Sélection VIH
et (coinfections) hépatites

Lionel Piroth

Journée SPILF 2024

Morbidity and Mortality Weekly Report

Vital Signs: Progress Toward Eliminating HIV as a Global Public Health Threat Through Scale-Up of Antiretroviral Therapy and Health System Strengthening Supported by the U.S. President's Emergency Plan for AIDS Relief — Worldwide, 2004–2022

Helen M. Chun, MD[1,*]; Emilio Dirlikov, PhD[1,*]; Mackenzie Hurlston Cox, MSPH[1]; Michelle Williams Sherlock, MPH[1]; Yaa Obeng-Aduasare, MPH[1];

MMWR / March 24, 2023 / Vol. 72 / No. 12

- 54 pays
- 66550 PVVIH traitées en 2004
- > 20 millions en 2022

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 72 / No. 48
December 1, 2023

TABLE 1. Annual proportion of reported deaths and crude mortality ratios among persons living with HIV and receiving antiretroviral treatment — U.S. President's Emergency Plan for AIDS Relief, 28 supported countries and regions,* 2021–2022†

	2021			2022			2021 and 2022 (annual mean)§		
Characteristic	% Died	No. died	No. receiving ART	% Died	No. died	No. receiving ART	% Died	No. died	No. receiving ART
Age group, yrs									
<1	4.4	585	13,223	5.5	587	10,737	4.9	586	11,980
1–4	2.6	2,786	108,325	2.5	2,581	102,695	2.5	[illegible]	105,510
5–14	0.5	2,943	537,867	0.5	2,772	534,105	0.5		535,986
15–49	0.7	94,539	13,089,351	0.6	90,672	13,984,027	0.7	92,606	13,536,689
≥50	1.4	50,001	3,488,945	1.3	51,913	3,936,499	1.4	50,957	3,712,722
Total	**0.9**	**150,854**	**17,237,711**	**0.8**	**148,525**	**18,568,063**	**0.8**	**149,691**	**17,902,887**

= x9,2

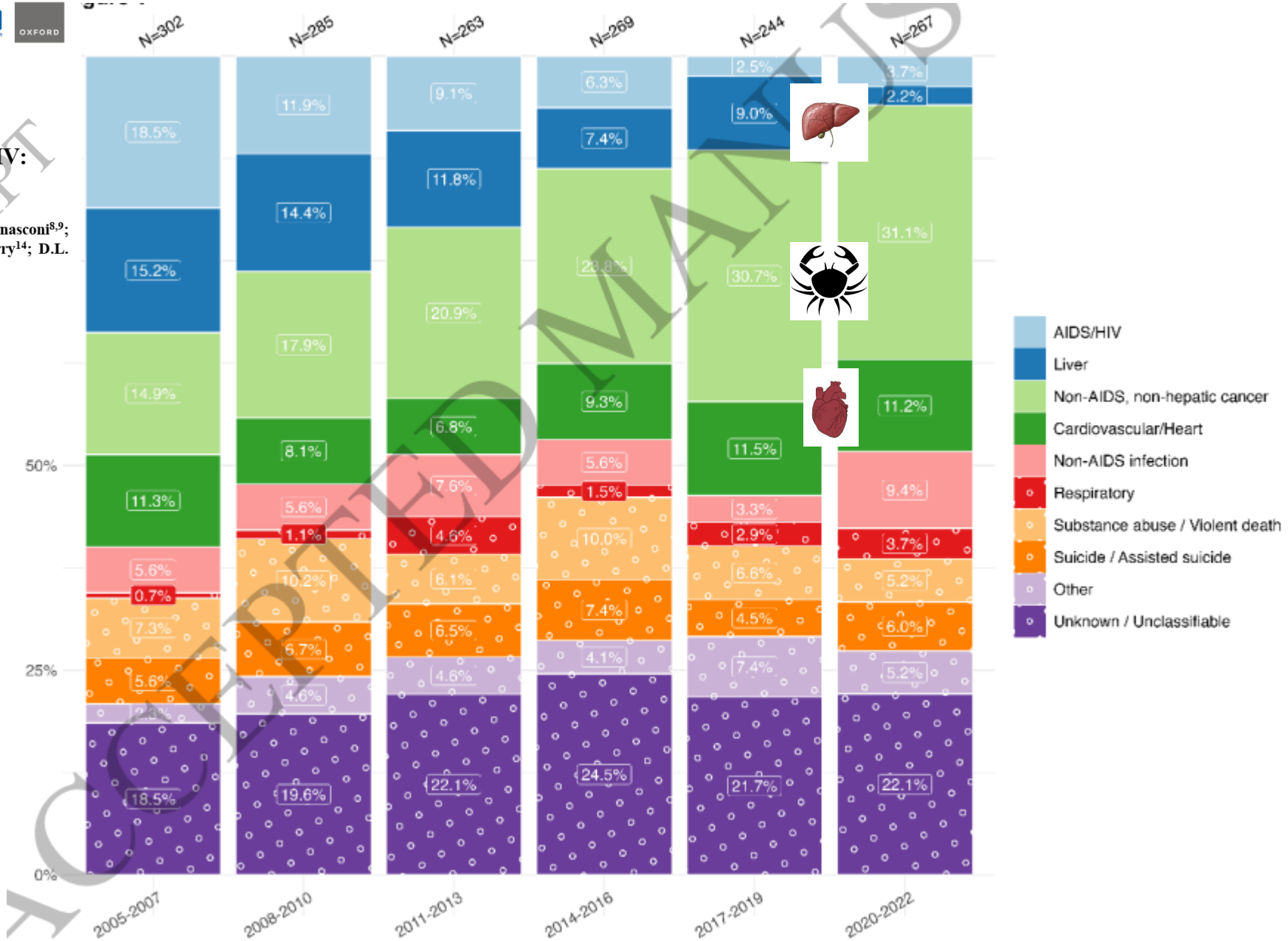
= x7,2

Clinical Infectious Diseases

MAJOR ARTICLE

Time Trends in Causes of Death in People with HIV: Insights from the Swiss HIV Cohort Study

M.S.R. Weber[1,2]; J.J. Duran Ramirez[1,2]; M. Hentzien[3,4,5]; M. Cavassini[6,7]; E. Bernasconi[8,9]; E. Hofmann[10]; H. Furrer[10]; H. Kovari[11]; M. Stöckle[12]; P. Schmid[13]; D. Haerry[14]; D.L. Braun*[1,2]; H.F. Günthard*[1,2]; K. Kusejko*[1,2]; Swiss HIV Cohort Study**

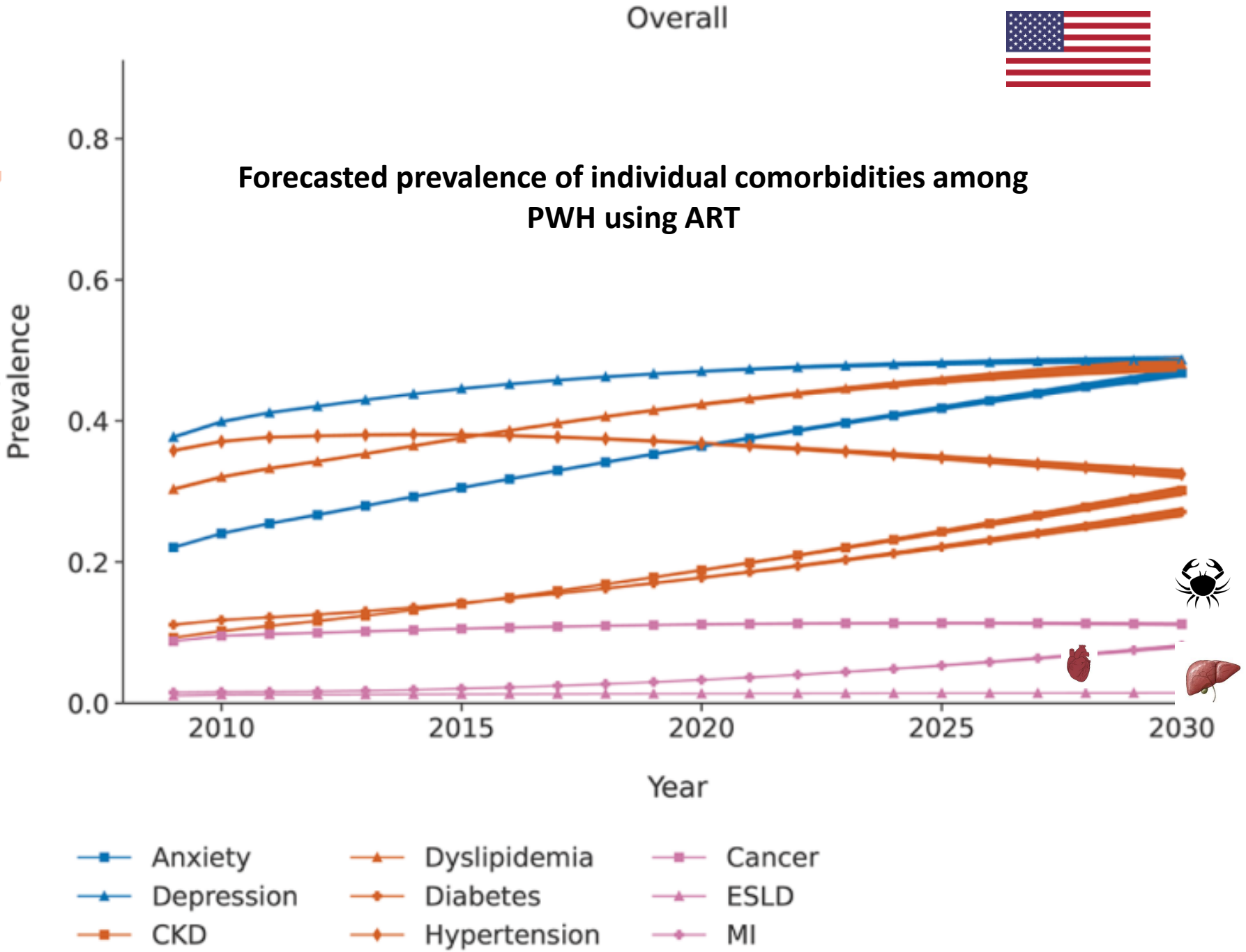


The forecasted prevalence of comorbidities and multimorbidity in people with HIV in the United States through the year 2030: A modeling study

