Nutrition and the HIV-associated lipodystrophy syndrome

Cathriona Rosemary Loonam and Anne Mullen*

Diabetes and Nutritional Sciences Division, School of Medicine, King’s College London, Franklin-Wilkins Building, 150 Stamford Street, London SE1 9NH, UK

(Submitted 25 March 2011 – Final revision received 19 June 2012 – Accepted 12 July 2012)

Abstract

HIV-associated lipodystrophy syndrome (HALS), comprising metabolic and morphological alterations, is a known side effect of highly active antiretroviral therapy (HAART). Evidence for the role of nutrition in the management of the systemic parameters of HALS is currently limited. In the present paper we review the current knowledge base surrounding HALS, focusing particularly on the role of nutrition in mitigating the systemic parameters of the syndrome. Reported prevalence of HALS was found to vary from 9 to 83% due to lack of a standardised definition, as well as variations in assessment methods and in the study population used. HALS is associated with both morphological (lipoatrophy, lipohypertrophy) and metabolic (dyslipidaemia, glucose intolerance, diabetes, hypertension, endothelial dysfunction and atherosclerosis) alterations, which may occur singly or in combination, and are associated with an increased risk of CVD. HAART-induced adipocyte inflammation, oxidative stress and macrophage infiltration, as well as altered adipocyte function and mitochondrial toxicity, have been shown to be central to the development of HALS. The adipocyte, therefore, represents a plausible target for treatment. Pharmacological and surgical treatment interventions have shown effect. However, their use is associated with numerous adverse effects and complications. Targeted lifestyle interventions may provide a useful alternative for managing HALS owing to their safety and tolerability. A Mediterranean-style diet has been found to be effective in improving the systemic parameters of HALS. Furthermore, the effects of n-3 PUFA supplementation are encouraging and future randomised controlled trials investigating the beneficial effects of n-3 PUFA in HALS are justified.

Key words: HIV-associated lipodystrophy syndrome: Highly active antiretroviral therapy: Nutrition therapy: Mediterranean diet: n-3 PUFA

Introduction

The number of individuals living with HIV/AIDS has increased globally, with a current estimated global prevalence of 33·3 million. In the UK alone, the incidence of HIV/AIDS has almost doubled in the past decade and there are now an estimated 86 200 individuals living with HIV/AIDS. This represents less than 1% of the global HIV/AIDS population, while Sub-Saharan Africa remains most severely affected by the HIV pandemic, with 67% of the global HIV/AIDS population located here.

A significant turning point in the management of HIV came with the introduction of the nucleoside RT inhibitor (NRTI) zidovudine (ZDV), the first antiretroviral drug approved by the Food and Drug Administration in 1987. For those with access to antiretroviral therapy (ART), HIV infection no longer represented an immediate threat to mortality, and was, in many cases, transformed into a chronic condition.

The development of subsequent antiretroviral drugs zalcitabine (ddC), didanosine (ddI) and stavudine (d4T) led to combination ART (cART), the first of which was ZDV and ddC. cART, commonly referred to as highly active ART, consists of at least two antiretrovirals, most usually from one of three main drug classes: NRTI and nucleotide RT inhibitors (NtRTI), protease inhibitors (PI) and non-nucleoside RT inhibitors (NNRTI). NRTI and NtRTI interact with the substrate-binding site of the HIV RT enzyme, which halts the production of new virions. NNRTI bind specifically with a non-substrate-binding site of RT, disrupting the enzyme’s catalytic site. PI inhibit the protease enzyme, thus preventing the host cell from cleaving the viral proteins into active viral particles; fusion inhibitors

Abbreviations: ART, antiretroviral therapy; cART, combination antiretroviral therapy; CT, computed tomography; d4T, stavudine; HALS, HIV-associated lipodystrophy syndrome; LA, lipoatrophy; LH, lipohypertrophy; MI, myocardial infarction; n-5 LC-PUFA, n-5 long-chain PUFA; NCEP ATP III, National Cholesterol Education Program Adult Treatment Panel III; NNRTI, non-nucleoside RT inhibitor; NRTI, nucleoside RT inhibitor; PI, protease inhibitor; REE, resting energy expenditure; T2DM, type 2 diabetes mellitus; ZDV, zidovudine.

* Corresponding author: Dr Anne Mullen, fax +44 20 7848 4171, email anne.mullen@kcl.ac.uk
Nutrition Research Reviews

sponds with a Mediterranean-style dietary pattern (44,45) and altered cytokine and adipokine secretion.

Shortly after the introduction of PI, which were in the context of sole use or cART, case reports of disorders of the host cell genome (14) began to appear in the literature. HIV-associated lipodystrophy syndrome (HALS) was the term subsequently used to define these metabolic and morphological alterations, and was first described in 1998 by Carr et al. (20). Though ART, particularly PI and NRTI, are the main drivers of HALS, the virus itself and host genetics also contribute to its pathogenesis (21).

HALS comprises peripheral lipoatrophy (LA) and central lipohypertrophy (LH) (22), which can occur together or separately (22), dyslipidaemia (24), insulin resistance (25), type 2 diabetes mellitus (T2DM) (26–28), hypertension (25), endo-thelial dysfunction (29), and altered cytokine and adipokine production (29). Collectively these abnormalities have been associated with an increased risk of CVD in this population (20,32). HALS has been associated with risk factors for premature CVD and premature myocardial infarction (MI) (33–38).

Nutrition plays a key role in maintaining health in HIV infected individuals (39). According to a recent consensus statement from the American Dietetic Association (39), evidence on the role of diet in mitigating systemic parameters in HALS is limited. There are a number of studies that have generally investigated the area by cross-sectional analysis or by comparing those with HIV infection with those without HIV infection (20,32,46–48), and only one of these compares prevalence rates between HIV-infected individuals receiving PI, those who were PI-naïve and healthy men (20).

The methods used to identify HALS also greatly affect prevalence estimates. Currently used methods include patient self-report, physician examination/report, a combination of these, anthropometric indices, biochemical indices, dual-energy X-ray absorptiometry, computed tomography (CT) and MRI. Patient self-report and physician report are commonly used methods; however, the accuracy of these subjective methods has not been evaluated (49), and physician and patient assessments of HALS have been shown to vary (50).

Carter et al. (51) showed that differences in the definition of the syndrome can contribute to a variation in prevalence of between 19 and 65%. Existing definitions include LA or LH (48,52–62), LA alone (20,61–75), LH alone (61–68,70–78), or a combination of LA and LH (72,54,55,61,62,64,66–68,71–75,79–85). The main definitions for the metabolic alterations associated with HALS (abdominal obesity, dyslipidaemia, raised blood pressure, insulin resistance and a pro-inflammatory, prothrombotic state) are the National Cholesterol Education Program Adult Treatment Panel (NCEP ATP) III criteria (50), used by the majority of researchers (24–25,32,47,73,87,88), the International Diabetes Federation ( IDF) Guidelines (89) used in one study (75), a combination of NCEP and IDF used in three studies (25,88,90) and the ‘Report of the National Heart, Lung, and Blood Institute/American Heart Association Conference on Scientific Issues Related to Definition’ (91) used in one study (46), and the US National Institutes of Health Division of AIDS definition (2004 version) (92) used in one study (93). In addition to metabolic definitions, anthropometric techniques have been used in the identification of central adiposity in HALS (59). The use of anthropometry in detecting small changes in fat distribution in HIV patients is, however, limited, as it is associated with inter-individual differences in the measurement of fat distribution in HIV patients (94).

Carr et al. (82) have attempted to objectively define HALS and developed an objective case definition for the syndrome based on age, sex, duration of HIV infection, HIV disease stage, waist:hip ratio, anion gap, serum HDL concentration, trunk:peripheral fat ratio, percentage leg fat, and intra-abdominal:extra-abdominal fat ratio. This definition is 79% sensitive and 80% specific for the diagnosis and intensity of the syndrome. However, the definition requires anthropometric variables from dual-energy X-ray absorptiometry and CT, reducing its utility in clinical practice (50).

