 2 months. If kept refrigerated (36ºF to 46ºF or 2ºC to 8ºC), LPV/r oral solution remains stable until the expiration date printed on the label.
- Children aged <18 years who receive once-daily dosing of LPV/r have shown considerable variability in plasma concentrations and have a higher incidence of diarrhea. Therefore, once-daily dosing **is not recommended** for this age group.
- **Do not use** once-daily dosing in patients receiving concomitant therapy with NVP or EFV.
- Use of LPV/r once daily is **contraindicated** if three or more of the following LPV resistance–associated substitutions are present: L10F/I/R/V, K20M/N/R, L24I, L33F, M36I, I47V, G48V, I54L/T/V, V82A/C/F/S/T, and I84V. This is because higher LPV trough concentrations may be required to suppress resistant virus.

Metabolism/Elimination

- Cytochrome P450 (CYP) 3A4 substrate and inhibitor. LPV/r **is contraindicated** with (1) drugs that are highly dependent on CYP3A4 for clearance and for which elevated plasma concentrations are associated with serious and/or life-threatening reactions; and (2) drugs that are potent CYP3A inducers for which significantly reduced LPV plasma concentrations may be associated with the potential for loss of virologic response and possible resistance and cross-resistance.
- LPV/r is eliminated primarily by hepatic metabolism. Use caution when administering LPV to patients with hepatic impairment, because LPV concentrations may be increased. No dosing information is currently available for children or adults with hepatic insufficiency.

Child and Adolescent (Aged >12 Months to ≤18 Years) Dose

- Once-daily dosing **is not recommended.**
- LPV/r 300 mg/75 mg per m^2 of body surface area per dose twice daily. See the table below for weight-band dosing when using tablets.

Adult (Aged ≥18 Years) Dose

- The FDA-approved dose is LPV/r 500 mg/125 mg twice daily, given as a combination of two tablets of LPV/r 200 mg/50 mg and one tablet of LPV/r 100 mg/25 mg. Alternatively, three tablets of LPV/r 200 mg/50 mg can be used for ease of dosing.
- Once-daily dosing **should not be used.**

LPV/r Used in Combination With Maraviroc (MVC)

- MVC doses may need modification (see the HIV Drug Interaction Checker) and the Maraviroc section.

Weight-Band Dosing for LPV/r 100-mg/25-mg Pediatric Tablets in Children and Adolescents

Recommended Number of LPV/r 100-mg/25-mg Tablets Given Twice Daily		
Dosing target	300 mg/m^2 per dose given twice daily	230 mg/m^2 per dose given twice daily
Body Weight		
15 kg to 20 kg	2	2
>20 kg to 25 kg	3	2
>25 kg to 30 kg	3	3
>30 kg to 35 kg	4[a]	3
>35 kg to 45 kg	4[a]	4[a]
>45 kg	4[a] or 5[b]	4[a]

[a] Two tablets that each contain LPV/r 200 mg/50 mg can be substituted for the four LPV/r 100-mg/25-mg tablets in children who are capable of swallowing a larger tablet.

[b] In patients who weigh >45 kg and who are receiving concomitant NVP or EFV, the FDA-approved adult dose is LPV/r 500 mg/125 mg twice daily, given as a combination of two tablets of LPV/r 200 mg/50 mg and one tablet of LPV/r 100 mg/25 mg. Alternatively, three tablets of LPV/r 200 mg/50 mg can be used for ease of dosing.

- In the coformulation of LPV/r, ritonavir (RTV) acts as a pharmacokinetic enhancer, not as an ARV agent. RTV inhibits the metabolism of LPV and increases LPV plasma concentrations.

Drug Interactions

Additional information about drug interactions is available in the Adult and Adolescent Antiretroviral Guidelines and the HIV Drug Interaction Checker.

- *Metabolism:* Lopinavir/ritonavir (LPV/r) is a cytochrome P450 (CYP) 3A4 substrate and inhibitor with the potential for multiple drug interactions. Coadministering LPV/r with drugs that induce CYP3A4 may decrease lopinavir (LPV) plasma concentrations, whereas coadministering LPV/r with other CYP3A4 inhibitors may increase LPV plasma concentrations. Coadministering LPV/r with other CYP3A4 substrates may require dose adjustments and additional monitoring.

