TABLE 1. HISTOLOGIC AND FUNCTIONAL FINDINGS IN 12 PATIENTS WITH FUNDIC ATROPHIC GASTRITIS AND *H. PYLORI* INFECTION, BEFORE AND AFTER ERADICATION OF THE INFECTION.*

VARIABLE	GROUP 1		GROUP 2		
	AT ENTRY	12 MO AFTER ERADICATION	AT ENTRY	12 MO LATER	12 MO AFTER ERADICATION
	mean ±SD				
Histologic findings†					
Fundic					
Glandular atrophy	1.7±0.8	0.2±0.4‡	1.3±0.5	1.3±0.5	0‡
Mononuclear-cell infiltrate	1.7±0.5	0.2±0.4‡	1.2±0.4	1.2±0.4	0‡
Neutrophilic infiltrate	1.2±0.4	0‡	0.8±0.4	1.0±0.6	0‡
Intestinal metaplasia	0.2±0.4	0	0.7±0.5	0.5±0.8	0.4±0.6
Antral					
Glandular atrophy	1.2±1.0	0.2±0.4	1.3±1.2	0.8±0.8	0.4±0.6
Mononuclear-cell infiltrate	1.2±0.8	0‡	1.0±0.6	1.0±0.6	0‡
Neutrophilic infiltrate	0.7±0.8	0	0.8±0.8	0.8±0.8	0‡
Intestinal metaplasia	0.3±0.5	0.2±0.4	0.8±1.0	0.8±1.0	0.2±0.5
Gastric acid secretion (mEq/hr)§					
Basal output	0.33±0.63	2.75±1.44‡	0.67±0.95	0.23±0.36	1.22±0.90‡
Peak output	9.95±6.57	19.70±7.10‡	10.0±0.90	8.60±6.80	15.60±7.30‡
Basal serum gastrin (pg/ml)¶	256±368	80±29	221±266	247±315	52±34
Gastric emptying (%/min)‖	0.54±0.28	0.62±0.15	0.49±0.29	0.48±0.27	0.50±0.20

*Patients in group 1 were evaluated at entry and 12 months after the eradication of *H. pylori;* patients in group 2 were evaluated at entry, 12 months later (before treatment), and 12 months after the eradication of *H. pylori.*

†Histologic findings were scored as 0, absent; 1, mild; 2, moderate; or 3, severe.

‡$P<0.05$, by the Wilcoxon rank-sum test, for the comparison with the base-line value

§The normal range is 0 to 6.9 mEq per hour for basal output and 7.8 to 35.4 mEq per hour for peak output.

¶The normal range is 0 to 100 pg per milliliter.

‖The normal range is 0.31 to 1.03 percent per minute.

there is a rationale for eradicating *H. pylori* in patients with this infection and fundic atrophic gastritis.

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Viral Load and Combination Therapy for Human Immunodeficiency Virus

To the Editor: In their editorial, Corey and Holmes (Oct. 10 issue)[1] state, "All persons with HIV [human immunodeficiency virus] infection who have CD4 cell counts below 500 cells per cubic millimeter should be encouraged to begin antiretroviral therapy." Such an early instigation of therapy is in line with the current understanding of HIV infection and experience with other infectious diseases, but we do not yet know whether we have good enough therapies — those that have negligible long-term risks and do not jeopardize the efficacy of future therapies the patient may be given — to say that this statement is now true in practice.[2]

No randomized trials in asymptomatic patients have established that those treated early survive any longer than those for whom treatment is deferred. Extended follow-up of patients in one trial, the Concorde study, has shown a significantly increased risk of death among the patients treated early.[3] The trials mainly involve monotherapy with zidovudine. The suggestion is that the situation is different for combination therapy. But where is the evidence that for a patient with a CD4 count of 450 cells per cubic millimeter and a low plasma virus level, it would not be better to wait before initiating therapy? On average, such patients are not at serious risk for more than five years, and there is no evidence that the efficacy of treatment lasts this long. If therapy is delayed, there may eventually be better drugs from which to choose.

