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Switching to dual therapy with darunavir/ritonavir and etravirine: a simplification strategy

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Background

Long term maintenance with NRTI-sparing regimens may be preferable for patients with NRTI toxicities, and may offer potential cost savings. Dual ART with once daily darunavir/r and etravirine may be preferable to previous PI/r/NNRTI combinations due to its theoretical higher genetic barrier to resistance and good PK profile. We looked at the use of this regimen within our HIV cohort.

Methods

Patients prescribed dual ART with darunavir/ritonavir 800mg/100mg QD with etravirine 400mg/day (DRV/r/ETR) until January 2010 were identified by our virtual clinic database. Reason for switch, HIV resistance, viral outcomes were identified.

Results

21 patients were switched to DRV/r/ETR with median time on regimen of 51.5 weeks (IQR 33-69 wks). 85% (18/21) where given ETR 400mg QD. 62% (13/21) switched from dual PI/r regimens, 10 combined with efavirenz or nevirapine. 28% (6/21) switched from conventional cART (2 NRTI + PI/r or NNRTI). Patients had a median exposure to 9 ARV drugs prior to switch (IQR 4-11), with 90% (19/21) having previous NNRTI exposure, 7 of which had CNS toxicity with efavirenz. At switch, 57% (12/21) had no previous resistance, 19% (4/21) NRTI mutations only, and 19% (4/21) had NNRTI mutations (K103N (2), Y181C combined with NRTI K65R, M184V mutations (1), prior NNRTI failure (2)). 90% (19/21) had VL<50cps/ml at switch, with 95% (20/21) achieving/maintaining VL<50cps/ml on regimen. Four patients discontinued the regimen, 2 switching to darunavir/r monotherapy, one switching to kivexa/darunavir/r due to non-adherence, and one switching back to previous regimen after 4 weeks. One patient was lost to follow up. Median virological follow of patients remaining on therapy was up 40.8 wks (IQR 32-58 wks). Median CD4 change for the 17/21 who remained on therapy was +101 cells/mm^3 (IQR -50-138) with median 39 wks follow up (IQR 31-58 wks). Indications for switch were desire for simplification (9) (typically from dual PI), and need for NRTI-sparing regimen (12), including previous renal toxicity with tenofovir (4), lipoatrophy (7), peripheral neuropathy (1) and lactic acidosis (2).

Conclusions

For patients with VL<50cps/ml, simplification to dual therapy with darunavir/r 800/100mg QD plus etravirine 400mg QD maintains viral suppression and immune reconstitution.

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