



## HIV s100 Prescribers' Information Sheet

Locked Mail Bag 5057, Darlinghurst NSW 1300  
Phone 02 8204 0700 Fax 02 9212 2671

[www.ashm.org.au](http://www.ashm.org.au)  
[ashm@ashm.org.au](mailto:ashm@ashm.org.au)

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### Australasian Consensus Statement on Antiretroviral therapy and Infectiousness

A joint consensus statement has been released from Australasian Society for HIV Medicine, the National Centre in HIV Epidemiology and Clinical Research, the Australian Federation of AIDS Organisations and the National Association of People Living with HIV/AIDS in response to the Swiss Consensus statement on Antiretroviral Therapy and Infectiousness. This follows a meeting held at the Stamford Plaza Hotel at Sydney Airport in April that was attended by representatives from all four organisations plus other stakeholders and interested parties from the sector.

The text of the Australasian statement is as follows:

"Consistent use of effective antiretroviral therapy (ART) will, in most cases, lead to an undetectable viral load (VL), as measured in blood, semen and vaginal fluids. As a result, the average viral load of the community of people living with the human immunodeficiency virus (HIV) will be reduced. By reducing the VL, ART will also complement the benefits of consistent condom use and effective sexually transmitted infections (STI) detection and treatment, in preventing HIV transmission that may otherwise occur due to condom failure. However, there are no data to suggest that a population HIV prevention strategy based solely or predominately on the use of ART and associated with a reduction in condom use, will lead to fewer people becoming infected in the Australian and New Zealand populations, especially in the context of rising rates of STI."

The PDF document relating to the Australasian statement, including a summary of the evidence with references is available when you [click here](#)

The PDF document relating to the original Swiss statement, including a summary of the evidence with references is available when you click [here](#).

### Upcoming HIV CME activities in NSW

#### NSW

- 20 August 2008 - *HIV GP Study Group, Sydney NSW*  
Topic: Management of patients with HIV and hepatitis C coinfection 1 HIV CME pt  
Speaker: Dr Gail Matthews MB ChB, MRCP National Centre in HIV Epidemiology and Clinical Research
- 3 September 2008 - *HIV GP Study Group, Sydney NSW* 1 HIV CME pt  
Topic: Haematology  
Speaker: Dr Sam Milliken Senior Staff Specialist in Haematology and HIV Medicine, St Vincents Hospital.
- 14 – 16 September Short Course in HIV Medicine, Perth WA 2 HIV CME pts per module
- 17 – 20 September ASHM Conference 3 HIV CME pts per day

For further information on HIV CME activities in NSW, please contact Niamh Lynn at [Niamh.lynn@ashm.org.au](mailto:Niamh.lynn@ashm.org.au) or on (02) 8204 0723.

#### Online CME activities

[www.CMEonHIV.com.au](http://www.CMEonHIV.com.au): Three new presentations have been adjudicated. Please see below for details

1. Pathogenesis, presentation and management of IRIS by Prof. Martyn French 1HIV CME
2. Hepatitis and HIV Coinfection by Dr. Joe Sasadeusz 1HIV CME
3. HIV and Indigenous Australians by Dr. David Bradford 0.5 HIV CME

### Coverage of the International AIDS conference and available options for online HIV CME

HIV Community s100 prescribers can access coverage of the International AIDS Conference, in Mexico City 3-8 August, some of it with associated online CME exercises, from most major online HIV CME providers. Prescribers are encouraged to register with websites and browse through them to identify suitable online HIV CME activities. Please submit a copy of an online HIV CME certificate of completion to ASHM so that we can update your CME records and points total. Most websites will email participants proof of completion of CME activities or will allow downloading of a PDF certificate after the activity is completed – proof of completion of online CME exercises is required before prescriber HIV CME points totals can be updated. If there are any difficulties with obtaining proof of completion from an online CME provider, prescribers are advised to pursue that matter with the provider concerned. There may be internet browser and other technical issues with website functionality.

The following websites are recommended for conference coverage with associated accredited HIV CME activities. A state-wide initiative of the NSW Health Department, managed by the Australasian Society for HIV Medicine Inc.