Research has also focused on grading the severity of the components of HALS. The HIV Outpatient Study scale was

Prevalence and definition

The prevalence of HALS has been shown to vary widely from 9 to 83% depending on the assessment criteria used (Table 1). Furthermore, the study populations used to assess prevalence of the condition may also account for the observed differences in published prevalence.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Study design</th>
<th>n</th>
<th>Participants</th>
<th>Methods used to define HALS</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Europe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bergersen et al. (2005)</td>
<td>CS</td>
<td>308</td>
<td>HIV+, F</td>
<td>Anthro, Biochem</td>
<td>37.3% of patients on ART v. 10.9% ART-naive 43% had at least one sign of HALS; 28% LA; 30% LH</td>
</tr>
<tr>
<td>Bernasconi et al. (2002)</td>
<td>P</td>
<td>1359</td>
<td>HIV-, SHCS cohort</td>
<td>Self-report; physician report</td>
<td></td>
</tr>
<tr>
<td>Boufassa et al. (2001)</td>
<td>CS</td>
<td>685</td>
<td>HIV+, 70-5% M</td>
<td>Physician report</td>
<td>58-8% HALS</td>
</tr>
<tr>
<td>Chêne et al. (2002)</td>
<td>RCT</td>
<td>120</td>
<td>HIV+, 81% M</td>
<td>Physician report; Biochem</td>
<td>31% HALS after 30 months, 18% LA, 6% LH; 7% mixed</td>
</tr>
<tr>
<td>Elgalib et al. (2011)</td>
<td>CS</td>
<td>678</td>
<td>HIV+, 74 M, CREATE cohort, 74% receiving ART</td>
<td>IDF (2005)(83) and NCEP ATP III criteria (NCEP, 2005); 68% metabolic syndrome</td>
<td>25% HALS (IDF, 2005); 24% HALS (NCEP ATP III); 68% metabolic syndrome</td>
</tr>
<tr>
<td>Fellay et al. (2001)</td>
<td>CS</td>
<td>1160</td>
<td>HIV+, SHCS cohort</td>
<td>Physician report; according to Carr et al. (1998)(20)</td>
<td>47% with clinical and 27% with laboratory adverse events related to HALS</td>
</tr>
<tr>
<td>Galli et al. (2002)</td>
<td>CS</td>
<td>655</td>
<td>HIV+, 72-1% M, LipolCoNa study</td>
<td>Self-report; retrospective and prospective physician reports</td>
<td>19-5% HALS</td>
</tr>
<tr>
<td>Galli et al. (2003)</td>
<td>P</td>
<td>212</td>
<td>HIV+, F</td>
<td>Self-report; physician report</td>
<td>44-8% central LH; 42-9% peripheral LA; 33% mixed</td>
</tr>
<tr>
<td>Galli et al. (2003)</td>
<td>CS</td>
<td>2258</td>
<td>HIV+, 70% M</td>
<td>Self-report; physician report</td>
<td>10-4% HALS</td>
</tr>
<tr>
<td>Gervasconi et al. (1999)</td>
<td>CS</td>
<td>306</td>
<td>HIV+, F</td>
<td>Self-report; physician report; DXA</td>
<td></td>
</tr>
<tr>
<td>Galli et al. (2003)</td>
<td>CS</td>
<td>143</td>
<td>HIV+, French PRIMO cohort</td>
<td>Physician report</td>
<td></td>
</tr>
<tr>
<td>Jericó et al. (2005)</td>
<td>CS</td>
<td>710</td>
<td>HIV+, 72% M</td>
<td>Physician report; Biochem; NCEP ATP III criteria</td>
<td>17% metabolic syndrome</td>
</tr>
<tr>
<td>Martinez et al. (2001)</td>
<td>CSOS</td>
<td>494</td>
<td>HIV+, 76% M</td>
<td>Self-report; two physician reports</td>
<td>17% HALS</td>
</tr>
<tr>
<td>Mauss et al. (2002)</td>
<td>CSOS</td>
<td>221</td>
<td>HIV+, 87% M, DAGNAE LipART cohort</td>
<td>Self-report; two physician reports</td>
<td>34% HALS; 18% LA; 8% LH; 74% mixed</td>
</tr>
<tr>
<td>Nguyen et al. (2009)</td>
<td>P</td>
<td>5427</td>
<td>HIV+, 68% M, SHCS cohort</td>
<td>Physician report</td>
<td>33-9% HALS</td>
</tr>
<tr>
<td>Saint-Marc et al. (2000)</td>
<td>CS</td>
<td>154</td>
<td>HIV+, M, LIPPOCO cohort, ART experienced or ART-naive</td>
<td>Self-report; physician report</td>
<td>53-25% HALS; 15-89% LA; 4-21% LH; 18-22% mixed</td>
</tr>
<tr>
<td>Saves et al. (2002)</td>
<td>CS</td>
<td>614</td>
<td>HIV+, 80% M, APROCOC cohort</td>
<td>Physician report</td>
<td>62% HALS</td>
</tr>
<tr>
<td>Seminari et al. (2002)</td>
<td>CS</td>
<td>504</td>
<td>HIV+, M, receiving ART</td>
<td>Physician report</td>
<td>29-3% HALS; 23% LA; 20% LH; 25% mixed; 32% isolated metabolic alterations</td>
</tr>
<tr>
<td>Thiébaut et al. (2000)</td>
<td>CS</td>
<td>581</td>
<td>HIV+, &gt; 13 years, Aquitaine cohort</td>
<td>Physician report</td>
<td>38% HALS; 16% LA; 12% LH; 10% mixed; 54% metabolic abnormalities</td>
</tr>
<tr>
<td>Young et al. (2005)</td>
<td>P</td>
<td>925</td>
<td>HIV+, ART-naive</td>
<td>Self-report; physician report</td>
<td>9% HALS</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jevtovic et al. (2009)</td>
<td>CS</td>
<td>582</td>
<td>HIV+, stable on ART</td>
<td>Self-report; physician report</td>
<td>29-1% HALS; 47% hyperlipidaemia; 9-6% T2DM</td>
</tr>
<tr>
<td>Africa</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>RT</td>
<td>571</td>
<td>HIV+, receiving ART for ≥ 6 months</td>
<td>Self-report; confirmed by physician</td>
<td>34% HALS; 9% LA; 19% LH; 72% mixed</td>
</tr>
<tr>
<td>van Griensven et al. (2007)</td>
<td>CS</td>
<td>409</td>
<td>HIV+, 21-5% M, stable on ART ≥ 1 year</td>
<td>Self-report; physician report</td>
<td>34-2% HALS; 9-8% LA; 4-9% LH; 19-6% mixed</td>
</tr>
<tr>
<td>Dakar</td>
<td>OB</td>
<td>361</td>
<td>181 HIV+ cases and 180 HIV+ controls treated with ART for 4-8 years</td>
<td>Validated physician report of patients' self-report using Carr et al. (2003)(83)</td>
<td>31-1% HALS; 13-3% LA; 14-5% LH; 3-3% mixed</td>
</tr>
<tr>
<td>Benin</td>
<td>P</td>
<td>79</td>
<td>HIV+, 40-5% M, ART-naive</td>
<td>Self-report; physician report; Biochem; IDF (2005)(83) criteria</td>
<td>Cumulative incidence HALS 30%; 9% LA; 24% LH; 2-5% mixed; 13% metabolic syndrome</td>
</tr>
<tr>
<td>Asia-Pacfic Region</td>
<td>OB</td>
<td>2072</td>
<td>HIV+ commencing ART</td>
<td>US NIH Division of AIDS (2004 version)(20) definition (severity grade ≥ 3)</td>
<td>10-5% HALS</td>
</tr>
<tr>
<td>West India</td>
<td>CS</td>
<td>180</td>
<td>HIV+ cases and 126 HIV+ controls, receiving first-line ART for &gt; 1 year</td>
<td>Self-report; physician report</td>
<td>46-1% HALS</td>
</tr>
</tbody>
</table>

Table 1. Prevalence of the HIV-associated lipodystrophy syndrome (HALS)
<table>
<thead>
<tr>
<th>Authors</th>
<th>Study design</th>
<th>n</th>
<th>Participants</th>
<th>Methods used to define HALS</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>South India</td>
<td>CS</td>
<td>363</td>
<td>145 HIV+ on ART, 146 HIV- ART-naive, seventy-two HIV-</td>
<td>–</td>
<td>60.7% HALS; 51.1% LA; 22.7% LH; 22.7% mixed</td>
</tr>
<tr>
<td>Kalyanasundaram et al. (2012)</td>
<td>CS</td>
<td>410</td>
<td>HIV+, receiving ART and ART-naive</td>
<td>Self-report; physician report</td>
<td>45.9% LA; 32.4% LH; 8.3% mixed</td>
</tr>
<tr>
<td>Singapore</td>
<td>CS</td>
<td>278</td>
<td>HIV+, 60% M, ART and ART-naive</td>
<td>Self-report; physician report</td>
<td>17% HALS</td>
</tr>
<tr>
<td>Paton et al. (2002)</td>
<td>CS</td>
<td>51</td>
<td>HIV+, ART-naive</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Thailand</td>
<td>CS</td>
<td>60</td>
<td>HIV+, receiving ART and ART-naive</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Puttawong et al. (2004)</td>
<td>CS</td>
<td>95</td>
<td>HIV+, ART-naive</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Australia</td>
<td>CS</td>
<td>295</td>
<td>HIV+, 116 receiving PI, thirty-two PI-naive</td>
<td>Self-report; physician report</td>
<td>64% HALS in PI recipients; 3% in PI-naive</td>
</tr>
<tr>
<td>Carr et al. (1999)</td>
<td>CS</td>
<td>158</td>
<td>HIV+, 113 receiving PI, forty-five PI-naive</td>
<td>Self-report; physician report</td>
<td>83% HALS in PI recipients; 4% in PI-naive</td>
</tr>
<tr>
<td>Paton et al. (2002)</td>
<td>CC</td>
<td>1081</td>
<td>HIV+, 85% M, ART and ART-naive</td>
<td>Self-report; physician report; Biochem; DXA; CT</td>
<td>9% LA; 6% LH</td>
</tr>
<tr>
<td>Carter et al. (2001)</td>
<td>CS</td>
<td>159</td>
<td>HIV+M, 76% receiving PI, 14% received PI in past</td>
<td>Self-report; physician report;Biochem; Anthro; DXA</td>
<td>HALS prevalence varied (19–65%) depending on the definition</td>
</tr>
<tr>
<td>Miller et al. (2003)</td>
<td>CS</td>
<td>1348</td>
<td>HIV+, 95% M, &gt; 17 years, 20% AIDS, ART and ART-naive</td>
<td>Physician assessment</td>
<td>53% HALS; 20% LA; 6% LH; 27% mixed</td>
</tr>
<tr>
<td>Samaras et al. (2007)</td>
<td>CS</td>
<td>788</td>
<td>HIV+, Lipodystrophy Case Definition cohort, ART and ART-naive</td>
<td>Self-report; physician report; Biochem; IDI (2005) and NCEP ATP III criteria</td>
<td>Metabolic syndrome: 14% (IDI, 2005); 18% (NCEP ATP III)</td>
</tr>
</tbody>
</table>

