

**HIV & HCV**  
**Coinfection:**  
**Challenges from the**  
**Perspective of TAG**

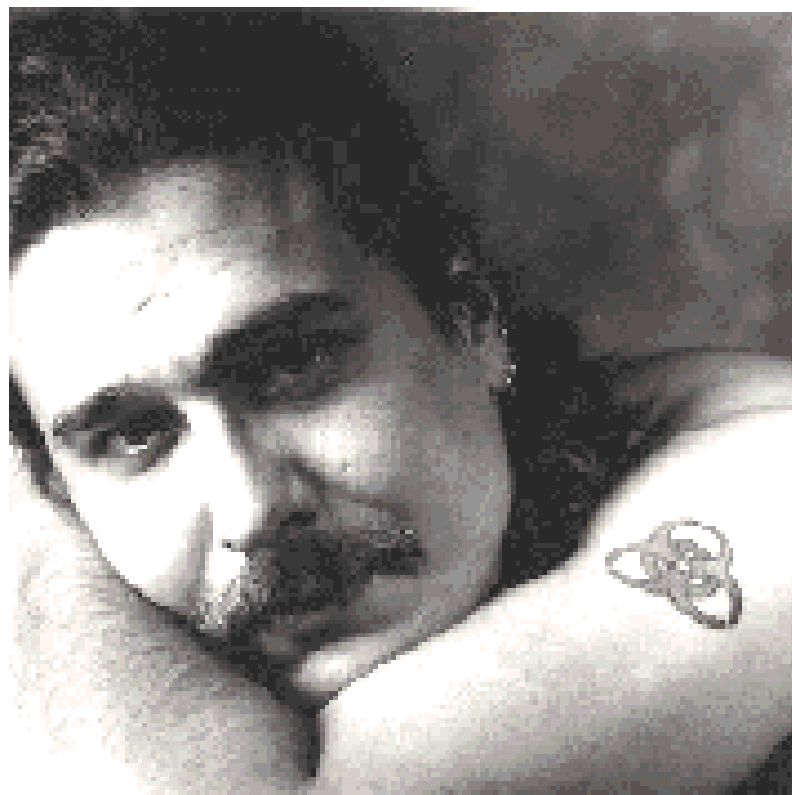
**Tracy Swan**

**Treatment Action Group**

**Hepatitis C/HIV Coinfection Project Director**

# Carlton Hogan

1961-2003



# HIV Treatment Activism

“...from acts of civil disobedience  
to acts of congress..”



**S.1: The NIH Revitalization Act of 1993**

- Created “parallel track”/expanded access programs
- Developed Accelerated Approval, based on surrogate markers
- Called for legislation to double the NIH budget
- Demanded—and obtained—the opportunity to become full participants in government funded HIV research
- Are vital participants in all stages of HIV drug development

# Survival After an AIDS Diagnosis (1999)

12 months      24 months      36 months

MSM N=13,680	92%	89%	87%
IDU (male only) N=6,048	88%	82%	78%

(CDC, 2005)

# **Double-Edged Sword: HCV & HIV Treatment**

HCV coinfection triples the risk for  
antiretroviral-associated hepatotoxicity

(Sulkowski, Benhamou; J Viral Hepat, 2007)

Coinfected people more likely to discontinue  
HIV treatment due to toxicity, patient/  
physician choice

(Mocroft, et al; EuroSIDA study group; AIDS Res Hum  
Retroviruses; 2005)

# Natural History of Coinfection In the HAART Era

- Survival from HIV diagnosis to death, & AIDS diagnosis to death, significantly shorter for coinfecting people, despite no difference in CD4 recovery with HAART

(Anderson, et al; CID 2004)

- Liver-related death is now the most frequent cause of non-AIDS-related death among HIV-positive people

(Weber, et al; Arch Intern Med 2006)

# HCV Treatment Uptake

**845 coinfecting patients at  
a Baltimore HIV clinic**

**277 referred for  
HCV care & TX**

**125 completed pre-TX evaluation**

**69 eligible for TX**

**29 treated**

**6 had SVR**

(Mehta, et al; AIDS 2006)

# 149 Coinfected Patients at an Urban HIV Clinic

44 eligible, but only  
16 chose HCV TX

## WHY?

105 ineligible (70%)

Potential side effects (32%)

Concern for ability to work (11%)

Concern about relapse to IDU  
(7%)

