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EDITORIAL

We are starting 2018 with a new look for HTB.

This builds on the move last year to electronic only distribution.

Rather than collecting articles every two months we plan to send 2-3 shorter email bulletins each month.

As we published most articles last year online long before they were compiled in HTB, this will make it easier for readers to get earlier news.

The format will also expand on journal reviews, with short summaries and hyperlinks to the original research. We will also highlight other community activity again with hyperlinks.

We still continue to print non-technical booklets and leaflet for HIV positive people. These resources will continue to be free, including in bulk to UK clinics.

To subscribe please register your email address online:

http://i-base.info/forms/esub.php

Supplements

Supplements to HTB include i-Base publications and resources.

HIV and Pregnancy - Swahili translation (January 2018)

The translation of the i-Base pocket leaflet is available online and in PDF format.

http://i-base.info/pregnancy-swahili

Guide to changing treatment: what to do if viral load rebounds (January 2018)

This 20-page A5 booklet is available in print format, online and as a PDF file. Print copies are free.

http://i-base.info/guides/changing

i-Base 2018 appeal

we still need your help...

Last year we launched a funding appeal to help i-Base continue to provide free publications and services.

Your help has been inspiring – and we hope this support will continue during 2018. If 1000 people support us with £5 a month we will be on course to meet our shortfall.

All help is appreciated.

http://i-base.info/i-base-appeal-we-need-your-help/

SPECIAL REPORT

2017: a year in review – great news and why we still fight…

Polly Clayden and Simon Collins, HIV i-Base

The following review uses hyperlinks in the text to articles from HIV Treatment Bulletin (HTB) in 2017.

Great news is always good to report…

Steady advances reported in HTB in 2017 were broadly categorised as great news. These are important given the political change and uncertainty over the year.

There was good news both within the UK and globally that will affect the majority of HIV positive people – especially the growing acceptance that undetectable viral load makes HIV untransmittable (U=U) and the impact of better treatment with

new drugs and formulations and the wider use of PrEP. Together with earlier use of ART and more regular testing, many countries and regions are meeting some or all of the 90:90:90 goals and HIV incidence has dropped significantly when all these advances were available and easy to access.

We also reported on progress towards a cure and a vaccine, on new treatment strategies, and on complications linked to current treatment and side effects.

But in the interest of balance, we also had to report alternative good news (also known as bad news...) showing that that none of the advances can be taken for granted. Overcoming AIDS is not inevitable unless we make it so.

Treatment access

The big news for global HIV treatment was a new pricing agreement that will speed up access to generic, dolutegravir-based fixed dose combinations (FDCs).

This will mean that HIV positive people in generic-accessible low- and middle-income countries (LMICs), can be treated at an annual cost per person of around US $75. The price announcement was made on 21 September 2017.

The FDCs combine tenofovir disoproxil fumarate, lamivudine, and dolutegravir (TLD) and were developed by Mylan and Aurobindo under licensing agreements from ViiV Healthcare. Both generics received tentative approval from the US FDA for TLD in August.

The FDCs will help enable countries to transition to DTG-based regimens. As of the end of the year, almost 60 countries had adopted or are planning to include DTG in national treatment guidelines for first-line ART. Brazil, Botswana, Kenya and Uganda have already started treating people with DTG. PEPFAR has recommended rapid introduction of DTG in their key target countries. It has been estimated that approximately 15 million people will be taking DTG by 2025 and it will replace first-line efavirenz.

This year DTG (as well as PrEP) was added to WHO essential medicines list.

And the country with the highest national prevalence in the world, Swaziland, with 32% among a population of just under 1.5 million in 2011, using currently recommended ART, saw a decrease in HIV incidence by almost half and a doubling of viral load suppression among adults, between 2011 and 2016.

The new DTG-based regimens will help more countries to provide ART to more people and get nearer to 90-90-90 targets.

HIV transmission: UK response

Closer to home, the year began with remarkable news on the 40% drop in HIV diagnoses at central London clinics, confirmed throughout the year.

The annual UK surveillance reports consolidated this phenomenon, showing similar percentage reductions in all seven regions of the UK.