Keri N. Althoff[1]*, Cameron Stewart[1], Elizabeth Humes[1], Lucas Gerace[1], Cynthia Boyd[1,2,3], Kelly Gebo[4], Amy C. Justice[5,6], Emily P. Hyle[7,8], Sally B. Coburn[1], Raynell Lang[9], Michael J. Silverberg[10,11], Michael A. Horberg[12], Viviane D. Lima[13], M. John Gill[9], Maile Karris[14], Peter F. Rebeiro[15], Jennifer Thorne[16], Ashleigh J. Rich[17], Heidi Crane[18], Mari Kitahata[18], Anna Rubtsova[19], Cherise Wong[20], Sean Leng[2], Vincent C. Marconi[21,22], Gypsyamber D'Souza[1], Hyang Nina Kim[18], Sonia Napravnik[23], Kathleen McGinnis[6], Gregory D. Kirk[1,4], Timothy R. Sterling[24,25], Richard D. Moore[26], Parastu Kasaie[1]

PLOS Medicine

January 12, 2024

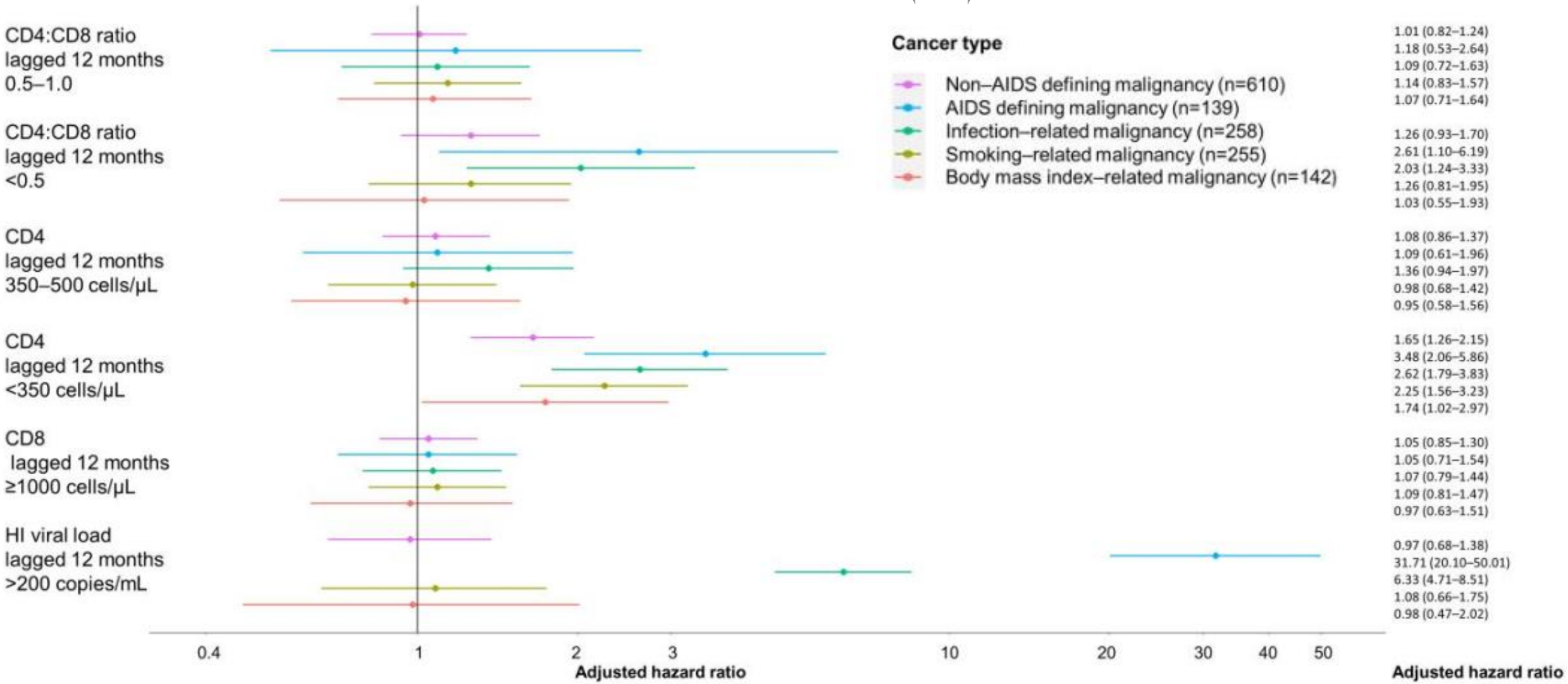


Measures of Longitudinal Immune Dysfunction and Risk of AIDS and Non-AIDS Defining Malignancies in Antiretroviral Treated People With Human Immunodeficiency Virus (HIV)

Frédérique Chammartin,[1,©] Amanda Mocroft,[2,3] Alexander Egle,[4] Robert Zangerle,[5] Colette Smith,[6] Cristina Mussini,[7] Ferdinand Wit,[8] Jörg Janne Vehreschild,[9] Antonella d'Arminio Monforte,[10] Antonella Castagna,[11] Laurent Bailly,[12] Johannes Bogner,[13] Stéphane de Wit,[14] Raimonda Matulionyte,[15] Matthew Law,[16] Veronica Svedhem,[17] Joan Tallada,[18] Harmony P Garges,[19] Andrea Marongiu,[20] Álvaro H. Borges,[2,21] Nadine Jaschinski,[2] Bastian Neesgaard,[2] Lene Ryom,[2,22] and Heiner C Bucher[1]; for the RESPOND Study Group

Clinical Infectious Diseases

MAJOR ARTICLE



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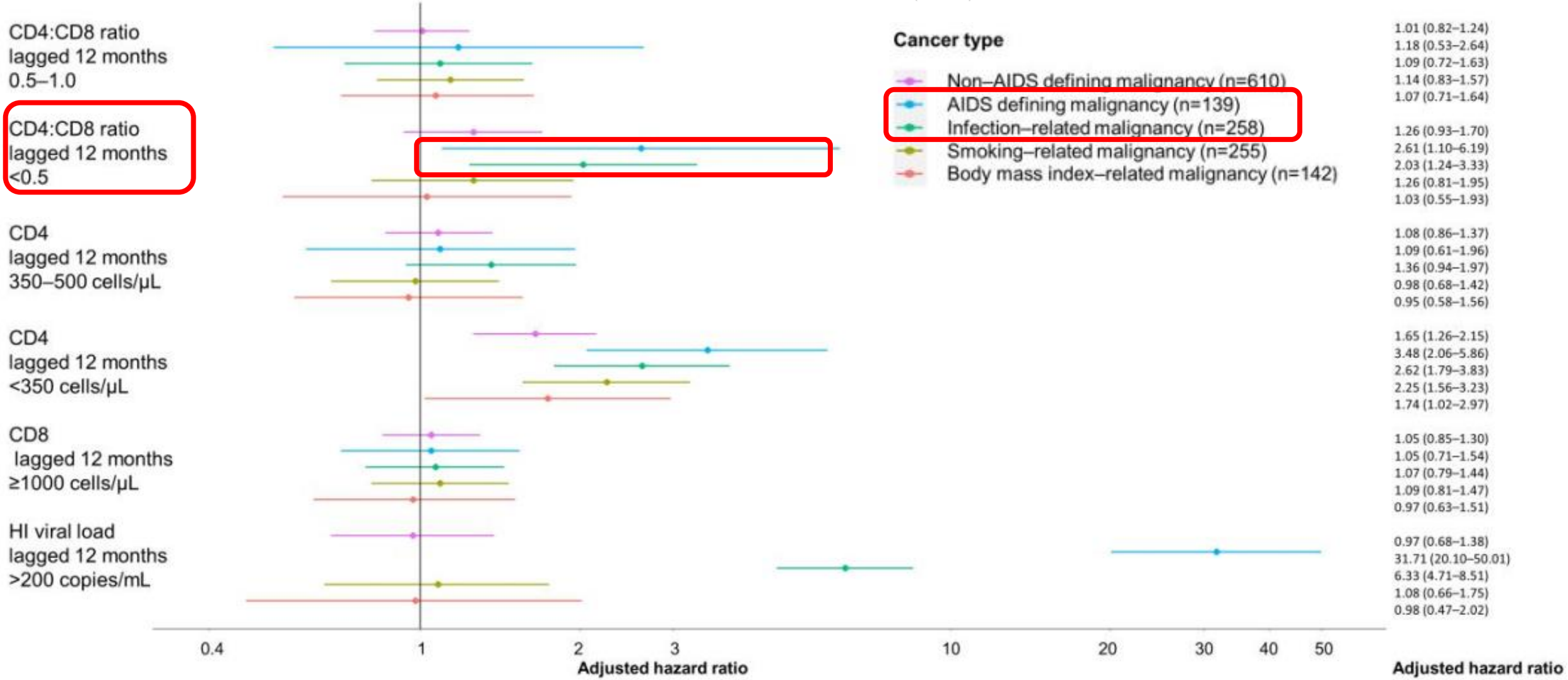

