Original Research Article

Comparison and evaluation of the clinical features of the patients of ART 1 failure who have started ART 2 medication

R. K. Verma¹, Narendra Singh²*, Richa Giri², Lalit Kumar², Desh Nidhi Singh³, Vipin Kumar⁴

¹Department of Medicine, Government Medical College, Azamgarh, Uttar Pradesh, India
²Department of Medicine, KPS Institute of Medicine, GSVM Medical College, Kanpur, Uttar Pradesh, India
³Department of Microbiology, Rama Hospital and Research Centre, Kanpur, Uttar Pradesh, India
⁴Department of Anatomy, KGMU, Lucknow, Uttar Pradesh, India

Received: 10 March 2019
Revised: 01 June 2020
Accepted: 06 June 2020

*Correspondence:
Dr. Narendra Singh,
E-mail: narendrasingh0011@ gmail.com

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ABSTRACT

Background: ART introduction was a breakthrough step and a boon for HIV infected and AIDS patients. Since the launch of world’s second largest ART programme by Indian Government on 1st April 2004, duration and quality of patient’s life has improved significantly. But after years of treatment with first line ART drugs clinical deterioration is being observed in several patients. This study was done to find out clinical symptoms present in treatment failure cases and to look for any improvement after one year of second line ART.

Methods: This is a Single tertiary care teaching hospital based clinical (assessment with investigation) continuous longitudinal, prospective and retrospective, observational study at ART plus Centre, Kanpur. All patients on 1st line ART treatment in the centre were screened for treatment failure as decided by SACEP from 2016 to 2018. Treatment failure was suspected in patients on first line ART treatment with deterioration or non-improvement of clinical symptoms which was later confirmed by immunological and virological test.

Results: Study included 71 (61%) female and 47 (39%) male patients. Heterogeneous mode of transmission of disease was most common (97 (82%)) followed by Blood transfusion (11 (9%)). HIV infection prevalence in age group of 30 to 40 years was 54 (45%). Most common clinical features of the patients with first line ART treatment failure were weight loss (105 patients), chronic diarrhoea (56 patients), fever (34 patients), and cough (24 patients). After treatment for one year with 2nd line ART drugs above symptoms were reduced to 20, 5, 5 and 12 patients respectively.

Conclusions: First line ART failure was most common among female patients and heterogeneous mode of transmission was the commonest. Most common clinical features of first line ART failure were weight loss, chronic diarrhoea, fever, and cough which were reduced significantly after treatment with 2nd line ART drugs for one year.

Keywords: Acquired immunodeficiency syndrome, ART, Human immunodeficiency virus, SACEP

INTRODUCTION

HIV is virus, cause of AIDS, it belongs to the family of human retrovirus (retroviridae) and subfamily Lentiviruses. There are four retroviruses known to cause human disease belong to two distinct groups the human T lymphotropic virus (HTLV-1) and human T lymphotropic virus-2 (HTLV-2) which are transforming retroviruses and human immunodeficiency virus HIV-1 and HIV-2. HIV-1 group is have different group as M, N, O and P and M group is having nine subtype A, B, C, D, F, G, H, I and k. There are about 60 recombinant form presents.
CRFs range from highly prevalent form such as CRF01 that is common in southeast Asia and CRF02AG from West and central Africa, HIV-1 group M subtype C dominate the global pandemic and HIV-1 came from Chimpanzees and Gorila. HIV-2 was first identified in 1986 in west Africa. HIV-2 came from Sooty Mangabeys. HIV-2 was spread from West Africa. In India 95% of infection of HIV -1 and group C but in United States there are more infected population is from HIV-1 and group B. AIDS first recognized in United States in summer of 1981 when the U.S. Centres for disease control and prevention (CDC) reported the unexplained occurrence of Pneumocystis Jiroveci in previously healthy homosexual men in Los Angeles And Kaposi sarcoma (KS) with and without P. Jiroveci and other opportunistic infections in 26 previously healthy homosexual men in New York San Francisco and Loss Anglees. First time in 1983 Human Immunodificiency Syndrome (HIV) was isolated from a patient of lymphadenopathy and by 1984 it was demonstrated clearly causative agent of AIDS. In 1985 A sensitive enzyme- linked immune sorbent assay (ELISA) was developed. Person with positive HIV serology who have ever had a CD4 lymphocyte count below 200cells/mcl and CD4 lymphocyte percentage below 14% are considered as AIDS, HIV infected patient in Word-wide are about 37.9 million and 23.3 million patients taking antiretroviral treatment that are only 62% of infected patients. Africa have about 25.7 % of total infected patients that is largest but patients taking ART in Africa is about 16.35 of whole world. In India about 18.13 lacks are estimated total no of PL HIV patient and 6.5 lacks are taking first line ART.

