ISSUE Nº 33

HIV TRAINEES CLUB

Editorial

Welcome to the summer edition of the HIV Trainees Club Newsletter.

Our pre-BHIVA meeting this year in Manchester was full of clinical updates and we hope you found this useful. Included in this newsletter are the presentations reviewing the new PEPSE guidelines and the BASHH Syphilis guidelines which were both updated in 2015. In this edition we have also summarised the very helpful talk on how to prepare for and pass the Dip HIV exam.

As always we welcome any comments or suggestions for future topics to cover at our workshops. Any ideas can be emailed to us at: secretariat@hivtc.org.uk. The website has recently been updated to include past programmes and newsletters.

We look forward to hopefully seeing lots of you at our next workshop in London in September that will be themed around chronic HIV and ageing.

Many thanks to our sponsors who allow us to continue to provide these valuable educational workshops: Gilead, Janssen and Viiv.

Isobel Hawkins

SpR GUM/HIV

MEETINGS CALENDAR

27 September 2016

Chronic HIV and ageing related issues

(London)

17 November 2016

Public Health

(London)

Further details from:

HIVTC Secretariat

Email: secretariat@hivtc.org.uk

Web: www.hivtc.org.uk

Twitter: @hivtc

BASHH Syphilis Guidelines 2015

Dr Margaret Kingston – GUM Consultant Central Manchester NHS Foundation Trust

Dr Kingston gave an excellent interactive summary of the latest BASHH Syphilis Guidelines 2015.

The guidelines can be found at http://www.bashh.org/documents/UK%20syphilis%20guidelines%202015.pdf

She explained the process of generating the guidelines, which involved use of the GRADE system for assessing evidence and making recommendations. Unfortunately despite great effort they were unable to recruit a patient for involvement in the development of the guidelines. The changes to the new guidance include;

- Procaine penicillin is now an alternative, not preferred treatment, for all stages of syphilis (where benzathine penicillin is suitable) except neurosyphilis. This is due to the pain associated with treatment courses requiring multiple injections and inconvenience and cost for patients and staff.
- Resistance to macrolide antibiotics limits their utility; they are to be used only when there are no suitable alternatives and with assured follow-up. If allergy to penicillin is an issue then desensitisation should be sought (especially in neurosyphilis).
- In asymptomatic disease there is no need for full routine examination or chest X-ray (CXR).
- Amended recommendation to period of sexual abstinence following treatment of early infectious syphilis to two weeks after patient and partner have been treated.
- The duration for the recommended treatment of neurosyphilis is reduced to 14 days, consistent with expert opinion and other guidelines.
- Amended minimal follow-up recommendations with clinical and serological (RPR or VDRL) follow up at 3, 6 and 12 months, then if indicated, six monthly until VDRL/ RPR negative or serofast.
- Some neonates will not need serology following delivery and the new guidelines include a syphilis birth plan.
- Tables summarising clinical criteria for diagnosing congenital Syphilis and for interpreting CSF in suspected neurosyphilis

The second half of the session used interactive cases to put the guidelines to use.

Tips for Passing Dip HIV: *Dr Chris Ward – Locum GUM Consultant, Central Manchester NHS Foundation Trust*

Dr Ward presented an extremely useful session on tips for passing the Dip HIV.

OSCE

The exam includes 12 stations (you need to pass 8) and tests the application of knowledge.

He suggested it is useful to prepare a list of all the potential cases or scenarios you can think of based on BHIVA guidelines and position statements. For each possible station generate a list of 10 points you would like to cover for that topic in the exam and then practice running through them with colleagues. Have a logical approach to each station. If during the exam you forget what you have revised; revert to exactly what you would do in clinic.

In every station it is important to ask if the simulated patient has understood what was said and if they have any questions.

Best of Five Paper

There are 120 questions in a single best answer, which works out at approximately 1 ½ minutes per question. All questions are based on the based on the syllabus.

He suggested a good approach is to read question first then think of what the answer is prior to looking at the list of options; if that answer appears in the list then you were probably right.

General Sources for Revision

Guidelines and slide sets

Position statements

CROI slide sets

BHIVA/ BASHH/ EAGA/ NICE/ IAS

One day revision course (BHIVA/BASHH)

Focus on hart hitting research trials; especially ones that have changed clinical practice or guidelines.

He wished us all luck.

Review of the new PEPSE guidelines:

Dr Laura Waters, HIV Consultant, Mortimer Market Centre

The latest version of the PEPSE guidelines were published at the end of 2015, and Dr Waters gave an excellent overview of the main changes in this guideline, in addition to some of the key principles we need to remember when counselling patients about PEPSE.