Before initiating therapy with LPV/r, a patient's medication profile should be carefully reviewed for potential drug interactions. In patients treated with LPV/r, fluticasone (a commonly used inhaled and intranasal steroid) should be avoided, and an alternative steroid should be used. Fluticasone is a CYP3A substrate and LPV/r significantly increases fluticasone exposures, potentially resulting in adverse systemic corticosteroid effects including Cushing's syndrome and adrenal suppression.[1] Drug interactions with antituberculous drugs are common. Coadministration of LPV/r with the antituberculosis drug rifampin—a strong CYP3A4 inducer—may lead to suboptimal LPV levels.[2-4] Patients who are receiving both LPV/r and antituberculous drugs may need a dose adjustment for LPV/r, or they may need to switch to an antiretroviral (ARV) regimen that does not include LPV/r.

Major Toxicities

- *More common:* Diarrhea, headache, asthenia, nausea and vomiting, rash, insulin resistance,[5] and hyperlipidemia, especially hypercholesterolemia and hypertriglyceridemia,[6-8] which may be more pronounced in girls than in boys.[9] LPV requires a higher dose of ritonavir than some other protease inhibitors (PIs); this higher dose may exacerbate these adverse events.
- *Rare:* New-onset diabetes mellitus, hyperglycemia, ketoacidosis, exacerbation of preexisting diabetes mellitus, hemolytic anemia, spontaneous and/or increased bleeding in hemophiliacs, pancreatitis, elevation in serum transaminases, hepatitis (which has been life-threatening in rare cases), PR interval prolongation, QT interval prolongation, and Torsades de Pointes may occur.[10]

Special Populations: Neonates

- An increased risk of toxicity in premature infants has been reported, including cases of transient symptomatic adrenal insufficiency,[11,12] life-threatening bradyarrhythmias and cardiac dysfunction (including complete atrioventricular block, bradycardia, and cardiomyopathy),[13-15] lactic acidosis, acute renal failure, central nervous system depression, and respiratory depression. Transient asymptomatic elevation in 17-hydroxyprogesterone levels also has been reported[11] in term newborns treated at birth with LPV/r. These toxicities may be caused by the drug itself and/or by the inactive ingredients in the oral solution,[15] which include propylene glycol (15.3%) and ethanol (42.4%).
- Since these cases have been reported, the pharmacokinetics (PK) and safety of LPV/r have been studied in neonates in two clinical trials. In IMPAACT P1106, a Phase 4 prospective study evaluating the safety and PK of ARV medications in low and normal birthweight infants <3 months old, one group received LPV/r as standard of care.[16] A total of 28 neonates with HIV were enrolled, with a median birth weight of 2,288 g (interquartile range [IQR] 1,360–3,320 g) and a median gestational age of 36 weeks (IQR 27–39 weeks). All infants started LPV/r at ≥13 days postnatal age and 34 weeks postmenstrual age. In 25 infants with available PK data, the median LPV dose was 418 mg/m^2 twice daily (23.6 mg/kg). The median trough LPV level was 5.14 (IQR 2.95–8.51) µg/mL, above the minimal effective target concentration of 1 µg/mL.

Nearly half of infants initiated therapy prior to 42 weeks postmenstrual age with no observed safety or PK differences compared with infants who initiated LPV/r at or after 42 weeks postmenstrual age. No adverse events Grade 3 or higher were considered related to LPV/r treatment. The authors concluded that oral LPV/r solution is safe and effective in preterm infants at ≥13 days postnatal age and ≥34 weeks postmenstrual age.[16] The PETITE study evaluated the PK and safety of LPV/r oral granules in term neonates exposed to HIV in South Africa.[17] No adverse events of Grade 2 or higher related to study drugs occurred among 16 infants exposed to LPV/r granules. The authors also concluded that administration of LPV/r granules to term neonates beginning at birth was safe and well tolerated.[17] It should be noted that the use of LPV/r oral granules avoids exposure to the excipients present in the oral solution (propylene glycol and ethanol), which may reduce the risk of neonatal toxicity; however, the LPV/r granule formulation is not readily available in the United States.