HIV virus is transmitted through HIV infected patients to uninfected patient by number of ways as

- Sexual Transmission
- Transmission through injection drugs use
- Transmission by transfused blood and blood products.
- Occupational transmission of HIV
- Mother to child transmission of HIV
- By different body fluids.

Table 1 show that the blood transfusion is most common mode of HIV transfusion and oral intercourse is the lowest amount of transmission method and also biting, spitting has negligible mode of method transmission. After infection of patient by different mode there are event in the body is happening that are

**Primary infection**

HIV virus inter to the body through the different way and inter to susceptible cell in the body, CD4 cell via receptor CCR5 AND CXCR4. In the cell it multiplied through replication process.

**Eclipse phase of infection**

Once infection is established, the virus replicate in lymphoid cells in the mucosa, sub mucosa, and to some extent the lymphoreticular tissue that drain the Gut Tissues. For a variable period of time ranging from a few to several days, the virus cannot yet be detected in the plasma. This period is referred to as the eclipse phase of infection.

**Burst of virimia stage**

Within several days to weeks, it is disseminated, first to draining lymph node and then to other lymphoid compartments where it has easy access to dense concentration of CD4 count, allowing for burst of high level of viremia that are readily detected by available assays.

**Chronic persistent stage**

Once infection has been established the virus succeeds in escaping complete immune - mediated clearance. Paradoxically seems to thrive on immune activation and is never eliminated completely from the body. The chronic infection develops and persists with varying degrees of continual viral replication in untreated patient for a median of 10 years. It is this established of a chronic persistent infection.

**Advanced disease stage**

In untreated patients or in whom therapy has not adequately controlled replication after a variable period

Table 1: Estimated per ACT probability of acquiring HIV from an infected source by exposure ACT.

<table>
<thead>
<tr>
<th>Type of exposure</th>
<th>Rout of exposure</th>
<th>Risk per 10000 exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental</td>
<td>Blood transfusion</td>
<td>9250</td>
</tr>
<tr>
<td></td>
<td>Injection drugs use</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>Percutaneous</td>
<td>23</td>
</tr>
<tr>
<td>Sexual</td>
<td>Receptive anal intercourse</td>
<td>138</td>
</tr>
<tr>
<td></td>
<td>Insertive anal intercourse</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Receptive vaginal intercourse</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Insertive vaginal intercourse</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Receitve oral intercourse</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Insertive oral inter course</td>
<td>Low</td>
</tr>
<tr>
<td>Mother to child</td>
<td>Vaginal delivery</td>
<td>1500</td>
</tr>
<tr>
<td></td>
<td>Breast feeding</td>
<td>54</td>
</tr>
<tr>
<td>Other</td>
<td>Biting</td>
<td>Negligible</td>
</tr>
<tr>
<td></td>
<td>Spitting</td>
<td>Negligible</td>
</tr>
<tr>
<td></td>
<td>Througheing body fluid</td>
<td>Negligible</td>
</tr>
<tr>
<td></td>
<td>Sharing sex toys</td>
<td>Negligible</td>
</tr>
</tbody>
</table>
usually measured in year, The CD4 Count fall below a critical level <200 /micro L and the patient become highly susceptible to opportunistic diseases.

**HIV reservoir stage**

The resting CD4 count cell carry an integrated form of HIV DNA in the genome of the host and can remain in the state until a activation signal drives the expression of HIV transcript and ultimately replication –competent virus.

The clinical consequence of HIV infection encompasses a spectrum ranging from an acute syndrome associated with primary infection to a prolonged asymptomatic state to advanced stage.

It is best to regard HIV disease beginning at time of primary infection and progressing to various stages that are

**Primary infection**

HIV virus inter to the body through the different way and inter to susceptible cell in the body, CD4 cell via receptor CCR5 AND CXCR4. In the cell it multiplied through replication process.

