



# New Society PEP guidelines: draft thinking

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# Processes..

- 1<sup>st</sup> Society guidelines... published 2008 – Steve Andrews/Marc Mendelsohn – amalgamated occupational/non-occupational; also 3 drugs in all exposures
- 2nd round – 2013 requests
- WHO process – delayed while these are finalised, due end 2014
- NO DoH harmonisation



# DoH

- Original guidelines 1993 – AZT TDS, indinavir
- Now located in EDL – still AZT/3TC
- Pleas for upgrade

**POST-HIV EXPOSURE PROPHYLAXIS GUIDELINES<sup>1,2</sup>**

The following actions should be taken immediately upon possible exposure to HIV.

- 1 Treatment of exposure site**  
Wounds and skin sites:  
Wash with soap and water  
Mucous membranes:  
Flush with water
- 2 Timing of post-HIV exposure prophylaxis initiation**  
If therapy is necessary, prophylaxis should be initiated promptly, preferably within 1 to 2 hours post-exposure
- 3 Assessment of exposure risk**  
**Low risk exposure is:**
  - exposure to a small volume of contaminated fluids from a positive partner with a low viral load
  - an injury with a solid mouth-to-mouth exposure
  - any superficial injury or mucous membrane exposure**High risk exposure is:**
  - exposure to a large volume of blood or potentially infectious fluids
  - exposure to blood or blood contaminated fluids from a patient with a high viral load, e.g. in the AIDS phase or early seroconversion phase of HIV
  - injury with broken bone needles
  - deep and extensive injury
  - drug resistance in source patient
- 4 Post-HIV exposure prophylaxis**

Risk category	Antiretroviral prophylaxis	Duration
Low Risk	RETROVIR® 200mg 8-hourly 3TC 150mg 12-hourly	28 days
High Risk	RETROVIR® 200mg 8-hourly 3TC 150mg 12-hourly Indinavir 800mg 8-hourly	
- 5 Recommended drug toxicity and HIV serology testing after exposure**

Time period from exposure	Recommended tests
Baseline	Full blood count Liver & renal function tests HIV serology
Two weeks	Full blood count Liver & renal function tests HIV serology
Six weeks	HIV serology
Three months	HIV serology
Six months	HIV serology

**HIV/AIDS Hotline 0800 110 605**

GlaxoWellcome

3TC/Retrovir

Stop AIDS Now! Depend on B

# Occupational versus non-occupational

- Sex worker burst condom versus medical student
- WHO following our lead – dumping these categories (some ‘special occupations’ in new guidelines)



# Is it a problem?

- Huge number of traditional occupational exposures – not just side effects, costs, also anxiety, burnout
- Other exposures – bewildering array, as awareness goes up – more request for PEP



# Big thorny questions in PEP?

- Should I give antiretrovirals? (and high vs low risk)
- Should I give 2 or 3?
- Role of Prep?



# Big new ideas

- Make peace with limited data – and that we are unlikely to get better ‘pure PEP’ data
- Occupational vs non-occupational
- Safe ‘third’ drugs



# Should we give a third drug?

- NO data on this – whether adding gives additional protection or any drug being better than the other (and we probably will never know)
- Adds very little to current prevention BUT
- Simpler, less anxiety
- Problem is toxicity and cost





# Which third drug?

- Lop/rit safer than ATV/rit; Darunavir/rit
- EFV – unpopular
- Integrase inhibitors – decrease price, excellent side effect profile



# WHO

- Almost all low quality evidence (except adherence!)

World Health Organization  
Guidelines on Post Exposure  
Prophylaxis for HIV  
Recommendations for a public  
health approach



# Big recommendations

A two antiretroviral drug regimen is effective but three drugs are preferred.



# Which drug?

## Preferred antiretroviral regimen for adults and adolescents

TDF+3TC(or FTC) is recommended as the preferred backbone regimen for HIV PEP in adults and adolescents.

LPV/r or ATV/r are suggested as preferred third drugs for HIV PEP in adults and adolescents.

Where available the following alternatives can be considered: DRV/r, RAL, EFV.

*(Conditional recommendation, very low quality of evidence)*



## Preferred antiretroviral regimen for children $\leq 10$ years

AZT+3TC is recommended as the preferred backbone for HIV PEP in children 10 years and younger. ABC+3TC or TDF+3TC (or FTC) can be considered as alternative regimens.

*(Strong recommendation, low quality evidence)*

LPV/r is recommended as the preferred third drug for HIV PEP in children less than 10 years.



## Prescribing frequency

A full 28 day prescription of antiretrovirals should be provided for HIV PEP following initial risk assessment.

## Adherence support

Enhanced adherence counselling is suggested for all individuals initiating HIV PEP.

*(Conditional recommendation, moderate quality of evidence)*

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# Likely?

- WHO guidelines plus...
- Recommend integrase inhibitors as third drug (?rilpivarine, others)
- All usual suggestions around hepatitis B, followup etc etc

