

# Etravirine as a first-line switch option: real world experience in one UK centre

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## Background

Etravirine (ETV) has been shown to be a viable first-line switch option for patients experiencing side effects with Efavirenz (EFV)<sup>1,2</sup>. It remains unlicensed for this indication, but evidence accumulates to support its use<sup>3,4</sup>. Evidence also suggests that ETV is effective in patients experiencing virological failure with EFV<sup>5</sup> and other NNRTIs<sup>6,7</sup>. This UK unit has used ETV as a switch option re tolerability for treatment-experienced patients for over 2 years and we present our experience.

## Methods

All patients switched to ETV prior to 30/06/11 were identified via pharmacy records, providing at least 6 months follow up. Data on sex, age, orientation, ethnicity and hepatitis co-infection were collected. CD4 count, viral load (VL) (Abbott Realtime), liver enzymes and lipid data at baseline and 6 months were recorded.

## Results

25 patients were identified and evaluated (23 male, 2 female; 22 Caucasian, 2 Black African, 1 Asian; 23 MSM, 2 heterosexual) with a mean age of 41 years (range 23-56). 4 patients were co-infected with Hepatitis B (HBV), none with Hepatitis C.

The majority of patients (21/25, 84%) switched from EFV with the predominant reason for this switch being CNS side-effects (16/21, 76%). 2 switched from Nevirapine, and 2 from protease inhibitors (rash and gastrointestinal side effects respectively). All received ETV 400mg once daily. Co-prescribed drugs were nucleoside backbones (Truvada [20/25, 80%], Kivexa [5/25, 20%]). One patient who received Truvada (HBV+, K65R) was also co-prescribed Raltegravir; K65R present due to prior Tenofovir monotherapy pre-HIV diagnosis.

One HBV PCR+ patient, who recommenced HAART following a prolonged treatment gap, discontinued therapy as a precaution due to rising serum transaminases. No other adverse events were experienced.

22 patients (88%) had undetectable viral loads throughout the study period with 2 patients (8%) each having single viral load blips (range 58-92 c/mL) – one of which was clearly related to an episode of poor adherence.

Median baseline and six month data (range in brackets)

	Baseline	6 Months
CD4 cells/ $\mu$ L	479 (181-1050)	541 (157-1026)
Alanine transaminase (ALT) IU/L	32 (10-90)	22.5 (10-56)
Bilirubin $\mu$ mol/L	6 (3-65)	7 (3-16)
Total cholesterol mmol/L	4.8 (2.8-6.2)	4.4 (3.5-6.4)
HDL mmol/L	1.2 (0.7-1.8)	1.15 (0.6-2)
Triglycerides mmol/L	1.4 (0.6-3.9)	0.95 (0.6-5.5)

## Discussion

Patients switching to ETV were offered a choice of a once or twice daily regimen. Although unlicensed, patient preference was clearly for once daily dosing. All patients received 4 x 100mg tablets. The predominant factor initiating a switch to ETV was CNS side-effects experienced with EFV. All these patients tolerated the switch well with reported improvement in mood and sleep health in line with existing evidence<sup>8</sup>. Only one precautionary discontinuation occurred, which may be related to HBV and could not be confidently attributed to etravirine. The rate of continued virological suppression was good, with 100% VL<40 at 6 months.

The data is limited by low patient numbers with a bias to Caucasian male MSM. There were no Hepatitis C co-infections in the study population.

## Conclusions

This data adds to other work supporting ETV as a first-line switch option for treatment-experienced HIV infected patients. ETV is a licensed effective switch option for NNRTI resistance; our experience suggests that ETV is well tolerated, effective, and with no adverse trend in serum biochemistry, and is a viable switch option for tolerability also. Given the limited data supporting once daily etravirine in this context, we will continue to collect data on this population for future presentation.

### References:

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