POST-EXPOSURE PROPHYLAXIS FOR HIV – WHAT ELSE TO CONSIDER?

Supporting the HIV, Viral Hepatitis and Sexual Health Workforce

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ACKNOWLEDGEMENTS:

- **EXPERT REFERENCE GROUP:** Jude Armishaw, Dr David Baker, A/Prof Katherine Brown, Dr John Dyer, Dr Paul Gaudry, Dean Gloede, Andrew Grulich, Dr Manoji Gunathilake, Mihaela Ivan, Sue Laing, Russell Levy, John McAllister, Lea Narciso, Dr Louise Owen, Dr Cheryn Palmer, Dr Anna Pierce, Dr Mike Seah, Ben Wilcock
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BACKGROUND

The biomedical prevention of HIV is now an integral part of the prevention paradigm. The Australian National Guidelines on post-exposure prophylaxis (PEP) after non-occupational and occupational exposure to HIV were recently reviewed in light of updates to international guidelines and new information about the use of antiretroviral drugs by HIV negative people to prevent HIV acquisition (pre-exposure prophylaxis, PrEP).

METHODS

- An existing expert reference group was reformed to provide guidance on latest best practice.
- A comprehensive literature review update was performed to identify the latest information on: HIV transmission risk; treatment as prevention (TasP); PrEP; which drugs to use for PEP; PEP in the context of PrEP; and the experience of those presenting for PEP.
- Wide stakeholder consultation was undertaken to identify areas not yet considered and collect accounts on patient and staff experiences.

RESULTS

The 2016 Australian PEP guidelines have been updated to reflect new information identified regarding: TasP for condomless anal sex; the interface between PEP and PrEP; which drugs to use in PEP; the use of PEP starter packs versus prescription for the entire PEP course; the experiences of those presenting for PEP; and other clinical management issues, such as children presenting following a risk event, as well as gender identity and history.

- PEP is no longer routinely recommended for non-occupational exposure when an HIV-positive source is on antiretroviral treatment, with an undetectable viral load (VL). This is based on preliminary data showing no transmissions within male homosexual or heterosexual couples, from a partner with an undetectable VL.[1-3]
- Patients presenting to sexual health clinics, HIV clinics or s100 prescriber GPs may be given a prescription for the entire 28 days.[4]
- Individuals on PrEP may be considered for PEP, where exposure risk warrants 3-drug PEP and adherence to PrEP has not been optimal.
- If presenting for PrEP within 72 hours of a possible exposure, offer PEP and transition to PrEP once confirmed HIV negative.
- Tenofovir and emtricitabine or tenofovir and lamivudine are recommended as the preferred 2-drug PEP regimen; while dolutegravir or raltegravir or rilpivirine are recommended as the preferred third agent for 3-drug PEP.
- For individuals who re-present for PEP, the PEP course should be extended by 28 days from the last HIV exposure risk.[5]
- For the individual presenting for PEP, research has now documented cases where people stated they did not re-present for PEP due to a previous negative experience and later sero-converted.[6] The need to respond to each individual presentation for PEP in a non-judgemental way, using non-stigmatising language, is now included in the guidelines in order to help reduce negative experiences of those accessing PEP. Repeat presentation(s) warrant the same support and careful assessment of the context of risk behaviour, and need for referral to other services.
- All minors presenting following a potential risk of HIV exposure should be considered for PEP.
- Disclosure of gender identity and history are not necessary for the provision of PEP and should always be optional. It is important not to make assumptions about an individual's gender identity, the type of sex they have, or the level of risk associated with that sex. Need for PEP should be assessed based on the type of exposure determined during clinical assessment.

CONCLUSIONS

Information concerning the biomedical prevention of HIV is dynamic and changes rapidly. People presenting for PEP require individualised support and careful consideration for appropriate care. Current recommendations for the use of PEP in the Australian context are now consistent with latest research findings. Consideration should be given to continuous review and more regular update. The final guidelines are available as a user-friendly, navigable website under:

www.pep.guidelines.org.au

REFERENCES:

1. Grulich AE et al. HIV transmission in male serodiscordant couples in Australia, Thailand and Brazil. 2015 Conference on Retroviruses and Opportunistic Infections (CROI 2015), February 23-26 2015, Seattle. Late breaker poster 1019 LB. http://www.croiconference.org/sessions/hiv-transmission-male-serodiscordant-couples-australia-thailand-and-brazil
2. Safran SA, Mayer KH, Ou SS, et al. Adherence to early antiretroviral therapy: Results from HPTN 052, a phase III, multinational randomized trial of ART to prevent HIV-1 sexual transmission in serodiscordant couples. J Acquir Immune Defic Syndr. 2015 Jun 1;69(2):234-40.
3. Rodger AJ, Cambiano V, Bruun T, et al. Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy.JAMA. 2016;316(2):171-181.
4. Ford N, Venter F, Irvine C, et al. Starter Packs versus full prescription of antiretroviral drugs for postexposure prophylaxis: a systematic review. Clin Infect Dis 2015;60:S182-6.
5. Seifert SM, Glidden DV, Meditz AL, et al. Dose Response for Starting and Stopping HIV Preexposure Prophylaxis for Men Who Have Sex With Men. Clin Infect Dis 2015;60:804-810.
6. Experiences of HIV: The Seroconversion Study Final Report 2007–2015. Monograph, The Kirby Institute, UNSW Australia, Sydney Australia, 2016;76.