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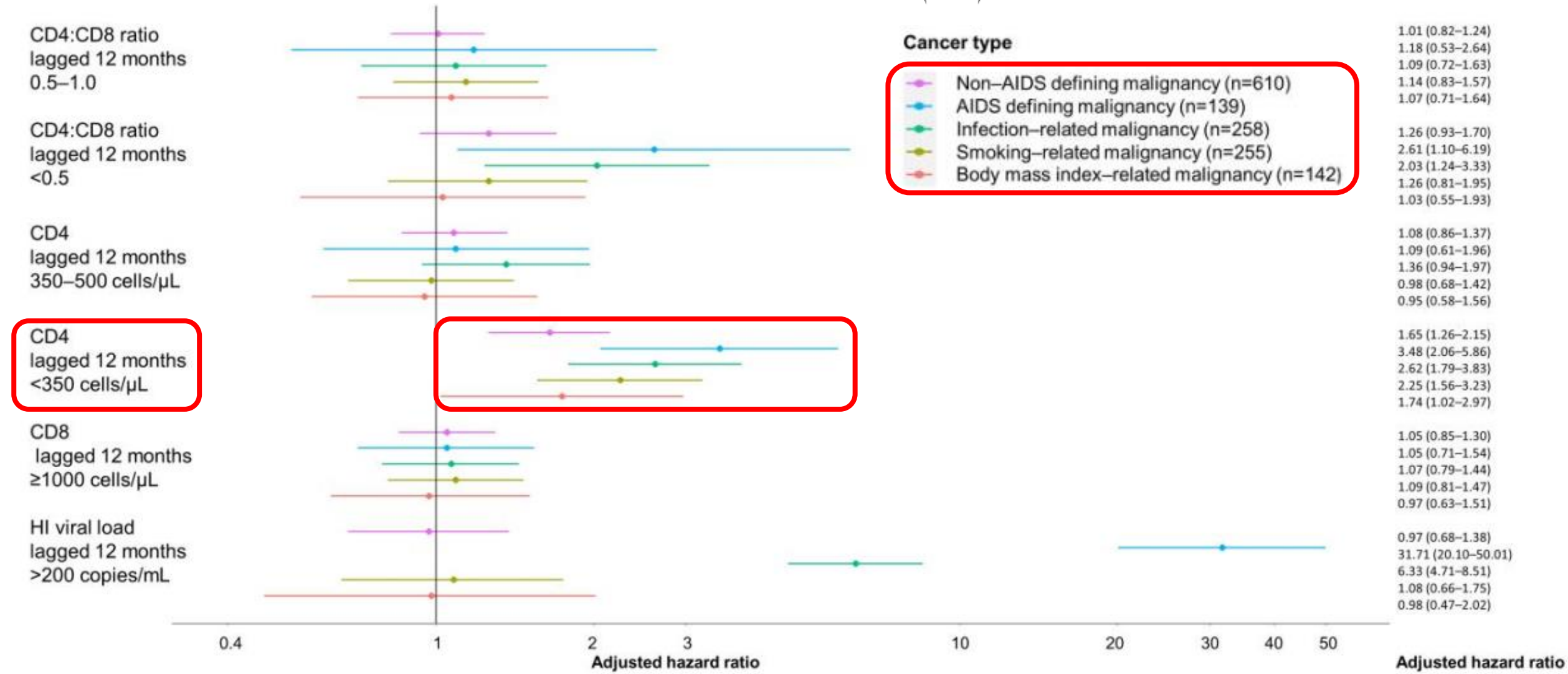

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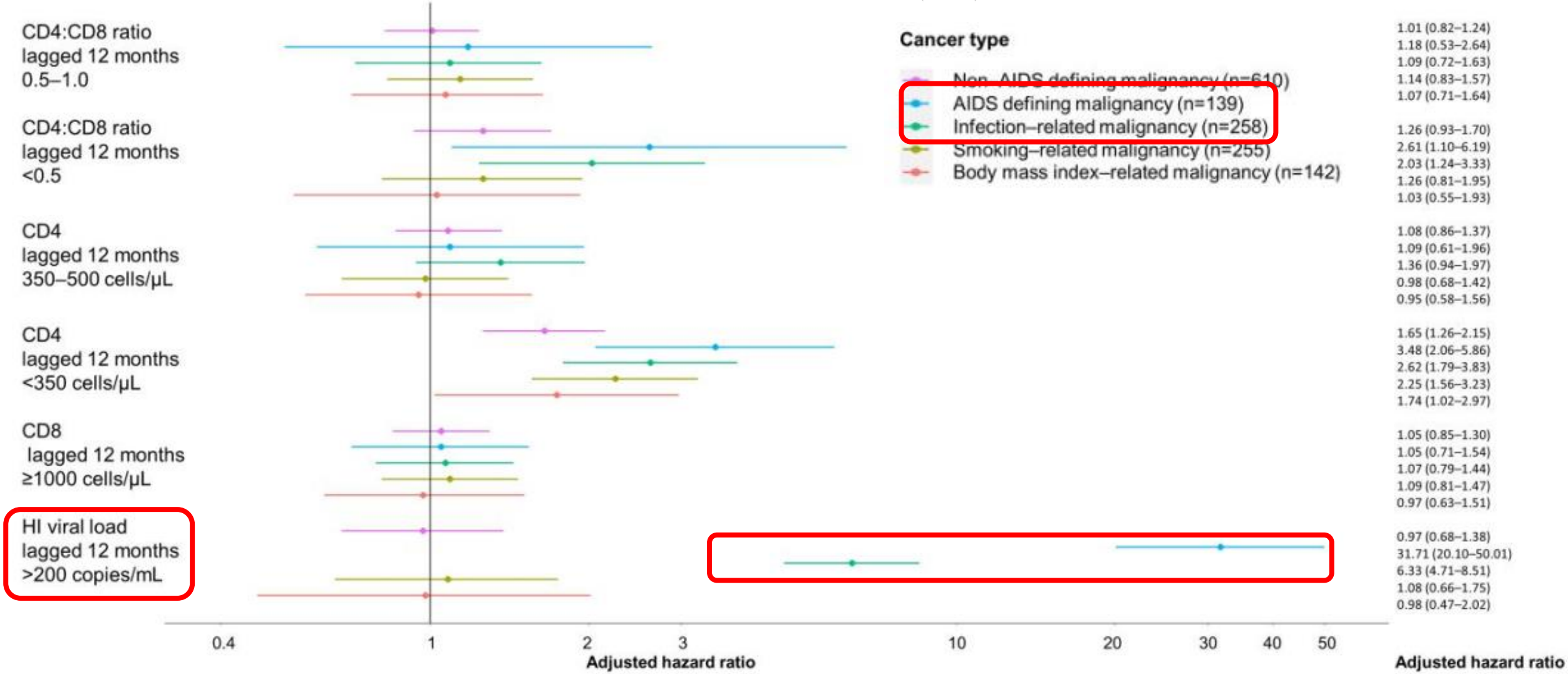


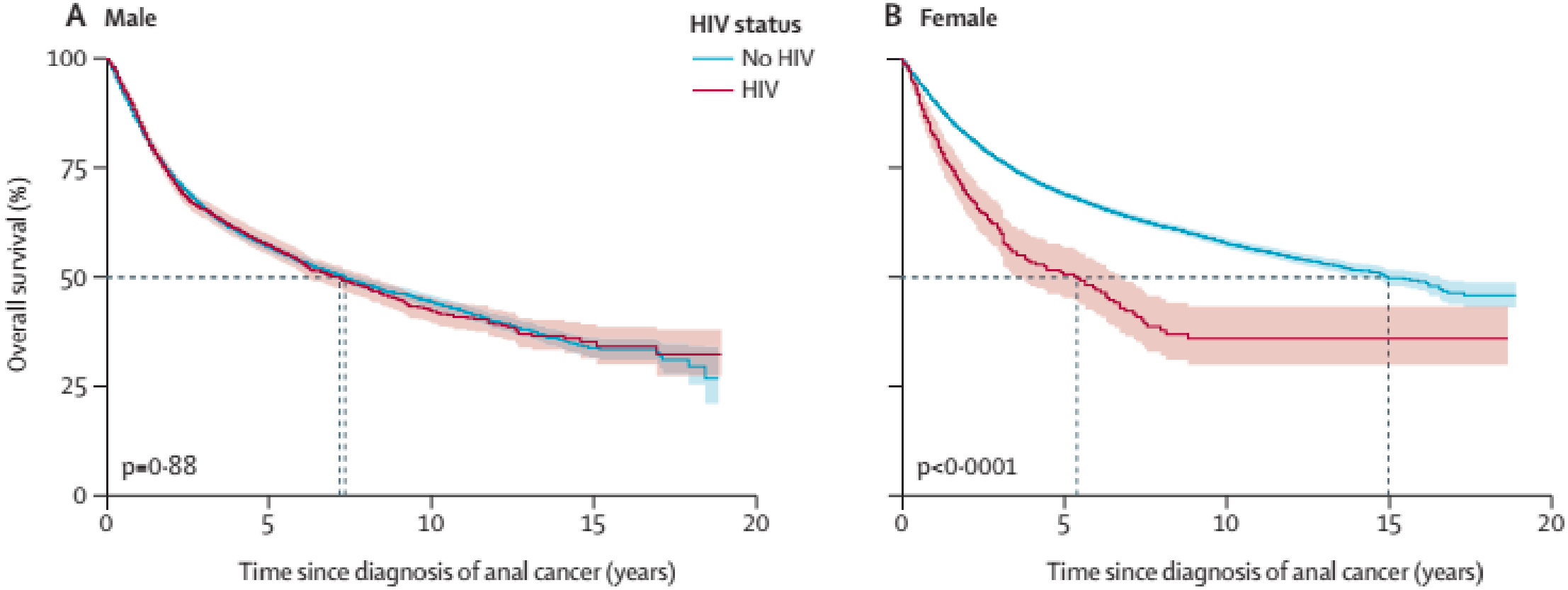
Survival by sex and HIV status in patients with anal cancer in the USA between 2001 and 2019: a retrospective cohort study

