Background

After the publication of big randomized clinical trials (SWOOD, TANGO, ASPIRE), between 2017 and 2018, lamivudine (3TC) + dolutegravir (DTG) and rilpirivir (RPV)+DTG were included among the recommended regimens for switching strategies in virologically suppressed PWH. However, real-life data regarding these two strategies are still scarce. Therefore, we aimed to describe our real-life cohort’s characteristics to better understand the profile of people who started these DTG-based dual-regimens.

Materials and Methods

We analysed data from SCOLTA (Surveillance Cohort Long-Term Toxicity Antiretrovirals) prospective database, including all experienced people with HIV who started treatment with 3TC/DTG or RPV/DTG. Demographical data, risk factors for HIV infection, viro-immunological data, and reasons for treatment interruption were collected.

Results

We included 359 people, of which 265 (73.8%) were treated with 3TC/DTG and 94 (26.2%) were treated with RPV/DTG. There was no difference in age and gender between the two groups, while there was a difference in HIV risk factors, with a higher percentage of people injecting drugs in the RPV/DTG group. Also, patients treated with RPV/DTG had a longer HIV history than 3TC/DTG (9.9 vs. 13.2 years, p=0.0015).

Not all patients who started dual regimens had an undetectable HIV-RNA; indeed, 17 (4.7%) did not.

Most people treated with RPV/DTG were previously treated with a NNRTI regimen (48.9%). General characteristics are summarized in Table 1.

During follow-up, 203 people up to 208 treated with 3TC/DTG kept an undetectable HIV-RNA (97.6%), while 78 up to 84 (92.8%); in RPV/DTG group; regarding people who had a detectable HIV-RNA at baseline, 8/11 (72.7%) treated with 3TC/DTG achieved a stable undetectable HIV-RNA, vs. 4/5 (80%) treated with RPV/DTG.

Regarding the interruption during the first two years, 31 (8.6%) people interrupted the treatment, of which 22 were in 3TC/DTG and 9 in RPV/DTG group, without statistical significant difference. Most common causes of interruption were adverse events (13, 3.62%) (Figure 1) and loss to follow-up (6, 1.67%).

Conclusions

Both treatments showed a high safety and efficacy in our cohort. RPV/DTG seemed to be preferred for people who came from an NNRTI-based regimen and for those with a longer HIV treatment history.