- Although these recent studies provide some reassurance about the safety of LPV/r in neonates, they enrolled small numbers of participants, and further studies are needed of LPV/r in this age group. The potential benefit of using LPV/r in infants who are <42 weeks postmenstrual age or <14 days postnatal age must be carefully balanced against the risk of potentially life-threatening metabolic and cardiac toxicity.

Resistance

The International Antiviral Society–USA maintains a list of HIV drug resistance mutations, and the Stanford University HIV Drug Resistance Database offers a discussion of each mutation.

Pediatric Use

Approval

LPV/r is approved by the U.S. Food and Drug Administration (FDA) for use in children, including neonates who have attained a postmenstrual age of 42 weeks and a postnatal age of at least 14 days. The potential benefit of using LPV/r in infants who have not met these age thresholds must be carefully balanced with the risk of metabolic and cardiac toxicity. In addition, in pediatric patients receiving LPV/r at a dose of 300 mg/75 mg per m^2 twice daily, lower LPV exposure has been observed in infants aged <6 weeks relative to older children.[18]

Efficacy

Clinical trials involving antiretroviral therapy (ART)–naive adults have shown that regimens that contain LPV/r plus two nucleoside reverse transcriptase inhibitors are comparable to a variety of other regimens, including regimens that contain atazanavir, darunavir, or efavirenz (EFV).[19-23]

LPV/r has been studied in both ART-naive and ART-experienced children and has demonstrated durable virologic activity and acceptable toxicity.[24-33]

Pharmacokinetics

General Considerations

Children have lower LPV/r exposure than adults when treated with doses that are directly scaled for body surface area. The directly scaled dose approximation of the adult dose in children is calculated by dividing the adult dose by the typical adult body surface area of 1.73 m^2. For the adult dose of LPV/r 400 mg/100 mg, the scaled pediatric dose would be approximately LPV/r 230 mg/57.5 mg per m^2 of body surface area. However, younger children have higher LPV clearance and need higher

doses to achieve LPV exposures that are similar to those seen in adults treated with standard doses. To achieve a trough concentration (C_{trough}) similar to that observed in adults, the pediatric dose needs to be increased 30% greater than the dose that is directly scaled for body surface area. LPV exposures in infants[18,26,31] are compared to those in older children[24] and adults[34] in Table A below.

Table A. Pharmacokinetics of Lopinavir/Ritonavir by Age

PK Parameters	Adults (n = 19)[34]	Children (n = 12)[24]	Children (n = 15)[24]	Infants[a] at 12 Months (n = 20)[31]	Infants at 6 Weeks to 6 Months (n = 18)[26]	Infants at 14 Days to <6 Weeks (n = 9)[18]
LPV Dose	400 mg	230 mg/m^2	300 mg/m^2	300 mg/m^2	300 mg/m^2	300 mg/m^2
$AUC_{0–12h}$ (mcg·hr/mL)	92.6	72.6	116.0	101.0	74.5	43.4
C_{max} (mcg/mL)	9.8	8.2	12.5	12.1	9.4	5.2
C_{trough} (mcg/mL)	7.1	4.7	7.9	4.9	2.7	2.5
C_{min} (mcg/mL)	5.5	3.4	6.5	3.8	2.0	1.4

[a] This column contains unreported data that were originally generated for a published study. The data were provided by Edmund Capparelli, Pharm.D., in a personal communication (April 18, 2012).

Note: Values are means, and PK parameters refer to the LPV component; all data come from studies wherein none of the participants received non-nucleoside reverse transcriptase inhibitors as part of their antiretroviral therapy.

Key: $AUC_{0–12h}$ = area under the curve from time zero to 12 hours after drug administration; C_{max} = maximum plasma concentration; C_{min} = minimum plasma concentration; C_{trough} = trough concentration; LPV = lopinavir; PK = pharmacokinetic

Models suggest that diet, body weight, and postnatal age are important factors in LPV PK, with higher bioavailability as dietary fat increases during the first year of life[35] and clearance slowing by age 2.3 years.[36] A study from the United Kingdom and Ireland compared outcomes of LPV/r treatment with either 230 mg per m^2 of body surface area per dose or 300 mg per m^2 of body surface area per dose in children aged 5.6 to 12.8 years at the time of LPV/r initiation. The findings suggested that the higher dose was associated with improved long-term viral load suppression.[37]