Jaimie Z Shing, Eric A Engels, April A Austin, Megan A Clarke, Jennifer H Hayes, Aimée R Kreimer, Analise Monterosso, Marie-Josèphe Horner, Karen S Pawlish, Qianlai Luo, Elizabeth R Zhang, Aimee J Koestler, Ruth M Pfeiffer, Meredith S Shiels

Lancet HIV 2024; 11: e31–41

2662 PVVIH avec cancer anal (43,6% décès) comparées à 21 824 personnes non infectées par le VIH (35,4% décès)

MORTALITE GLOBALE



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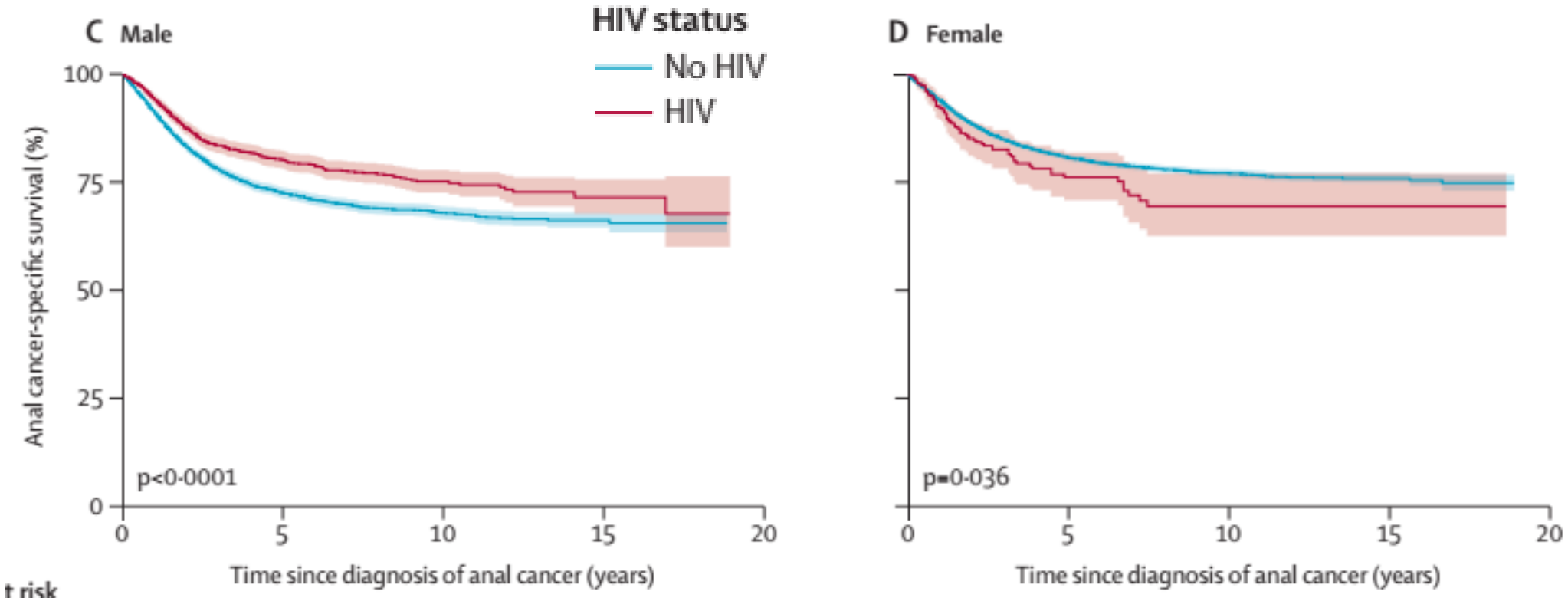
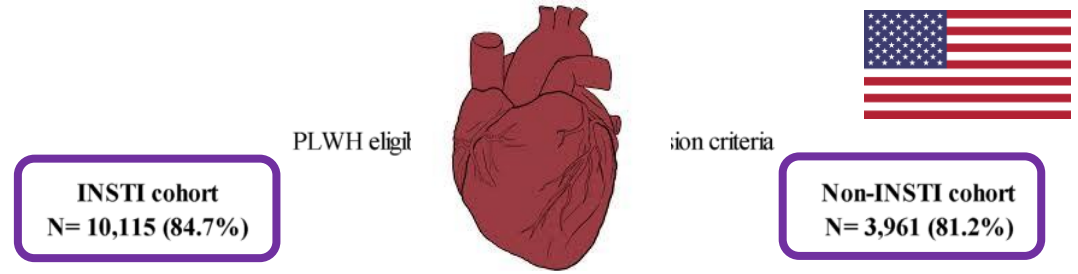
MORTALITE LIEE AU CANCER ANAL



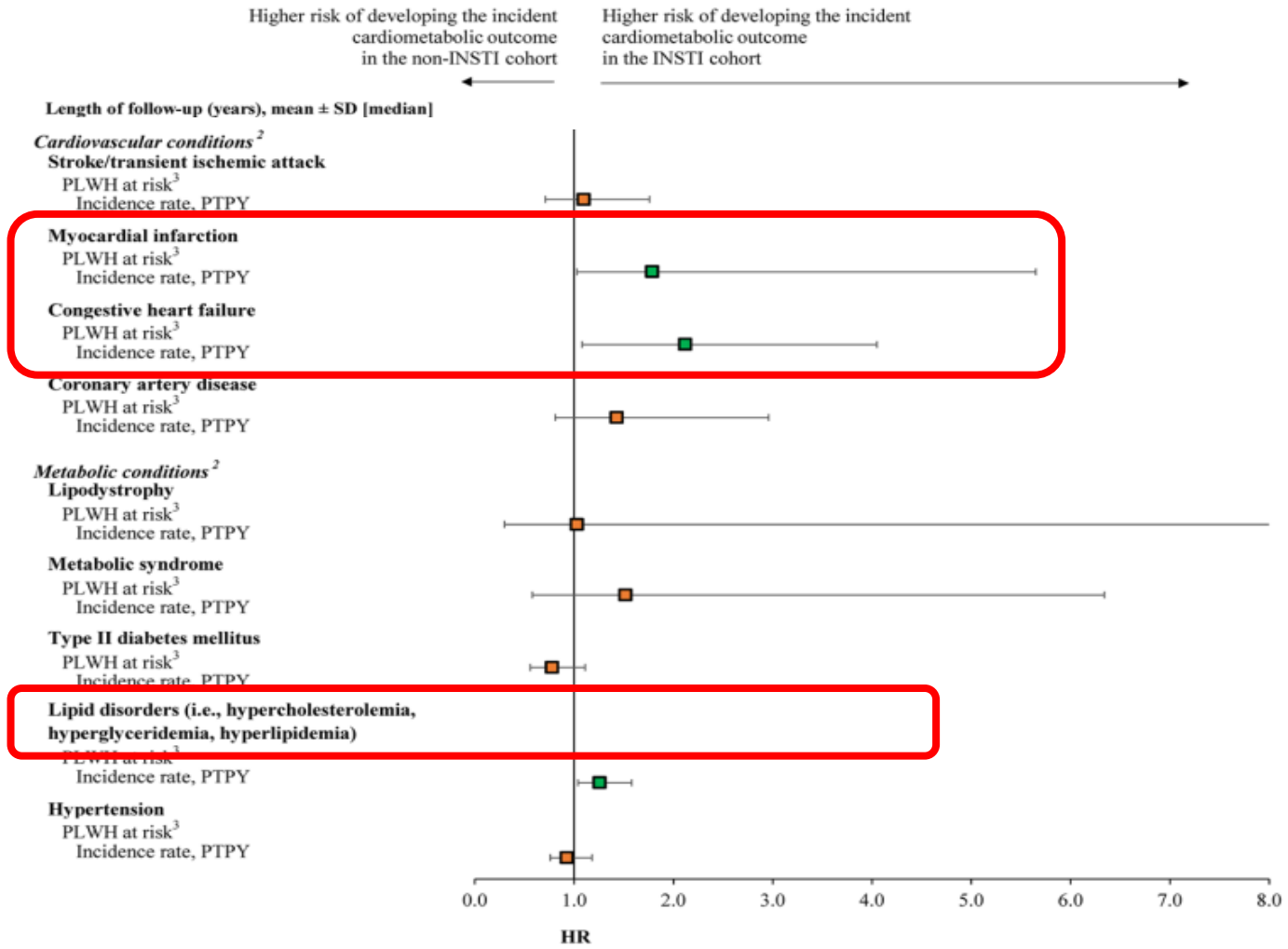
RESEARCH ARTICLE

Incidence of cardiometabolic outcomes among people living with HIV-1 initiated on integrase strand transfer inhibitor versus non-integrase strand transfer inhibitor antiretroviral therapies: a retrospective analysis of insurance claims in the United States

