



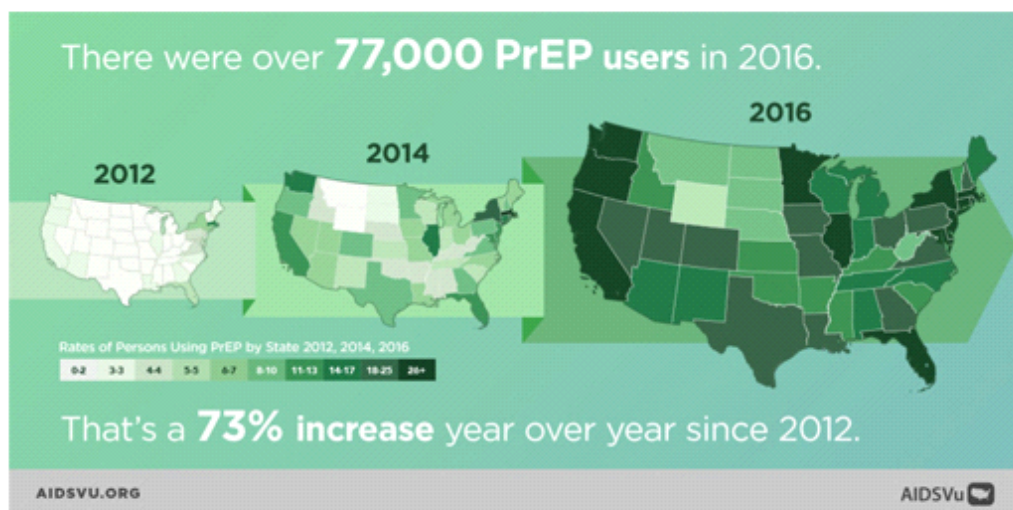
Wednesday 7 March 2018

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PrEP use growing in US, but not reaching all those in need



Graphic from the AIDSvU website: <https://aidsvu.org/resources/mapping-prep>

The number of people taking HIV pre-exposure prophylaxis (PrEP) in the United States is steadily [increasing](#), but PrEP is only reaching a small proportion of those who could benefit from it, the [25th Conference on Retroviruses and Opportunistic Infections \(CROI 2018\)](#) in Boston was told this week. Although African Americans and Latinos make up about two-thirds of people who stand to benefit from PrEP, they are much less likely than white people to be using it.

For several years, Gilead Sciences, the maker of *Truvada*, has been reporting PrEP use estimates based on surveys of commercial pharmacies (thought to represent over 85% of PrEP

prescriptions). Gilead have now collaborated with Patrick Sullivan of Emory University and [AIDSVu](#) to present the data. This could help health departments, medical professionals and community leaders to better understand and reduce disparities in PrEP usage.

Data come from 54,000 commercial pharmacies and a number of other medical settings, and include prescriptions paid by Medicaid and patient assistance programmes. However, it does not include demonstration studies, military veterans' health systems and managed care providers that run their own pharmacies, such as Kaiser Permanente.

During 2016, 77,120 people were using PrEP, up from 8768 in 2012. But behind these overall numbers lie some notable demographic and geographic disparities.

Although women account for about 19% of all new HIV diagnoses in the US, they make up only 7% of PrEP users. While 21% of new diagnoses are in people under the age of 25, only 11% of PrEP users are in this age group.

More than half of all new HIV diagnoses occur in the south, but this region was home to only 30% of PrEP users. After adjusting for population size, the states of New York, Massachusetts, Rhode Island, Washington and Illinois had the highest PrEP usage rates.

States with a higher proportion of people living in poverty, more people without health insurance and those that did not implement Medicaid expansion under President Obama's health reforms have lower rates of PrEP usage.

Prescription data often do not include information about race, but the Centers for Disease Control and Prevention (CDC) estimate that only 1% of African Americans who meet the PrEP eligibility criteria are using PrEP. Similarly, only 3% of Latinos are using PrEP.

There was a smaller but still considerable gap for white people, with 14% of eligible individuals receiving PrEP.

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New HIV infections halved after scale-up of HIV treatment and circumcision

[The rate of new HIV infections has halved since 2011 in a hyperendemic Ugandan fishing community](#) following large increases in male circumcision, antiretroviral treatment and viral suppression, the conference was told on Tuesday.

The study was based on repeat surveys in a single fishing community with a very high incidence and prevalence of HIV. Located on the shore of Lake Victoria, this is one of the communities that participates in the Rakai Community Cohort. Surveys were conducted with a total of 5005 people aged between 15 and 49 years, between 2011 and 2017.

During this time:

- ▮ The proportion of people with HIV taking antiretroviral treatment increased from 19% to 81%.

