BHIVA
British HIV Association

2022 Spring Conference

Wed 20th - Fri 22nd April
Manchester Central, Manchester
Guidelines/Position Statements

Chair: Dr Laura Waters
Co-chair: Dr Alexandra Maxwell
ART Guidelines

Dr John Walsh
Imperial College Healthcare NHS Trust, UK
Draft BHIVA antiretroviral guidelines 2022

Dr John Walsh
Consultant Physician
Imperial College Healthcare NHS Trust
ART guidelines chair
Thank you

- The whole writing committee
  - Led by Laura Waters & Alan Winston
  - Our community reps Ben Cromarty & Andy Hilton
- Cathy Nieman-Sims
Why am I chair?

• No special knowledge/skills
• All the work so far has been done by others
• Just volunteered to steer guidelines through consultation phase
Disclosures

• None
Main changes

- What to start
- Rapid ART
- Switching with a suppressed viral load
- ART for transgender people with HIV
- Spontaneously controlled HIV
- People choosing not to commence ART
WHAT TO START
Methodology

Critical outcomes ranked by the committee...

- Virological suppression
- Virological failure
- Failure with resistance
- Adverse events ...
  - Causing discontinuation
  - Serious adverse events
  - Grade 3/4 adverse events
Methodology

- Systematic literature search in November 2021
- Modified GRADE approach to produce
  - Summaries of evidence
  - Forest plots for key outcomes
- Evidence will be published as appendix to guideline
First-line treatment

No longer ‘preferred’ or ‘alternative’ options

Now...

• Regimens recommended for most people living with HIV (Grade 1A)

or

• Regimens recommended in certain clinical situations (Grade 2A)
REGIMENS RECOMMENDED FIRST-LINE FOR MOST PEOPLE LIVING WITH HIV
‘Tenofovir-XF/XTC’

In these slides T-XF/XTC =

- Tenofovir-DF or Tenofovir-AF plus
- 3TC or FTC
### Recommended first-line for most people

<table>
<thead>
<tr>
<th>Drug Combination</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenofovir-XF/XTC with dolutegravir</td>
<td></td>
</tr>
<tr>
<td>Abacavir/3TC/dolutegravir</td>
<td><strong>HLA B*5701 negative</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Estimated 10-year CVD risk &lt;10%</strong></td>
</tr>
<tr>
<td></td>
<td><strong>No hepatitis B treatment/prevention</strong></td>
</tr>
<tr>
<td>Tenofovir-AF/FTC/bictegravir</td>
<td></td>
</tr>
<tr>
<td>Dolutegravir/3TC</td>
<td><strong>No baseline resistance</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Viral load &lt;500,000</strong></td>
</tr>
<tr>
<td></td>
<td><strong>CD4 greater than 200</strong></td>
</tr>
<tr>
<td></td>
<td><strong>No hepatitis B treatment/prevention</strong></td>
</tr>
<tr>
<td></td>
<td><strong>No cognitive impairment</strong></td>
</tr>
</tbody>
</table>
WHY?
DOL + 2 NRTIs versus...

• DRV/b + 2 NRTIs
  – Virological success favour DOL

• EFV + 2 NRTIs
  – Virological success and adverse events favour DOL

However for ...

• BIC/ TAF/ FTC:
  – No difference in any outcome from DOL
Regimen A vs regimen B

VIROLOGICAL SUCCESS

FAVOURS A  FAVOURS B

VIRAL FAILURE or AEs

FAVOURS A  FAVOURS B
TDF/FTC/DOL vs. 3TC/DOL

VIROLOGICAL SUCCESS

VIROLOGICAL FAILURE
REGIMENS RECOMMENDED IN CERTAIN CLINICAL SITUATIONS
### Recommended first-line in certain situations

<table>
<thead>
<tr>
<th>Drug Combination</th>
<th>Recommended Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenofovir-XF/XTC with raltegravir</td>
<td>Viral load &lt;100,000 copies/mL</td>
</tr>
<tr>
<td>Tenofovir-XF/XTC with darunavir/b</td>
<td></td>
</tr>
<tr>
<td>Tenofovir-XF/XTC with doravirine</td>
<td></td>
</tr>
<tr>
<td>Tenofovir-XF/XTC with efavirenz</td>
<td>Consider during pregnancy and TB treatment but <strong>not</strong> otherwise not recommended</td>
</tr>
<tr>
<td>Abacavir/3TC with efavirenz</td>
<td></td>
</tr>
</tbody>
</table>
2NRTI + RAL vs. 2NRTI + DOL