**Acute HIV infection**

About 50% to 70% of individual with HIV infection experience an acute clinical syndrome about 3 to 6 weeks after primary infection. It has been reported that several symptoms of acute HIV syndrome such as

- Fever,
- Pharyngitis,
- Lymphadenopathy,
- Headache,
- Arthragia,
- Lethargy/Anorexia,
- Weight loss,
- Mucocutaneous ulceration,
- Meylopathy,
- Encephalopathy.

**Asymptomatic stage (latent stage)**

This the stage in which the symptom of infection is not present but HIV disease with active virus replication is on-going and progressive during this asymptomatic period.

In this stage the HIV RNA level is very low level.

But in this stage when CD4 Count decrease to the critical level and then the opportunistic infection occurred but symptoms of HIV infection is not occurred.

**Symptomatic stage**

Symptoms of HIV disease can appear at any time during the course of HIV infection. The spectrums of illness that can be present as CD4 Count Decline, more severe and life-threatening complications of HIV infection occurred in patients with CD4 count is less than 200 /micro L. That is

**AIDS defining illness**

The diseases published by the centres of disease control and prevention that are associated with AIDS and used world wise as a guideline for AIDS diagnosis that are

- Candidiasis of brochi, trachea or lungs
- Candidiasis of oesophagus
- Coccidiomycosis
- Cryptococcosis
- Cryptosporidiasis
- Cytomegalovirus retinitis
- Encephalopathy
- Herpes simplex
- Histoplasmosis
- Isosporidisis
- Kaposi, sarcoma
- Burkitts lymphoma
- Immunoblastic lymphoma
- Mycobacterium avium complex or mycobacterium kinase
- Mycobacterium tuberculosis
- Pneumocystis jiroveci pneumonia
- Progressive multifocal leukoencephalopathy
- Salmonella sepsis
- Toxoplasmosis of brains
- Tuberculosis disseminated
- Wasting syndrome
- Cervical cancer
- Pneumonia recurrent
- Mycobacterium tuberculosis any site (pulmonary).

** Opportunistic infection stage**

This is the infection occurred more often or is more severe in people with weakened immune systems than in people with healthy immune systems.

- Aspergillus sp
- Candida albicans
- Clostridium difficile
- Coccidioides amities
- Cryptococcus neoformans
- Cryptosporidium
- Cytomegalovirus
- Geomyces destructans
- Histoplasma capsulatum
- Isospora belli
- Polyoma virus JC polyomavirus


- Kaposi sarcoma
- Legionnaire disease
- Microsporidium
- Mycobacterium -Avium complex
- Mycobacterium tuberculosis
- Pneumocystis jiroveci
- Pseudomonas aeruginosa
- Salmonella
- Staphylococcus aureus
- Streptococcus pneumonia
- Streptococcus pyogenes
- Toxoplasmosis gondii.

**Non-AIDS defining illness**

- Non-AIDS related cancer
- Cardiovascular disease
- Renal disease
- Hepatic disease.
- Hodgkins disease.
- Multiple myeloma
- Leukemia
- Melanoma.

**HIV associated illness**

- Cardiomyopathy
- Enteropathy
- Nephropathy
- Lipodystrophy
- Arthropathy
- Fibromyalgia
- Neurocognitive disorder
- Dementia
- Encephalopathy
- Myelopathy
- Peripheral neuropathy.

**ART associated symptoms**

The disease occurred due to continue the antiretroviral therapy as

- Anemia
- Thrombocytopenia
- Jaundice
- Abdominal pain
- Pancreatitis
- Kidney injury
- Hypersensitivity syndrome
- Lipodystrophy
- Nausea, Vomiting, Diarrhoea
- Osteomalacia
- Hyperglycemia
- Vertigo.

**ELISA test**

It tests the presence of antibody of HIV and p24 Antigens. It has the 99.5% sensitivity. It used for screening test.

**Western blot test**

It is the specific assay that is used for confirming test for HIV infection it is 99% specific test for HIV infection.

**Immune complex-dissociated p 24 antigen capture assay**

It is used for measurement of level of HIV -1 CORE protein in an EIA -based format following dissociation of antigen -antibody complexes by weak acid treatment. It can detected the p24 level up to 15pg/ml.