Clinical Care Options HIV CME section <http://clinicaloptions.com/HIV.aspx>

Changing Concepts in HIV Disease (CCHIV) <http://www.cchiv.com/>

International AIDS Conference Symposium <http://www.iacsymposium.com/>

Medpage Today <http://www.medpagetoday.com/MeetingCoverage/IAC/>

CMEonHIV.com (no IAC 2008 coverage as yet) <http://www.cmeonhiv.com.au/>

HIVandHepatitis.com [http://www.hivandhepatitis.com/hiv\\_aids.html](http://www.hivandhepatitis.com/hiv_aids.html)

The following websites provide conference coverage and/or online HIV databases, but do not have associated HIV CME exercises. While they may be high quality online resources, they are not HIV CME accredited.

Kaiser Network (conference coverage without CME exercises) <http://www.kaisernetwork.org/aids2008/>

International AIDS Conference 2008 website (conference coverage without CME exercises)

<http://www.aids2008.org/>

AIDSinfo US DHHS site (conference coverage and HIV online resource database without CME exercises)

<http://www.aidsinfo.nih.gov/>

Aidsmap (conference coverage and HIV online resource without CME exercises) <http://www.aidsmap.com/en/default.asp>

Clinical Village (online forum for blogs associated with CCHIV) <http://clinicalvillage.com/>

Medscape ART CME section (there are several other HIV-specific sections in Medscape)

<http://www.medscape.com/resource/antiretroviral-therapy>

HIV InSite (conference coverage and HIV online resource database without CME exercises)

<http://hivinsite.ucsf.edu/InSite>

eMedicine HIV section (HIV online resource database without CME exercises)

<http://www.emedicine.com/rc/rc/pfeatured/i20/HIV.htm>

Copenhagen HIV Programme (HIV clinical trials database without CME exercises)

<http://www.cphiv.dk/CHIP/About/tabid/56/Default.aspx>

The Body (conference coverage and HIV online resource database without CME exercises)

<http://www.thebody.com/index.html>

(please highlight the weblinks only in the above text by changing the font colour to blue)

A downloadable easy to follow concise summary guide to the descriptive statistical terms commonly used in presentations and journals regarding the outcome of clinical trials is available from (registration required):

<http://www.medpagetoday.com/Medpage-Guide-to-Biostatistics.pdf>

For more details please [click here](#) for more details on the ASHM website.

## FDA Advice regarding changes to ART Paediatric Formulations

On June 24, 2008, FDA approved labeling changes to the Viramune (nevirapine) oral solution and tablets to reflect various updates, including:

- Dosing recommendations for pediatric patients 15 days to 2 months of age.
- Dose recommendations for all pediatric age groups are now based on body surface area (BSA) instead of weight-based dosing. Studies were conducted comparing weight-based dosing and BSA-based dosing. While comparable drug concentrations are achieved with either method, BSA dosing allows for smoother dose transitions between pediatric age groups and is therefore preferred.
- Addition of data from a pharmacokinetic hepatic impairment study
- Revision of the recommendation that nevirapine not be administered to patients with severe hepatic impairment to a recommendation that nevirapine not be administered to patients with moderate (Childs Pugh B) or severe (Childs Pugh C) hepatic impairment.
- Revision of recommendations for the occurrence of rash during the once daily lead-in phase of dosing. The label now states that lead-in dosing should not be extended beyond 28 days of dosing.

Please [click here](#) to refer to the updated Nevirapine drug label information.

On 24 June 2008, FDA approved changes to Kaletra (lopinavir/ritonavir) Tablet and Oral Solution labels to include dosing recommendations for pediatric patients 14 days to 6 months of age and from 12 to 18 years of age. In addition, information regarding oral and parenterally administered midazolam was updated in the Contraindication and Drug Interactions section.

Please [click here](#) to refer to the updated Kaletra drug label information.

On June 23, 2008, FDA approved a new Aptivus (tipranavir) oral solution (100 mg/mL). The product label has been updated to include dosing recommendations for pediatric patients 2-18 years of age. In addition, information regarding oral and parenterally administered midazolam was updated in the Contraindication and Drug Interactions section.