Peter F. Rebeiro[1], Bruno Emond[2,§], Carmine Rossi[2], Brahim K. Bookhart[3], Aditi Shah[2], Gabrielle Caron-Lapointe[2], Marie-Hélène Lafeuille[2] and Prina Donga[3]

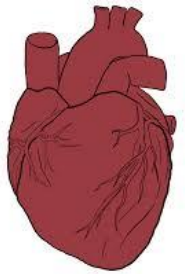


Rebeiro PF et al. *Journal of the International AIDS Society* 2023, **26**:e26123



	Weighted population		Doubly robust weighted HR (bootstrapped 95% CI)[1]	Bootstrapped p-value
	INSTI cohort	Non-INSTI cohort		
Length of follow-up (years), mean ± SD [median]	1.5 ± 1.5 [1.0]	1.1 ± 1.2 [0.7]		
Cardiovascular conditions[2]				
Stroke/transient ischemic attack				
PLWH at risk[3]	N=6,796	N=6,738		
Incidence rate, PTPY	9.18	9.44	1.10 (0.71, 1.76)	0.620
Myocardial infarction				
PLWH at risk[3]	N=5,951	N=5,859		
Incidence rate, PTPY	3.68	2.13	**1.79 (1.03, 5.65)**	**0.036***
Congestive heart failure				
PLWH at risk[3]	N=5,853	N=5,785		
Incidence rate, PTPY	4.81	2.78	**2.12 (1.08, 4.05)**	**0.036***
Coronary artery disease				
PLWH at risk[3]	N=5,656	N=5,598		
Incidence rate, PTPY	4.10	3.35	1.43 (0.81, 2.96)	0.232
Metabolic conditions[2]				
Lipodystrophy				
PLWH at risk[3]	N=7,046	N=7,000		
Incidence rate, PTPY	0.90	0.81	1.03 (0.30, 12.52)	0.960
Metabolic syndrome				
PLWH at risk[3]	N=7,041	N=6,996		
Incidence rate, PTPY	0.85	0.84	1.52 (0.58, 6.34)	0.360
Type II diabetes mellitus				
PLWH at risk[3]	N=6,464	N=6,444		
Incidence rate, PTPY	14.91	17.28	0.78 (0.56, 1.11)	0.168
Lipid disorders (i.e., hypercholesterolemia, hyperglyceridemia, hyperlipidemia)				
PLWH at risk[3]	N=5,728	N=5,543		
Incidence rate, PTPY	64.66	54.66	**1.26 (1.04, 1.58)**	**0.020***
Hypertension				
PLWH at risk[3]	N=5,083	N=4,967		
Incidence rate, PTPY	51.23	58.38	0.93 (0.76, 1.18)	0.532

Integrase strand-transfer inhibitor use and cardiovascular events in adults with HIV: an emulation of target trials in the HIV-CAUSAL Collaboration and the Antiretroviral Therapy Cohort Collaboration



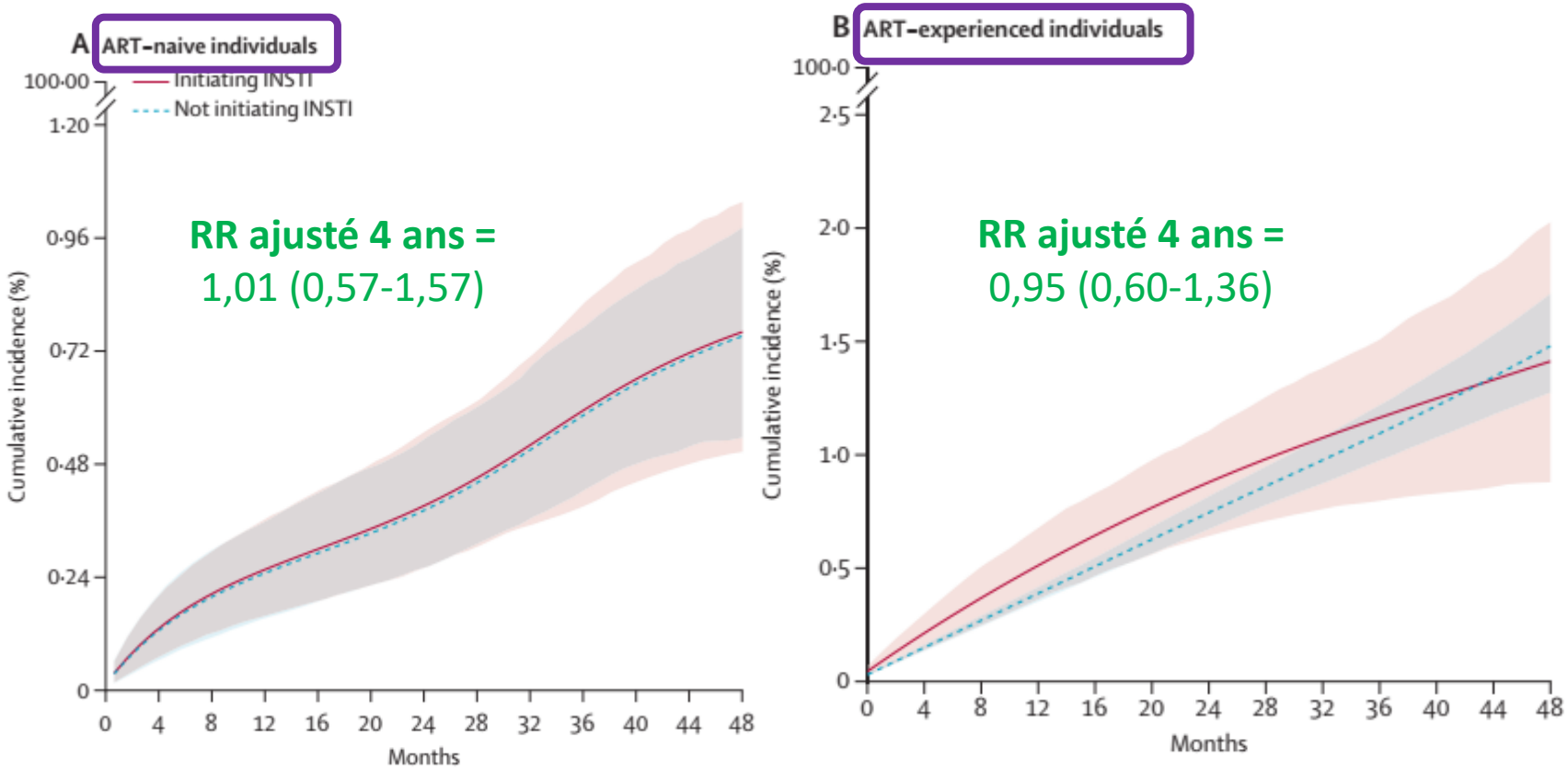
Sophia M Rein, Sara Lodi, Roger W Logan, Giota Touloumi, Anastasia Antoniadou, Linda Wittkop, Fabrice Bonnet, Ard van Sighem, Marc van der Valk, Peter Reiss, Marina B Klein, James Young, Inmaculada Jarrin, Antonella d'Arminio Monforte, Alessandro Tavelli, Laurence Meyer, Laurent Tran, Michael J Gill, Raynell Lang, Bernard Surial, Andreas D Haas, Amy C Justice, Christopher T Rentsch, Andrew Phillips, Caroline A Sabin, Jose M Miro, Adam Trickey, Suzanne M Ingle, Jonathan A C Sterne, Miguel A Hernán, on behalf of the Antiretroviral Therapy Cohort Collaboration and the HIV-CAUSAL Collaboration

Lancet HIV 2023; 10: e723–32

2013 - 2023

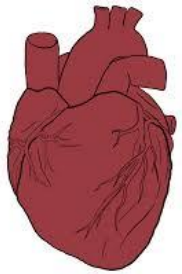
Naifs =
10767 sous INSTI /
8292 sous autres

Prétraités =
7875 sous INSTI /
67411 sous autres



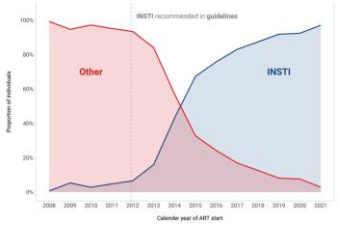
Estimated cumulative incidence of cardiovascular events

Impact of Integrase Inhibitors on Cardiovascular Disease Events in People With Human Immunodeficiency Virus Starting Antiretroviral Therapy