Did not return for follow-up visit  
(21%)

Unstable social circumstances  
(11%)

Other (18%)

Ongoing alcohol or drug use in  
previous 24 months (23%)

Active psychiatric illness within the  
last 6 months (21%)

Non-adherence: missing > 3 clinic  
appointments (23%)

Decompensated liver disease  
(Child-Pugh > 7) (12%)

Advanced HIV disease (CD4 < 100,  
100-200 & HIV > 10,000  
copies/mL) (13%)

Other comorbidities (8%)

**(Fleming CA, et al; CID 2003)**

# Acce\$\$ Issues

- ◆ Clinician/ nursing staff time
- ◆ HCV RNA testing (at multiple time points)
- ◆ Lab work, monitoring
- ◆ Side effects management: white & red blood cell growth factors cost \$8000 per month
- ◆ Psychiatric assessment, periodic screening for depression, mental health care & medication

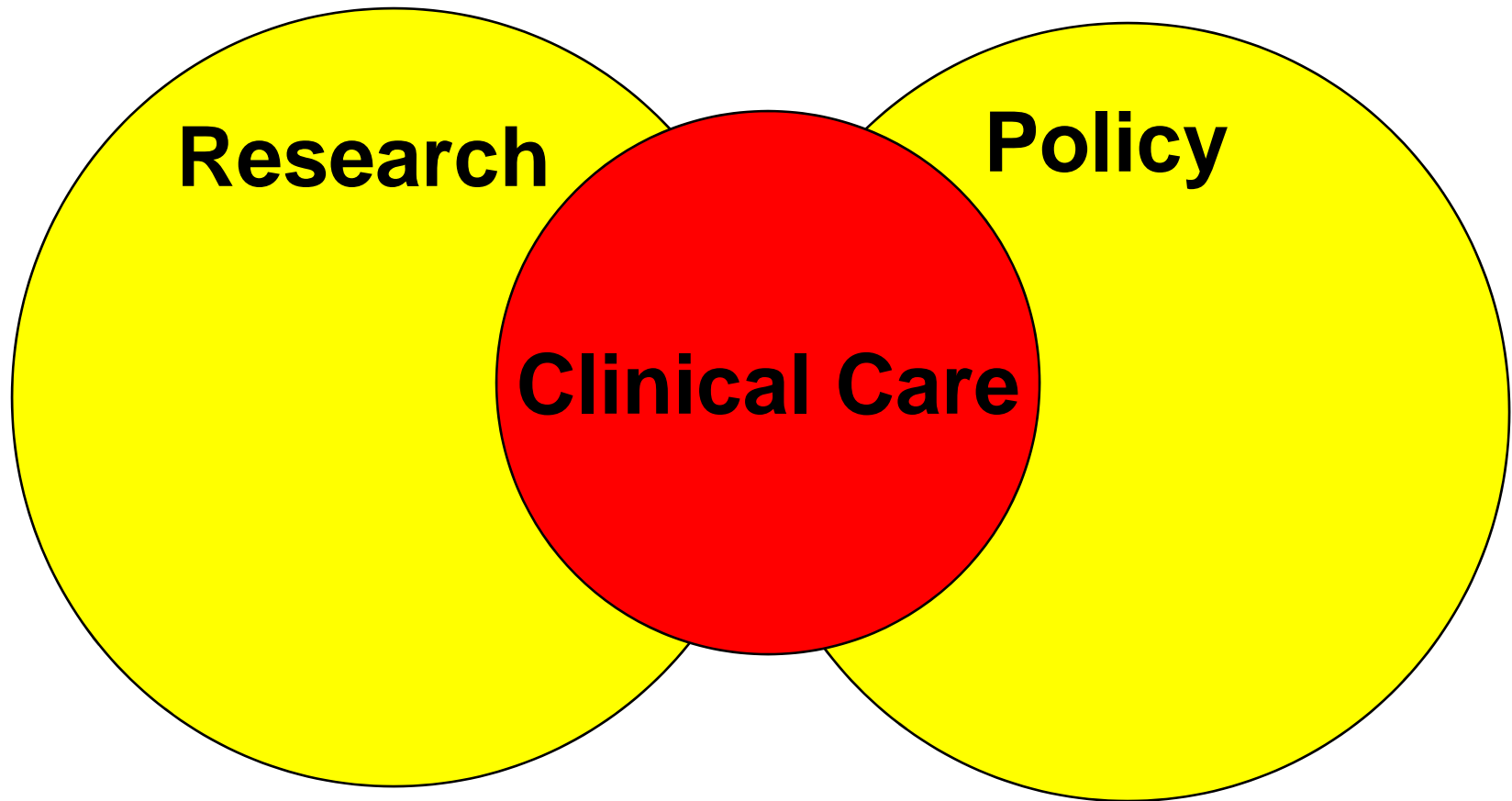
Some insurance plans have an injectable drug waiver

