

British Experts Recommend Statins for All HIV-Positive People 40 and Older

Updated guidance is based on findings from the REPRIEVE trial, which showed pitavastatin reduced the risk of cardiovascular events by 35%.

December 13, 2023 By [Liz Highleyman](#)

The British HIV Association (BHIVA) now recommends that all people living with HIV who are ages 40 and older should be offered a statin medication to reduce their risk of [cardiovascular disease](#) (CVD) as part of a holistic heart-healthy lifestyle that includes smoking cessation, a healthy diet and exercise.

The [new rapid guidance](#), released in November, is supported by findings from the large [REPRIEVE trial](#), which showed that HIV-positive people with low to moderate CVD risk can reduce the likelihood of heart attacks, strokes and other major cardiovascular events even further by taking daily pitavastatin (Livalo).

As people with HIV live longer thanks to effective antiretroviral treatment, cardiovascular disease has become a leading cause of illness and death. A growing body of research shows that HIV-positive people have around a twofold higher risk of CVD than their HIV-negative peers. What's more, people with HIV have excess plaque buildup in their arteries and experience cardiovascular complications at a younger age. Reasons may include chronic inflammation, adverse effects of antiretroviral drugs and higher rates of traditional risk factors such as smoking.

CVD scoring systems developed for the general population tend to underestimate the risk for people living with HIV, and this appears to be especially true for women. It is well known that HIV-positive and HIV-negative people with a high CVD risk score can benefit from statins, which decrease low-density lipoprotein (bad cholesterol) levels and may have additional effects, including reduced inflammation and blood clotting.

Statins generally are not recommended for people with low CVD risk scores unless they have certain comorbidities. However, as reported at this year's International AIDS Society Conference on HIV Science, the multinational REPRIEVE trial showed that pitavastatin [reduced the risk of major cardiovascular events by 35%](#) for HIV-positive people with low to moderate 10-year CVD risk scores and no previous history of atherosclerotic cardiovascular disease.

"We targeted a group that would not ordinarily have been prescribed a statin, or any therapy, who

would have been simply told to go home,” lead investigator Steven Grinspoon, MD, of Massachusetts General Hospital, told reporters at a conference media briefing. Based on the findings, he said he would “highly recommend that guidelines be changed” to expand the use of statins for people with HIV.

Now, BHIVA is the first group of HIV providers to call for universal statin use for all HIV-positive people ages 40 and older.

Former BHIVA chair Laura Waters, MD, of the Mortimer Market Centre in London, current chair Yvonne Gileece, MD, of University Hospitals Sussex NHS Trust, and colleagues performed a systematic review of medical literature and conference abstracts about HIV and CVD through August 2023.

Based on their findings, they advise baseline lipid assessments for all people living with HIV (including an assessment for familial hypercholesterolemia in those with high cholesterol levels) and optimization of antiretroviral therapy. They recommend that all people living with HIV ages 40 and older should be offered a statin for primary prevention of CVD, regardless of their lipid profile or estimated cardiovascular risk. Those with an estimated 10-year CVD risk of 5% or greater should be prioritized.

BHIVA recommends a 4 milligram daily dose of pitavastatin—the regimen tested in REPRIEVE—as the first-line choice for CVD primary prevention. Pitavastatin is now available in many countries, and it will become more broadly available once it goes off patent, likely in early 2024. A 20 mg daily dose of atorvastatin (Lipitor) can be used as an alternative. The guidance authors suggest that people on a low-intensity statin, such as lovastatin (Mevacor) or simvastatin (Zocor), should switch to a moderate-intensity drug if clinically appropriate and well tolerated. For people unable to tolerate statins, they recommend alternative lipid-lowering medications such as ezetimibe (Zetia) or bempedoic acid (Nexletol).

Statins are generally safe and well tolerated. In the REPRIEVE trial, serious adverse events were uncommon and occurred with similar frequency (about 4%) in the pitavastatin and placebo groups. Muscle damage (rhabdomyolysis) is a potential serious adverse event, but muscle-related symptoms were uncommon and mainly mild. Statins can trigger diabetes, and there were more cases in the pitavastatin group compared with placebo group, but the incidence rate was low overall (about 5% versus 4%, respectively) and comparable to that of the general U.S. population. Pitavastatin generally does not have clinically relevant interactions with antiretroviral drugs, and interactions with atorvastatin can be managed.

The BHIVA authors emphasize that CVD risk assessment and pharmacological primary prevention should be combined with “a holistic approach to lifestyle modifications,” including smoking cessation, limited alcohol consumption, a healthy diet, adequate exercise and weight management.

“Although the recommendation for offering statins for primary prevention of CVD are independent of estimated CVD risk, discussing estimated risk with people living with HIV is an important part of

shared decision-making with regards to motivation for modification of other risk factors,” they wrote.

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