Table 17a. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Central Nervous System Toxicity

Updated: September 30, 2025
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Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/ Monitoring	Management
Global CNS Depression	LPV/r oral solution that contains both ethanol (42.4% v/v) and propylene glycol (15.3% w/v) as excipients	**Onset** • 1–6 days after starting LPV/r **Presentation** *Neonates/Premature Infants* • Global CNS depression (e.g., abnormal EEG, altered state of consciousness, somnolence)	Unknown; rare case reports have been published.	Prematurity Low birth weight Aged <14 days (whether birth was premature or term)	Avoid use of LPV/r until a postmenstrual age of 42 weeks and a postnatal age of ≥14 days unless no other alternatives are available. See Lopinavir/Ritonavir.	Discontinue LPV/r; symptoms should resolve in 1–5 days. If needed, reintroducing LPV/r can be considered when the child is outside the vulnerable period (i.e., a postmenstrual age of 42 weeks and a postnatal age ≥14 days).
Neuropsychiatric Symptoms and Other CNS Manifestations	EFV	**Onset** • For many symptoms, onset is 1–2 days after starting EFV. • Many symptoms subside or diminish by 2–4 weeks, but symptoms may persist in a significant proportion of children.	Variable, depending on age, symptoms, and assessment method **Children** • 24% of children experienced any EFV-related CNS manifestation in one case series, with 18% of participants requiring drug discontinuation.	Insomnia is associated with elevated EFV trough concentration (≥4 mcg/mL). CYP2B6 polymorphisms that decrease EFV metabolism and cause increased EFV serum concentrations (CYP2B6 516 T/T genotype or co-carriage of CYP2B6 516 G/T and 983 T/C variants)	Avoid use of EFV for initial ART in children and adolescents to prevent EFV-associated CNS side effects. See What to Start: Antiretroviral Treatment Regimens Recommended for Initial Therapy in Infants and Children With HIV.	If symptoms are excessive or persistent, obtain EFV trough concentration. If EFV trough concentration is >4 mcg/mL and/or symptoms are severe, strongly consider drug substitution if a suitable alternative exists.[a]

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		Presentation (May Include One or More of the Following) *Neuropsychiatric Symptoms* • Abnormal dreams • Psychosis • Suicidal ideation or attempted/completed suicide *Other CNS Manifestations* • Dizziness • Somnolence • Insomnia or poor sleep quality • Impaired concentration • Seizures (including absence seizures) • Cerebellar dysfunction (e.g., tremor, dysmetria, ataxia) **Note:** CNS side effects (e.g., impaired concentration, abnormal dreams, sleep disturbances) may be more difficult to assess in children.	• Five of 45 participants (11%) experienced new-onset seizures in one study of children aged <36 months; two of these participants had alternative causes for seizures. • Cases of cerebellar dysfunction have been reported in children with very high EFV plasma levels. **Adults** • 30% incidence for any CNS manifestations of any severity • 6% incidence of EFV-related, severe CNS manifestations, including suicidality. However, evidence is conflicting about whether EFV use increases the incidence of suicidality. • Two case series reported late-onset ataxia with or without encephalopathy associated with high EFV levels.	History of psychiatric illness or use of psychoactive drugs	In situations where EFV treatment may be indicated, consider the following: • Administer EFV on an empty stomach, preferably at bedtime. • Prescreen for psychiatric illness; avoid use in the presence of psychiatric illness, including depression or suicidal thoughts. Avoid concomitant use of psychoactive drugs. • Consider using TDM in children with mild or moderate EFV-associated toxicities.	Alternatively, consider dose reduction with repeat TDM and dose adjustment (with input from an expert pharmacologist).

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	RPV	**Onset** • Most symptoms occur in the first 4–8 weeks of treatment. **Presentation** *Neuropsychiatric Symptoms* • Depressive disorders • Suicidal ideation • Abnormal dreams/nightmares *Other CNS Manifestations* • Headache • Dizziness • Insomnia • Somnolence	**Children** • Depressive disorders of all severity grades were reported in 22.2% of children and adolescents aged 12–17 years. • Somnolence was reported in 5 of 36 children (14%). **Adults** • CNS/ neuropsychiatric adverse events of all severity grades were reported in 43% of participants at 96 weeks (most were Grade 1). Depressive disorders of all severity grades were reported in 9% of participants; <1% of participants discontinued RPV because of severe depressive disorders. Higher frequency of depression and dizziness reported when coadministered with DTG.	History of neuropsychiatric illness	Monitor carefully for depressive disorders and other CNS symptoms.	Consider drug substitution in cases of severe symptoms.

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	RAL	**Onset** • As early as 3–4 days after starting RAL **Presentation** • Increased psychomotor activity • Headaches • Insomnia • Depression • Cerebellar dysfunction (e.g., tremor, dysarthria, ataxia)	**Children** • Increased psychomotor activity was reported in one child. **Adults** • Headache • Insomnia (<5% in adult trials) • Rare case reports of cerebellar dysfunction in adults	Elevated RAL concentrations Cotreatment with TDF, a PPI, or inhibitors of UGT1A1 Prior history of insomnia or depression	Prescreen for psychiatric symptoms. Monitor carefully for CNS symptoms. Use with caution in the presence of drugs that increase RAL concentration.	Consider drug substitution (RAL or coadministered drug) in cases of severe insomnia or other neuropsychiatric symptoms.
	DTG	**Onset** • Anytime, but usually 7–30 days after starting DTG **Presentation** *Neuropsychiatric Symptoms* • Depression or exacerbation of preexisting depression • Anxiety • Self-harm thoughts, suicidal ideation, or attempted/ completed suicide	**Children** • In a retrospective cohort analysis, neuropsychiatric events that resulted in discontinuation occurred in 2 of 29 (6.8%) children who initiated DTG.	Preexisting depression or other psychiatric illness History of ARV-related neuropsychiatric symptoms Higher frequency of overall neuropsychiatric symptoms reported when DTG is coadministered with ABC, and of depression and dizziness when DTG is coadministered with RPV. However, evidence is conflicting for ABC association.	Use with caution in the presence of psychiatric illness, especially in children and adolescents with depression or a history of ARV-related neuropsychiatric symptoms. Consider morning dosing of DTG.	For persistent or severe neuropsychiatric symptoms, consider discontinuing DTG if a suitable alternative exists. For mild symptoms, continue DTG and counsel that symptoms likely will resolve with time.

