OBSTACLE 1: MITIGATING CARDIOVASCULAR DISEASE (CVD) RISK IN AGING PEOPLE WITH HIV

Use an atherosclerotic CVD (ASCVD) risk estimator, such as ASCVD Risk Estimator+ (https://tools.acc.org/ascvd-risk-estimator-plus/#!/calculate/estimate/) or SCORE2 (https://www.escardio.org/Education/Practice-Tools/CVD-prevention-toolbox/SCORE-Risk-Charts) to assess risk in people with HIV. Be aware that these risk calculators do not account for HIV as a risk factor, so the patient's risk is likely higher.

HIV treaters should be prepared to initiate statin therapy in patients aged ≥40 years, according to their country's guidelines. Though guidelines differ by country and guideline committee, the consensus is that statins are a critical part of ASCVD prevention among people with HIV.

- Department of Health and Human Services guidelines:
  - Initiate at least moderate-intensity statin therapy in people with HIV with 5% to <20% 10-year ASCVD risk and high-intensity statin therapy for patients with ≥20% risk. Statin therapy may be considered in patients with <5% risk. Pitavastatin, atorvastatin, and rosuvastatin are the best options
- British HIV Association guidelines:
  - All people with HIV aged >40 years should be offered a statin, irrespective of lipid profile or estimated CVD risk. Pitavastatin (when available) or atorvastatin should be used
- European AIDS Clinical Society guidelines:
  - Initiate statin therapy when CVD risk is ≥10% for people with HIV aged ≥40 years. Initiate moderate-intensity statin therapy when CVD risk is 5% to <10% for people with HIV aged ≥40 years. Pitavastatin, atorvastatin, or rosuvastatin may be used

Consult a drug interaction checker (https://www.hiv-druginteractions.org/checker) to avoid potential drug-drug interactions with antiretroviral therapy (ART) regimens, which frequently occur with boosted protease inhibitors or boosted elvitegravir.

OBSTACLE 2: ADDRESSING HYPERTENSION (HTN) IN AGING PEOPLE WITH HIV

Ensure blood pressure (BP) is being measured accurately:

- Have the patient empty their bladder
- Patient should relax in a chair with their feet on the floor without talking for >5 minutes
- Take readings from both arms on first visit and use the arm with the higher reading for subsequent visits
- If repeating measures, separate by 1 to 2 minutes

Diagnosis of HTN and treatment goals may differ according to country guidelines:

- American College of Cardiology:
  - Stage 1 HTN: 130-139/80-29 mm Hg; stage 2 HTN: ≥140/90 mm Hg
  - Goal: <130/80 mm Hg, regardless of age
- European Society of Cardiology
  - Elevated BP: 120-139/70-90 mm Hg; HTN: ≥140/90 mm Hg
  - Goal: 120-129/70-79 mm Hg

Both society guidelines state that first-line pharmacotherapy consists of angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers/calcium channel blockers/diuretics. Treatment may need to be intensified depending on BP control.

OBSTACLE 3: OPTIMAL APPROACHES TO MANAGING TYPE 2 DIABETES (T2D) AND OBESITY IN PEOPLE WITH HIV

People with HIV with T2D should be treated as early as possible, as T2D can increase the risk of CVD, among other cardiometabolic comorbidities. Treatment often depends on other comorbidities or risk factors the patient has, with initial pharmacotherapy differing based on CVD risk factors and comorbid chronic kidney disease or obesity. According to the American Diabetes Association (https://diabetesjournals.org/care/issue/48/Supplement_1) and guidelines from other countries, sodium-glucose cotransporter 2 inhibitors and glucagon-like peptide-1 receptor agonists (GLP-1 RAs) or other GLP-1–targeting therapies are the top recommendations for most categories of patients with T2D.

Certain GLP-1–targeting therapies, namely semaglutide, tirzepatide, and liraglutide, are also indicated for management of obesity, even in patients without T2D. GLP-1 RAs for both T2D and obesity may be associated with gastrointestinal adverse events, though these typically lessen within the first few weeks of treatment.

Glucose-lowering therapies may interact with certain ART regimens; clinicians should consult guidelines to ensure T2D treatments do not interfere with ART regimens.

OBSTACLE 4: RECOGNIZING METABOLIC DYSFUNCTION–ASSOCIATED STEATOHEPATITIS (MASH) IN AGING PEOPLE WITH HIV

Recently, *MASH* and *metabolic dysfunction–associated steatosis* (MASLD) replaced *nonalcoholic steatohepatitis* and *nonalcoholic fatty liver disease* as preferred terminology. This helps emphasize the critical role that cardiometabolic comorbidities play in MASLD and MASH. Thus, patients with overweight, elevated glucose levels, HTN, elevated triglycerides, or low high-density lipoprotein cholesterol levels should be screened for MASLD.

A basic screening tool called Fibrosis-4 (FIB-4) uses age, platelet count, and liver enzymes to indicate whether a patient should be referred to a hepatologist for additional testing to confirm MASLD or MASH, including the level of fibrosis (https://www.hepatitisc.uw.edu/page/clinical-calculators/fib-4).

Early referral is critical, as there is now an approved treatment (resmetirom) for MASH in the US; as of March 2025, it is not yet available in other countries. Clinicians should also consider initiating GLP-1 RAs for treatment of obesity in patients with MASH and ensure their T2D, if applicable, is under control.