**USA and Canada**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Study design</th>
<th>n</th>
<th>Participants</th>
<th>Methods used to define HALS</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heath et al. (2001)</td>
<td>OB</td>
<td>1035</td>
<td>HIV+, 92% M, 62% receiving PI, 74% PI-naive</td>
<td>Self-report</td>
<td>50% HALS; 36% LA; 33% LH</td>
</tr>
<tr>
<td>Heath et al. (2002)</td>
<td>P</td>
<td>366</td>
<td>HIV+, 89% M, ART-naive</td>
<td>Self-report; Biochem</td>
<td>Cumulative incidence LA 29%; 23% LH; 13% mixed; 9% dyslipidaemia</td>
</tr>
<tr>
<td>Jacobson et al. (2006)</td>
<td>CS</td>
<td>477</td>
<td>HIV+ cases, HIV- comparison group from NHANES cohort, receiving ART</td>
<td>Physician report; Biochem; DXA; definition of metabolic syndrome†</td>
<td>24% metabolic syndrome</td>
</tr>
<tr>
<td>Lichtenstein et al. (2001)</td>
<td>OB</td>
<td>1077</td>
<td>HIV+, HOPS cohort, receiving ART</td>
<td>Self-report; physician report</td>
<td>49% HALS</td>
</tr>
<tr>
<td>Mondy et al. (2007)</td>
<td>PCS</td>
<td>471</td>
<td>HIV+, 66% M</td>
<td>Self-report; physician report; Biochem; NCEP ATP III criteria</td>
<td>26% metabolic syndrome</td>
</tr>
<tr>
<td>Sobieszczuk et al. (2008)</td>
<td>CS</td>
<td>2393</td>
<td>HIV+, F, 1725 seropositive, 668 high-risk seronegative</td>
<td>Self-report; physician report; Biochem; NCEP ATP III criteria</td>
<td>33% metabolic syndrome</td>
</tr>
<tr>
<td>Tien et al. (2003)</td>
<td>P</td>
<td>605</td>
<td>HIV+ cases, 210 HIV- controls, Women’s Interagency HIV cohort</td>
<td>Self-report; physician report</td>
<td>48.6% HALS</td>
</tr>
<tr>
<td>van der Valk et al. (2001)</td>
<td>RCT</td>
<td>175</td>
<td>HIV+, PI- or stavudine-naive</td>
<td>Self-report; physician report</td>
<td>17% HALS</td>
</tr>
<tr>
<td>Walmsley et al. (2008)</td>
<td>P</td>
<td>68</td>
<td>HIV+, 85% M</td>
<td>Self-report; physician report; Biochem; DXA, photographs at baseline and every 6 months</td>
<td>77% HALS; 25% LA; 32% LH; 19% mixed</td>
</tr>
</tbody>
</table>

**Multinational: EU, Australia, USA**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Study design</th>
<th>n</th>
<th>Participants</th>
<th>Methods used to define HALS</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worm et al. (2010)</td>
<td>POB</td>
<td>3347</td>
<td>HIV+, DAD study cohort</td>
<td>Biochem; modified NCEP ATP III criteria</td>
<td>Metabolic syndrome increased from 19-4 to 41-6% between 2000 and 2007</td>
</tr>
</tbody>
</table>

---

* Long-term follow-up of a randomised controlled trial.
† Based on the ‘Report of the National Heart, Lung, and Blood Institute/American Heart Association Conference on Scientific Issues Related to Definition’.

---

**Notes:**
- **CS**: cross-sectional; **HIV+**: HIV-positive; **F**: female; **Anthro**: anthropometry; **Biochem**: biochemical assessment; **ART**: antiretroviral therapy; **P**: prospective study; **SHCS**: Swiss HIV Cohort Study; **LA**: lipatrophy; **LH**: lipohypertrophy; **M**: male; **RCT**: randomised controlled trial; **CREATE**: Cardiovascular Risk Evaluation and Antiretroviral Therapy Effects; **IDF**: International Diabetes Federation; **NCEP ATP III**: National Cholesterol Education Program Adult Treatment Panel III; **LipolCoNa**: substudy of the Italian Cohort Naive Antiretrovirals; **DXA**: dual-energy X-ray absorptiometry; **CSOS**: cross-sectional observational study; **APRICO**: Antiprotéases Cohorte; **OB**: observational study; **T2DM**: type 2 diabetes mellitus; **RT**: randomised trial; **BIA**: bioelectrical impedance analysis; **NIH**: National Institutes of Health; **HIV-**: HIV-negative; **PI**: protease inhibitor; **CC**: case–control study; **CT**: computed tomography; **NHANES**: National Health and Nutrition Examination Survey; **HOPS**: HIV Out-Patient Study; **PCS**: prospective cross-sectional study; **EU**: European Union; **POB**: prospective observational study; **DAD**: Data Collection on Adverse Effects of Anti-HIV Drugs.

---
one of the first methods used to assess the severity of HALS in different areas of the body, including the abdomen, arms, legs, hips/buttocks and face\(^{(65)}\). Abnormalities in each area were graded from ‘subtle’ (noticeable only if looked for; no change in clothing fit), to ‘moderate’ (easily noticed by patient or physician; clothing has become tight or loose) and ‘severe’ (obvious to the casual observer; has required a change in clothing size). All changes were graded both subjectively (patient self-report) and objectively (physician examination)\(^{(65)}\). Subsequently, Carr & Law\(^{(95)}\) developed a severity grading scale based on their objective case definition of HALS; however, in the same paper they recommended abandoning the assessment of lipodystrophy severity, and suggested the lipodystrophy case definition score provided the best objective measure of severity. Recently, Fontdevila et al.\(^{(96)}\) have developed a CT-validated grading system for determining the severity of facial LA based on the loss of facial bone and muscle structures. This grading system is recommended for use when comparing the efficacy of fat grafting procedures and, therefore, may not be ideal in routine clinical practice.

In the absence of a clear definition for HALS, the incidence and prevalence of the syndrome remain uncertain\(^{(97)}\). It is clear that the definition and diagnostic criteria for HALS are poor, epidemiological data on its prevalence and incidence are also lacking, and as a result Guaraldi & Baraboutis\(^{(97)}\) question whether HALS ‘is over?’. In this paper, the authors suggest replacing the definition of HALS with the non-infectious co-morbidities that develop as a result of HIV infection.

**Morphological alterations**

In their original paper, Carr et al.\(^{(20)}\) refer to lipodystrophy as ‘fat wasting of the face, limbs and upper trunk’. Further research by the same authors acknowledged lipid accumulation as another feature of HALS\(^{(98)}\). A review, published the same year, concluded that LA and LH are distinct entities with individual pathophysiological mechanisms underlying their development\(^{(99)}\). Although these early findings separate LA and LH in the definition of HALS, recent findings conclude that the abnormalities associated with HALS, including LA and LH, can occur singly or in combination\(^{(22)}\), for the purposes of the present review they will be discussed separately.

**Lipoatrophy**

LA, characterised by loss of subcutaneous fat\(^{(100)}\), is distinctly different from the traditional HIV wasting syndrome, characterised by a disproportionate decrease in lean body mass\(^{(101)}\). LA, as a side effect of ART, is seen mainly in the face (facial LA) and the extremities (peripheral LA)\(^{(65)}\). Fat wasting of the face usually presents as malar or temporal wasting\(^{(22)}\). Peripheral fat wasting typically occurs in the arms, shoulders, buttocks and legs\(^{(102)}\). The latter type of fat wasting is often accompanied by prominent superficial veins, which contribute to the emaciated appearance observed in these individuals\(^{(103)}\).