**HIV RNA by BDN**

Measurement of level of particle - associated HIV - RNA IN a nucleic acid capture assay employing signal amplification. It is reliable to 50 copies /ml of HIV RNA.

**HIV RNA by TMA**

It is done by target amplification of HIV-1 RNA via reverse transcription followed by T 7 RNA polymerase. It is reliable to 100 copies/ml of HIV RNA.

**HIV RNA by NASBA**

It is done by isothermal nucleic acid amplification with internal controls. It is reliable to 80 copies /ml of HIV RNA.

**HIV RNA by PCR**

It is done by target amplification of HIV 1 RNA via reverse transcription followed by PCR. It is reliable to 40 copies/ml of HIV RNA.

Standard combination of antiretroviral regimens are two NRTI together with an NNRTI, Protease Inhibitor (PI) or Integrase Inhibitor. Starting regime of dual NRTIs combined with an NNRTI or a PI or an Integrase Inhibitor. These regimens should be monitored for resistant testing. If resistant testing is not available then PI in second line regimens are preferable.

The first line ART should consist of two nucleoside reverse transcriptase inhibitor (NRTI) + One Non-nucleoside reverse transcriptase.

**Monitoring of efficacy during ART treatment**

Base line viral load should be measured prior to initiating treatment. Viral load should be repeated 4 to 8 weeks after starting a new regimen when the count should show
at least a tenfold decrease. After six month of ART the viral load should be suppressed defined as below the detection of the assay (usually less than 50 copies /ml). WHO defined immunological failure as fall in CD 4 Count to base line or a 50% fall from peak on ART or persistent count below 100cell/mm. Failure of ART is defined as viral load become detectable after suppression typically more than 400 or more than 1000 copies/ml.

Aims and objective of this study was to Compare and evaluate the clinical features of the patients of ART 1 failure.

METHODS

This is a Single tertiary care teaching hospital based clinical (assessment with investigation) continuous longitudinal, prospective and retrospective, observational study at ART plus Centre, Kanpur, India.

Type of Study is Single tertiary care teaching hospital study. Study design was clinical (assessment with investigation) continuous longitudinal, prospective and retrospective, observational, single centre hospital-based study at ART Plus Centre, Kanpur from 2016 to 2018.

Study subject are all the patient on 1st line ART treating attending in our centre was screened for treatment failure of based on clinical, immunological and virological criteria’s as decided by SACEP from 2016 to 2018.

Inclusion criteria

- Patient over the age of 18 years at pre-inclusion and monitored under outpatient condition.
- Documented HIV-1 (group m) infection regardless of clinical stage and CD4 lymphocyte-count (taken in 6 months).
- Patient with treatment failure after first-line antiretroviral treatment with a combination including a non-nucleoside reverse transcriptase inhibitor and two nucleoside reverse transcriptase inhibitors, failure.
- Adherence (>80%) to first-line antiretroviral treatment (questionnaire) at pre inclusion.
- Patient agrees not to take any concomitant medication during the trial without informing the investigator.
- Informed consent.
- For women in childbearing age: negative pregnancy test at inclusion, with no plan of pregnancy in the coming 12 months and agreeing to use mechanical contraception (with or without hormonal contraception) during the study.

Exclusion criteria

- Adherence (<80%) to first-line antiretroviral treatment at pre inclusion.
- Participation in any other clinical trial.
- Presence of an uncontrolled, on-going opportunistic infection or of any severe of progressive disease.
- First-time treatment with a protease inhibitor, abacavir.
- Not interested to participate in study.
- Severe hepatic insufficiency.
- Creatinine clearance calculated by Cockcroft-Gault formula <50 ml/min.
- Hb ≤8 g/dl.
- Platelets <50,000 cells / mm3.
- Neutrophils <500 cells / mm3.
- Pregnancy or lactation.

Blood sample collection

On admission, 10 ml of peripheral venous blood was collected from the antecubital vein by an autoclaved syringe using 20 gauze needles. The blood was allowed to clot at room temperature for at least half an hour. The glass tube with clotted blood was centrifuged at 2000 rpm for 20 minutes and the centrifugation was repeated once more to remove the red cells completely. The supernatant serum, devoid of cellular elements, was separated from the clot and placed in two acid cleaned small test tubes.