The growing confidence that undetectable viral load means HIV is untransmittable (U=U) resulted in breakthrough endorsements, most crucially, from the US Centers for Disease Control and Prevention (CDC). A special report from i-Base reviewed the evidence and the 20-year timeline that it took to reach this stage, including new results from the Opposites Attract study.

Antiretrovirals: approvals and pipeline

During 2017 there were several approvals of new drugs and formulations and many other compounds are still in development.

At the end of the year, Symtuza (darunavir/cobicistat/FTC/TAF aka D/C/F/TAF) was approved for adults and adolescents in the EU, the first single pill protease inhibitor-based FDC.

Similarly, Juluca (dolutegravir/rilpivirine) was approved in the US as a dual therapy switch option for adults on stable ART (undetectable viral load for at least six months). The indication includes not having previous treatment failure of drug resistance to the individual components. The EU decision is expected in early 2018.

Bictegravir was also submitted in the US with accelerated review. [13]

CROI 2017 produced results for bictegravir (phase 2), doravirine (phase 3), and GS-9131 (preclinical).

IAS 2017 included results on once-daily raltegravir (96 week phase 3), the bictegravir FDC (phase 3), doravirine (48 week phase 3), long-acting cabotegravir/rilpivirine injections, D/C/F/TAF (phase 3) and MK-8591 (early results).

EACS 2017 included results for fostemsavir (phase 3), D/C/F/TAF (phase 3).

Developments in paediatric ART included the FDA approval of raltegravir for treatment of neonates from birth to four weeks of age – weighing at least 2 kg. This approval was supported by data from IMPAACT P1110, looking at the safety

and pharmacokinetics of raltegravir oral suspension in high-risk HIV exposed newborns. Raltegravir is now one of the few antiretrovirals approved for treating babies from birth.

Data presented at CROI 2017 revealed that tenofovir alafenamide (TAF) exposure is modestly higher in children aged 6–12 years than adults.

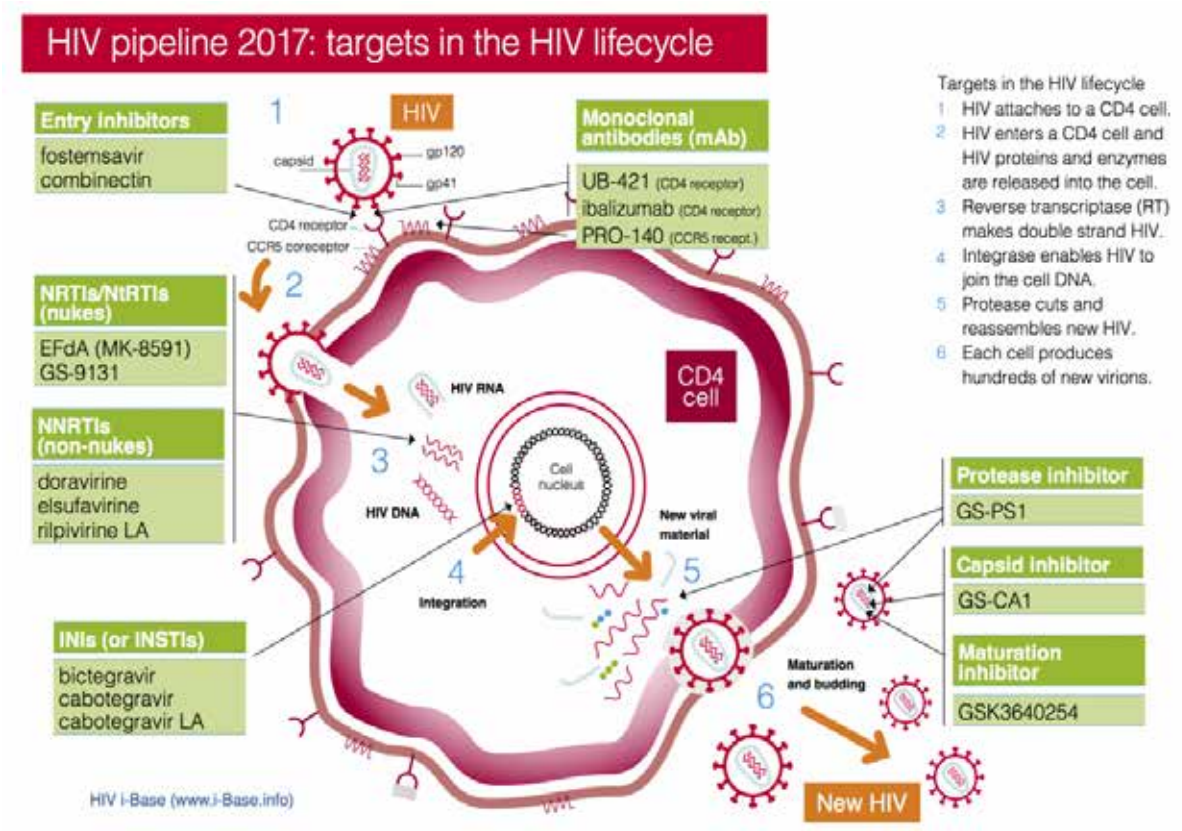
Another CROI presentation showed DTG granules-in-suspension achieved satisfactory exposures in children of the same age. This formulation will not be commercially available but these data will form the basis for DTG dosing as dispersible tablets to be studied in this and younger age (and weight-based) cohorts, which are now enrolling.

