Rapidly Starting PrEP Before All Labs Are Back Proves Feasible in NYC

Waiting for all lab tests to return before prescribing Truvada resulted in a high dropout rate among those visiting sexual health clinics.

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A program at New York City sexual health clinics of immediately starting people at risk for HIV on Truvada (tenofovir disoproxil fumarate/emtricitabine) as pre-exposure prophylaxis (PrEP) before all relevant laboratory tests return has proved feasible.

Only two out of nearly 1,400 people who were evaluated for PrEP and started immediately on Truvada were subsequently found to be acutely (very recently) infected with HIV according to a viral load test. Each took Truvada for no more than 10 days.

Presenting their findings at the 2019 Conference on Retroviruses and Opportunistic Infections (CROI) in Seattle, investigators analyzed data from New York City sexual health clinic medical records systems covering January 2017 to June 2018. They specifically looked at cisgender men and women who had been evaluated for PrEP use at such a clinic, had tested negative for HIV according to a 3rd or 4th generation rapid test and had provided blood samples for a series of metabolic lab tests as well as an HIV viral load test (which can detect an acute infection earlier than a rapid test).

The analysis excluded people who had previously had such metabolic tests or a hepatitis B virus (HBV) test ordered at the time they were evaluated for PrEP use at a sexual health clinic.

Of 1,437 PrEP candidates, 1,387 (96.5 percent) received an immediate 30-day supply of Truvada under the condition that they discontinue the drug if lab tests later indicated they should do so. Such test results included an eGFR below 60 (indicating reduced kidney function) or a positive HIV viral load.

The other 50 PrEP candidates (3.5 percent) were assigned to receive PrEP on a delayed basis because of concerns that they had symptoms of acute (very early) HIV infection (12 people), a history of chronic kidney disease (16 people), a history of HBV (nine people) or other medical problems (13 people).

A total of 10.2 percent of the study population was 40 years old or older, including 9.7 percent of

those in the immediate PrEP (iPrEP) group and 24 percent in the delayed PrEP (dPrEP) group. A total of 31.7 percent of the overall group was foreign born and 73.7 percent reported inconsistent condom use for anal or vaginal sex. A total of 94.7 percent of the overall cohort were men who have sex with men (MSM), including 95.1 percent of those in the iPrEP group and 84 percent of those in the dPrEP group.

A total of 29.9 percent of the overall group were Latino, while 23.2 percent were Black, 33.1 percent were white and 13.8 percent were other races.

Of the 1,387 people in the iPrEP group, 1,377 (99.3 percent) were cleared for continued PrEP use by the lab test results while 10 (0.7 percent) had results suggesting that Truvada may be contraindicated for them (meaning the drug should not be used). Of these 10 individuals, two (0.1 percent of the overall cohort) had detectable viral load, indicating an acute infection, while two (0.1 percent) had an eGFR below 60 and six (0.4 percent) tested positive for hep B.

Having HIV or a lower eGFR were considered absolute contraindications, requiring that people stop Truvada; all four people who fell in these categories in the iPrEP group stopped PrEP within 10 days of starting it.

Of the 50 people in the dPrEP group, 43 (86 percent) turned out not to have contraindications for Truvada use. Of that group, only 15 (35 percent) started PrEP within 60 days of their initial evaluation. Otherwise, seven people (14 percent) in the dPrEP group had contraindications for Truvada, including one person (2 percent) who had a detectable HIV viral load, four (8 percent) who had an eGFR below 60 and two (4 percent) who had hep B.

The study authors found that among the iPrEP cohort members, those who were at least 40 years old were six times more likely to have contraindications for Truvada use than younger individuals. Women were nearly four times more likely to wind up in the dPrEP group than men, although none of these women wound up having Truvada contraindications.

The study authors concluded that in a clinic setting in which there is no access to previous kidney or hep B test results, an on-site clinical assessment appears to adequately identify individuals who could start PrEP immediately before the return of pertinent lab results. Consequently, this is a promising, safe model for increasing the uptake of PrEP via walk-in clinics.

To read the conference abstract, click here.

To view a webcast of the conference presentation, click here.