Please [click here](#) to refer to the updated Aptivus drug label information:

## US DHHS release updated HIV Pediatric Treatment Guidelines

The Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection have been revised. The new version includes updated information on:

- Recommended antiretroviral regimens for initial therapy
- Nelfinavir, which now meets FDA limits for ethyl methane sulfonate (EMS)
- The changes in this revision are highlighted in yellow throughout the text and tables.

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The updated guidelines are available for download from the Pediatric Guidelines section of the AIDSinfo Web site: Please [click here](#) to view or download the updated guidelines.

## FDA approves changes to package insert for Abacavir

On July 18, 2008, FDA approved changes to the package insert for Ziagen (abacavir sulfate) highlighting information about the association of the HLA-B\*5701 allele (a part of a gene) and hypersensitivity reactions (HSR) caused by abacavir-containing therapy. Abacavir is associated with serious and sometimes fatal HSR. Abacavir HSR is a multi-organ syndrome characterized by 2 or more clinical signs or symptoms including fever, rash, gastrointestinal symptoms (nausea, vomiting, diarrhea or abdominal pain), respiratory symptoms (dyspnoea, cough or pharyngitis) and constitutional symptoms (generalized malaise, fatigue or myalgia). Occurrence of abacavir HSR requires immediate and permanent discontinuation of abacavir therapy. The label change recommends screening patients for the HLA-B\*5701 allele prior to initiating or reinitiating abacavir-containing therapy. Prospective screening for HLA-B\*5701 and selection of alternative therapy for subjects who carry this allele will reduce the incidence of abacavir hypersensitivity (HSR) reaction and improve the safety profile of this drug.

Abacavir is a nucleoside reverse transcriptase inhibitor (NRTI) antiretroviral indicated in combination with other antiretroviral agents for treatment of HIV-1 infection in adult and pediatric patients, manufactured by Glaxo SmithKline. Labeling for the abacavir-containing combination products marketed as Trizivir and Kivexa will be updated through labeling supplements in the near future.

The labeling changes described here are predicated on data from two studies. CNA106030 (PREDICT-1), a prospective, randomized, double-blind study, evaluated the clinical utility of pre-therapy HLA-B\*5701 screening compared to no screening on the incidence of abacavir hypersensitivity reaction in abacavir-naïve, HIV-1 infected subjects. ABC107442 (SHAPE), a retrospective, case-control study was designed to evaluate the sensitivity and specificity of the HLA-B\*5701 allele with respect to abacavir HSR within the racial groups of black and white subjects in the United States. These studies support the recommendation for pre-therapy screening for patients carrying the HLA-B\*5701 allele and selection of alternative therapy in positive subjects. Avoidance of abacavir therapy in HLA-B\*5701 positive patients will significantly decrease the risk of developing clinical abacavir hypersensitivity.

Abacavir HSR generally develops within the first 6 weeks of initiation of therapy (median 11 days) in the majority of subjects who are affected. However, due to the wide range of clinical signs and symptoms that may signify the development of abacavir HSR, and confounding multiple antiretroviral and prophylactic medications, definitive diagnosis can sometimes be difficult. Earlier studies suggested a genetic basis relating to the development of abacavir HSR. The product label for abacavir has been updated to include the following new information:

### WARNINGS AND PRECAUTIONS

#### Hypersensitivity Reaction

Serious and sometimes fatal hypersensitivity reactions have been associated with ZIAGEN and other abacavir-containing products. Patients who carry the HLA-B\*5701 allele are at high risk for experiencing a hypersensitivity reaction to abacavir. Prior to initiating therapy with abacavir, screening for the HLA-B\*5701 allele is recommended; this approach has been found to decrease the risk of a hypersensitivity reaction. Screening is also recommended prior to reinitiation of abacavir in patients of unknown HLA-B\*5701 status who have previously tolerated abacavir. For HLA-B\*5701-positive patients, treatment with an abacavir-containing regimen is not recommended and should be considered only with close medical supervision and under exceptional circumstances when the potential benefit outweighs the risk. HLA-B\*5701-negative patients may develop a hypersensitivity reaction to abacavir; however, this occurs significantly less frequently than in HLA-B\*5701-positive patients. Regardless of HLA-B\*5701 status, permanently discontinue ZIAGEN if hypersensitivity cannot be ruled out, even when other diagnoses are possible.