Pharmacokinetics and Dosing

14 Days to 12 Months (Without Concurrent Nevirapine or Efavirenz)

The PK of the oral solution at approximately LPV/r 300 mg/75 mg per m^2 of body surface area per dose twice daily were evaluated in infants aged <6 weeks[18] and infants aged 6 weeks to 6 months.[26] Even at this higher dose, C_{trough} levels were highly variable, but they were lower in infants than in children aged >6 months. C_{trough} levels were lower in infants aged ≤6 weeks than in infants aged 6 weeks to 6 months. By age 12 months, LPV area under the curve (AUC) was similar to that found in older children.[31] Because infants grow rapidly in the first months of life, it is important to optimize LPV dosing by adjusting the dose at frequent intervals. Given the safety of doses as high as 400 mg per m^2 of body surface area in older children and adolescents,[27] some practitioners anticipate rapid

infant growth and prescribe doses somewhat higher than the 300 mg per m^2 of body surface area dose to allow for projected growth between clinic appointments.

12 Months to 12 Years (Without Concurrent Nevirapine or Efavirenz)

Lower C_{trough} values have been observed in children receiving LPV/r 230 mg/57.5 mg per m^2 of body surface area per dose twice daily than in children receiving LPV/r 300 mg/75 mg per m^2 of body surface area per dose twice daily (see Table A above).[23] Therefore, some clinicians choose to initiate therapy in children aged 12 months to 12 years using LPV/r 300 mg/75 mg per m^2 of body surface area per dose twice daily (when LPV/r is given without nevirapine [NVP] or EFV), rather than the FDA-approved dose of LPV/r 230 mg/57.5 mg per m^2 of body surface area per dose twice daily.

For infants receiving LPV/r 300 mg/75 mg per m^2 of body surface area per dose twice daily, immediate dose reduction at age 12 months **is not recommended;** many practitioners would allow patients to "grow into" the dose of LPV/r 230 mg/57.5 mg per m^2 of body surface area per dose twice daily as they gain weight over time. Some practitioners would continue the infant dose (LPV/r 300 mg/75 mg per m^2 of body surface area per dose twice daily) while using the LPV/r liquid formulation.

Pharmacokinetics and Dosing With Concurrent Nevirapine or Efavirenz

In both children and adults, the LPV C_{trough} is reduced by concurrent treatment with non-nucleoside reverse transcriptase inhibitors (NNRTIs). Higher doses of LPV are recommended when the drug is given in combination with NVP or EFV. In 14 children who were treated with LPV/r 230 mg/57.5 mg per m^2 of body surface area per dose twice daily plus NVP,[24] the mean LPV C_{trough} was 3.77 ± 3.57 mcg/mL. Not only are these trough plasma concentrations lower than those found in adults treated with standard doses of LPV/r, but the variability in concentration is much higher in children than in adults.[24,38] In a study of 15 children with HIV aged 5.7 to 16.3 years who were treated with LPV/r 300 mg/75 mg per m^2 of body surface area per dose twice daily plus EFV 14 mg/kg body weight per dose once daily, there was a 34-fold interindividual variation in LPV C_{trough} values. Five of 15 children (33%) had LPV 12-hour C_{trough} values that were <1.0 mcg/mL, the plasma concentration needed to inhibit wild-type HIV.[39] A PK study in 20 children aged 10 to 16 years who were treated with LPV/r 300 mg/75 mg per m^2 of body surface area twice daily plus EFV 350 mg per m^2 of body surface area once daily reported only one patient (6.6%) with subtherapeutic LPV C_{trough} values,[40] perhaps because the trial used an EFV dose that was approximately 11 mg/kg body weight[40] instead of the 14 mg/kg body weight dose used in the trial discussed above.[39]

Dosing

Once Daily

A single daily dose of LPV/r 800 mg/200 mg is approved by the FDA for treatment of HIV in treatment-naive adults aged >18 years. However, **once-daily administration cannot be recommended for use in children in the absence of therapeutic drug monitoring (TDM);** once-daily administration may be successful in select, closely monitored children.[41] There is high interindividual variability in drug exposure for LPV/r, and trough plasma concentrations may fall below the therapeutic range for wild-type virus, as demonstrated in studies of ARV-naive children and adolescents.[42-45] The currently available tablet formulation of LPV/r has lower variability in trough levels than the previously used soft-gel formulation.[45,46] An international, randomized, open-label trial attempted to demonstrate that once-daily LPV/r dosing was non-inferior to twice-daily LPV/r dosing in

children and adolescents with HIV. This trial was unsuccessful, because a greater number of children and adolescents who received once-daily doses had viral loads ≥50 copies/mL within 48 weeks.[47]