Some State Medicare and Medicaid programs have limited coverage

Only 16 State AIDS Drug Assistance Programs cover PEG-IFN + RBV

(Henry J. Kaiser Family Foundation and the National Association of State and Territorial AIDS Directors; 2007 National ADAP Monitoring Project Annual Report; April 10th, 2007)

# **TAG's Hepatitis C/ HIV Coinfection Project**



# Research Priorities

Well-designed treatment trials in  
HCV monoinfection are crucial, and.....

HIV/HCV coinfecting people should *no longer* have to wait for years after approval for information about safety, efficacy & tolerability of new HCV treatments

# Lessons from HIV: We Need.....

- **Multi-purpose research:**

Registration trials for novel HCV therapies should be designed to help identify optimal treatment strategies, as well as for gaining approval for a single drug

- **Treatment Guidelines:**

to avert therapeutic chaos as SOC evolves

- **Infrastructure:**

to deliver HCV care & treatment, especially for multiply-diagnosed people

# Research Priorities

- Sponsors must study safety, efficacy, & tolerability of new HCV treatments and treatment regimens in clinically relevant populations prior to approval

# Registration Trials & “Real-World” Populations

**Regulatory:** “..to write a label we need to have a representative population. So, it is important that a good sampling of the patients who will receive the drug be part of registration trials.”

**Financial:** reimbursement for off-label use may be increasingly restricted. Broader indication=more sales

**Practical:** There is a limit to the number of cherry-picked, best case scenario, treatment naive patients and we will hit it soon

Thanks to the Forum For  
Collaborative HIV Research, and the  
participants of the May 1999  
Meeting, ***The Challenges of Clinical  
Trial Design in Assessing the  
Effects of Anti-HIV Therapy in  
Heavily Pre-treated Patients***

Available on-line at:

[http://www.hivforum.org/publications/  
clinicaltrial\\_design.pdf](http://www.hivforum.org/publications/clinicaltrial_design.pdf)

# Innovative Trials

**A + B + SOC**

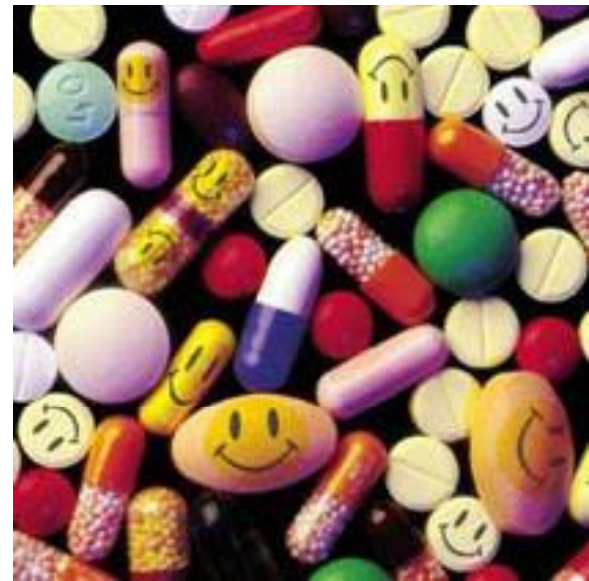
**A + C + SOC**

**B + C + SOC**

**A + B + C**

**and/or**

**A + B + C + SOC**



# Collaboration.....

To conduct such trials, companies will need to:

- Perform PK & drug-drug interaction studies at an early stage in drug development, & create a shared drug-drug interaction database
- Work together on study designs
- Be prepared to scale up drug production (this will also enable launch of expanded access program)

# Entering New Realms

Some NIH institutes and pharmaceutical companies have built relationships with treatment activists and community members, and realize the value of these collaborations.

**“As NIAID has learned, if you can't beat them, bring them in. Both sides will learn and profit from the experience.”**

**(Gregg Gonsalves and Mark Harrington, AIDS Research at the NIH, 1992)**