In 1990, after the results of the AIDS Clinical Trials Group (ACTG) 019 study in patients with CD4 counts of less than 500 cells per cubic millimeter had been published, a patient with a CD4 count of 450 cells per cubic millimeter would have been advised to start monotherapy with zidovudine.[4] We now tell such a patient that, in fact, follow-up data for up to 4.5 years since that time have shown no survival benefit from the early use of zidovudine[5] and that if the patient starts using a second nu-

cleoside drug now, the benefit will be smaller than if he [illegible] had waited and started to use zidovudine at the time as a second nucleoside drug.[1] There is no more evidence now of the benefits of early therapy than there was in 1990. We need new randomized trials to determine whether the notion that was probably not true in the era of zidovudine monotherapy — that early therapy prolongs survival as compared with deferred therapy — is still true.[2]

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To the Editor: Two recent editorials[1,2] mention the costs of drugs for treating HIV-infected patients, but specific costs are not given. Because there is so much discussion about the costs of these drugs, we have put together some facts on the average wholesale prices of drugs commonly

TABLE 1. COSTS OF COMMONLY USED AGENTS AND LABORATORY TESTS FOR AN HIV-INFECTED ADULT.*

AGENT OR TEST	TRADE NAME	COMMON REGIMEN	COST/YR ($)
Antiretroviral treatment			
Zidovudine (AZT)	Retrovir	200 mg orally 3 times/day	3,490
Didanosine (ddI)	Videx	200 mg orally 2 times/day	2,160
Zalcitabine (ddC)	Hivid	0.75 mg orally 3 times/day	2,520
Stavudine (d4T)	Zerit	20 mg orally 2 times/day	2,730
Lamivudine (3TC)	Epivir	150 mg orally 2 times/day	2,800
Saquinavir	Invirase	600 mg orally 3 times/day	7,080
Ritonavir	Norvir	600 mg orally 2 times/day	8,120
Indinavir	Crixivan	800 mg orally 3 times/day	6,020
Nevirapine	Viramune	200 mg orally 2 times/day	3,020
Prophylaxis against *Pneumocystis carinii* pneumonia or toxoplasmosis			
TMP-SMX	Bactrim DS	160 mg of TMP and 800 mg of SMX orally 3 times/wk	30
Dapsone		100 mg orally daily	70
Atovaquone	Mepron	750 mg orally 2 times/day	8,190
Prophylaxis against *Mycobacterium avium* complex			
Rifabutin	Mycobutin	300 mg orally daily	1,390
Clarithromycin	Biaxin	500 mg orally 2 times/day	2,380
Azithromycin	Zithromax	1200 mg orally every week	1,510
Antifungal prophylaxis or treatment			
Clotrimazole troche	Mycelex	10 mg orally 5 times/day	1,360
Nystatin suspension	Mycostatin	5 ml orally 4 times/day	2,660
Fluconazole	Diflucan	100 mg orally daily	2,510
Ketoconazole	Nizoral	200 mg orally daily	1,070
Itraconazole	Sporanox	200 mg orally daily	4,260
Prophylaxis against cytomegalovirus			
Ganciclovir, oral	Cytovene	1 g orally 3 times/day	17,080
Herpes simplex treatment			
Acyclovir	Zovirax	400 mg orally 2 times/day	1,610
Nutritional maintenance			
Food supplement	Ensure	1 8-oz can orally 3 times/day	1,610
	Ensure Plus	1 8-oz can orally 3 times/day	1,970
Dronabinol	Marinol	2.5 mg orally 2 times/day	1,820
Megestrol acetate	Megace	800 mg orally daily	3,290
Laboratory monitoring			
Complete blood count and chemistry profile†		4 times/yr	200
CD4 cell count		4 times/yr	400
HIV viral-load measurement		4 times/yr	800

*Costs are based on average wholesale prices, rounded to the nearest $10, with prices for generic products used when available. TMP-SMX denotes trimethoprim–sulfamethoxazole.

†The chemistry profile includes measurements of electrolytes and renal and liver-function tests.