Initial reports attributed the development of LA to PI\(^{(20)}\); however, it is now known that the use of NRTI such as d4T is more strongly linked with its development\(^{(61,104)}\). Some NRTI combinations, such as d4T and didanosine (ddI), are contraindicated as a result of their severe lipoatrophic side effects\(^{(105)}\). In addition to type of ART, a number of other risk factors for LA have been identified: including older age\(^{(105)}\), a decrease in BMI before ART\(^{(69)}\), white race\(^{(69)}\), use of PI for greater than 2 years\(^{(98)}\), and factors relating to disease progression including lower CD4 cell count\(^{(69)}\), duration and severity of HIV infection\(^{(65,106)}\) and prior diagnosis of AIDS\(^{(65)}\).

**Lipohypertrophy**

LH is characterised by adipose tissue accumulation mainly in the intra-abdominal (‘Crix belly’)\(^{(19,20,102,107,108)}\) and dorso-cervical (‘buffalo hump’) regions\(^{(17,18,109)}\). Other characteristic features of LH include breast enlargement, observed in both males and females\(^{(59,68,77,81)}\), accumulation of adipose tissue on the anterior region of the neck\(^{(110)}\), side of the neck\(^{(59,68)}\), under the axillae\(^{(110)}\) and in the suprapubic region\(^{(111)}\), and localised or generalised lipomas\(^{(56)}\). LH is distinct from simple visceral fat accumulation, as it is associated with a decrease, rather than an increase, in subcutaneous fat\(^{(90,108)}\). It is worth noting that abdominal LH is the most commonly identified lipohypertrophic change in HALS patients\(^{(52,56,57,59,68,77–81,102)}\).

Risk factors associated with the development of LH in the context of HIV and ART include age, female sex, having a BMI of greater than 25 kg/m\(^2\)\(^{(260)}\), and having a low CD4 cell count\(^{(65,69)}\). The type of ART has also been shown to play a role in the pathogenesis of LH. Jacobson et al.\(^{(46)}\) demonstrated that LH was observed in both patients who have and have not been exposed to PI, indicating that PI are not the only cause of LH. Thymidine analogues in particular have been shown to increase the risk of developing LH\(^{(71)}\). Novel drugs, such as the peptidic HIV-1 fusion inhibitor enfuvirtide, have also recently been implicated in the development of LH\(^{(112)}\). In addition to the type of ART, a longer duration of treatment has been associated with an increased risk of developing LH\(^{(79)}\).

**Metabolic alterations**

**Dyslipidaemia**

Before the advent of ART, evidence suggested that HIV infection itself caused abnormalities of blood lipids\(^{(113,114)}\). One study investigating lipid abnormalities associated with seroconversion in men found that HIV infection was associated with a reduction in total
cholesterol, LDL and HDL. Subsequent initiation of ART in the same subjects led to a significant increase in total cholesterol and LDL concentrations from baseline to follow-up, confirming the role of ART in the pathogenesis of dyslipidaemia in HIV.

The prevalence of lipid disorders in HIV-infected individuals treated with ART has been shown to vary from 24 to 72% (53, 64, 70, 75, 88, 116, 117). Characteristic lipid abnormalities associated with HALS include elevated total cholesterol and LDL, elevated TAG, and reduced HDL. Early studies attributed the development of dyslipidaemia to PI therapy (119, 120). Subsequent studies have, however, shown that both NRTI and NNRTI are involved in the development of lipid abnormalities in HIV (121, 122). Furthermore, both in vitro and in vivo studies have demonstrated an association between cART and the development of more pronounced lipid abnormalities (118, 123). A recent UK study found that impaired postprandial TAG clearance in HIV patients receiving ART was exacerbated by a combination of NRTI and PI (124). A recent retrospective cohort study from Brazil found that PI increased serum TAG but not total cholesterol concentrations in 102 HIV-infected patients (125). In the same study NNRTI were associated with an increase in total cholesterol with no significant effect on TAG levels. Similarly, Walmsley et al. (72) in their prospective cohort study of HIV patients found that after 12 months of treatment with NNRTI, only total cholesterol concentrations increased significantly. Results pertaining to the duration of ART and risk of lipodystrophy are inconsistent, with some showing that increased duration increases risk of dyslipidaemia (81, 118), while other studies have shown no effect of duration on the risk of dyslipidaemia (52).

A number of factors have been identified which are associated with an increased risk of dyslipidaemia in patients receiving ART. Similar to the general population, dyslipidaemia in HIV has been shown to occur to a greater extent in female patients (126). Although African-Americans in the general population have been shown to have a lower prevalence of hypertriglyceridaemia (127), Foulkes et al. (128) found that exposure to PI induced the greatest increase in TAG concentrations in black compared with white and Hispanic populations. This may indicate a role for race/ethnicity in increasing the risk of dyslipidaemia in HIV. It is important to note, however, that this study had, according to the authors, limited power, making it difficult to detect small interaction effects within these racial/ethnic groups. A number of polymorphisms of genes including APOA5, APOC3, APOE, sterol-regulatory element-binding protein-1c (SREBP1c) and TNF have also been associated with an increased risk of dyslipidaemia in HIV-infected individuals (129–135).

It has been suggested that the diagnosis of dyslipidaemia in HIV-infected individuals should be made using recommendations for non-HIV-infected individuals (90). For the general population, dyslipidaemia is diagnosed using a fasting lipid profile and defined using the NCEP ATP III criteria. Ideally, fasting lipid profiles should be offered to patients before initiation of ART in order to gain an insight into the exact changes caused thereafter by ART (90). LDL levels are the primary target of the NCEP ATP III guidelines, which recommend that lifestyle modifications be trialled first, followed by statins, to lower LDL (96).

**Glucose abnormalities**

Before the ART era, the development of T2DM in HIV-infected individuals was attributed to the anti-microbial medication pentamidine (134) and was relatively uncommon (135). Following the introduction of PI, however, a greater number of reported glucose disorders began to emerge in HIV-infected individuals (15, 136, 137).

Abnormalities in fasting blood glucose concentration have been found in up to 20% of patients (64, 72, 74, 88), while prevalence figures for impaired fasting glucose (59, 74, 75, 81, 88) and impaired glucose tolerance (57, 72, 73, 81, 98, 116) have been shown to vary from 3-8% to 18% and from 7 to 37%, respectively. In comparison, the prevalence of impaired glucose tolerance and impaired fasting glucose in the general population is 8-4% and 6-3%, respectively (130).

Puttawong et al. (57) and Tomazic et al. (116) identified the prevalence of insulin resistance in 30 and 38% of their HIV subjects, respectively. The prevalence of diabetes in the general population has been shown to be 9.8% for men and 9.2% for women (139), while in patients receiving ART, prevalence has been shown to range from 7 to 27% (73, 81, 98, 116). Although the aforementioned studies have shown a relationship between ART and glucose abnormalities in HALS, a number of studies have failed to show a relationship with either glycaemic parameters (74, 53, 140) or insulin resistance (141), highlighting the inconsistencies that currently exist in the literature.

Risk factors for the development of glucose abnormalities in the context of HIV and ART have been recently reviewed and were found to include older age, existing LA, non-white race, family history of T2DM, and disease factors, such as co-infection with hepatitis C (90). Furthermore, a recent study from Bangkok found that the risk of pre-diabetes in HIV-infected patients receiving ART increased with each 5 kg increase in body weight (114). In the same study, the NNRTI nevirapine was found to be protective for pre-diabetes. Both in vitro and in vivo studies have demonstrated the negative effect of PI on glucose homeostasis in HIV (27, 143, 144). Results from the Women’s Interagency HIV Study showed that long-term exposure to NRTI increased the incidence of T2DM, indicating their role in increasing the risk of glucose abnormalities in HALS (145).

Diagnosis of glucose disorders in HALS is similar to the general population and has been made on the basis of guidelines from the International Diabetes Federation (89) and the American Diabetes Association (146). According to
these guidelines, fasting plasma glucose greater than 5·6 mmol/l is defined as impaired glucose tolerance and a value greater than 7 mmol/l is indicative of frank diabetes. The American Diabetes Association criteria for diagnosing abnormalities of glucose metabolism state that patients must present with symptoms (polyuria, polydipsia, weight loss) and a random glucose of greater than 11·1 mmol/l for a diagnosis of diabetes to be made. Furthermore, Wohl et al. (147) recommend follow-up with fasting blood glucose every 3–6 months for at-risk patients and those undergoing changes in their ART regimen.

**Hypertension**

Both LA and LH have been shown to be independently associated with hypertension in HIV-infected individuals receiving ART (148). As for the general population, hypertension in HIV patients is associated with an increased risk of CVD (149). A recent UK study of HIV patients with the metabolic syndrome found that raised systolic blood pressure was associated with risk factors such as being male, higher BMI and higher CD4 cell count and viral load (148,150). Crane et al. (148) suggest that increased BMI may be involved in mediating hypertension associated with LH in HALS. When the authors adjusted for BMI, patients with LA had an increased risk of hypertension compared with those without anthropometric abnormalities (148). The role of ART in mediating hypertension is somewhat unclear. A study by Thiebaut et al. (151) showed that ART was not independently associated with any negative effects on blood pressure; in fact, use of NNRTI was associated with a lower risk of hypertension in this group.