And a presentation at the 9th International Workshop on HIV Pediatrics 2017 showed chewable raltegravir tablets can be crushed and stirred until dispersed in liquids and given to younger children according to WHO weight bands.

Fit for Purpose, our twice-yearly review of developments in ART optimisation expanded in July to include our review of the adult pipeline (a comprehensive summary of 25 compounds) as well as paediatric developments.

We also produced a more detailed HIV pipeline review.

Figure 1: HIV pipeline 2017: targets in the HIV lifecycle



Key: INSTI: Integrase strand transfer inhibitors; NRTI: Nucleoside/tide reverse transcriptase inhibitors; NNRTI Non-nucleoside reverse transcriptase inhibitors.

Treatment strategies

Almost as quickly as the first reports appeared of using dolutegravir monotherapy the risks of this approach were quickly discovered.

The plausibility that this single drug might hold back resistance surprisingly maintained viral load at undetectable levels for a large percentage of people. But for those with viral rebound – highly unpredictable – the cost was high-level integrase resistance, and future loss of arguably the most important current drug class. No-one should now be using dolutegravir monotherapy.

Neither of these problems have so far been reported in the ongoing dual therapy studies using dolutegravir plus 3TC. These include both as first-line ART and numerous studies as a switch option. But this strategy – the focus of ongoing two phase 3 GEMINI studies – does have the potential to improve quality of life from treatment simplification – and so the research is important.

Another much-discussed strategy of whether anti-inflammatory drugs might have a role in addition to ART will be informed by long-awaited results from the CANTOS canakinumab study. But while the accumulating research linking HIV to ongoing immune inflammation – even on ART – suggest an easy target, many of the prospective drugs studies so far have produced disappointing results.

Pregnancy and breastfeeding

One of the reasons that DTG is an alternative and not a preferred option in WHO guidelines was the lack of data in pregnant women.

So, it was reassuring that reports presented at IAS 2017 on DTG use in pregnancy from Botswana, Europe and the Antiretroviral Pregnancy Registry, did not show an increased risk of adverse outcomes compared with other antiretrovirals.

But more data are needed, particularly with DTG exposure before conception, to reach definitive conclusions – and we expect that to be forthcoming in 2018 and a guideline change is likely.

Other important findings in pregnant women this year included:

Maternal ART of efavirenz, tenofovir and FTC – the current WHO preferred regimen – was associated with lower risk of adverse birth outcomes compared with other regimens, among infants exposed to ART from conception in Botswana.

Women receiving lopinavir/ritonavir-based regimens were at higher risk of preterm delivery compared with those on NNRTI-based ones in **UK and Ireland.**

A pharmacokinetic study of 400 mg efavirenz during pregnancy, showed lower drug concentrations in the third trimester, compared with post-partum, but these were within adequate ranges described elsewhere – so the reduced dose could be used in pregnant women.

And good news from Tanzania on breastfeeding was that no HIV exposed infants who were negative at birth, whose mothers started ART before delivery, had suppressed viral loads and exclusively breastfed, were HIV positive after breastfeeding, in a rural cohort.

