

Federal HIV Guidelines Add Chapter on Cardiovascular and Metabolic Health

Latest update includes expanded information about chronic inflammation, statin therapy, weight gain and the cost of antiretroviral treatment.

October 8, 2025 By [Liz Highleyman](#)

On September 25, the Department of Health and Human Services released the latest update to its [Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV](#). Among the changes is a new chapter on cardiovascular and metabolic health for people living with HIV. The guidelines are revised periodically by an expert panel as more data become available.

The new chapter covers immune activation and inflammation, cardiovascular complications, statin therapy and weight gain. “Other important cardiovascular disease manifestations and metabolic complications are not currently covered in detail here, such as insulin resistance and risk for diabetes mellitus, metabolic syndrome, metabolic dysfunction-associated steatotic liver disease, heart failure, sudden cardiac death and bone disease,” the authors write. “At this time, guidance on the management of these conditions remains similar for people with and without HIV infection. Still, these conditions represent areas of active research, and as future evidence arises that informs management specific to people with HIV, this section may be expanded.”

As effective antiretroviral therapy has enabled people with HIV to live longer, they are prone to a host of age-related comorbidities, including heart disease, diabetes, kidney and liver disease, certain cancers and cognitive impairment. All of these are linked to persistent immune activation and chronic inflammation, which occurs even among people on effective treatment with viral suppression.

Much remains to be learned about this phenomenon and how to manage it. For now, the guidelines do not recommend switching or adding antiretroviral drugs solely to reduce immune activation or inflammation, except in clinical trials. The use of immunomodulatory or anti-inflammatory therapies and routine monitoring of biomarkers of immune activation or inflammation are also not recommended.

People living with HIV have about a twofold higher risk for developing atherosclerotic cardiovascular disease compared with their HIV-negative peers. HIV-positive women have an even greater increase in relative risk. What’s more, standard risk equations tend to underestimate cardiovascular risk in people with HIV, especially women.

In 2024, [the guidelines added a recommendation](#) for statin therapy for HIV-positive people ages 40 to 75 with low to moderate cardiovascular risk scores, based on findings from the [REPRIEVE trial](#). The large study showed that people in this group who took a daily statin lowered their risk for heart attack, stroke and other major cardiovascular events by 35%. The guidelines favor statins even for those with low risk scores, though the benefits are more modest and the evidence is less compelling for this group. Regardless of HIV status, statins are strongly recommended for people with high cardiovascular risk scores. There is not enough evidence to make a recommendation for people under 40.

The guidelines also call for counseling about ways to reduce cardiovascular risk through behavioral modifications such as a healthy diet, weight management, regular exercise, smoking cessation and limiting alcohol consumption. “Optimal management of comorbidities (e.g., hypertension, diabetes, obesity) remains important to further reduce cardiovascular disease risk among people with HIV,” the guidelines state.

Weight gain is also a growing concern for people living with HIV. Studies of the association between antiretroviral therapy and weight gain have yielded mixed results. The guidelines emphasize that people should not delay or interrupt antiretroviral treatment or switch drugs in an effort to control their weight. However, clinicians should include weight monitoring and counseling as part of comprehensive care for people with HIV. Lifestyle modification, including healthy eating and exercise, “remains the starting point and gold standard weight management intervention,” according to the authors.

This section touches on GLP-1 agonists—popular weight-loss drugs like semaglutide (Wegovy or Ozempic) and tirzepatide (Zepbound or Mounjaro)—but notes that there have been few studies of their use by people living with HIV. [Recent small studies](#) suggest that GLP-1 agonists may help reduce inflammation, improve cognitive function and gut health, reduce alcohol use and even slow biological aging in people with HIV. The [SLIM LIVER trial](#) found that semaglutide reduced liver fat by about 30% in HIV-positive people with metabolic dysfunction-associated steatotic liver disease (MASLD). In August, the Food and Drug Administration [approved Wegovy](#) as a treatment option for metabolic dysfunction-associated steatohepatitis (MASH), a more advanced stage of fatty liver disease, based on a study of HIV-negative people.

The latest guidelines also include some key updates to other sections, including laboratory testing for initial assessment and monitoring of people on antiretroviral therapy, viral load and CD4 count monitoring, initiation of antiretroviral treatment and suboptimal CD4 cell recovery despite viral suppression.

The update also discusses cost considerations around antiretroviral treatment. The authors note that disengagement from HIV care occurs more frequently during transitions in care and coverage, for example, transitioning from pediatric to adult care, being released from incarceration, moving from one state to another, changing employment status or switching insurance, including transitioning to Medicare as people age.

“The complexities of the U.S. health care system may require that the costs for antiretroviral therapy, especially out-of-pocket costs for the person with HIV, be one of the considerations in regimen selection, because such expenditures can directly affect affordability and adherence,” the authors write. “Health insurance and prescription drug coverage can directly affect clinical outcomes for people with HIV; changes to coverage can result in lapses in viral suppression and should be anticipated as best possible.”

Click here to read the full [Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV](#).

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