**Carotid artery intima thickness**

Arterial stiffness has been shown to be an independent predictor of cardiovascular morbidity and mortality in the general population (152). Exposure to ART in HIV-infected individuals is associated with thickening of the carotid artery intima and arterial stiffness (153,154). Recent findings from the Women’s Intergency HIV Study and the Multicenter AIDS Cohort Study found a significant association between HIV-related immunosuppression and increased carotid artery stiffness, independent from the impact of ART or other traditional atherosclerotic risk factors (155). These results suggest that disease factors may predict the development of arterial stiffness and subsequent atherosclerosis in HALS.

**Endothelial dysfunction**

Endothelial dysfunction is a critical initial step in the progression of atherosclerosis in HIV-infected individuals (156). A recent prospective study showed that the presence of lipodystrophy predicted endothelial dysfunction in fifty-five HIV-infected patients, independent of other CVD risk factors (29). Contrary to initial findings, different classes of ART have been implicated in the pathogenesis of endothelial dysfunction in HALS (29). Currently, results appear conflicting, some showing that use of ART contributes to endothelial dysfunction (157), some showing no association between ART and endothelial function (158), and others showing improved endothelial function following treatment in previously ART-naive subjects (159). Interestingly, recent in vitro work has shown increased oxidative stress and cellular senescence in human coronary artery endothelial cells following long-term exposure to ritonavir and lopinavir–ritonavir (160), highlighting a potential mechanism for PI-associated endothelial dysfunction. Larger long-term prospective studies are, however, required to determine the effect of ART on endothelial dysfunction in vivo.

**Atherosclerosis**

Patients with lipodystrophy have been shown to be at a higher risk of atherosclerosis (161). Calza et al. (162) recently reviewed the link between HIV infection, ART and the development of premature atherosclerosis. Similar to the general population, the most commonly identified risk factors associated with atherosclerosis were age, smoking, increased BMI, hypertension and dyslipidaemia. Of nine studies, four found an association between the use of PI and premature atherosclerosis. Furthermore, three of five studies showed that HIV infection itself was associated with atherosclerosis. This, coupled with the association between risk of atherosclerosis and CD4 cell count (163), indicates that disease factors play an important role in the pathogenesis of atherosclerosis.

**CVD**

It has been well established that ART contributes to a ‘metabolic syndrome’ encompassing abdominal obesity, atherogenic dyslipidaemia, insulin resistance, endothelial dysfunction and inflammation, known as HALS. In recent years, therefore, research has begun to focus on the deleterious effects of ART on risk of CVD (155).

Early reports of CVD appeared in peer-reviewed literature shortly after the introduction of PI (164,165). Evidence for the association between ART and increased risk of CVD is, at present, inconsistent. Some studies show no association between the use of ART and risk of CVD or cerebrovascular disease (166), while others show a positive association for PI (90,118,167,168). Research has shown that between 5 and 31% of patients with HIV/AIDS are at risk for cardiovascular events (169,170,171), and, similar to the general population, patients with the metabolic syndrome have a greater risk than those without (170).

Variations in observed risk could be explained by differences in the risk factors of the study population.
Commonly identified risk factors for MI or cardiovascular events include AIDS before ART initiation, age over 40 years, cigarette smoking, family history of CVD, diagnosis of dyslipidaemia, hypertension, lipodystrophy or T2DM or pre-existing vascular disease. Unlike the general population, Bozzette et al. showed that risk of serious cardiovascular events was lower for African-American subjects, indicating that race/ethnicity may also be a risk factor. It has also been found that the prevalence of CVD is higher for patients receiving a combination of PI and NNRTI. In a recent review, Schafer et al. referred to studies which show an increased risk of CVD associated with recent, but not cumulative, use of abacavir, a NRTI. However, a recent 96-week randomised controlled trial did not find an association between the NRTI combination abacavir–lamivudine and cardiovascular morbidity and mortality in HIV-infected individuals. These researchers suggest that differences in results may be attributed to variations in pre-study viral load among patients. The increased longevity observed in the HIV population as a result of advanced drug therapy has also been associated with an increase in the incidence of CVD. Evidence indicates that disease progression and associated immune deficiency in HIV patients are associated with an increased CVD risk. Recent evidence that a low CD4 cell count was associated with an increased prevalence of carotid artery lesions in HIV patients further supports this finding. Paradoxically, interruption of ART has been shown to increase CVD risk, suggesting that HIV infection itself may play a role in increasing the risk of CVD. A recent treatment interruption trial in Thai HIV-infected patients demonstrated an association between markers of CVD, including increased vascular cell adhesion molecule-1, decreased adiponectin, and increased HIV RNA replication, which further supports this finding.

Currently, risk-prediction models such as the Framingham score are recommended for use in estimating CVD risk. The Framingham equations, developed over a decade ago for use in non-HIV-infected individuals, have been used to estimate CVD risk in HIV-infected subjects; however, studies assessing the accuracy of this model in HIV-infected patients are limited. Fris-Moller et al., in a large prospective cohort, used CVD risk-scoring estimates for the general population to determine cut-offs to define HIV patients at ‘high risk’ of CVD. More recently, May et al. have developed another risk model for predicting the risk of MI or death from CHD in HIV-infected men. These researchers use data from five cardiovascular cohorts of HIV-uninfected men and adapt the model for the known risk factors observed in HIV patients following initiation of ART. However, the authors state that only a modest change in CHD risk factors may be detected using the risk model. In addition, the model does not take into account changes in CHD risk attributable to lifestyle changes. To the best of the current authors’ knowledge, this model has also not yet been evaluated.

Underlying molecular mechanisms

Altered adipocyte inflammatory status

Studies of human adipose tissue from HIV-infected patients receiving ART have demonstrated an increase in the expression of genes relating to inflammation. In particular, HALS has been associated with an increase in pro-inflammatory cytokine expression, in addition to increased systemic pro-inflammatory cytokine activity. Increased circulating levels of TNF-α, IL-6 and IL-1β have been shown in both in vitro and ex vivo studies. IL-6 has been shown to mediate insulin resistance and may modulate insulin signalling in adipose tissue. A large body of research has focused on the hypersecretion of TNF-α, which has a number of pathophysiological effects including mediating insulin resistance via reduction of insulin receptor kinase activity, inducing apoptosis and lipolysis, and down-regulating insulin receptor kinase substrate (IRS)-1 and GLUT-4. IL-6 has been shown to mediate insulin resistance and modulate insulin signalling in adipose tissue.

In addition to an increase in inflammatory cytokine production, HALS has been associated with a reduced expression of adiponectin in both plasma and adipose tissue. Adiponectin is a potent insulin sensitiser and, hence, its down-regulation contributes to insulin resistance. In vitro and ex vivo studies have shown reduced expression, secretion and release of adiponectin from adipose tissue, while in vivo studies in HALS patients have identified the presence of hypoadiponectinaemia, which is a risk factor for cardiovascular impairment. Inhibition of adipocyte differentiation, such as that caused by PI, has been shown to down-regulate adiponectin expression. Furthermore, down-regulation of adiponectin expression by NRTI has been suggested to occur as a result of the reduction in fat mass associated with NRTI use. Malleva et al. also refer to the negative feedback loop that exists between cytokines, whereby high levels of TNF-α and IL-6 may inhibit the expression of adiponectin, which may also account for the observed reduction in adiponectin in HALS.

Adipose tissue macrophage infiltration, resulting in chronic low-grade inflammation, has also been suggested
to contribute to the development of HALS\(^ {198}\). Macrophage infiltration of adipose tissue has been shown to be greater in HALS patients compared with healthy controls\(^ {183}\). Recently, Hammond \textit{et al.}\(^ {179}\) demonstrated an increase in adipose tissue macrophage count associated with thymidine NRTI treatment.

**Altered adipocyte functionality**

Microarray analysis of gene expression during adipogenesis has revealed numerous effects of ART on genes involved in adipocyte lipid and glucose metabolism\(^ {196}\). In a recent study, Sievers \textit{et al.}\(^ {184}\) showed that NRTI caused a general decrease in the expression of genes involved in adipocyte differentiation and lipid and glucose metabolism within the cell (CCAAT/enhancer-binding protein-\(\alpha\) (\textit{CEBP}\(\alpha\)), \textit{CEBBP}, cyclo-oxygenase-3 (\textit{COX3}), \textit{GLUT4}, hexokinase-1 (\textit{HEXOK1}), perilipin (\textit{PLIN}), \textit{SREBP1c}), and an increase in markers of cell proliferation and genes involved in mitochondrial transcription (\textit{COX4}, \textit{HEXOK1}, \textit{LAMINB}, \textit{LAMINA}), proliferating cell nuclear antigen (PCNA), PPAR-\(\gamma\) co-activator-1b (\textit{PGC1B}).