Basic science

Throughout the year, Richard Jefferys produced a consistently impressive series of reports on developments on basic science, cure and vaccine research.

This included:

- Identifying markers for the cellular reservoir,
- Estimating the size of the viral reservoir,
- Remission news from IAS 2017, and
- A compelling update – the Miami macaque – on vaccine research.

These were supported by reports by Gareth Hardy, including on CD163 as a marker of immune activation and CMV antibody as a marker of HIV progression. Plus other articles on rosuvastatin for COPD, and on kidney disease.

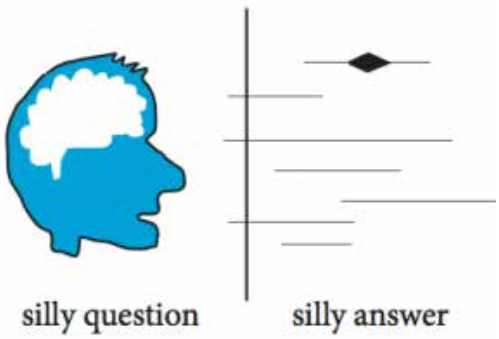
Alternative good news (aka bad news...)

Two Cochrane reviews: low points.

Most issues of HTB include i-Base reviews of key publications in peer-review journals. While most of our reports from conferences bring important research to readers well in advance of publication, the consolidation of full results in journals is still essential.

Unfortunately, this year included two papers that i-Base (and many others) promptly and publicly criticised – almost before the ink had dried in the email alerts. Both papers used problematic methodology to reach flawed conclusions.

These attempts to generate headlines are not merely academic – they can have serious consequences.



Our review of the BMJ paper on the safety of HIV drugs during pregnancy highlighted both the lack of evidence for claims to challenge WHO guidelines and the potential destabilising impact this would have on the majority of HIV positive women of child bearing age throughout the world dependent on currently recommended ART.

We also highlighted problems in a Cochrane review of new hepatitis C drugs which, by asking inappropriate questions, risked removing pressure to provide these life-saving new drugs.

UK access to PrEP

Each year PrEP makes headlines and 2017 was no exception. In the UK, much of this focus was on access (and lack of).

While the NHS now provide free PrEP in Scotland and in Wales, in England, the controversial PrEP IMPACT Study has started to enrol as the only way to currently get free PrEP. As with Wales and Scotland, this includes broadening access beyond gay and bisexual men. However, with many of the first sites fully enrolled almost as soon as they opened, and others taking longer to start, access problems are likely to continue.

IPERGAY provided important additional results on the efficacy of on-demand dosing for anal sex from both the expanded access study and for men having less frequent sex. This is only an option when the risk is only from anal sex.

We also reported the psychological benefits from PrEP.

EMA move to Amsterdam

One of the many unforeseen consequences of Britain's 23 June 2016 act of self-harm will be the relocation of the EMA to Amsterdam.

The agency has been based in London since its establishment in 1995. It currently employs almost 900 staff at its headquarters in Canary Wharf. Now it has been forced to relocate by the end of March 2019, and the UK will be much poorer for it.

UK drug approval post-Brexit is now currently unknown, as we clearly don't have the resources to evaluate new drugs on an individual country level. Although the government has stated it wishes to work closely with the EMA in regulating medicines for the UK market and global drug companies are in favour of some form of cooperation, it will be up to EU member states to decide how this will work.

The relationship with the Medicines Health and Regulatory Agency (MHRA), which regulates UK drugs and healthcare products, will have to change. MHRA has had a lucrative working arrangement with the EMA and has carried out 20 to 30% of the licensing work for the agency.

This change is not only going to be costly but likely to result in delays in approvals to new medicines for British patients compared with those in EU countries.

Proposals to relax evidence requirements for drug approval

Another major concern over the last year has been a shift to reduce regulatory requirements for the approval process of new medicines.

Disturbingly, the publicity supporting lobbying for such changes is frequently presented as the result of community demand for faster access to medicines. Actually, the opposite is more likely to be true. The lobbying – and the great expense behind it – is closely connected to the financial interests of large pharmaceutical companies.

In December 2016, the US Congress passed the 21st Century Cures Act making the demands for new drug approval less strict and more flexible. More specifically, this act aims to reduce the role of large randomised clinical studies and allows companies to sell products supported by less evidence to patients cloaked as a "right to try" access. In turn, companies could also use so-called "real world" or even anecdotal reports to support full drug approval.