VIROLOGICAL SUCCESS

VIROLOGICAL FAILURE
2NRTI + RAL vs. 2NRTI + DOL

High baseline viral load (96 week data)

\[
\begin{align*}
\text{≤100,000 copies/mL} \\
>100,000 \text{ copies/mL}
\end{align*}
\]
DORAVIRINE
TXF/XTC + DOR

- RCT data comparing DOR with
  - DRV/r
  - EFV
- But not DOL or BIC
- Hence DOR not in ‘for most people’ list
2NRTI + EFV vs. 2NRTI + DOR

Virological Success

Discontinuations due to AEs
Rapid ART

• Pros and cons of starting antiretroviral therapy at diagnosis should be discussed
  – including lack of proven benefit for same-day ART in a UK or similar settings (GPP)

• We recommend same-day ART in the following situations (GPP):
  – Symptomatic primary HIV
  – Where an individual wishes to start ART same day and this is clinically appropriate
  – Where it is likely not commencing ART will result in disengagement from care

• We recommend that readiness to start is assessed and decisions about starting ART tailored accordingly (GPP)
Rapid ART or Transmitted Drug Resistance

Recommended regimens

- DTG + TDX/XTC
- DRV/b + TDX/XTC
- BIC/TAF/FTC
SWITCHING WITH A SUPPRESSED VIRAL LOAD
### Acceptable for switch if virologically suppressed

<table>
<thead>
<tr>
<th>ANY FIRST LINE COMBINATION OR ...</th>
<th>INSTI-based 3 drug regimens</th>
<th>NNRTI-based 3 drug regimens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abacavir/3TC with raltegravir</td>
<td>Tenofovir-XF/XTC with rilpivirine Abacavir/3TC with rilpivirine</td>
<td></td>
</tr>
<tr>
<td>Tenofovir-XF/FTC/elvitegravir/c</td>
<td>Abacavir/3TC with doravirine</td>
<td></td>
</tr>
<tr>
<td>PI-based 3 drug regimens</td>
<td>2 drug regimens</td>
<td></td>
</tr>
<tr>
<td>Tenofovir-XF/XTC with atazanavir/b Abacavir/3TC with atazanavir/b</td>
<td>Dolutegravir/rilpivirine</td>
<td></td>
</tr>
<tr>
<td>Abacavir/3TC with darunavir/b</td>
<td>Injectable cabotegravir/rilpivirine</td>
<td></td>
</tr>
<tr>
<td>Tenofovir-XF/XTC with lopinavir/r Abacavir/3TC with lopinavir/r</td>
<td>3TC with darunavir/b</td>
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</tbody>
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NEW SECTIONS
ART for transgender people with HIV

- Holistic assessment considering impact of ...
  - Drug-drug interactions
  - Mental health concerns
  - Stigma
  - Cardiovascular disease
  - Bone mineral density

- Individualised interpretation of gender-influenced laboratory and other assessments that may impact ART choice

- Clinics should collect accurate data on gender identity to better reflect outcomes for transgender people
Spontaneously controlled HIV

Confirmed HIV infection with viral load <50 without treatment

- Strong recommendation to start treatment
- But if well with normal CD4 count and CD4:CD8 ratio
  - remaining off ARVs may be considered
  - in specific circumstances
  - with 4-6 monthly monitoring
Persons choosing not to commence ART

- Explore reasons for this choice
- Ensure person understands
  - Risk to their own health
  - Risk of transmission to others
- Assess capacity to make this decision
- Offer psychological support
NEXT STEPS
Next steps

• Pre-consultation version has been circulated to BHIVA executive & guidelines committees
• After tweaks the consultation will open on 26th April
• 4-week consultation period
• Virtual community consultation
• 2-4 weeks for final review
• FINAL VERSION JUNE 2022
Thank you!
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HIV, disclosure & the law

Professor Matt Phillips
North Cumbria Integrated Care NHS Foundation Trust, UK
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