Viral load testing

Patient of HIV suspecting first line ART failure send to BHU Varanasi Department of Microbiology, IMS BHU Banaras. For estimation of viral load. In BHU viral load is tested quantitatively real time PCR from HIV RNA by PCR machine.

Measuring

Viral load is typically reported as copies of HIV in a milliliter (mL) of blood. Changes in viral load are usually reported as a log change (in powers of 10). For example, a three-log increase in viral load (3 Log10) is an increase of 103 or 1000 times the previously reported level, while a drop from 500,000 to 500 copies would be a three-log-drop (also 3 Log10).

CD4

CD4 count is done by BD facts flow machine by kit in GSVM medical college Kanpur in Microbiology department and report is analysed and given same day.

RESULTS

This study was conducted in ART PLUS centre K.P.S. POST GRADUATE Institute of Medicine (G.S.V.M. medical college Kanpur India). In this study maximum patients were in the age group of 30-40-year (54 (45%)), followed by patients in the age group of 30-40 years (29
In this study the symptoms of opportunistic infection were present that are oral candidiasis, pulmonary tuberculosis, chronic diarrhoea, LRTI, Tubercular lymphadenitis, Tuberculosis of pericardium, Tubercular meningitis, Extra pulmonary tuberculosis, Abdominal Koch’s (Table 6).

Table 6: Opportunistic infections seen in study subjects.

<table>
<thead>
<tr>
<th>Opportunistic infection</th>
<th>No: of subjects</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral candidiasis</td>
<td>28</td>
<td>23%</td>
</tr>
<tr>
<td>LRTI</td>
<td>10</td>
<td>8%</td>
</tr>
<tr>
<td>Pulmonary tuberculosis</td>
<td>27</td>
<td>23%</td>
</tr>
<tr>
<td>Chronic diarrhoea</td>
<td>5</td>
<td>4%</td>
</tr>
<tr>
<td>TB Lymphadenitis</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Tuberculosis of pericardium</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>TBM</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Extra pulmonary tuberculosis</td>
<td>14</td>
<td>11%</td>
</tr>
<tr>
<td>Abdominal Koch’s</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>No infection</td>
<td>25</td>
<td>21%</td>
</tr>
</tbody>
</table>

In this study authors found that heterosexual mode of transmission is 97 (82%) was the most common followed by blood transfusion mode is about 11 (0.09) patients (Table 7).

Table 7: Mode of transmission in study subject.

<table>
<thead>
<tr>
<th>Mode of transmission</th>
<th>No. of patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>97</td>
<td>82%</td>
</tr>
<tr>
<td>Unknown</td>
<td>6</td>
<td>0.05%</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>11</td>
<td>0.09%</td>
</tr>
<tr>
<td>Track driver</td>
<td>2</td>
<td>0.01%</td>
</tr>
</tbody>
</table>

Table 8: Adverse effect in study subjects taking ART 2 regimens.

<table>
<thead>
<tr>
<th>Adverse effect</th>
<th>No. of patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>30</td>
<td>25%</td>
</tr>
<tr>
<td>Vomiting</td>
<td>46</td>
<td>38%</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>25</td>
<td>21%</td>
</tr>
<tr>
<td>Anaemia</td>
<td>37</td>
<td>31%</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>20</td>
<td>16%</td>
</tr>
<tr>
<td>Jaundice</td>
<td>28</td>
<td>23%</td>
</tr>
<tr>
<td>Kidney abnormality</td>
<td>5</td>
<td>0.04%</td>
</tr>
<tr>
<td>Headache</td>
<td>24</td>
<td>20%</td>
</tr>
<tr>
<td>Muscle pain</td>
<td>46</td>
<td>38%</td>
</tr>
<tr>
<td>Skin rash</td>
<td>18</td>
<td>15%</td>
</tr>
</tbody>
</table>