- | The proportion of people with HIV (including undiagnosed people) who were virally suppressed rose from 33% to 78%.
- | The proportion of men who were circumcised rose from 39% to 63%.
- | There was no change in sexual behaviour.

Following this, overall HIV incidence more than halved from 3.97 per 100 person-years in 2011 to 1.61 per 100 person-years in 2017, a 58% reduction. Similar declines in incidence occurred in women and in men. Substantial falls were seen in all age groups, but especially in people aged 15 to 24 years.

HIV prevalence fell from 41% to 36%.

Dr Joseph Kagaayi of the Rakai Health Sciences Program said that his findings are amongst the first to show that combination HIV prevention can successfully reduce HIV incidence in a hyperendemic community. "These results suggest that HIV treatment and prevention interventions can be rapidly scaled and have substantial population-level impact on HIV incidence in high prevalence settings," he commented.

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Bictegravir-based combination maintains viral suppression after switching therapy



Jean-Michel Molina presenting at CROI 2018. Photo by Liz Highleyman.

People who switched to a single-tablet regimen containing the integrase inhibitor bictegravir were as likely to maintain an undetectable viral load as those who stayed on their current suppressive regimen containing dolutegravir, according to a presentation at CROI 2018.

Gilead Science's bictegravir is a next-generation integrase strand transfer inhibitor. In February, US regulators approved *Biktarvy*, a new once-daily single tablet regimen containing bictegravir, emtricitabine and tenofovir alafenamide (TAF), the new kidney- and bone-friendly formulation of tenofovir. The combination pill is currently under regulatory review in Europe.

Previous studies, in people taking HIV treatment for the first time, have shown that the bictegravir combination was non-inferior to regimens containing ViiV Healthcare's integrase inhibitor dolutegravir.

The study presented this week evaluated the bictegravir combination in people changing treatment. Eligible patients already had suppressed viral load on a regimen containing dolutegravir, lamivudine and abacavir (the drugs in the *Triumeq* single-tablet regimen).

A total of 563 participants were recruited in Europe, North American and Australia. They were predominantly male and white, with a CD4 cell count of around 700 cells/mm³. The study only recruited participants with moderate or better kidney function (estimated glomerular filtration rate or eGFR above 50 ml/min).

At 48 weeks, viral suppression rates were high in both arms: 98.6% in the bictegravir group and 95.0% in the dolutegravir group. No participants developed treatment-emergent resistance to any study drug.

Both treatment regimens were generally safe and well tolerated. Half as many people in the bictegravir group experienced drug-related adverse events (mostly headache), but eGFR rose by a small amount in the bictegravir group while falling slightly in the dolutegravir group.

The researchers concluded that switching to bictegravir was non-inferior to continuing on a dolutegravir-based regimen in terms of efficacy and safety.

When asked what might motivate someone who is doing well on dolutegravir to switch to *Biktarvy*, they noted that the tenofovir-containing regimen might be preferable for someone with hepatitis B co-infection, as tenofovir is active against both HIV and hepatitis B.

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Success of same-day start to HIV treatment in Lesotho



Starting treatment at home, on the day of diagnosis, proved acceptable in rural Lesotho and resulted in improved linkage to care and viral suppression compared with routine care, the conference was told.

A number of studies in sub-Saharan African countries have reported substantial problems with linkage to care following diagnosis. Home-based testing programmes have found that only one in three people diagnosed with HIV link to care if they receive a referral – more active measures are needed.

The CASCADE study was carried out in a mountainous district of Lesotho where around half of people need to walk to a clinic. Individuals who had been diagnosed with HIV during a home-based testing and counselling campaign were randomised to either receive a 30-day supply of antiretroviral drugs on the day of diagnosis or the standard of care (referral to a medical facility for antiretroviral therapy [ART]).

Of 441 adults who were diagnosed as part of the campaign, 278 were willing and eligible to participate. Those taking part needed to agree that they understood the implications of starting lifelong ART after home-based counselling.

Same-day initiation resulted in significantly greater proportions linked to care within three months (68.6% in the same-day arm and 43.1% in the standard-of-care arm). It also resulted in a significantly greater proportion being virally suppressed after 12 months (50.4% in the same-day arm and 34.3% in the standard-of-care arm).

Around 30% in each arm did not link to care because they were 'too busy'; 25% in the same-day-initiation arm and 30% in the standard-of-care arm were lost to follow-up; and 10% said they did not understand that they should have attended care when traced by a community health worker.

Dr Niklaus Labhardt of the Swiss Public Health Institute said that the results were likely to be generalisable to other rural settings in sub-Saharan Africa where home-based testing and counselling is being implemented.