Similarly, a number of \textit{in vitro} studies have demonstrated changes in gene expression following exposure of adipocytes to antiretroviral drugs. Both PI and NRTI have been shown to down-regulate the expression of adipocyte differentiation genes such as \textit{Pparg}, \textit{Cebp}, adiponectin (\textit{Adipop}), leptin (\textit{Lept}), the scavenger receptor \textit{CD36}, \textit{Cd36}, adipocyte lipid-binding protein-2 (\textit{Ap2}), fatty acid synthase (\textit{fasn}) and acetyl-coenzyme A Carboxylase (\textit{Acc})\(^ {196,199}\). In particular, the NRTI d4T and ZDV have been found to cause a reduction in mRNA expression of adipogenic markers involved in lipid accumulation including fatty acid synthase, acetyl-coenzyme A Carboxylase and adipocyte lipid-binding protein-2\(^ {196,196,199,200}\). Pacenti \textit{et al.}\(^ {190}\) demonstrated that NRTI regulate the expression of various transcription factors, such as \textit{Aebp1}, \textit{Pou5f1} and \textit{Phf5}, which may play a role in determination of the adipocyte phenotype.

Adiponectin plays a role in glucose and lipid metabolism within the adipocyte\(^ {182}\) and a number of \textit{in vitro} studies have shown a reduction in adiponectin expression following exposure of 3T3-L1 murine and Simpson–Goldabi–Behmel syndrome (SGBS) human adipocytes to PI\(^ {182,196,200}\). These alterations in gene expression correspond with findings of altered adipocyte function including reduced capacity of insulin to activate lipogenesis\(^ {199}\), decreased lipid accumulation\(^ {199}\) and reduced adipocyte lipid content\(^ {181,182}\).\(^ {2}\)

Two \textit{ex vivo} studies have investigated gene expression in subcutaneous adipose tissue samples from HALS patients and found reduced nuclear mRNA expression of mitochondrial proteins (PGC-\(1\alpha\), transcription factors (PPAR-\(\gamma\)) and adipocyte metabolic markers (GLUT-4, lipoprotein lipase)\(^ {193,201}\). Further support for these findings comes from results by Kim \textit{et al.}\(^ {201}\), which showed that the expression of PPAR-\(\gamma\) increased after PI withdrawal. Moreover, mRNA expression of uncoupling protein-3 and preadipocyte factor-1, both inhibitors of adipocyte differentiation and metabolism, has been shown to be increased in HALS\(^ {193}\). As with the work of Sievers \textit{et al.}\(^ {184}\), these findings suggest that ART impair mitochondrial biogenesis, adipocyte differentiation and metabolism, and are involved in the down-regulation of adipogenic transcription factors.

**Mitochondrial toxicity**

ART-mediated inhibition of mitochondrial DNA-polymerase-\(\gamma\), leading to mitochondrial toxicity, has been suggested to not only be involved in cell death and loss of fat mass, but in the aetiology of alterations in adipose tissue function\(^ {179}\). As a result of these defects in adipose tissue function, the liver and skeletal muscles are exposed to increased concentrations of fatty acids, which has been associated with the development of the metabolic alterations seen in HALS\(^ {202}\). Studies examining the effect of ART on mitochondrial toxicity are somewhat conflicting, with some showing limited or no effect of certain ART regimens on mitochondrial toxicity\(^ {203,204}\), while others found effects for both single ART and cART\(^ {179,199,205}\). According to Walker \textit{et al.}\(^ {206}\), mitochondrial toxicity is sometimes more pronounced with use of cART. A recent study examining the effect of switching from d4T to tenofovir found improvements in mitochondrial toxicity after just 1 month\(^ {207}\). Mallewa \textit{et al.}\(^ {188}\) suggest that these observed differences may be due to differing levels of affinity of the active metabolites of the drugs for mitochondrial DNA-polymerase-\(\gamma\). Furthermore, PI and NRTI have been associated with increased oxidative stress, which has been shown to induce mitochondrial dysfunction in 3T3-F442A adipocytes\(^ {208,209}\). This PI- and NRTI-associated mitochondrial dysfunction and oxidative stress have also been shown to trigger premature senescence in a number of cell models, including primary human fibroblasts\(^ {208}\), human coronary artery endothelial cells and peripheral blood mononuclear cells\(^ {160}\). In the context of HIV and ART, it has been suggested that premature senescence may contribute to accelerated cellular ageing, which might increase the risk of premature CVD as observed in HALS\(^ {160}\).

**Treatment**

**Pharmacological and surgical management**

A number of pharmacological and surgical interventions have been used in the management of HALS. Pharmacological interventions include switching to more ‘lipid-friendly’ antiretrovirals\(^ {210}\), use of synthetic growth hormone analogues to reduce excess visceral adipose tissue\(^ {211}\), statins to improve dyslipidaemia\(^ {212–214}\) and...
anti-diabetic drugs\(^{(215–218)}\) to improve glucose abnormalities. A number of adverse events are associated with these pharmacological interventions, which range from drug–drug interactions\(^{(219)}\) to more serious side effects such as a higher virologic failure\(^{(220,221)}\) and increased risk of MI\(^{(222)}\) (Table 2).

To correct the morphological abnormalities associated with HALS, patients often undergo surgical procedures. These include liposuction\(^{(223)}\) and excisional lipectomy\(^{(224)}\) for LH and silicone gluteal prostheses\(^{(225)}\), facial fillers\(^{(226–228)}\), facial grafting\(^{(96)}\) and fat transplantation\(^{(229)}\) for LA. Surgical interventions such as these are radical interventions and are associated with numerous adverse events, which often offset their success (Table 2).

**Lifestyle interventions**

Although pharmacological and surgical interventions have a role to play in the management of HALS, lifestyle interventions are increasingly being trialled as first-line strategies in the management in HALS, due to their greater safety and tolerability.

**Exercise**

A number of studies have investigated the role of exercise in improving the systemic parameters in HALS and have shown mixed results. One study failed to show an effect of exercise and resistance training in improving lipid parameters in HALS\(^{(230)}\), while four have shown a beneficial effect, particularly in reducing central fat accumulation and in increasing body weight and limb girth\(^{(231–234)}\).

A recent cross-sectional study investigated the effect of leisure time physical activity on central fat accumulation in adults receiving ART and showed a significant negative correlation between leisure time physical activity and central fat\(^{(235)}\). As for the general population, exercise in HALS patients has proven effective in improving lipid parameters and insulin resistance. Yarasheski et al.\(^{(236)}\) investigated the effect of exercise on dyslipidaemia and showed that progressive weight-lifting reduced serum TAG levels in eighteen men receiving ART. Furthermore, a recent study of twenty men receiving supervised strength and endurance training demonstrated increases in insulin-mediated glucose uptake and hence improved insulin sensitivity after 16 weeks of training\(^{(237)}\). Overall, it appears that exercise has a beneficial effect in improving lipid parameters and central adiposity in HALS.

**Nutrition**

Relatively little is known about the influence of diet on the metabolic complications of HIV and associated lipodystrophy\(^{(238)}\). There are a number of studies that have generally investigated the area by cross-sectional analysis of diet and systemic parameters of HIV-positive adults with and without lipodystrophy. Dietary fibre intake has been shown to be positively associated with metabolic health in HIV-positive adults\(^{(40,41,43)}\). In another study, fibre had no association\(^{(239)}\). A recent Brazilian cross-sectional study found that individuals with HIV who consumed more than two servings of dairy food per day had a lower BMI, waist circumference and blood pressure than those who consumed less than this amount\(^{(42)}\).

### Table 2. Adverse events associated with the pharmacological and surgical management of the HIV-associated lipodystrophy syndrome

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Associated adverse event(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacological</strong></td>
<td></td>
</tr>
<tr>
<td>Switch strategies</td>
<td>Higher virologic failure(^{(217)})</td>
</tr>
<tr>
<td>Switch from one PI to another, for example, atazanavir</td>
<td>Higher virologic failure(^{(216)})</td>
</tr>
<tr>
<td>Switch from PI to NRTI, for example, abacavir</td>
<td>Arthralgia, erythema and pruritis at site of injection; abdominal pain, swelling, myalgia; worsening glycaemic control(^{(207)})</td>
</tr>
<tr>
<td>Synthetic growth hormone analogues</td>
<td>Pharmacokinetic interaction with PI(^{(209,210,215)})</td>
</tr>
<tr>
<td>Growth hormone-releasing hormone:</td>
<td>Glucose intolerance; transient increases in insulin resistance(^{(248)})</td>
</tr>
<tr>
<td>tesamorelin (Egrifta(^{e}))</td>
<td>Increased risk of lactic acidosis when taken with NRTI(^{(213,214)})</td>
</tr>
<tr>
<td>Lipid-lowering drugs</td>
<td>Increased postprandial lipaemia; increased risk of myocardial infarction(^{(214,218)})</td>
</tr>
<tr>
<td>Statins</td>
<td>Pharmacokinetic interaction with PI(^{(214)})</td>
</tr>
<tr>
<td>Niacin</td>
<td>Relapse/recurrence of abdominal lipohypertrophy common(^{(219)})</td>
</tr>
<tr>
<td>Anti-diabetic drugs</td>
<td>High rate of recurrence of dorsocervical fat pad(^{(220)})</td>
</tr>
<tr>
<td>Metformin</td>
<td>Painful postoperative period(^{(221)})</td>
</tr>
<tr>
<td>Rosiglitazone</td>
<td>Granuloma formation; local migration of particles(^{(96)})</td>
</tr>
<tr>
<td>Pioglitazone</td>
<td>Operative risks and facial fat hypertrophy(^{(225)})</td>
</tr>
<tr>
<td>Surgical</td>
<td>Fat resorption(^{(96)})</td>
</tr>
<tr>
<td>Lipohypertrophy</td>
<td></td>
</tr>
<tr>
<td>Ultrasonic liposuction</td>
<td></td>
</tr>
<tr>
<td>Excisional lipectomy</td>
<td></td>
</tr>
<tr>
<td>Lipohypertrophy</td>
<td></td>
</tr>
<tr>
<td>Silicone gluteal prostheses</td>
<td></td>
</tr>
<tr>
<td>Facial fillers</td>
<td></td>
</tr>
<tr>
<td>Fat transplantation</td>
<td></td>
</tr>
<tr>
<td>Facial grafting</td>
<td></td>
</tr>
</tbody>
</table>