When therapy with ZIAGEN has been discontinued for reasons other than symptoms of a hypersensitivity reaction, and if reinitiation of ZIAGEN or any other abacavir-containing product is under consideration, carefully evaluate the reason for discontinuation of ZIAGEN to ensure that the patient did not have symptoms of a hypersensitivity reaction. If the patient is of unknown HLA-B\*5701 status, screening for the allele is recommended prior to reinitiation of ZIAGEN. If hypersensitivity cannot be ruled out, DO NOT reintroduce ZIAGEN or any other abacavir-containing product. Even in the absence of the HLA-B\*5701 allele, it is important to permanently discontinue abacavir and not rechallenge with abacavir if a hypersensitivity reaction cannot be ruled out on clinical grounds, due to the potential for a severe or even fatal reaction. Skin patch testing is used as a research tool and should not be used to aid in the clinical diagnosis of abacavir hypersensitivity. In any patient treated with abacavir, the clinical diagnosis of hypersensitivity reaction must remain the basis of clinical decision-making.

Risk Factor: HLA-B\*5701 Allele: Studies have shown that carriage of the HLA-B\*5701 allele is associated with a significantly increased risk of a hypersensitivity reaction to abacavir. CNA106030 (PREDICT-1), a randomized, double-blind study, evaluated the clinical utility of prospective HLA-B\*5701 screening on the incidence of abacavir hypersensitivity reaction in abacavir-naïve HIV-1-infected adults (n = 1,650). In this study, use of pre-therapy screening for the HLA-B\*5701 allele and exclusion of subjects with this allele reduced the incidence of clinically suspected abacavir hypersensitivity reactions from 7.8% (66/847) to 3.4% (27/803). Based on this study, it is estimated that 61% of patients with the HLA-B\*5701 allele will develop a clinically suspected hypersensitivity reaction during the course of abacavir treatment compared with 4% of patients who do not have the HLA-B\*5701 allele. Screening for carriage of the

A state-wide initiative of the NSW Health Department, managed by the Australasian Society for HIV Medicine Inc.

HLA-B\*5701 allele is recommended prior to initiating treatment with abacavir. Screening is also recommended prior to reinitiation of abacavir in patients of unknown HLA-B\*5701 status who have previously tolerated abacavir. For HLA-B\*5701-positive patients, initiating or reinitiating treatment with an abacavir-containing regimen is not recommended and should be considered only with close medical supervision and under exceptional circumstances where potential benefit outweighs the risk.

## Genotype Testing

Funds have been provided by the NSW Department of Health AIDS Program from 1<sup>st</sup> January 2008 for HIV genotypic drug resistance testing (HIVDR) to the laboratories at St Vincent's, Westmead and Royal Prince Alfred Hospitals. Testing is subject to specific eligibility criteria being met, this is available for S100 HIV prescribers from [http://www.ashm.org.au/uploads/genotype\\_testing\\_eligibilitycriteria.pdf](http://www.ashm.org.au/uploads/genotype_testing_eligibilitycriteria.pdf)

Genotypic drug resistance testing allocations were made on the basis that the laboratories will provide statewide access across NSW. The eligibility criteria were developed through a consultative process and have been endorsed by the Ministerial Advisory Committee on HIV and Sexually Transmissible Infections. It is important that the medical practitioner notes for the laboratory, the reason for the test from the listed criteria of acute or recent infection, treatment naive with chronic/established HIV infection, virology failure or pregnancy. The IAS USA 2008 Guidelines on HIV resistance testing are available at: <http://www.journals.uchicago.edu/doi/full/10.1086/589297>. Guidance is also available from the HIV Models of Care section of the ASHM website [http://www.ashm.org.au/uploads/MOC\\_160.pdf](http://www.ashm.org.au/uploads/MOC_160.pdf) and from the Australian commentary to the US DHHS Antiretroviral Therapy Guidelines at: <http://www.ashm.org.au/guidelines/>

The funding of genotypic drug resistance testing actions a recommendation of the 2007 NSW HIV-related pathology services costing study. The allocation of funding was recommended as the test is complex, important to the management of HIV/AIDS and without an alternative source of funding. If you wish to obtain further information the appropriate Department of Health contact is Ms Marlene Velecky, Senior Policy Analyst, AIDS/Infectious Diseases Branch, on (02) 9391 9239.