The guidelines can be found at http://www.bashh.org/documents/PEPSE%202015.pdf

New in the 2015 guidelines:

- PEPSE is not routinely recommended, regardless of the type of sexual exposure, if the source is HIV positive and has a confirmed and sustained (>6 months) undetectable (<200 copies/ml) viral load on ARVs.
- This is based on TasP data from HPTN 052 and PARTNER studies. HPTN showed a 96% reduction in HIV transmission when the HIV positive partner was on ART. PARTNER has observed no linked transmissions, to date, where the VL was undetectable, despite fairly high rates of STIs, and including a large group of MSM
- Dr Waters emphasised that particularly for receptive anal intercourse, the viral load result must be confirmed with the HIV centre managing the index case.
- PEPSE should ideally be started within 24 hours of exposure, but may be given up to 72 hours.

- The recommended regimen for PEPSE is Truvada 1 tablet OD plus Raltegravir 400mg BD for 28 days
- Routine monitoring bloods are not required with Raltegravir-based PEPSE, provided baseline renal and liver function are normal, and there are no clinical concerns.
- Baseline bloods should include creatinine, ALT, HIV, Hepatitis B and C and Syphilis serology, in addition to urinalysis or uPCR, and an STI screen (as appropriate)
- It is acceptable to give the full 28 day PEPSE course at initial presentation provided the patient has seen a health advisor and there are no adherence or other clinical concerns.
- This is unlikely to be possible for those presenting to A+E initially, so 5-day starter packs are still likely to be required outside of sexual health settings.
- It should be reinforced that PEPSE is an emergency method of HIV prevention, other methods of HIV prevention should be discussed
- Dr Waters showed data that PEP use was a predictor for subsequent HIV seroconversion, so we should be mindful that these patients represent a very high risk group for HIV, and should therefore be counselled accordingly by an experienced member of staff.
- If there is a further high risk exposure in the last 2 days of the PEPSE course, it should be extended for a further 48 hours after the last exposure.
- This is based on data from PrEP studies using Truvada for HIV prevention.
- If HIV is diagnosed while on PEPSE, this should be continued and the patient referred to an HIV specialist for ongoing care.
- Patients should be advised of symptoms which could be in keeping with HIV seroconversion, and that urgent review is required in this situation.
- If more than 48 hours of medication has been missed, PEPSE should be discontinued.

The new guidelines include updated tables for estimates of HIV prevalence in various groups, and also the estimated rate of HIV transmission via different sexual, and non-sexual, exposures. The general principles of when PEPSE is recommended remain the same:

Risk >1 in 1000 = Recommended

Risk <1 in 1000 but >1 in 10000 = Consider

Risk < 1 in 10000 = Not recommended

Other factors which should be taken into account when 'considering' PEPSE include high viral load in source (especially primary HIV infection), breaches of the mucosal barrier, menses/other bleeding, con-current STIs (especially ulcerative), ejaculation, and non-circumcision. Patients presenting for PEPSE should also be offered full screening for STIs, accelerated vaccination course for Hepatitis B if clinically indicated, and emergency contraception when relevant. Note pregnancy, or risk of pregnancy, is not a contraindication for PEPSE, but women must be counselled about the risks and benefits. These guidelines should help clinicians who are involved in managing patients who are at high risk of HIV acquisition, including those presenting after an actual or potential exposure to HIV, when PEPSE has the potential to avert HIV infection by inhibiting viral replication following that exposure. The updated risk tables may also provide some reassurance to those patients who have had a low risk exposure, and for whom PEPSE is not recommended.

Appointments

Name	Hospital	S'ty	Date
Emma Page	Leeds Teaching Hospital	GUM	1/3/16
Eoghan de Barra	Imperial College	ID	1/3/16
Thomas J Blanchard	Royal Liverpool Hospitals	ID	1/3/16
Manish Pareek	Leicester University	ID	1/3/16

Please send any comments/views to:
HIV Trainees Club Secretariat
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Tel/Fax: 01384 381662
Email:secretariat@hivtc.org.uk
Twitter:@hivtc

Steering Committee Members April 2016

Daisy Ogbonmwan (Chairman)
North East

Prita Banerjee
Midlands

Charles Williams
London/South East

Johnny Boylan
Wales, South West Peninsula & Severn

Isobel Hawkins
East of England

Rebecca Metcalfe
Scotland/N. Ireland

Sally Jewsbury
N. West

Seema Malik
ID: Wessex/Thames Valley

Megan Jenkins
ID: Wales/South West

Sian Warren
Wales/South West

Sophie Candfield
Rep

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The Descovy® backbone contains a novel NRTI[1] that can be combined with a third agent to achieve high virological success* with significantly (p<0.001) improved renal tubular markers and bone mineral density (hip & spine) vs. FTC/TDF-based regimens at Week 48[1,2]