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		• Drowsiness • Neurocognitive deficits (lower total competence and school performance) *Other CNS Manifestations (Generally Mild)* • Sleep disturbances • Dizziness • Headache	• Higher frequency of suicidal ideation or behavior reported in children in the ODYSSEY trial receiving DTG (2.3%) than those receiving SOC ARVs (1.4%). Overall neuropsychiatric adverse events were 4.3% in children receiving DTG and 2.2% in children receiving SOC ARVs. Most neuropsychiatric AEs were transient and did not lead to treatment changes. **Adults** • 2.7% of the neuropsychiatric AEs reported in a large prospective cohort resulted in treatment discontinuation. • Higher frequency of neuropsychiatric symptoms reported with DTG than with other INSTIs. A class effect has been suggested.			

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	BIC	**Onset** • 1–63 days after starting BIC (as late as 233 days for schizoaffective disorders) **Presentation** *Neuropsychiatric Symptoms* • Depression or exacerbation of preexisting depression • Suicidal ideation or attempted suicide • Schizoaffective disorders • Anxiety *Other CNS Manifestations (Generally Mild)* • Sleep disturbances • Dizziness • Insomnia	**Children** • One child (1%) had Grade 2 insomnia and anxiety that led to drug discontinuation in clinical trials. **Adults** • Overall, the frequency of neuropsychiatric events in BIC and DTG comparator arms appeared similar in adult clinical trials. • Abnormal dreams, dizziness, and insomnia occurred in 1–5% of adults. • Suicidal ideation, suicide attempts, schizoaffective disorders, and depression occurred in <1% of adults.	Preexisting depression or other psychiatric conditions History of ARV-related neuropsychiatric symptoms	Use with caution in the presence of psychiatric conditions or in children and adolescents with a history of ARV-related neuropsychiatric symptoms.	For persistent or severe neuropsychiatric symptoms, consider discontinuing BIC if a suitable alternative exists. For mild symptoms, continue BIC and counsel that symptoms are likely to resolve with time.

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			• A recent study reported a 3.3% short-term BIC-related discontinuation rate due to neuropsychiatric AEs after ART switch in a large cohort of adults with HIV in routine clinical practice setting.			
	CAB	**Presentation** *Neuropsychiatric Symptoms (Generally Mild or Moderate, Occasionally Serious)* • Mood disorders, including depression and suicidal ideation or attempt • Anxiety disorders *Other CNS Manifestations (Generally Mild or Moderate)* • Sleep disorders • Dizziness • Headache • Somnolence	**Children** • Insomnia was reported in 1 of 8 adolescents in the ongoing MOCHA trial. **Adults** • 2–4% pooled incidence was reported in Phase 3 trials for CNS AEs, including sleep disorders, dizziness, and headache. • 5% pooled incidence for anxiety, 3% for depression and <1% for suicidal ideation in Phase 3 trials at 48 weeks, with comparable incidence in CAB and control groups.	Preexisting depression or other psychiatric conditions could be contributing factors, but causal links have not clearly been identified. CAB exposure did not differ between study participants with and without CNS or neuropsychiatric manifestations.	Monitor individuals for depressive symptoms or self-injurious thoughts or behavior, especially with prior history of such symptoms.	Promptly evaluate severe depressive symptoms, self-injurious behavior, or other CNS symptoms for a possible relationship with CAB and assess risks and benefits of continued CAB treatment. If CAB is discontinued— • Counsel the individual about prolonged residual CAB levels in the blood for 52 weeks or longer and monitor frequently for symptom resolution. • Ensure that a new suppressive regimen is started within 30 days of last injection.

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[a] Even in cases wherein patients have achieved sustained virologic suppression (i.e., suppression for 6–12 months) on their current regimen, clinicians should consider switching patients to new ARV regimens to permit the use of pills instead of liquids; reduce pill burden; allow the use of once-daily medications; reduce the risk of adverse events; minimize drug interactions; and align a child's regimen with widely used, efficacious adult regimens. See Modifying Antiretroviral Regimens in Children with Sustained Virologic Suppression on Antiretroviral Therapy for more information.

Key: ABC = abacavir; AE = adverse event; ARV = antiretroviral; BIC = bictegravir; CAB = cabotegravir; CNS = central nervous system; CYP2B6 = cytochrome P450 2B6; DTG = dolutegravir; EEG = electroencephalogram; EFV = efavirenz; INSTI = integrase strand transfer inhibitor; LPV/r = lopinavir/ritonavir; MOCHA = More Options for Children and Adolescents; PPI = proton pump inhibitor; RAL = raltegravir; RPV = rilpivirine; SOC = standard of care; TDF = tenofovir disoproxil fumarate; TDM = therapeutic drug monitoring; UGT1A = uridine diphosphate-glucuronosyltransferase family 1 member A complex; v/v = volume per volume; w/v = weight per volume

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