Dosing and Its Relation to Efficacy

LPV/r is effective in treatment-experienced patients with severe immune suppression,[48,49] although heavily pretreated patients may be slower to reach undetectable viral loads[49,50] and may have less robust CD4 T lymphocyte (CD4) cell count percentage responses.[51]

The relationship between LPV exposure and the susceptibility of the HIV-1 isolate is a key component of successful treatment. The ratio of C_{trough} to half maximal effective concentration (EC_{50}) is called the inhibitory quotient (IQ), and in both adults and children treated with LPV/r, viral load reduction is more closely associated with IQ than with either C_{trough} or EC_{50} alone.[52-54] One study investigated the use of the IQ as a guide for therapy by administering higher doses of LPV/r to children and adolescents until a target IQ of 15 was reached. This study showed that doses of LPV/r 400 mg/100 mg per m^2 of body surface area per dose twice daily (without NVP or EFV) and LPV/r 480 mg/120 mg per m^2 of body surface area per dose twice daily (with NVP or EFV) were safe and tolerable.[27] Results of a modeling study suggest that standard doses of LPV/r may be inadequate for treatment-experienced children and indicate the potential utility of TDM when LPV/r is used in children who were previously treated with PIs.[55] An LPV plasma concentration of ≥1 mcg/mL is cited as a minimum target C_{trough},[56-58] but this C_{trough} may not adequately control viremia in patients with multiple LPV resistance mutations.[59,60]

Formulations

Palatability

The poor palatability of the LPV/r oral solution can be a significant challenge to medication adherence for some children and families. Numbing the taste buds with ice chips before or after administering the solution, masking the taste of the solution by administering it with sweet or tangy foods (e.g., chocolate syrup, peanut butter), or having the pharmacist flavor the solution prior to dispensing it are examples of interventions that may improve tolerability. Alternative pediatric formulations of LPV/r, including oral pellets and oral granules, are tentatively approved by the FDA, but are largely used in resource-limited settings and are not readily available in the United States.[17,34,61-64]

Do Not Use Crushed Tablets

LPV/r tablets must be swallowed whole. Crushed tablets are slowly and erratically absorbed and result in significantly reduced AUC, maximum concentration , and C_{trough} compared with swallowing the whole tablet. The variability of the reduced exposure with the crushed tablets (5% to 75% reduction in AUC) means that a dose modification cannot be relied on to overcome the reduced absorption. **Crushed tablets cannot be recommended for use.**[65] In a PK study that used a generic adult formulation of LPV/r manufactured in Thailand, 21 of 54 children were administered cut (not crushed) pills and had adequate LPV C_{trough} measurements.[46]

Toxicity

Children treated with LPV/r may have less robust weight gain and smaller increases in CD4 percentage than children treated with NNRTI-based regimens.[29,66-70] However, one study did not observe this difference in the effect of LPV/r on CD4 count,[71] and another study found that the difference did not persist after a year of therapy.[32] Some studies found no differences between the weight gain of children treated with LPV/r and those treated with EFV.[69,72] Switching to an EFV-

based regimen at or after age 3 years removed the risk of LPV-associated metabolic toxicity, with no loss of virologic control (see Table 16 in Modifying Antiretroviral Regimens in Children With Sustained Virologic Suppression on Antiretroviral Therapy).[69,70] Bone mineral density improved when children were treated with EFV-containing regimens instead of regimens that contained LPV/r.[73] Among 212 children randomized to either remain on an LPV/r-based regimen or switch to an EFV-containing regimen, osteocalcin—a biochemical marker of bone turnover—was higher in the LPV/r group than the EFV group at both 8 weeks and 2 years post-randomization. Levels of C-telopeptide of type 1 collagen and procollagen type I N-terminal propeptide did not differ between the two groups.[74] In a separate study, among 220 children with HIV (mean age 6.38 years), lower bone mass was observed in children on LPV/r-based regimens than those with EFV-based regimens over 2 years of follow-up.[75]

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