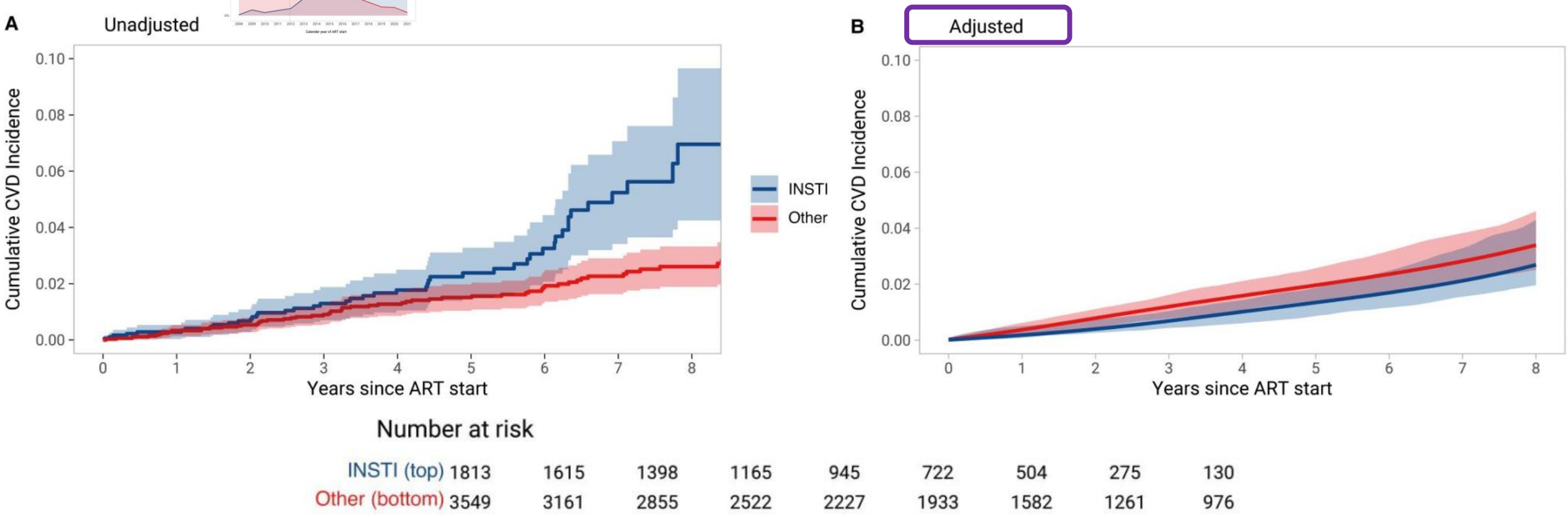


Bernard Surial,[1,a] Frédérique Chammartin,[2] José Damas,[3] Alexandra Calmy,[4] David Haerry,[5] Marcel Stöckle,[6] Patrick Schmid,[7] Enos Bernasconi,[8] Christoph A. Fux,[9] Philip E. Tarr,[10] Huldrych F. Günthard,[11,12] Gilles Wandeler,[1,a] Andri Rauch,[1,a] and the Swiss HIV Cohort Study

Clinical Infectious Diseases® 2023;77(5):729–37

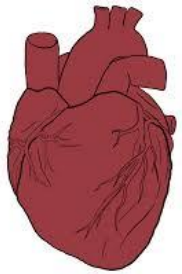


5362 participants naïfs de traitement ARV = 1837 INSTI/ 3525 autres



The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 AUGUST 24, 2023 VOL. 389 NO. 8



Pitavastatin to Prevent Cardiovascular Disease in HIV Infection

Steven K. Grinspoon, M.D., Kathleen V. Fitch, M.S.N., Markella V. Zanni, M.D., Carl J. Fichtenbaum, M.D.,

- Essai randomisé vs placebo phase 3
- 7769 participants 40-75 ans à risque faible à modéré CV (score AHA)
- 4mg pitavastatine ou placebo
- CDJP = évènement cardiovasculaire majeur (**MACE** = décès cause inconnue ou CV, infartcus, angine de poitrine instable, AVC, AIT, ischémie artérielle périphérique)

Table 1. Characteristics of the Participants at Baseline.*

Characteristic	Pitavastatin (N=3888)	Placebo (N=3881)	Total (N=7769)
Age			
Median (IQR) — yr	50 (45–55)	50 (45–55)	50 (45–55)
Range — yr	40 to 72	40 to 74	40 to 74
Sex — no. (%)†			
Male	2677 (68.9)	2673 (68.9)	5350 (68.9)
Female	1211 (31.1)	1208 (31.1)	2419 (31.1)
CD4 count — no. (%)†			
≤500 cells/per mm^3	1257 (32.3)	1253 (32.3)	2510 (32.3)
>500 cells/per mm^3	2631 (67.7)	2628 (67.7)	5259 (67.7)
HIV-1 RNA — no./total no. (%)‖			
<LLOQ copies/ml	2641/3009 (87.8)	2609/2988 (87.3)	5250/5997 (87.5)
LLOQ to <400 copies/ml	305/3009 (10.1)	312/2988 (10.4)	617/5997 (10.3)
≥400 copies/ml	63/3009 (2.1)	67/2988 (2.2)	130/5997 (2.2)

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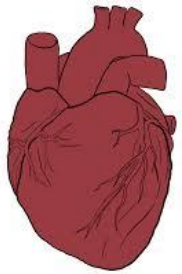

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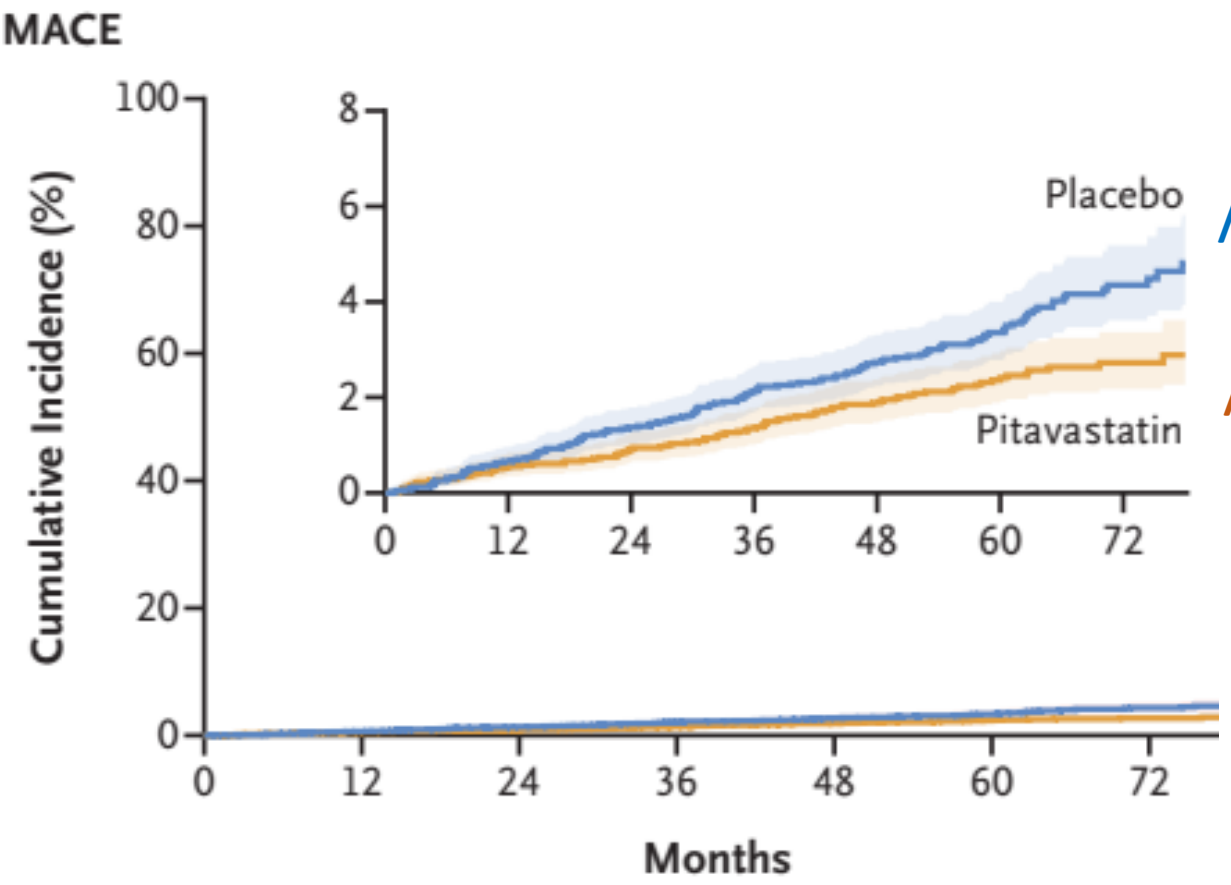
ARRET PREMATURE PAR DSMB



7,32 /1000 p-a

-35%

4,81 /1000 p-a

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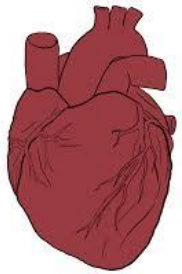

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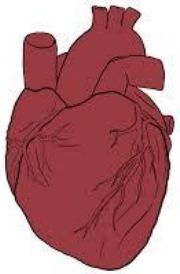
Subgroup	Pitavastatin	Placebo	Pitavastatin	Placebo	Hazard Ratio (95% CI)
	no. of participants		*no./1000 person-yr (no. of events)*		
Overall	3888	3881	4.81 (89)	7.32 (136)	0.65 (0.48–0.90)
ASCVD risk score					
0 to <2.5%	1096	1060	1.6 (9)	3.1 (17)	0.51 (0.23–1.16)
2.5 to <5%	1030	1025	5.3 (27)	4.1 (21)	1.30 (0.73–2.30)
5 to 10%	1474	1521	5.5 (36)	11.5 (78)	0.48 (0.32–0.71)
>10%	288	275	13.9 (17)	17.5 (20)	0.79 (0.41–1.50)
Smoking status					
Current smoker	920	1014	9.0 (36)	12.0 (54)	0.75 (0.49–1.14)
Former or never	2965	2862	3.7 (53)	5.8 (82)	0.62 (0.44–0.88)
Hypertension					
No	2496	2499	3.0 (36)	6.4 (77)	0.47 (0.31–0.69)
Yes	1392	1382	8.3 (53)	9.1 (59)	0.91 (0.63–1.31)
LDL cholesterol at screening					
<130 mg/dl	2973	3044	4.8 (68)	7.4 (107)	0.64 (0.48–0.87)
≥130 mg/dl	915	837	4.9 (21)	7.2 (29)	0.69 (0.39–1.21)
CD4 count (cells/mm^3)					
≤500	1257	1253	4.7 (28)	6.9 (41)	0.67 (0.42–1.09)
>500	2631	2628	4.9 (61)	7.5 (95)	0.65 (0.47–0.89)