In Europe, similar lobbying led to the EMA proposing the Adaptive Pathways approach, which set out to enable circumstances for faster drug approval – although none of the 62 compounds submitted in the pilot phase led to successful faster approval.

Vulnerable, entitlement, diversity, transgender, foetus, evidence-based, science-based

Finally, more alarming news from the Trump administration.

In December, the US CDC was instructed that words and phrases including the above, were to be banned from use in budget documents.

It is important that the CDC denied that they would follow such restrictions. Similar resistance needs to become universal.

Striking out words is like striking out people. More than ever, this is a time to make our networks of friendships stronger.

i-Base news and publications

Conference reports

Although many of these articles will have been referred to in the summary above, i-Base continued to report on hundreds of studies in comprehensive reviews from at least eight major HIV conferences and workshops.

All coverage is linked to the holding page for each of these meetings:

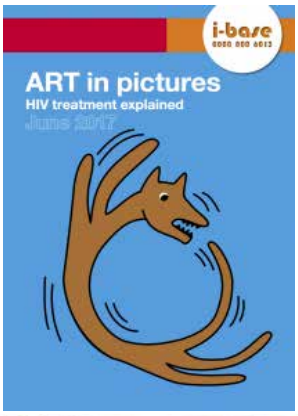
CROI 2017; BHIVA 2017; HIV PK workshop; 11th INTEREST Workshop; 9th International Paediatric Workshop; IAS 2017; EACS 2017; 8th HIV and Ageing Workshop.

Resources

Running alongside HTB, i-Base produces non-technical resources for HIV positive people.

During 2017 this included an expanded range of pocket-size concertina leaflets, updated guides to PrEP in the UK, changing HIV treatment, a summarised guide to PrEP in Scotland, Trans health, Pregnancy in Swahili...

Also a 32-page A4 publication ART in pictures: HIV treatment explained which was quickly translated in Russian.



Funding appeal

The i-Base appeal was launched in April to support our projects that are increasingly vulnerable due to changes in financial support.

i-Base continues to be the only HIV organisation that provides all patient resources free to NHS clinics – the only ethical model to match the NHS principal of free at point of care access.

Please become an active supporter if you are able to help these services during 2018.

Conclusion

Altogether, 2017 was a lively year.

There is every prospect that many of the trends reported above will continue into 2018.

We hope you join us to realise and build on the positive news and similarly help to highlight ways to make the fight for the best quality health care in the UK and globally.

TREATMENT STRATEGIES

Early ART is not associated with a higher risk of HIV drug resistance

Simon Collins, HIV i-Base

A paper using observational data from the HIV CAUSAL collaboration, published ahead-of-print in the journal AIDS, is helpful in allaying the concern of developing drug resistance with early ART. [1]

This question is important because viral load does not always become undetectable in a small percentage of people on first-line ART – commonly due to pre-existing drug resistance or intermittent adherence. This, together with a concern for side effects at a time when people were asymptomatic, was a reason for running the large randomised START trial. [2]

While START clearly showed that clinical benefits of early ART at high CD4 count outweighed the risk of side effects, leading to recommendations in 2015 for universal access to treatment, START hasn't yet reported on drug resistance.

The current paper, from Sara Lodi and colleagues, used a retrospective analysis of samples from more than 50,000 people with baseline CD4 counts >500 cells/mm^3 before ART.

The results showed no significant differences in the development of resistance by CD4 count in 794/2,672 with resistance test results. The estimated 7-year risk (95% CI) of acquired drug resistance was 3.2% (2.8 to 3.5), 3.1% (2.7 to 3.3) and 2.8% (2.5 to 3.0) for starting ART with CD4 counts >500, 350 to 500 and < 350 cells/mm^3 respectively. When the analysis was restricted to people with baseline in 2005–2015, the corresponding estimates were 1.9% (1.8 to 2.5), 1.9% (1.7 to 2.4) and 1.8% (1.7 to 2.2).

C O M M E N T

Although these data were not protected by randomisation, the results are reassuring from a real world setting that there is no signal that accumulation of drug resistance is a risk from earlier ART.