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Twice-daily dolutegravir and TB treatment



Kelly Dooley presenting at CROI 2018. Photo by Liz Highleyman.

Twice-daily dosing of dolutegravir when combined with the tuberculosis (TB) drug rifampicin is safe and effective, according to a 24-week interim analysis of the INSPIRING study. The results suggest that dolutegravir can be used alongside TB treatment as part of first-line antiretroviral treatment.

Dolutegravir is recommended as an alternative to efavirenz in first-line antiretroviral treatment in lower- and middle-income countries and a fixed-dose combination pill containing dolutegravir, tenofovir and lamivudine priced at \$75 a year became available in 2017. Although dolutegravir has relatively few drug interactions with other medicines, a pharmacokinetic study showed that rifampicin reduces dolutegravir blood levels.

When dolutegravir received marketing approval regulators recommended that the drug should be dosed twice daily if used alongside rifampicin to overcome the drug interaction. The INSPIRING study was designed to provide evidence that this dosing pattern is safe and effective.

The phase 3a, randomised, open-label study recruited 113 participants, all of whom had been taking rifampicin-based TB therapy for at least eight weeks and had a CD4 cell count above 50 cells/mm³.

The participants were randomised to receive an antiretroviral therapy regimen based on either twice-daily dolutegravir or once-daily efavirenz. A minimum of two weeks after completing TB treatment, those in the dolutegravir arm could switch to once-daily dosing.

At baseline, the median CD4 cell count in both arms was a little over 200 cells/mm³. The viral load in both arms was around 5 log₁₀ copies/ml.

After 24 weeks, viral load was undetectable in 81% of people in the dolutegravir arm and 89% of the efavirenz arm. This difference appeared to be driven by more discontinuations unrelated to therapy in the dolutegravir arm.

CD4 cell increases were comparable between the two regimens (146 cells/mm³ for dolutegravir vs 93 cells/mm³ for efavirenz).

Only two people, both of whom were in the efavirenz arm, stopped treatment because of side-effects. There were no discontinuations due to liver-related side-effects. The rate of immune reconstitution inflammatory syndrome (IRIS) was low (6% for dolutegravir vs 9% for efavirenz).

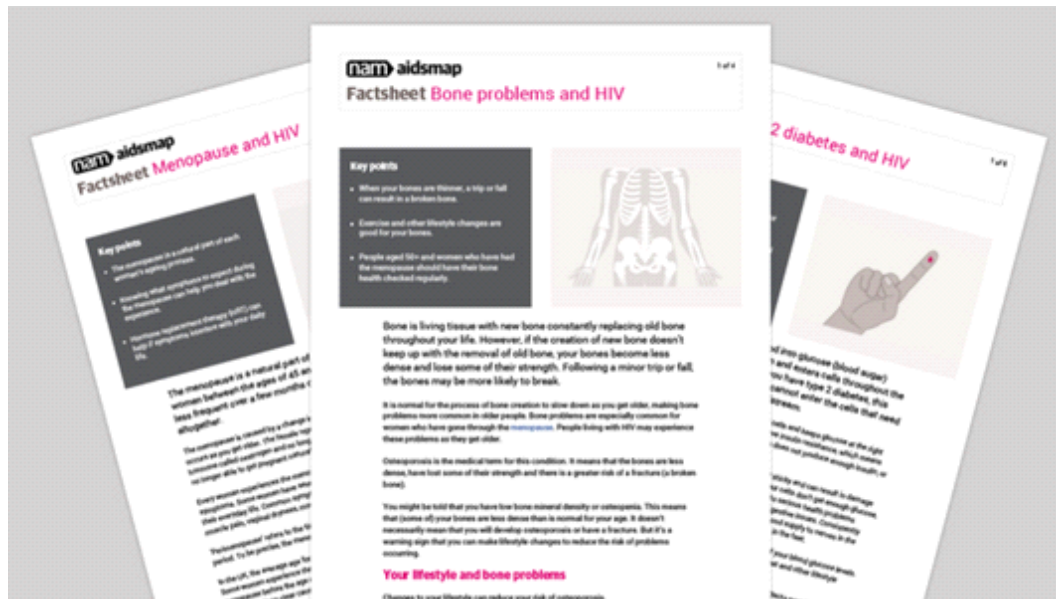
The study is continuing, but the investigators believe that these interim results support the use of dolutegravir-based regimens in HIV/TB co-infection.

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New resources: Living with HIV as you get older



A range of resources on health problems, co-morbidities and challenges that people living with HIV may face as they get older is available online.

This includes factsheets, an online *Side-effects checker* tool, *Side-effects* information booklet and translated editions of a number of our factsheets in Spanish, Portuguese and Greek.

Related links

[Visit the *Living with HIV as you get older* page](#)

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