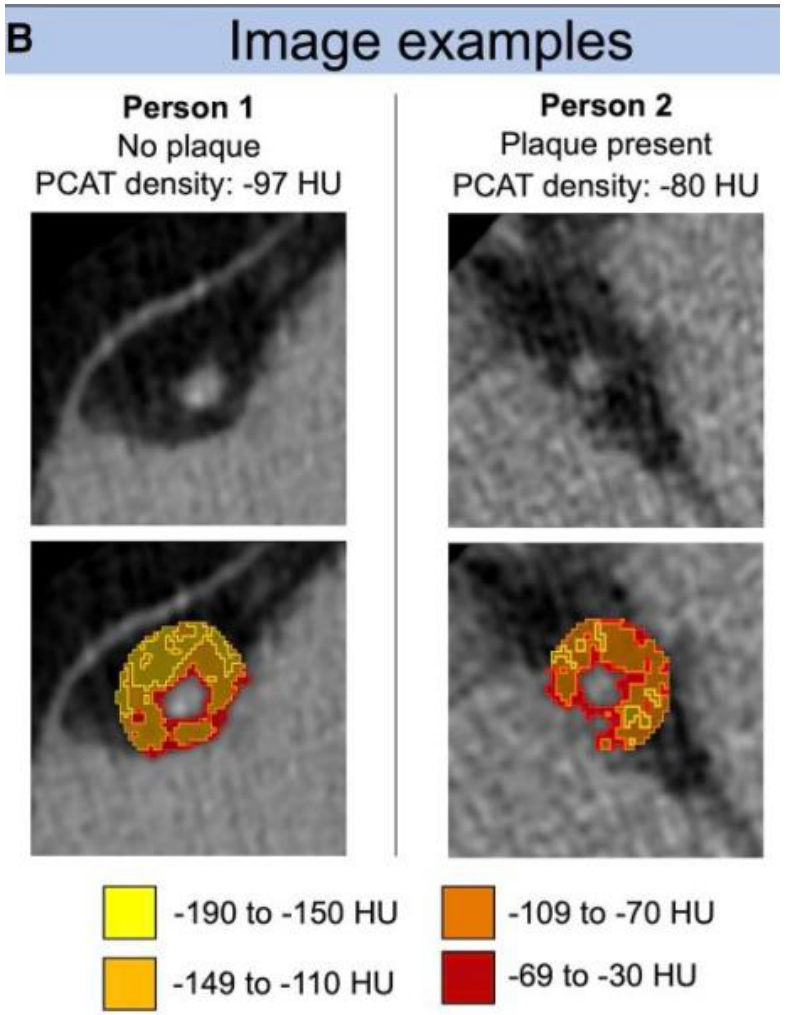
Pericoronary Adipose Tissue Density, Inflammation, and Subclinical Coronary Artery Disease Among People With HIV in the REPRIEVE Cohort

Borek Foldyna,[1] Thomas Mayrhofer,[1,2] Markella V. Zanni,[3] Asya Lyass,[4] Radhika Barve,[1] Julia Karady,[1] Sara McCallum,[3] Tricia H. Burdo,[5] Kathleen V. Fitch,[3] Kayla Paradis,[1] Evelynne S. Fulda,[3] Marissa R. Diggs,[3] Gerald S. Bloomfield,[6] Carlos D. Malvestutto,[7] Carl J. Fichtenbaum,[8] Judith A. Aberg,[9] Judith S. Currier,[10] Heather J. Ribaudo,[11] Udo Hoffmann,[12] Michael T. Lu,[1] Pamela S. Douglas,[13] and Steven K. Grinspoon[3]



Clinical Infectious Diseases® 2023;77(12):1676–86

Sous étude 727 participants REPRIEVE



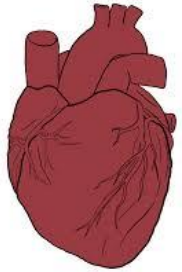
Importance du tissu adipeux péricoronarien =

- corrélé significativement avec plaques coronariennes, calcifiées ou non, après ajustement sur tous les FDR « habituels »
- plus importante qu'une cohorte comparative de personnes non infectées par le VIH (Framingham)

Clinical Infectious Diseases
MAJOR ARTICLE

Randomized Placebo-Controlled Trial to Evaluate Effects of Eplerenone on Myocardial Perfusion and Function Among Persons With Human Immunodeficiency Virus (HIV)—Results From the MIRACLE HIV Study

Suman Srinivasa,[1,©] Allie R. Walpert,[1] Teressa S. Thomas,[1] Daniel M. Huck,[2] Michael Jerosch-Herold,[3] Sabeeh Islam,[3] Michael T. Lu,[4] Tricia H. Burdo,[5] Christopher R. deFilippi,[6] Carolyn N. Dunderdale,[1] Meghan Feldpausch,[1] Sanjna Iyengar,[1] Grace Shen,[1] Stephen Baak,[5] Martin Torriani,[7] Gregory K. Robbins,[8] Hang Lee,[9] Raymond Kwong,[3,©] Marcelo DiCarli,[2] Gail K. Adler,[10] and Steven K. Grinspoon[1]



Clinical Infectious Diseases 2023;77(8):1166–75

- Dysfonction microvasculaire ➔ diminution perfusion myocardique, même si pas de coronaropathie et/ou de maladie cardiovasculaire symptomatique
- Peut être évaluée par la réserve coronarienne (CFR par TEP), ou par perfusion myocardique de stress (sMBF par IRM)
- Dans population générale = altération CFR = 5 fois plus de mortalité cardiovasculaire, facteur prédictif indépendant de la présence d'une coronaropathie obstructive
- Hypothèse = système RA est le médiateur physiopathologique / le bloquer = bénéfice?

➔ **MIRACLE HIV (MIneralocorticoid Receptor Antagonism for CardiovascuLar hEalth in HIV) study**

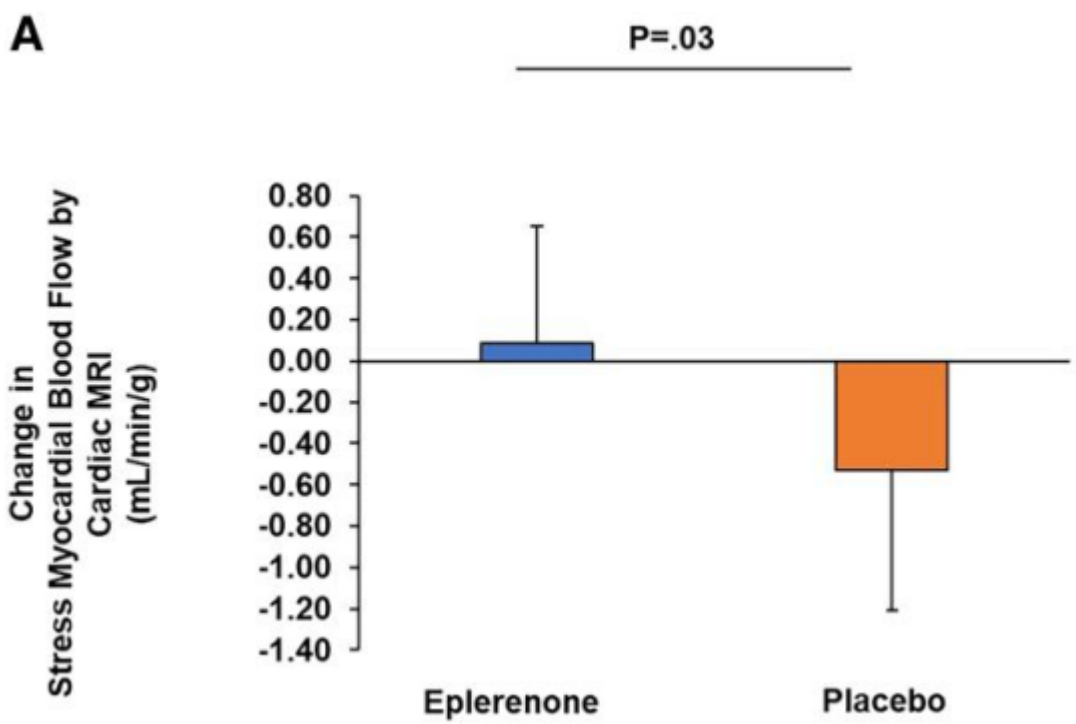
- Essai randomisé contre placebo 20/20 patients VIH+ contrôlés virologiquement sans maladie cardiovasculaire connue, avec scores de risque CV à 10 ans équivalents
- Eplerenone 50 mgx2/j vs placebo pendant 12 mois