It is important to note that this data was from countries with good access to viral load and genotype testing.

References

1. Lodi S et al. Effect of immediate initiation of antiretroviral treatment on the risk of acquired HIV drug resistance. AIDS: Post Acceptance: November 10, 2017 doi: 10.1097/QAD.0000000000001692,

http://journals.lww.com/aidsonline/Abstract/publishahead/Effect_of_immediate_initiation_of_antiretroviral.97360.aspx
2. Initiation of antiretroviral therapy in early asymptomatic HIV infection. Lundgren JD, Babiker AG, Gordin F, Emery S, Grund B, Sharma S, Avihingsanon A, Cooper DA, Fätkenheuer G, Llibre JM, Molina J-M, Munderi P, Schechter M, Wood R, Klingman KL, Collins S, Lane HC, Phillips AN, Neaton JD. NEJM 2015; 373(9):795-802. (27 August 2015).
http://www.nejm.org/doi/full/10.1056/NEJMoa1506816

PAEDIATRICS

FDA approves raltegravir for newborns

Polly Clayden, HIV i-Base

At the end of November 2017, the US FDA approved raltegravir for treatment, in combination with other antiretrovirals, of neonates from birth to four weeks of age, weighing at least 2 kg. [1,2]

This approval was supported by data from IMPAACT P1110 – an open label, clinical trial looking at the safety and pharmacokinetics of raltegravir oral suspension in 42 full term, HIV-exposed newborns, at high risk of vertical transmission.

Raltegravir is not recommended in pre-term newborns or infants weighing less than 2 kg, as no data are yet available in these populations. If the mother has taken raltegravir within two to 24 hours before delivery, the newborn's first dose should be given between 24 to 48 hours after birth.

C O M M E N T

Raltegravir is now one of the few antiretrovirals approved for treating babies from birth.

Having the option to use an integrase inhibitor from birth is a significant development for paediatric HIV.

References
1. Merck press release. Merck receives FDA approval for ISENTRESS (raltegravir), in combination with other antiretroviral agents, for the treatment of HIV-1 infection in newborns weighing at least 2 kg. 29 November 2017.
http://www.mrknewsroom.com/news-release/prescription-medicine-news/merck-receives-fda-approval-isentress-raltegravir-combinatio
2. US Food and Drug Administration. Supplement approval fulfillment of postmarketing requirement raltegravir. 22 November 2017.
https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2017/205786orig1s006,022145orig1s037,203045orig1s014ltr.pdf

TRANSMISSION AND PREVENTION

London signed up as a fast-track HIV city by Mayor Sadiq Khan

Simon Collins, HIV i-Base

On Wednesday 10 January 2018, Sadiq Khan, the Mayor of London hosted a signing ceremony at City Hall for London to be the second UK city to join the HIV Fast Track City initiative. [1]

Other sponsors of this event included the London Councils, Public Health England, NHS England and IAPAC.

This UNAIDS-backed Fast Track Cities Initiative was launched three years ago in Paris when 27 Mayors from high-incidence cities globally signed up to achieve the UNAIDS 90:90:90 targets by 2020 and to end the AIDS epidemic by 2030. [2, 3]

Additional objectives include having combination prevention services and to eliminate stigma and discrimination. So far, more than 200 cites have signed up from Africa, Latin America, Europe, Asia and North America.

This political focus on HIV in London is important. Approximately 37,000 Londoners are living with HIV – 43% of the UK total – with 2,000 new diagnoses in 2016. Also, 18 of the 20 highest prevalence local authorities are in London.

The event was used to publicise that London has already achieved the main 90:90:90 targets. In 2016 in London, 90% of people living with HIV were diagnosed, 97% of whom are on ART and 97% of those on ART have undetectable viral

load. [4]

It also highlighted the collaborative work from London boroughs to support the Do It London campaign. Launched in 2016, this uses a combined prevention approach: testing, condoms, PrEP and early treatment – fully supporting that having an undetectable viral load means HIV is effectively untransmittible (U=U). [5]

But London only just scrapes though on the HIV testing target. So although many of the speeches at the launch were positive, there was no time for questions. Instead, many discussions with doctors and community activists highlighted how demand for services, including HIV testing, actively limits clinics from achieving these goals.

