How Well Do Docs Manage Potential Conflicts Between Hep C and HIV Meds?

A recent study of Dutch clinicians found that they generally did a good job of preventing drug-drug interactions.

April 9, 2018 By Benjamin Ryan

Dutch clinicians in a recent study apparently did a good job of negotiating potential harmful drug-drug interactions (DDIs) between antiretroviral (ARV) treatments for HIV and direct-acting antiviral (DAA) treatments for hepatitis C virus (HCV) among those coinfected with both viruses. However, researchers found that these health care providers could do a better job of preventing pairings of DAAs and contraindicated non-HIV medications.

Use of two drugs in combination is considered contraindicated, or ill advised, when research indicates such a combination could be harmful.

Publishing their findings in HIV Medicine, researchers analyzed data from the Dutch ATHENA HIV observational cohort on 423 HIV/HCV-coinfected individuals who were treated with DAAs. Of a total of 418 individuals (99 percent) on ARVs, 405 (96 percent) had a fully suppressed HIV viral load. A total of 251 (59 percent) were taking non-ARV medications as they prepared to undergo DAA treatment.

For their ARV regimen, 298 (70 percent) of the participants were taking a nucleoside/nucleotide reverse transcriptase inhibitor (NRTI) backbone of Truvada (tenofovir disoproxil fumarate/emtricitabine); and 63 participants (15 percent) were taking an NRTI backbone of Epzicom (abacavir/lamivudine). A total of 125 (30 percent) took boosted protease inhibitors, 175 (41 percent) took non-nucleoside reverse transcriptase inhibitors (NNRTIs) and 76 (18 percent) took integrase inhibitors.

The study authors looked at the medications that the participants were taking prior to starting DAAs and categorized them as posing no expected threat of interaction with DAAs, posing a potential threat of an interaction (considered a category 2 DDI), being a contraindication (a category 3 DDI) or lacking proper data to make a recommendation about combining with DAAs.

Prior to starting treatment for hep C, 84 participants were taking non-ARV medications in class 2 or

3 of DDIs; of these 17 (20 percent) discontinued those drugs before starting DAAs, including two out of six (33 percent) of the drugs in category 3. A total of 196 of those on ARVs (47 percent) had a category 2 or 3 DDI for their HIV meds. Of the 147 with a category 2 DDI between their ARVs and DAAs, 78 (53 percent) switched their ARVs; of the 48 with a category 3 DDI between their ARVs and DAAs, 47 (98 percent) switched their ARVs.

In preparation for starting DAA treatment, 166 (40 percent) of the participants switched their boosted protease inhibitor, NNRTI or integrase inhibitor, and 57 (14 percent) switched their NRTI backbone. The majority switched from a boosted protease inhibitor or NNRTI to an integrase inhibitor such as Isentress (raltegravir) or Tivicay (dolutegravir).

A total of 213 (50 percent) of the participants were treated for hep C with Harvoni (ledipasvir/sofosbuvir), 115 (27 percent) received Sovaldi (sofosbuvir) and Daklinza (daclatasvir) with or without ribavirin and 59 (14 percent) received Sovaldi and Olysio (simeprevir) with or without ribavirin.

A total of 367 (87 percent) of the participants achieved a sustained virologic response 12 weeks after completing therapy (SVR12, considered a cure).

The study authors concluded: “Prescription patterns suggest that physicians are aware of potential DDIs between [other medications] and DAAs, in particular potential DDIs with [ARVs]. Greater awareness is needed concerning category 3 interactions between non-[ARV] comedication and DAAs.”

To read the study abstract, click here.

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http://beta.docker.poz.com/article/docs-manage-potential-conflicts-hep-c-hiv-meds