Note: This poster contains updated results compared with the submitted abstract

Dual Antiretroviral Therapy in a Treatment Experienced HIV Cohort

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Background

❖Dual boosted protease (PI/r) based therapy, ie. PI/r + 1 agent from another class, (DT) is not a recommended strategy[1].

❖Small studies have shown good virological efficacy and it is sometimes used in clinical practice where treatment options are limited due to resistance or toxicity.

❖ We aimed to describe the characteristics, indications and outcomes of those prescribed DT.

Methods

❖Patients attending the Mortimer Market Centre, London prescribed DT between 1999 and 2012 were identified using electronic patients records.

❖ Patient demographics and clinical characteristics were collated.

❖ The number of virological failures, cumulative resistance, number of previous regimens, reasons for DT and rates of viral load suppression were collected.

Results

Patient Demographics

❖132 (77% male) patients identified

❖Median (range) age 49 (17-73) years

❖36% had a history of an aids-defining illness.

❖78% ART-experienced; median prior regimens 3 (range 0-11)

Illustration 1: ARV regimen prior to switching to DT

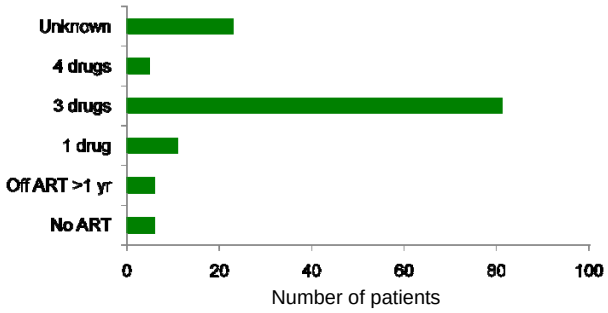
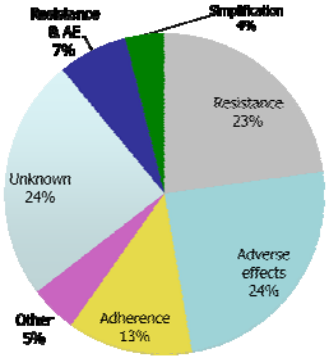


Illustration 2: Reasons for switching to DT



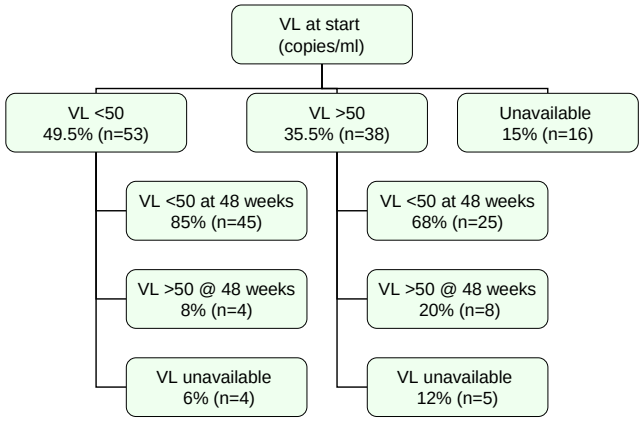
Other included: drug interactions (3) HCV (2), trial (2), CD4 <350 (2), neurocognitive concerns (2)

Table 1: DT regimens used (PI/r with additional agents)

PI/r	NRTI	NNRTI	Raltegravir	Maraviroc
ATZ/r (n=34)	32	2	0	0
DRV/r (n=71)	55	4	9	3
FSP/r (n=4)	4	0	0	0
LPV/r (n=10)	10	0	0	0
SQV/r (n=13)	12	1	0	0

❖Patients remained on DT for median 23 months (range 1-123).
❖At last measured VL 89% (77/87)of those with a result avilable maintained a VL<50 copies/ml.
❖19% (n=25) went on to stop dual therapy (table 2).

Fig 3: Virological outcomes (n=132; 25 excluded as on DT <12 months)



❖Of those with a VL>50 at week 48 (n=12), seven had an undetectable VL and one had a decreasing VL at the last measured result, median 172 weeks (range 120-364) and 144 weeks, respectively.
❖ Of the 4 that remain detectable at the last measured VL, two had poor documented adherence and two had resistance.

Table 2: Reasons for stopping DT

Reason	Number (%)
Adverse effects	6 (24%)
Adherence	2 (8%)
Neuro-cognitive concerns	2 (8%)
Resistance	5 (20%)
Viral blips	2 (8%)
Improve regimen	4 (16%)
Unknown	4 (16%)

❖Of the 5 individuals with resistance on stopping DT:
- ❖4 had pre-existing 2 (2), 3 (1) or 5 class resistance (1).
- ❖1 had emergent NRTI & PI mutations. Their VL was 10,300 on commencing DT. Addition of 3TC resulted in viral suppression.

❖Median CD4 change was +50 cells/mm^3 (range -840-720) at 48 weeks.

Discussion

❖We demonstrate that DT is an efficacious, well tolerated and useful alternative strategy in those for whom standard ART is not an option due to resistance or toxicity.

❖Careful monitoring is required particularly with those with prior resistance to avoid the risk of accumulating further mutations.

References: 1 Williams,.I et al, British HIV Association British HIV Association guidelines for the treatment of HIV-1 positive adults with antiretroviral therapy 2012; DOI: 10.1111/j.1468-1293.2012.01029_1.x HIV Medicine (2012), 13 (Suppl. 2), 1–85.