\(^{e}\) PI, protease inhibitor; NRTI, nucleoside RT inhibitor.
The authors of this study suggest that Ca intake may be involved in mediating these changes. In most cross-sectional studies no association was found between saturated fat, total fat, or other fat subclasses, and metabolic health in HIV-positive adults. Samaras et al. in their study of men with HALS showed that saturated fat intake was significantly positively associated with percentage body fat. Weak evidence suggests that polyunsaturated fat intake is positively associated with insulin sensitivity in HIV-infected individuals. Contrary to these findings, Samaras et al. demonstrated that fat subtype did not relate to fasting insulin, insulin resistance, total cholesterol, HDL, TAG, glucose or adiponectin concentrations in HALS.

Turčinov et al. cross-sectionally investigated the diets of 136 HIV-positive Croatian adults on ART. Adherence to a Mediterranean diet was assessed by a 150-item questionnaire and a point scale that stratified subjects as having low or moderate to high adherence. Although HALS was not an inclusion factor in the study, it was determined that Croats who did not smoke and moderately or highly adhered to the Mediterranean diet were least likely to have LA and LH. In another cross-sectional study, adherence to a Mediterranean-style diet was positively correlated with HDL and marginally negatively correlated with TAG levels.

Interestingly, a negative association between total and supplemental vitamin E intake and diastolic blood pressure has been shown among HIV-positive adults. Two association studies have shown that dietary energy intake is not associated with metabolic dysregulation among HIV-positive adults, and one has shown significant positive associations.

A number of intervention studies have investigated the effects of diet in mitigating the metabolic and morphological abnormalities of HALS. Barrios et al. showed that adherence to a low-fat diet for 6 months reduced total cholesterol by 10% and TAG by 23% among HIV-positive adults, and one has shown significant positive associations.

An interesting set of studies by Kosmiski et al. has shown that lipodystrophy in HIV is associated with an increase in resting energy expenditure (REE) per kg lean body mass. Furthermore, 3 d of eu-energetic feeding, which normally would not induce a change in REE, resulted in a significant increase in REE among HIV-positive adults with lipodystrophy compared with HIV-positive adults without lipodystrophy and healthy controls. The same researchers found that 3 d of hypo-energetic feeding induced a significant drop in REE and 3 d of hyper-energetic feeding induced a significant increase in REE in HIV-positive adults with lipodystrophy compared with HIV-positive adults and healthy controls. The group concluded that lipodystrophic subjects have higher REE per kg lean body mass than non-lipodystrophic subjects, that short-term over-feeding increases REE among lipodystrophic subjects and that short-term energy restriction reduces REE among lipodystrophic subjects. The authors suggest that hypermetabolism associated with lipodystrophy, and a form of adaptive thermogenesis invoked to dissipate energy that cannot be stored in a normal manner underlie these observations.

Despite weak support from observational studies, a number of intervention trials focusing on the role of n-3
### Table 3. Intervention trials investigating the effect of nutrition in the HIV-associated lipodystrophy syndrome (HALS)

<table>
<thead>
<tr>
<th>Reference</th>
<th>Study design</th>
<th>n</th>
<th>Subjects</th>
<th>Type of intervention</th>
<th>Duration</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barrios et al. (2002)</td>
<td>PI</td>
<td>230</td>
<td>HIV+, dyslipidaemic, receiving ART</td>
<td>Low-fat diet</td>
<td>6 months</td>
<td>TC, TAG and weight significantly in subjects with good compliance. Patients receiving protease inhibitors had a slightly greater decline in lipid levels than those not on protease inhibitors</td>
</tr>
<tr>
<td>Kosmiski et al. (2007)</td>
<td>CT</td>
<td>28</td>
<td>HIV+, 82% M, nine HALS +, ten HALS −, nine healthy controls</td>
<td>3 d eu-energetic feeding followed by 3 d overfeeding.</td>
<td>6 d</td>
<td>REE significantly in HALS + but not control groups</td>
</tr>
<tr>
<td>Kosmiski et al. (2007)</td>
<td>CT</td>
<td>30</td>
<td>HIV+, 77% M, eleven HALS +, ten HALS − (all receiving ART); nine healthy controls</td>
<td>3 d eu-energetic feeding followed by 3 d hypoenergetic feeding</td>
<td>6 d</td>
<td>REE significantly higher in HALS + compared with HALS − and healthy controls. Energy restriction caused significant decline in REE in HALS + but not in HALS − and healthy controls</td>
</tr>
<tr>
<td>Ng et al. (2011)</td>
<td>Pilot RCT</td>
<td>48</td>
<td>HIV+</td>
<td>Modified Mediterranean diet v. low-fat, low-cholesterol diet</td>
<td>1 year</td>
<td>Mediterranean diet: no change in TAG, significant ↑ serum TC</td>
</tr>
<tr>
<td>Roubenoff et al. (2002)</td>
<td>CR</td>
<td>1</td>
<td>HIV+, M, receiving ART</td>
<td>Moderate-fat, low-GI, high-fibre diet + exercise three times per week</td>
<td>4 months</td>
<td>↑ Total and trunk fat, LDL, TC, fasting glucose and insulin resistance</td>
</tr>
<tr>
<td>Terry et al. (2006)</td>
<td>RCT</td>
<td>30</td>
<td>HIV+, 67% M, HALS, receiving ART</td>
<td>Low-lipid diet + aerobic exercise</td>
<td>3 months</td>
<td>Body weight, body fat and WHR significantly ↓</td>
</tr>
<tr>
<td>Vázquez et al. (2006)</td>
<td>CR</td>
<td>1</td>
<td>HIV+, M, HALS, receiving ART</td>
<td>Eu-energetic substitution of MCT for long-chain fatty acids</td>
<td>3 months</td>
<td>↑ Lean mass, ↓ fat mass, improvement in lipid profile</td>
</tr>
<tr>
<td>Wohl et al. (2005)</td>
<td>OLRT</td>
<td>26</td>
<td>HIV+, hypertriacylglycerolaemic</td>
<td>Diet (↑ total and trans-fat, ↑ fibre) + aerobic exercise</td>
<td>16 weeks</td>
<td>Significant ↓ BMI at week 16</td>
</tr>
<tr>
<td>Supplements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benedini et al. (2009)</td>
<td>RIT</td>
<td>9</td>
<td>HIV+, 56% M, receiving protease inhibitors/NRTI, nine healthy controls</td>
<td>2 g L-acetylcarnitine per d</td>
<td>8 months</td>
<td>↑ Intramyocellular TAG content; ↓ plasma NEFA; ↑ respiratory quotient; ↑ % leg fat</td>
</tr>
<tr>
<td>Balasubramanyam et al. (2011)</td>
<td>RDBPCT</td>
<td>191</td>
<td>HIV+, hypertriacylglycerolaemic</td>
<td>Diet + exercise + niacin (2 g/d)</td>
<td>24 weeks</td>
<td>Significant ↑ HDL</td>
</tr>
<tr>
<td>Calmy et al. (2010)</td>
<td>PR</td>
<td>45</td>
<td>HIV+, M, lipoatrophic patients</td>
<td>36 g uridine t.d.s.</td>
<td>24 weeks*</td>
<td>No significant ↓ in limb fat mass</td>
</tr>
<tr>
<td>McComsey et al. (2007)</td>
<td>POL</td>
<td>14</td>
<td>HIV+, 79% M, receiving ART, lipoatrophic patients</td>
<td>36 g NucleomaxX (uridine) t.d.s. every other day</td>
<td>32 weeks†</td>
<td>Lipatrophy scores by patient and physician improved significantly at weeks 16 and 32 compared with baseline. No changes in fat or blood mitochondrial DNA levels</td>
</tr>
<tr>
<td>Sutinen et al. (2007)</td>
<td>RDBPCT</td>
<td>20</td>
<td>HIV+, 85% M, ten cases, ten controls, receiving ART, lipoatrophic patients</td>
<td>36 g uridine supplement t.d.s.</td>
<td>3 months</td>
<td>Significant ↑ total limb fat, intra-abdominal fat and total body fat from baseline to 3 months in intervention group. Non-significant ↓ in HDL in intervention group</td>
</tr>
</tbody>
</table>