## IAS-USA Antiretroviral Therapy 2008 Guidelines published in JAMA

The IAS-USA Antiretroviral Therapy 2008 Guidelines have been published in the 6 August issue of JAMA. One of the most topical sections of the guidelines deals with 'When to start antiretroviral therapy' and it states:

"At present, there are no definitive randomized clinical trial data to define a specific CD4 cell count threshold of 350/ $\mu$ L or more for beginning therapy. Therefore, in this group, decisions should be based on comorbidities, risk of disease progression (including risk of non-AIDS diseases), and patient willingness and estimated ability to adhere to long-term treatment. Rapid decline in CD4 cell count (ie, >100/ $\mu$ L per year), a plasma HIV-1 RNA level greater than 100 000 copies/mL, and risk factors for cardiovascular and other non-AIDS diseases are indicators that favour earlier therapy (AIIa, AIIb). Risk factors for cardiovascular disease, such as hypertension, hyperlipidemia, diabetes, and tobacco use, should be aggressively managed in all patients. Although controlled clinical trials have not directly addressed whether earlier initiation of antiretroviral therapy might reduce cardiovascular or other non-AIDS-related disease risks, it is clear that the risk is higher when viral replication is uncontrolled. Patient readiness, drug interactions, adherence challenges, toxicities, and costs should be considered when determining whether to initiate therapy at higher CD4 cell counts, recognizing that treatment must be sustained. There is no upper CD4 cell limit for starting therapy when one or more of these considerations are present. An individual risk-benefit assessment is appropriate in such circumstances."

Hence, these indications regarding when to start are somewhat broader in patients in the >350 group than the January 2008 update of the US DHHS/Australian guidelines.

JAMA have made the guidelines available to download from their website at (subscription required) : <http://jama.ama-assn.org/cgi/reprint/300/5/555>

## Making it work: Employment Forum and Expo

Positive Life NSW in partnership with BGF, SESIAHS, HREOC, and Jobfuture is organising "Making it Work: an Employment Forum and Expo", to be held at the Y Hotel (5-11 Wentworth Avenue, Sydney) on Wednesday 10th September from 6pm to 8pm. Please [Click here](#) to download the flyer for this forum.

The Forum aims to assist people with HIV to continue to develop skills and make decisions around meaningful occupation (returning to full or part time work, study or volunteering) as well as supporting them with information to remain in work.

The forum will consist of a panel of speakers on employment issues (focused on people returning to work, study or volunteering and focused on people with HIV remaining at work, including employment rights, managing career change, financial planning, disclosure/ privacy issues and maintaining health and life balance while working).

If you would like to discuss the Forum with Positive Life NSW, please call Hedimo Santana, Glenn Flanagan or Rob Lake on 9361 6011.

## HIV and Insurance

Positive Life NSW is developing a new resource on Insurance and HIV, and is inviting people with HIV to share with us their experiences. Please call Hedimo Santana on 9361 6011 or via email [hedimos@positivelife.org.au](mailto:hedimos@positivelife.org.au) Please [click here](#) for more information and to view the flyer..

## Raltegravir

A state-wide initiative of the NSW Health Department, managed by the Australasian Society for HIV Medicine Inc.

A laminated copy of the Raltegravir Potassium (ISENTRESS) has been enclosed with the hardcopy of this HIV s100 info sheet. Please follow this link for an electronic copy:

<http://www.health.nsw.gov.au/PublicHealth/Pharmaceutical/S100/raltegravir.asp>

***Included with this Information Sheet:***

Declaration Form: Raltegravir Potassium (ISENTRESS)

Talkabout –June/July 2008 Issue

STIGMA - Newsletter