Adverse effect of different drugs used in ART2 Regime was also studied. Symptoms were nausea, vomiting, diarrhoea, anaemia, abdominal pain, jaundice, kidney abnormality, headache, and muscle pain and skin rashes (Table 8).
Table 9: Baseline characteristics of the patients in study.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. of patient</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>47</td>
<td>39%</td>
</tr>
<tr>
<td>Female</td>
<td>71</td>
<td>61%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30 years</td>
<td>23</td>
<td>19%</td>
</tr>
<tr>
<td>30-40 years</td>
<td>54</td>
<td>45%</td>
</tr>
<tr>
<td>40-50 years</td>
<td>29</td>
<td>25%</td>
</tr>
<tr>
<td>50-60 years</td>
<td>11</td>
<td>9%</td>
</tr>
<tr>
<td>60-70 years</td>
<td>1</td>
<td>0.001%</td>
</tr>
<tr>
<td><strong>Geographical area</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>65</td>
<td>55%</td>
</tr>
<tr>
<td>Rural</td>
<td>53</td>
<td>45%</td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>13</td>
<td>11%</td>
</tr>
<tr>
<td><strong>Alcohol</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>53</td>
<td>45%</td>
</tr>
<tr>
<td><strong>Tobacco</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td>8</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Regime 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TLE</td>
<td>90</td>
<td>76%</td>
</tr>
<tr>
<td>ZLN</td>
<td>28</td>
<td>24%</td>
</tr>
<tr>
<td><strong>Regime 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TLLP/R</td>
<td>35</td>
<td>30%</td>
</tr>
<tr>
<td>ZLLP/R</td>
<td>74</td>
<td>59%</td>
</tr>
<tr>
<td>TLLP/R</td>
<td>5</td>
<td>4%</td>
</tr>
<tr>
<td>ZLLP/R</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Clinical symptoms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td>24</td>
<td></td>
</tr>
</tbody>
</table>

Out of total 118 study subject maximum no: of subject belong to age group of 30 to 40 years that is 45% and minimum no: of subject are in the age group of 60 to 70 years that is 0.8%. Mean value 37.21; SD 9.4.

In this study male was found to be 40% and female 60%. In this study authors found that female patients were having more ARTI failure as compared to males.

Distribution of study subjects on the basis of residence. This study shows that patents from rural area are more (55%) as compared to patents from urban area (45%).

In this study weight loss was seen n 105 subjects that reduced to 20, fever was in 34 that reduce to 5, chronic diarrhoea was in 56 and it reduced to 5 and cough was seen in 24 cases that reduced to 12 cases after one year of ART2 initiation.

Magnitude of opportunistic infection in this study subjects. This study show that oral candidiasis is the most common opportunistic infection (28) 23% followed by pulmonary tuberculosis (27) 23%. But overall total no: of subjects having tuberculosis of any types 36% (pulmonary tuberculosis 23%, tuberculosis of pericardium 0.8%, extra pulmonary tuberculosis 11% and pulmonary koch's 1%, tubercular meningitis 1% and tubercular lymphadenitis 2%). LRTI was n 8% and chronic diarrhoea is 4% (15).

Table 7 show that the heterosexual mode of transmission is most common 97 (82%) patients followed by blood transfusion in 11 (0.09%) patients. Truck driver having the mode of transmission that was 2 patients.

Table 8 show that several adverse effects were found in patients tang ART 2 treatment.

DISCUSSION

Patil VC et al, clinical manifestation and outcome of patient with Human Immunodeficiency virus infection at tertiary care Teaching hospital. This considered 111 patients as observational retrospective study and in which about 75 were male and 36 were female and there was pulmonary tuberculosis and community acquired pneumonia is present. In this study the oral candidiasis and lymphadenitis was present in 6 patients. In this study there was pulmonary tuberculosis anaemia. LRTI, chronic diarrhoea is seen. In this study the male was less and female was more. Wal N, et al, Clinical feature of HIV Positive patients attending a tertiary care hospital of North India.2 There was enrolled 317 patients in this study in which 193 was male and 124 was female patients, Mean age of patient was 34. 2 years and most was in the age group of 20 to 40 year of age. In this study mostly was from rural background 83.9%. In this study the common symptoms was weakness body ache joint pain lethargy, fever weight loss, cough and loss of appetite. Tuberculosis also most common opportunistic infections. In this study the age group mostly infected was 30 to 40 year of age, rural patients were mostly infected but female were mostly infected pulmonary tuberculosis is more common of opportunistic infection. The symptoms more common are weight loss, fever, muscle pain, chronic diarrhoea and cough was present.