Descovy® is indicated in combination with other antiretroviral agents for the treatment of adults and adolescents (aged 12 years and older with body weight at least 35 kg) infected with human immunodeficiency virus type-1 (HIV-1)[1]

PRESCRIBING INFORMATION
Consult the Summary of Product Characteristics (SPC) before prescribing. **Descovy®▼ emtricitabine 200mg/ tenofovir alafenamide 10mg or 25mg film coated tablets. Indication:** In combination with other antiretroviral agents for the treatment of HIV-1 infection in adults & adolescents (aged 12 years & older weighing at least 35 kg). **Dosage:** Adults & adolescents (aged ≥ 12 years, weighing at least 35 kg): One tablet, once daily, orally with or without food. The dose of Descovy should be administered according to the third agent in the HIV treatment regimen. Please consult the SPC for further information. Children (< 12 years or weighing < 35kg): Safety & efficacy has not been established. Elderly: No dose adjustment is required. Renal: No dose adjustment is required in adult or adolescent patients (aged ≥ 12 years, weighing at least 35 kg) with estimated creatinine clearance (CrCl) ≥ 30 mL/min. In patients with CrCl < 30 mL/min: not recommended. Should be discontinued in patients whose CrCl declines to < 30 mL/min during treatment. Hepatic: Mild/moderate hepatic impairment: no dose adjustment required. Severe hepatic impairment: not recommended. **Contraindications:** Hypersensitivity to the active substances or to any excipients. **Warnings & Precautions:** Safety & efficacy in HBV/HCV co-infection has not been established. Co-infected HIV/HBV patients should be closely monitored for at least several months following discontinuation for symptoms of severe acute exacerbations of hepatitis. Descovy should be avoided in antiretroviral patients with HIV-1 harbouring the K65R mutation. Risks of mitochondrial dysfunction, immune reactivation syndrome, opportunistic infections, osteonecrosis with CART therapy. **Interactions:** Co-administration with certain anticonvulsants (eg. carbamazepine, oxcarbazepine, phenobarbital & phenytoin), antimycobacterials (eg. rifampicin, rifabutin & rifapentine), boceprevir, telaprevir, St. John's wort and HIV PIs other than atazanavir, lopinavir and darunavir is not recommended. Should not be administered concomitantly with medicines containing tenofovir disoproxil (as fumarate), lamivudine or adefovir dipivoxil. Co-administration of emtricitabine with medicinal products that are eliminated by active tubular secretion may increase concentrations of emtricitabine. Medicinal products that decrease renal function may increase concentrations of emtricitabine. Medicinal products that induce P-glycoprotein (P-gp) are expected to decrease the absorption of tenofovir alafenamide, resulting in decreased plasma concentration of tenofovir alafenamide, which may lead to loss of therapeutic effect of Descovy and development of resistance. Co-administration with medicinal products that inhibit P-gp are expected to increase the absorption and plasma concentration of tenofovir alafenamide. Tenofovir alafenamide is a substrate of OATP1B1 and OATP1B3 *in vitro*. The distribution of tenofovir alafenamide in the body may be affected by the activity of OATP1B1 and OATP1B3. **Pregnancy & lactation:** Use in pregnancy only if potential benefit justifies the potential risk to the foetus. Breast-feeding; not recommended. **Side effects:** Refer to SPC for full information regarding side effects. Very common (≥1/10): Nausea. Common (≥1/100 to <1/10): Headache, dizziness, diarrhoea, vomiting, abdominal pain, flatulence, abnormal dreams, rash & fatigue. Uncommon (≥1/1000 to <1/100): anaemia, arthralgia, dyspepsia, angioedema & pruritus. **Legal Category:** POM. **Pack:** Bottle of 30 film-coated tablets. **Price:** UK NHS List Price - £355.73; Eire/Ireland – TBC. **Marketing Authorisation Number:** EU/1/16/1099/001; EU/1/16/1099/003.
Further information is available from Gilead Sciences Ltd, 280 High Holborn, London, WC1V 7EE, UK; Telephone: +44 (0) 8000 113700, For Ireland: +353 214 825 999. E-mail: ukmedinfo@gilead.com. Descovy is a trademark. **Date of approval:** March 2016; FTAF/UK/16-03/MM/1052.

▼ This medicinal product is currently subject to additional monitoring. Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Any suspected adverse reactions to Descovy should be reported to Gilead via email to Safety_FC@gilead.com or by telephone +44 (0) 1223 897500.

