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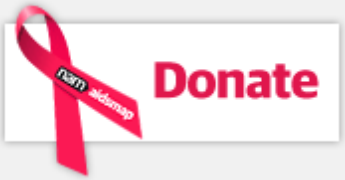

When will Europe get PrEP?

Gus Cairns and panel at the PrEP session at EACS 2015. Photos by Liz Highleyman, hivandhepatitis.com

Pressure is mounting at community level for access to pre-exposure prophylaxis (PrEP) in Europe and it is likely to continue to increase in the absence of decisions by funding authorities and regulators, leading to more informal use, the conference heard.

In the United States, the use of *Truvada* (tenofovir and emtricitabine) as PrEP was approved by the Food and Drug Administration (FDA) in 2012 and US guidelines on PrEP use were published in 2014. However, in Europe, PrEP is not currently being funded by national or regional governments, and any use outside of clinical trials is either the result of individual arrangements with doctors, private prescribing outside the public health systems, or informal and unmonitored use.

Grassroots demands for PrEP are emerging through social media at a rapid pace and supporting people to make informal use of PrEP safe and effective is likely to become a growing part of the work of community organisations.

Plans for implementing PrEP as a fully-funded component of national HIV prevention strategies are still at an early stage, even in countries where research has been very active, such as France and the UK. Delegates heard that a single European approach to implementation of PrEP in Europe is going to be far from straightforward because of the variety of healthcare systems and funding mechanisms for health across the continent.

Even where the infrastructure already exists to deliver PrEP to those who need it, regulatory and funding barriers still prevent people from getting access to PrEP, and for many countries the issue remains one of cost. Despite evidence that PrEP is cost-effective in some circumstances, funding authorities are dragging their feet.

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Benefits of early HIV treatment are clear, but some questions still unanswered

Jens Lundgren, presenting at EACS 2015. Photo by Liz Highleyman, hivandhepatitis.com

The long-running controversy over when to start antiretroviral therapy (ART) has been definitively answered, Professor Jens Lundgren told the conference, but “drug safety is not a closed chapter in HIV medicine.”

Earlier this year, the START trial found that people who began ART immediately after they were diagnosed with HIV had a lower risk of illness and death than those who waited until their CD4 count fell to 350. These findings are already starting to have an effect in practice. The World Health Organization's latest HIV treatment guidelines and a growing number of national guidelines now recommend that everyone diagnosed with HIV should start treatment regardless of CD4 count.

However, unresolved issues remain, including a lack of knowledge about the long-term effects of decades of antiretroviral drug exposure. Researchers will continue to follow people who took part in the START trial for at least the next two years – and hopefully for the next five to ten years – to better understand long-term outcomes.

Other studies have found increased rates of cardiovascular disease and cancers in people living with HIV, and the START trial found a higher risk of non-AIDS-related illness and death among people with high CD4 counts who were not taking ART. The mechanisms underlying co-morbidities such as cardiovascular disease and cancer in people living with HIV are also not well understood. Persistent immune activation and inflammation, unrecognised antiretroviral drug toxicities and traditional risk factors may all play a role.

Along with these unanswered scientific questions, there are also policy issues that must be addressed to ensure that antiretroviral treatment is made available to everyone, worldwide, living with HIV.

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Majority of migrants living with HIV in Europe may have acquired HIV in their new country

Material promoting the aMASE survey. See www.amase.eu

A study presented at the conference has found evidence that the majority of migrants living with HIV in Europe, who were diagnosed less than five years ago, probably acquired HIV in the country they migrated to, rather than the country in which they were born.

The findings came from the aMASE study (Advancing Migrant Access to Health Services in Europe), which included 2249 migrants living in nine European countries.

Many people don't know for sure when they acquired HIV. During the questionnaire, participants where asked when and where they were diagnosed, were asked about HIV risk behaviours before and after migrating, and also gave permission for researchers to contact the clinic where they had been diagnosed and to conduct an independent interview with their doctor to confirm diagnosis and probable date of infection.

The researchers found that more people had a documented or probable date of acquiring HIV which was after they had migrated to Europe (or within Europe) than those with a documented or probable date which was before they migrated.

One important caveat is that for a large minority of people (in the case of people from sub-Saharan Africa, as many as 48%) the date of infection could not be established. Nonetheless, the findings are striking; in men who have sex with men in particular, the vast majority acquired HIV in their host country rather than in their country of origin.

Débora Álvarez del Arco, presenting the findings, told the conference that the figures showed that people from Western Europe and Latin America and the Caribbean had a particularly high probability of acquiring HIV post-migration, as did men who have sex with men. She and audience members called for more research into migrant vulnerability to HIV in the countries to which they migrate.

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Could dolutegravir be used in dual therapy or monotherapy?

Pedro Cahn, presenting at EACS 2015. Photo by Liz Highleyman, hivandhepatitis.com

The integrase inhibitor dolutegravir (*Tivicay*) taken with a single well-tolerated NRTI was able to fully suppress viral load in people starting antiretroviral therapy (ART) for the first time, while dolutegravir alone was able to keep HIV suppressed in most treatment-experienced people who started with undetectable viral load, according to a set of studies presented at the conference.

As people living with HIV continue to face decades on treatment, researchers have attempted to find regimens that are better tolerated, simpler and easier to take – while still effectively suppressing viral load.

Most HIV treatment regimens are made up of a combination of at least three drugs, from two or more different drug classes. Some regimens are combined into one pill, taken once a day, which simplifies treatment for many people.

New approaches to ART may be especially beneficial for people who have taken a lot of different drugs in the past and who have drug-resistant virus, and those who cannot tolerate drug side-effects.

In Argentina, a combination of dolutegravir and lamivudine was trialled in a small study of 20 people (19 men and one woman), none of whom had taken HIV treatment before. At the start of the study, the median viral load was just over 24,000 copies/ml – though four participants had more than 100,000 copies/ml – and CD4 count was approximately 400.

All participants took 50mg dolutegravir plus 300mg lamivudine, once daily, for 48 weeks. Pedro Cahn presented results from the 24-week analysis, which showed that viral load declined rapidly after starting therapy. All participants had a viral load below 400 copies/ml at week 3 and below 50 copies/ml from week 8 onward.

In Spain and France, two separate studies looked at dolutegravir monotherapy (taken on its own) for people who already had suppressed viral loads on treatment.

In Barcelona, researchers worked with 33 people (more than half were women) who had no known history of virological failure or evidence of resistance to integrase inhibitors. The participants switched from their current regimens to dolutegravir and, at 24 weeks, all but one maintained viral suppression.

In Paris, a similar study involved 28 people (more than half were men) with undetectable viral loads on treatment. At week 24 after switching therapy, 89% of participants (25 out of 28) maintained undetectable viral load. The three people who did not maintain undetectable viral loads regained viral suppression after adding tenofovir/emtricitabine to their treatment regimen. All three had previously taken integrase inhibitors and had various integrase resistance mutations.

After these presentations, experts offered evidence in favour of and opposed to simplifying treatment, disagreeing about whether this strategy is beneficial or too risky.

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