Matin N, et al, clinical profile of HIV/AIDS -Infected patients admitted to a new specialist unite in Dhaka, Bangladesh -a low prevalence country for HIV-This study was considering about 109 patients and was a retrospective study in this study mean age was 33.4 and 62% patients were male and 41% patients were female. This study showed that the heterosexual transmission was recorded in 87 (80%) patients’ pulmonary tuberculosis aural candidiasis is found 25 and 11 patients. In this study there was maximum no. of HIV patient in age group of 30 to 40 years that was 54 (45%) and second most common age was 40 to 50 year of age group that was 35 (29%) and minimum no of subject is in age group of 60 to 70 year of age group 1 (0.001%). It meant there was HIV infection maximally occurred in more sexually active person and also more economically productive

International Journal of Advances in Medicine | July 2020 | Vol 7 | Issue 7 | Page 1118
group. There was life span of HIV patient is 50 to 60 year of age. In this study female was having more HIV disease that was 71 (61%) out of 118 subjects and male was having less HIV disease that is 47 (39%) out of 118 and this study show that mode of transmission was most common was heterogeneous mode that was 97 (82%). Blood transfusion mode of transmission was second most common that is 11 (9%) last was truck driver and injection drug user was last that is 2 (less than 1%). Pulmonary tuberculosis and oral candidasis is opportunistic infection was present. Mahy M et al, increasing trends in HIV prevalence among people aged 50 years and older: evidence from estimates and survey data. AIDS. This study shows the HIV-prevalence rates among people aged over 50 have increased steadily in the recent years. Care and treatment services need to address the specific needs of older people living increasing trends in HIV prevalence among people aged 50 years and older: evidence from estimates and survey data. In this study the maximum number of patients was in age group of 30 to 40 year and life span of PL HIV Patient was 50 to 60 year of age.

Anant A et al, Study of opportunistic infections in HIV seropositive patients admitted to community care centre (CCC). This study stated that out of 110 cases, 60.9% were males and 39.1% females. 77.2% respondents agreed that HIV could be transmitted through sexual means (96.2%), blood transfusion (96.7%) and sharing of sharp objects (92.5%). A few of the respondents believed that HIV can be transmitted through drinking cups (9.4%) and mosquito bites (13.6%) with HIV. Action mode of transmission of hiv/aids: perception of dental patients in a Nigerian teaching hospital. Anant A et al, Study of opportunistic infections in HIV seropositive patients admitted to community care centre (CCC). Distribution of case as per presenting symptoms is shown in table 1. In 79 (71.8%) patients commonly observed symptoms were fever (82.2%), followed by weight loss (65.8%), cough and dyspnoea (45.5%), diarrhoea (41.7%) and ulcers in oropharynx needed to incorporate Biomedical Research and symptoms improve after the treatment of ART this study also have the symptoms as weight loss chronic diarrhoea, fever cough and the symptoms were decrease one year after the ART 2 Ogunrinde T. J and O I Opeodu et al, mode of transmission of hiv/aids: perception of dental patients in a nigerian teaching hospital. This study is prospective study taking 212 dental patients and show transmission of HIV is through sexual mean in 96.2% and blood transfusion mean is 96.7% and also sharing sharp object mean in 92.5% patient, in this study the transmission of HIV is through heterosexual mode and also by blood transfusion. Chauhan N S, et al. A safety analyses of different drugs regimens in immunodeficiency virus – positive patient; This study considering 2983 subjects and taken TLE and ZLN regime and at result there are Zaduvudine containing regime having anemia. In this study the anemia is the adverse effect is seen. Onoya D et al, Second Line Antiretroviral Therapy in South Africa. This study was considering about 7708 patients initiating second line ART. Anemia is was most common and experience in 2389 cases second kidney problems was also found. Gastrointestinal problems were also found in this study. In this study Anaemia, kidney problems and gastrointestinal problems were present. Anaemia was present in Zaduvudine containing regimens and kidney problems in Tenofovir containing regime.

**CONCLUSION**

In this study authors found that first line ART failure was most common among female patients and heterogeneous mode of transmission was the commonest. Majority of patients in the study were from rural area were in the age group of 30-40 years.

Most common clinical features of the patients with first line ART treatment failure were weight loss, chronic diarrhoea, fever, and cough which were reduced significantly after treatment with 2nd line ART drugs for one year.

**Funding:** No funding sources

**Ethical approval:** The study was approved by the Institutional Ethics Committee of GSVM Medical College Kanpur, India

**REFERENCES**