PI, prospective intervention; HIV+, HIV-positive; ART, antiretroviral therapy; TC, total cholesterol; ↓, decrease; CT, control trial; M, male; HALS +, HIV patients with HALS; HALS −, HIV patients without HALS; REE, resting energy expenditure; ↑, increase; RCT, randomised controlled trial; CR, case report; GI, glycaemic index; WHR, waist/hip ratio; MCT, medium-chain TAG; OLRT, open-label randomised trial; RIT, randomised intervention trial; NRTI, nucleoside RT inhibitor; RDBPCT, randomised double-blind placebo-controlled trial; PR, prospective randomised trial; t.d.s., ter die sumendum (three times per d); POL, prospective open label study. *10 d per month for 24 weeks. †16-week intervention followed by 16-week washout.
long-chain PUFA (n-3 LC-PUFA) in mitigating the metabolic abnormalities in HALS patients have been pursued. In the pre-ART era, intervention trials investigating the immunomodulatory effects of EPA and DHA as an adjunct therapy in HIV patients were pursued\(^{(256)}\). Their hypothesis was based on the immunomodulatory effects of EPA and DHA previously documented. Evidence strongly supports a role for n-3 LC-PUFA in HIV therapy, but in lipid lowering rather than immune regulation.

In a study of 120 HIV-positive adults on ART, 8 weeks of supplementation with 6 g n-3 LC-PUFA per d induced a 25-5 and 38.7% reduction in plasma TAG concentrations among moderate and severe hypertriacylglycerolaemics, respectively\(^{(257)}\). Similarly, plasma TAG concentrations decreased by 25% following 4 weeks of supplementation with 1750 mg EPA and 1150 mg DHA per d among fifty-two HIV-positive adults with moderately raised TAG\(^{(258)}\). In a study of 100 HIV-positive adults with hypertriacylglycerolaemia, fish oil supplements taken at 6 g/d for 8 weeks reduced TAG concentrations by 46%, fenofibrates reduced TAG concentrations by 58%, and the combination of fish oil and fenofibrates by 65.5%\(^{(259)}\). Manfredi et al.\(^{(260)}\) showed that rates of TAG normalisation were non-significantly different, at 25.9 and 34%, between HIV-positive subjects with raised TAG supplemented with ethyl esters of n-3 LC-PUFA or treated with pharmaceutical lipid-lowering therapy, respectively. Salmon oil, administered at 3 g/d, significantly reduced TAG concentrations after 12 to 24 weeks of supplementation in eighty-eight HIV-positive adults on ART\(^{(261)}\). The TAG-lowering effects of the n-3 LC-PUFA among HIV-positive adults are supported by three smaller prospective studies\(^{(262–264)}\), although Virgili et al.\(^{(265)}\) showed no significant effect among nine HIV-positive subjects receiving 1120 mg EPA and 720 mg DHA daily for 6 weeks. A review of 237 hospital charts from HIV-positive adults with hypertriacylglycerolaemia showed that the use of n-3 LC-PUFA supplements was associated with a 32% reduction in TAG concentrations\(^{(266)}\). Furthermore, at baseline 11% of subjects used these dietary supplements, whereas at 6 months 25% of subjects used the supplements\(^{(266)}\). This demonstrates an enthusiasm and acceptance of these dietary supplements by HIV-positive adults with hypertriacylglycerolaemia. The effects of n-3 LC-PUFA on lipoprotein concentrations in HIV-positive adults are unclear, with no effect\(^{(262)}\), 11% raised HDL\(^{(266)}\) and 22.4% raised LDL\(^{(258)}\) reported.

EPA and DHA have been shown to have anti-inflammatory effects in vitro via their role as PPAR-γ ligands\(^{(267)}\) and modulation of the NF-κB signalling system\(^{(268,269)}\). Despite the strength of evidence to support anti-inflammatory effects of EPA and DHA in vitro, studies investigating the effects of n-3 LC-PUFA supplementation on cytokine production in HIV-positive adults are limited. One study found no effects on the concentration of the soluble TNF-α receptor following 6 months of dietary supplementation with a product containing 17 g n-3 LC-PUFA and 7.4 g arginine\(^{(270)}\). Another study demonstrated that among ten subjects consuming a bar containing 1.96 g n-3 LC-PUFA, PGF-1α secretion was decreased, and IL-1β and IL-6 secretion increased, from peripheral blood mononuclear cells\(^{(271)}\). Overall, n-3 LC-PUFA appear to have beneficial TAG-lowering effects; however, their role in modulating inflammation in HALS remains to be elucidated.

Conclusion

There is a clear disparity in the reported prevalence of HALS owing to lack of a standardised definition, use of different methods for diagnosing the syndrome, as well as variations in the study population. It has been suggested that the search for a standardised definition for HALS should be abandoned and instead replaced with a description of the non-infectious co-morbidities associated with HIV, a condition that is slowly and globally acquiring chronic disease status. HALS is associated with fat maldistribution and metabolic complications such as dyslipidaemia, insulin resistance, hypertension, endothelial dysfunction and atherosclerosis, which lead to a rise in the incidence of CVD among this population group. Alterations in adipocyte inflammatory status and functionality, as well as mitochondrial toxicity, have been shown to underlie the development of HALS. Although current pharmacological and surgical interventions are effective in the treatment of HALS, their use is not without limitations. Targeted lifestyle interventions, such as exercise, may provide a useful alternative for managing non-infectious co-morbidities in HIV patients. Diet, particularly in the context of what we currently consider cardioprotective, appears to offer a safe, tolerable and effective treatment strategy for HALS, with evidence accumulating to supporting the use of n-3 LC-PUFA in future interventions.

Acknowledgements

The present review received no specific grant from any funding agency in the public, commercial or not-for-profit sectors. C. L. completed the review; A. M. advised in relation to the review content and approach and critically evaluated the manuscript. Both authors approved the final review. The authors declare no conflicts of interest.

References

Nutrition Research Reviews

et al

19. Viraben R & Aquilina C (1998) Indinavir-associated lipo-

dysmetabolicsyndromeinHIV-infectedpatientsreceiving

highlyactiveantiretroviralthereapyusingInternational

DiabetesFoundationandAdultTreatmentPanelIICriteria.

Diabetes Care 30, 113–119.


metabolic syndrome in HIV-infected patients receiving

highly active antiretroviral therapy using International

Diabetes Foundation and Adult Treatment Panel III criteria.

Diabetes Care 30, 113–119.


in patients receiving protease inhibitors for the treatment of

human immunodeficiency virus (HIV). http://www.fda.gov/

ForConsumers/ByAudience/ForPatientAdvocates/HIVand

AIDSActivities/ucm118915.htm


glucose tolerance, β-cell function and lipid metabolism in

HIV patients under treatment with protease inhibitors.

AIDS 13, F63–F70.


and the prevalence and incidence of diabetes mellitus in the

Multicenter AIDS Cohort Study. Arch Intern Med 165,

1179–1184.


function is impaired in HIV-infected patients with lipo-
dysmetabolicsyndrome. Antivir Ther 15, 101–110.

nation antiretroviral therapy and the risk of myocardial


disease risks and lifestyle behaviors in persons with HIV

infection. J Assoc Nurses AIDS Care 17, 3–17.

32. Mondy K, Overton E, Grubb J, et al. (2007) Metabolic syn-
drome in HIV-infected patients from an urban, midwestern


disease in HIV-infected patients in the highly active antire-
troversial treatment era. AIDS 17, Suppl 1, S70–S76.


infarction in human immunodeficiency virus-infected


35. Bozzette SA, Ake CF, Tam HK, et al. (2008) Long-term sur-

vival and serious cardiovascular events in HIV-infected

patients treated with highly active antiretroviral therapy.

AIDS 22, 91–99.


Cardiovascular manifestations in human immunodeficiency

virus-infected patients. Am J Cardiol 102, 635–642.


the risk of cardiovascular disease in HIV-infected patients:

the data collection on adverse effects of anti-HIV drugs


aging in HIV-infected patients. Clin Infect Dis 49,

1756–1762.


ican Dietetic Association: nutrition intervention and human

immunodeficiency virus infection. J Am Diet Assoc 110,

1105–1119.


diet in HIV-positive men is associated with lower risk of


diet, exercise and smoking in dyslipidemia in HIV-infected

patients with lipodystrophy. HIV Med 6, 291–298.

42. Leite LHM & Sampaio ABMM (2010) Dietary calcium, dairy

food intake and metabolic abnormalities in HIV-infected


dietary habits and their relation to metabolic abnormalities

in men and women with human immunodeficiency virus


and linked to morphological changes and insulin resistance in HIV-1-infected lipodystrophic patients. *Antivir Ther* **9**, 555–564.


221. van Vonderen MGA, Gras L, Wit F, et al. (2009) Baseline lipid levels rather than the presence of reported body shape changes determine the degree of improvement in lipid levels after switching to atazanavir. *HIV Clin Trials* 10, 168–180.