For example, both the 56 Dean Street clinic in Soho and the Burrell Street clinic in Southwark ask people to register for appointments online, but report that allocated spaces are quickly taken. Dean Street estimate that of the 1600 daily requests, only 400 spaces are available.

The plans to reducing stigma and discrimination still have a long way to go too – and a strategy for how this will be reduced to zero are unclear.

Several presentations to the BHIVA 2017 conference last year showed that even basic knowledge and confidence about HIV is still worryingly low and that HIV positive people are still unable to access many health services on an equal basis. [6] So although the launch included good news there is still much to do.

As part of the Martin Fisher Foundation "Towards Zero" campaign, Brighton was the first UK city to be designated with fast track status, for World AIDS Day 2016. [7, 8]

C O M M E N T

The political focus on HIV from this initiative is good news.

While London has already passed the 90:90:90 preliminary goal thanks to new models of care at many of the highest-incidence HIV clinics, these services are currently threatened with caps for something as basic as routine and regular HIV testing.

HIV budgets are currently facing year-on-year real cuts and are suffering from the shifted responsibility for sexual health in England from the NHS to local authorities.

The commendable and appropriate goals to provide integrated prevention services and to end stigma and discrimination need to be matched with a strategy for how this will be achieved.

References
1. Mayor of London. Press release. London joins Fast-Track Cities initiative to reduce new HIV infections. (10 January 2018) https://www.london.gov.uk/press-releases/mayoral/london-joins-hiv-fast-track-cities-initiative
2. UNAIDS. Mayors from around the world sign Paris Declaration to end the AIDS epidemic. (1 December 2014). http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2014/december/20141201_PR_citiesreport
3. Fast track cities initiative. http://www.fast-trackcities.org
4. Public Health England. Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK: 2017 report. (November 2017) https://www.gov.uk/government/publications/hiv-in-the-united-kingdom
5. Do It London campaign. https://doitlondon.org
6. Community presentations: dental care, HIV awareness and access to formula milk. HTB report. April 2017. http://i-base.info/htb/31569
7. HTB. Brighton heads towards zero HIV: first UK city with UN Fast Track status. (01 December 2016). http://i-base.info/htb/31350
8. Martin Fisher foundation press release. Brighton heads towards zero HIV. (1 December 2016). http://www.martinfisherfoundation.org

OTHER NEWS

Forbidden words: transgender, diversity, foetus, vulnerable banned from US budget documents

Simon Collins, HIV i-Base

For many HTB readers the demands for the US CDC to follow a new Trump administration list of forbidden words in official documents will be old news: tweets and blogs responded immediately.

But lodging this as a short article in the January HTB is important for anyone that missed the story.

On 17 December 2017, an article in the Washington Post reported on a 90-minute briefing with senior officials at the US CDC responsible for 2018 budget.

The banned words are: vulnerable, entitlement, diversity, transgender, foetus, evidence-based and science-based.

Trumpspeak = newspeak = alternative facts.

Reference

Sun LH and Eilperin J. CDC gets list of forbidden words: Fetus, transgender, diversity, Washington Post. (15 December 2017)

https://www.washingtonpost.com/national/health-science/cdc-gets-list-of-forbidden-words-fetus-transgender-diversity/2017/12/15/f503837a-e1cf-11e7-89e8-edec16379010_story.html?utm_term=.b871790acf26

ON THE WEB

Community resources

New booklets for trans women and men – from cliniQ

Two new resources about sexual health and PrEP from cliniQ, a London-based specialist clinic providing sexual health and well-being services for trans people. (www.cliniQ.org.uk)

- A trans woman's guide to the sex club scene: https://cliniq.org.uk/resources/the-hook-up-a-trans-womans-guide-to-the-sex-club-scene
- A trans guy's guide to the gay sex scene: https://cliniq.org.uk/resources/cruising-a-trans-guys-guide-to-the-gay-sex-scene

Peer-review journals

Selected articles, usually available online as open access.

