



**POSTTEST**

To receive credit for this activity, please complete the posttest by recording the best answer to each question in the answer key on the evaluation. A statement of credit will be issued only upon receipt of a completed activity evaluation form and a completed posttest with a score of 70% or better. Your statement of credit will be mailed to you within 3 weeks.

1. In patients with first virologic failure, resistance to which of the following drugs is the first to emerge?
  - a. d4T
  - b. AZT
  - c. ddI
  - d. 3TC
  
2. What is the primary goal for salvage therapy?
  - a. undetectable viral load
  - b. immunologic maintenance
  - c. reduced pill burden
  - d. once-daily dosing
  
3. In the CPCRA 058 study, which drug class had the highest rate of resistance at baseline?
  - a. PIs
  - b. NNRTIs
  - c. fusion inhibitors
  - d. NRTIs
  
4. Which type of failure most frequently requires a change in therapy?
  - a. immunologic
  - b. clinical
  - c. virologic
  - d. none of the above
  
5. Which drug class is best to reserve for second- or third-line regimens?
  - a. NNRTIs
  - b. NRTIs
  - c. PIs
  - d. NtRTIs
  
6. What PI can be used after a patient fails on a nelfinavir-containing regimen?
  - a. fosamprenavir
  - b. atazanavir
  - c. lopinavir/ritonavir
  - d. all of the above
  
7. What should be done for a patient who develops the M184V mutation?
  - a. switch out 3TC
  - b. switch out FTC

- c. keep 3TC or FTC and add another drug
  - d. do nothing
8. Which one of the following combinations *is not* a once-daily regimen?
- a. ABC/3TC
  - b. AZT/3TC
  - c. TDF/FTC
  - d. TDF/3TC
9. What switching strategy can be used in patients who develop lipoatrophy?
- a. switch AZT to d4T
  - b. switch ABC to AZT
  - c. switch d4T to ABC
  - d. switch 3TC to TDF
10. What switching strategy can be used in patients who develop dyslipidemia?
- a. switch LPV/r to fAPV
  - b. switch ATV to fAPV
  - c. switch ATV to LPV/r
  - d. switch LPV/r to IDV

To obtain credit, please complete the evaluation form below, putting the answers to the Posttest in the answer key. Fax the entire completed Evaluation form to 303-790-4876

EVALUATION FORM

*Optimal Management of HIV Therapies CD ROM Series: Managing HIV/AIDS Therapy in Treatment-Experienced Patients*

Project ID: 3443-ES-31

**Evaluation Form and Posttest Answers**

**Optimal Management of HIV Therapies CD-ROM Series:  
CD 2—Managing HIV/AIDS Therapy in Treatment-experienced Patients**

Project ID: 3443-ES-31

**Evaluation**

Postgraduate Institute for Medicine respects and appreciates your opinions. To assist us in evaluating the effectiveness of this activity and to make recommendations for future educational offerings, please take a few minutes to complete this evaluation form. *You must complete this evaluation form to receive acknowledgement of participation for this activity.*

**Please answer the following questions by circling the appropriate rating:**

5 = Outstanding      4 = Good      3 = Satisfactory      2 = Fair      1 = Poor

**Extent to Which Program Activities Met the Identified Objectives**

*After completing this activity, participants should be better able to:*

- Compare and contrast the goals of therapy for treatment-experienced patients with HIV infection to those of treatment-naïve patients.      5 4 3 2 1
- Describe how to assess a patient who is failing treatment.      5 4 3 2 1
- Discuss the key factors to consider when making decisions to alter antiretroviral therapy.      5 4 3 2 1
- Describe the strategies behind the design of a salvage regimen.      5 4 3 2 1

**Overall Effectiveness of the Activity**

Was timely and will influence how I practice      5 4 3 2 1  
Will assist me in improving patient care      5 4 3 2 1  
Fulfilled my educational needs      5 4 3 2 1  
Avoided commercial bias or influence      5 4 3 2 1

**Impact of the Activity**

***The information presented:***

(check all that apply)

- Reinforced my current practice/treatment habits       Will improve my practice/patient outcomes
- Provided new ideas or information I expect to use       Enhanced my current knowledge base

Will the information presented cause you to make any changes in your practice?

- Yes       No



**Request for Credit**

Name \_\_\_\_\_ Degree \_\_\_\_\_

Organization \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Signature \_\_\_\_\_ Date Completed \_\_\_\_\_

**For Physicians Only**

I certify my actual time spent to complete this educational activity to be:

I participated in the entire activity and claim 1.75 credit.

I participated in only part of the activity and claim \_\_\_\_\_ credit. |