Adverse events should be reported. For the UK, reporting forms and information can be found at www.yellowcard.mhra.gov.uk

For Ireland, suspected adverse reactions should be reported to the HPRA Pharmacovigilance using a Yellow Card obtained either from the HPRA, or electronically via the website at www.hpra.ie. Adverse reactions can also be reported to the HPRA by calling +353 1 6764971.

* HIV-1 RNA <50 copies/mL.

ABBREVIATIONS:
ARV, antiretroviral; FTC/TDF, emtricitabine/tenofovir disoproxil fumarate; NRTI, nucleoside reverse transcriptase inhibitor; RNA, ribonucleic acid

REFERENCES:
1. Descovy® SmPC. Available at https://www.medicines.org.uk/emc.
2. Gallant JE, *et al*. Lancet HIV 2016;3(4):e158–165.

FTAF/UK/16-03/M1/1050
Date of preparation: April 2016

GILEAD

Descovy®▼
emtricitabine/tenofovir alafenamide
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Challenges in HIV

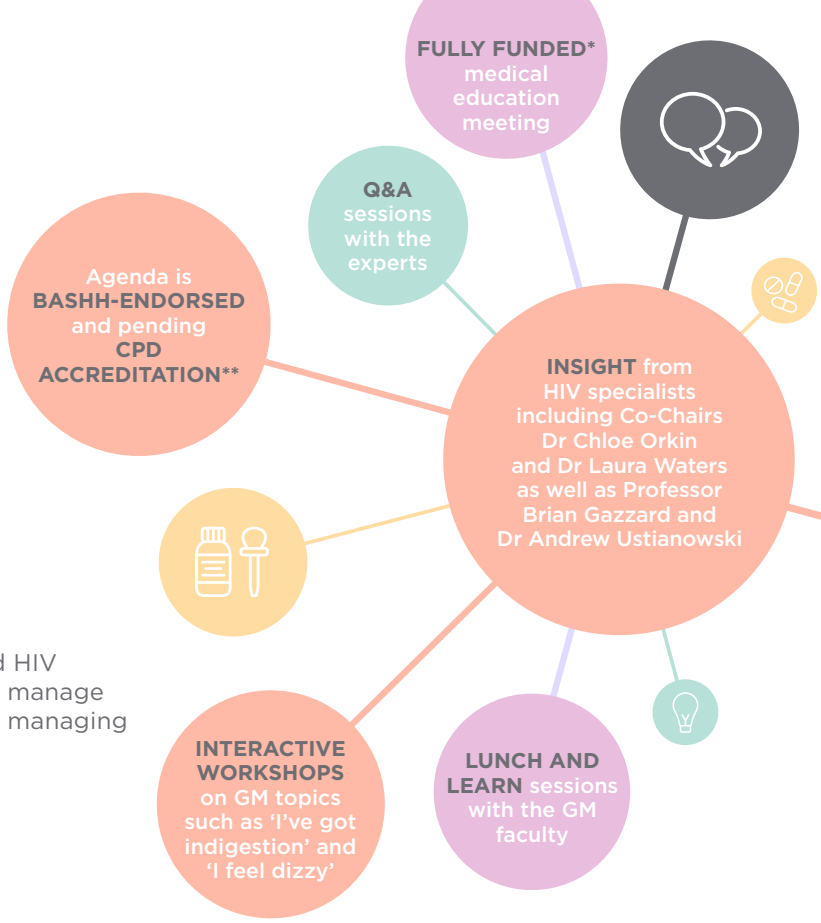
OI complexities & general medicine basics

Thursday 29th September 2016
Hilton London Paddington
9.00am – 5.00pm

JOIN CO-CHAIRS
Dr Chloe Orkin
(Barts Health NHS Trust)
&
Dr Laura Waters
(Mortimer Market Centre)

as they engage with an expert general medicine (GM) and HIV faculty to discuss practical tips on how to investigate and manage common GM symptoms, as well as review best practice in managing opportunistic infections (OIs) in patients with HIV.

All healthcare professionals specialising in HIV are welcome but places are limited so please register your interest at **JanssenHIV@succinctcomms.com**



*There are no registration fees and support for standard class travel to the event can be provided. Accommodation can be provided to those who are unable to travel to and from the meeting on the day.

**Pending approval by the Federation of the Royal College of Physicians of the United Kingdom for 6 category 1 (external) CPD credits.

This is a medical education meeting organised and funded by Janssen
PHGB/MEDed/0516/0011 May 2016

Endorsed by BASHH

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PHGB/MEDed/0715/0019c
Date of preparation: October 2015

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