When to start antiretroviral treatment? A history and analysis of a scientific controversy

Nathan Geffen, Marcus O Low. S Afr J HIV Med. 2017;18(1), a734. doi:10.4102/sajhivmed.v18i1.734, (05 December 2017)

http://sajhivmed.org.za/index.php/hivmed/article/view/734/1060

PLoS Medicine: Advances in HIV prevention, treatment and cure - Special issue

http://collections.plos.org/hiv-special-issue

Selected articles from the 20 wide-reaching papers in this issue include:

- The end of HIV: Still a very long way to go, but progress continues -Steven Deeks, Sharon Lewin, Linda-Gail Bekker
- Extensive virologic and immunologic characterization in an HIV-infected individual following allogeneic stem cell transplant and analytic cessation of antiretroviral therapy - Cummins et al.
- Respondent-driven sampling for identification of HIV- and HCV-infected people who inject drugs and men who have sex with men in India - Solomon S et al.
- The expanding epidemic of HIV-1 in the Russian Federation - Beyrer C et al.
- HIV pre-exposure prophylaxis and early antiretroviral treatment among female sex workers in South Africa - Eakle R et al.
- Safety, pharmacokinetics, and immunological activities of multiple intravenous or subcutaneous doses of an anti-HIV monoclonal antibody VRC01 - Meyer K et al.
- Prospects for passive immunity to prevent HIV infection - Morris L et al.
- HIV prevalence and behavioral and psychosocial factors among transgender women and cisgender men who have sex with men in 8 African countries - Poteat T et al.

- Cardiovascular disease (CVD) and chronic kidney disease (CKD) event rates in HIV-positive persons at high predicted CVD and CKD risk: A prospective analysis of the D:A:D observational study - Boyd MA et al.
- Reaching global HIV/AIDS goals: What got us here, won't get us there - El Sadr W et al.

FUTURE MEETINGS

Conference listing 2018

The following listing covers some of the most important upcoming HIV-related meetings and workshops.

8th International Workshop of HIV & Women

2 – 3 March 2018, Boston

www.virology-education.com

Conference on Retroviruses and Opportunistic Infections (CROI 2018)

4 – 7 March 2018, Boston

www.croiconference.org

BHIVA 'Best of CROI' Feedback Meetings 2018

Monday 19 March, London

Tuesday 20 March, Birmingham

Wednesday 21 March, Haydock

Tuesday 27 March, Cardiff

Wednesday 28 March, Wakefield

Thursday 29 March, Edinburgh

www.bhiva.org/BestofCROI2018.aspx

4th Joint BHIVA/BASHH Spring Conference

17 – 20 April 2018, Edinburgh

www.bhiva.org

12th INTEREST

29 May – 1 June 2018, Kigali

interestworkshop.org

International Workshop on Clinical Pharmacology of Antiviral Therapy 2018

Tbc May 2018, Washington

www.virology-education.com

22nd International AIDS Conference (AIDS 2018)

23 – 27 July 2018, Amsterdam

www.aids2018.org

International Workshop on HIV & Aging

13 –14 September 2018, New York, USA.

www.virology-education.com

HIV Glasgow 2018

28 – 31 October 2018

www.hivglasgow.org

PUBLICATIONS & SERVICES FROM i-BASE

i-Base website

All i-Base publications are available online, including editions of the treatment guides.

http://www.i-Base.info

The site gives details about services including the UK Community Advisory Board (UK-CAB), our phone service and Q&A service, access to our archives and an extensive range of translated resources and links.

Publications and regular subscriptions can be ordered online.

The Q&A web pages enable people to ask questions about their own treatment:

http://www.i-base.info/qa

i-Base treatment guides

i-Base produces six booklets that comprehensively cover important aspects of treatment. Each guide is written in clear non-technical language. All guides are free to order individually or in bulk for use in clinics and are available online in web-page and PDF format.

http://www.i-base.info/guides

- Introduction to ART (September 2016)
- HIV & quality of life: side effects & long-term health (Sept 2016)
- Guide to PrEP in the UK (November 2016)
- HIV testing and risks of sexual transmission (June 2016)
- Guide to changing treatment and drug resistance (February 2015)
- Guide to HIV, pregnancy & women's health (December 2015)

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A new series of pocket-size concertina folding leaflets that is designed to be a very simple and direct introduction to HIV treatment.

The first five pocket leaflets are: Introduction to ART, HIV and pregnancy, ART and quality of life, UK guide to PrEP and HCV/HIV coinfection.

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h-tb

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