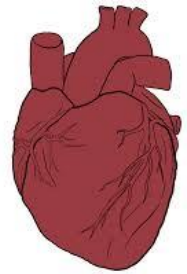
Clinical Infectious Diseases

MAJOR ARTICLE

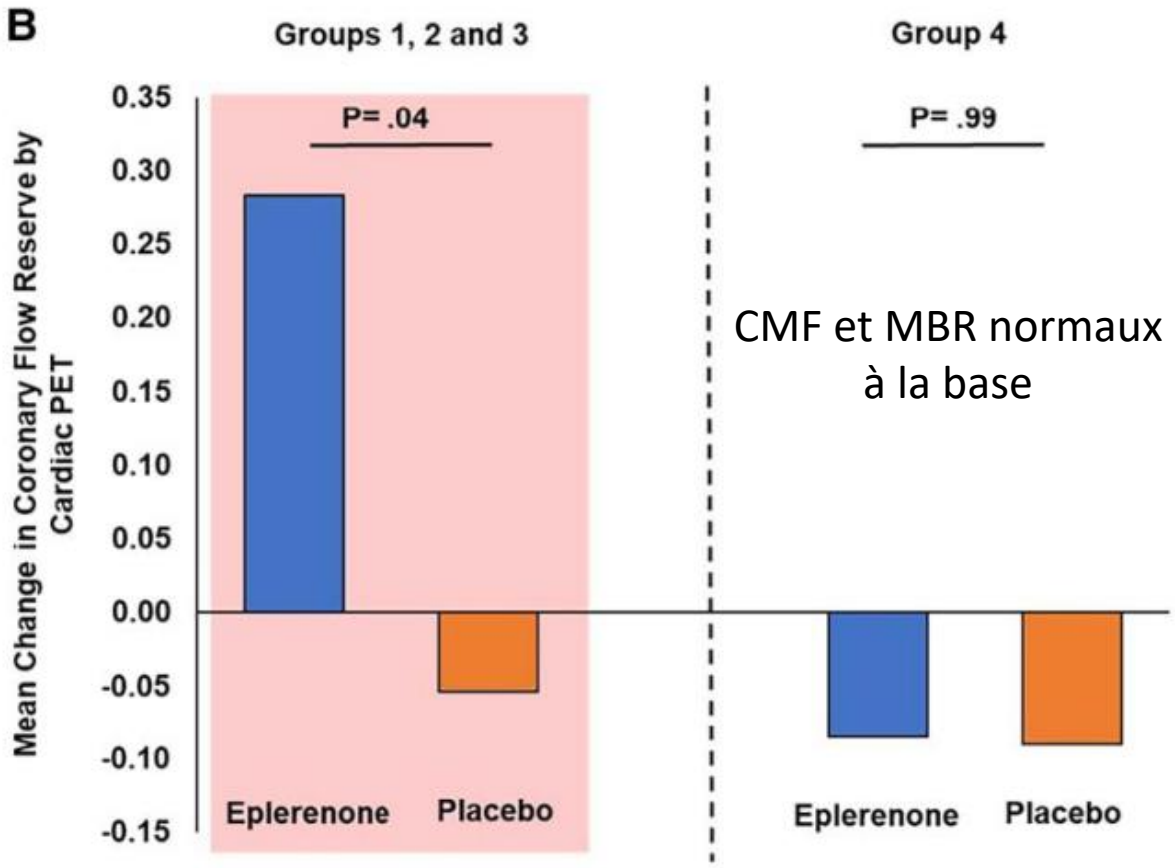
Randomized Placebo-Controlled Trial to Evaluate Effects of Eplerenone on Myocardial Perfusion and Function Among Persons With Human Immunodeficiency Virus (HIV)—Results From the MIRACLE HIV Study

Suman Srinivasa,[1,©] Allie R. Walpert,[1] Teressa S. Thomas,[1] Daniel M. Huck,[2] Michael Jerosch-Herold,[3] Sabeeh Islam,[3] Michael T. Lu,[4] Tricia H. Burdo,[5] Christopher R. deFilippi,[6] Carolyn N. Dunderdale,[1] Meghan Feldpausch,[1] Sanjna Iyengar,[1] Grace Shen,[1] Stephen Baak,[5] Martin Torriani,[7] Gregory K. Robbins,[8] Hang Lee,[9] Raymond Kwong,[3,©] Marcelo DiCarli,[2] Gail K. Adler,[10] and Steven K. Grinspoon[1]





Clinical Infectious Diseases 2023;77(8):1166–75



CMF et MBR normaux à la base

Association of HIV Infection and Incident Abdominal Aortic Aneurysm Among 143 001 Veterans

Alexandra M. Filipkowski, BS; Suman Kundu, DSc, MSc; Svetlana K. Eden, PhD; Charles W. Alcorn, MA; Amy C. Justice, MD, PhD; Kaku A. So-Armah, PhD; Hilary A. Tindle, MD, MPH; Quinn S. Wells, MD, PharmD, MSCI, MSc; Joshua A. Beckman, MD, MSc; Matthew S. Freiberg, MD, MSc; Aaron W. Aday, MD, MSc

Circulation. 2023;148:135–143.

>143.000 personnes suivies prospectivement

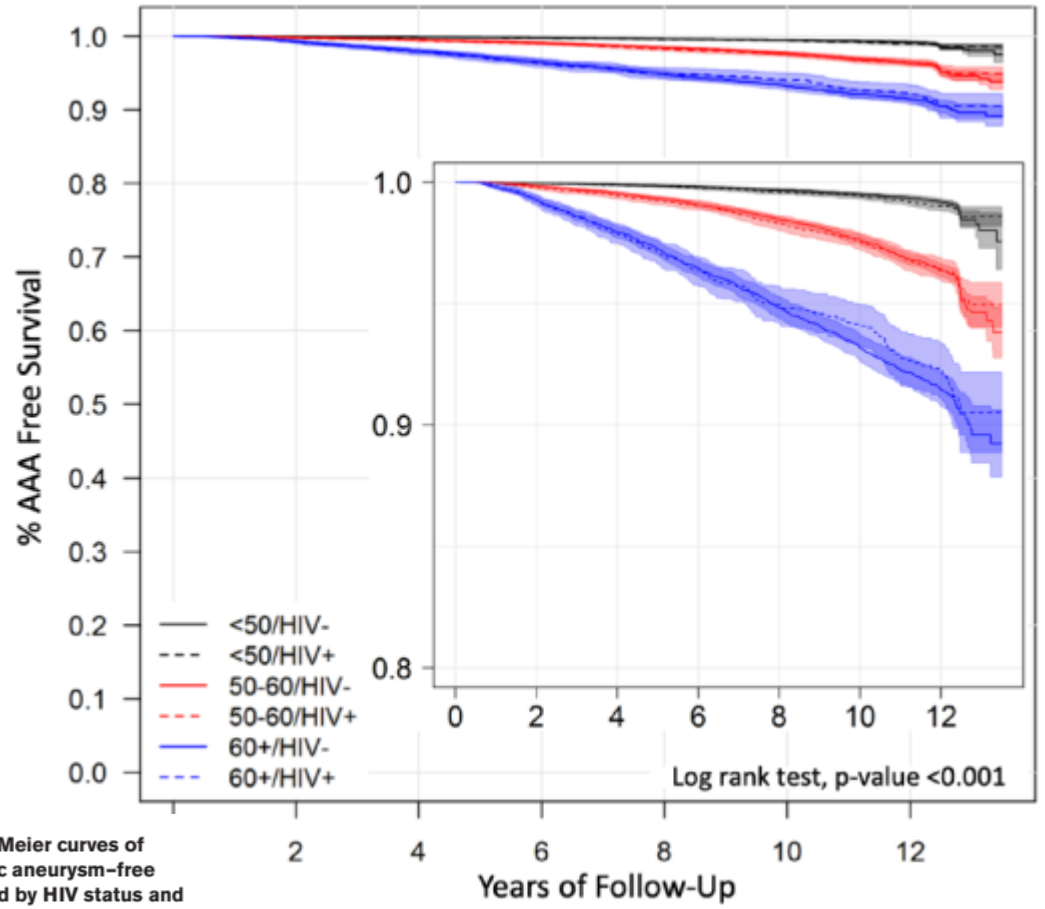


Figure. Kaplan-Meier curves of abdominal aortic aneurysm–free survival stratified by HIV status and age.

Stratification	AAA events/N*	Time-updated fully adjusted AAA risk (95% CI)‡
People without HIV	1790/99 235	1.00
PWH, CD4+ ≥ 500 cells/mm³	178/12 539	0.92 (0.81–1.05)
PWH, 200 ≤ CD4+ < 500 cells/mm³	214/14 725	1.07 (0.93–1.24)
PWH, CD4+ < 200 cells/mm³	103/8360	1.29 (1.02–1.65)
Stratified by HIV status and viral load		
People without HIV	1790/99 235	1.00
PWH, VL < 500 copies/mL	274/16 385	0.95 (0.85–1.07)
PWH, VL ≥ 500 copies/mL	224/19 202	1.29 (1.09–1.52)

Contribution of Low CD4 Cell Counts and High Human Immunodeficiency Virus (HIV) Viral Load to the Efficacy of Preferred First-Line Antiretroviral Regimens for Treating HIV Infection: A Systematic Review and Meta-Analysis

Clinical Infectious Diseases® 2023;76(11):2027–37

Jose A. Perez-Molina,[1,2,3] Clara Crespillo-Andújar,[1,2,3] Javier Zamora,[2,4,5,6] Borja M. Fernández-Félix,[2,4,5] Andrea Gaetano-Gil,[2,4,5] Juan C. López-Bernaldo de Quirós,[3,7,8] Sergio Serrano-Villar,[1,2,3] Santiago Moreno,[1,2,3] Noelia Álvarez-Díaz,[9] and Juan Berenguer[3,7,8]

Late initiation of ART has detrimental effects on the prognosis and survival of PLHIV. How does low CD4 cell count or high HIV viral load impair ART response?

Sistematic review and meta-analysis

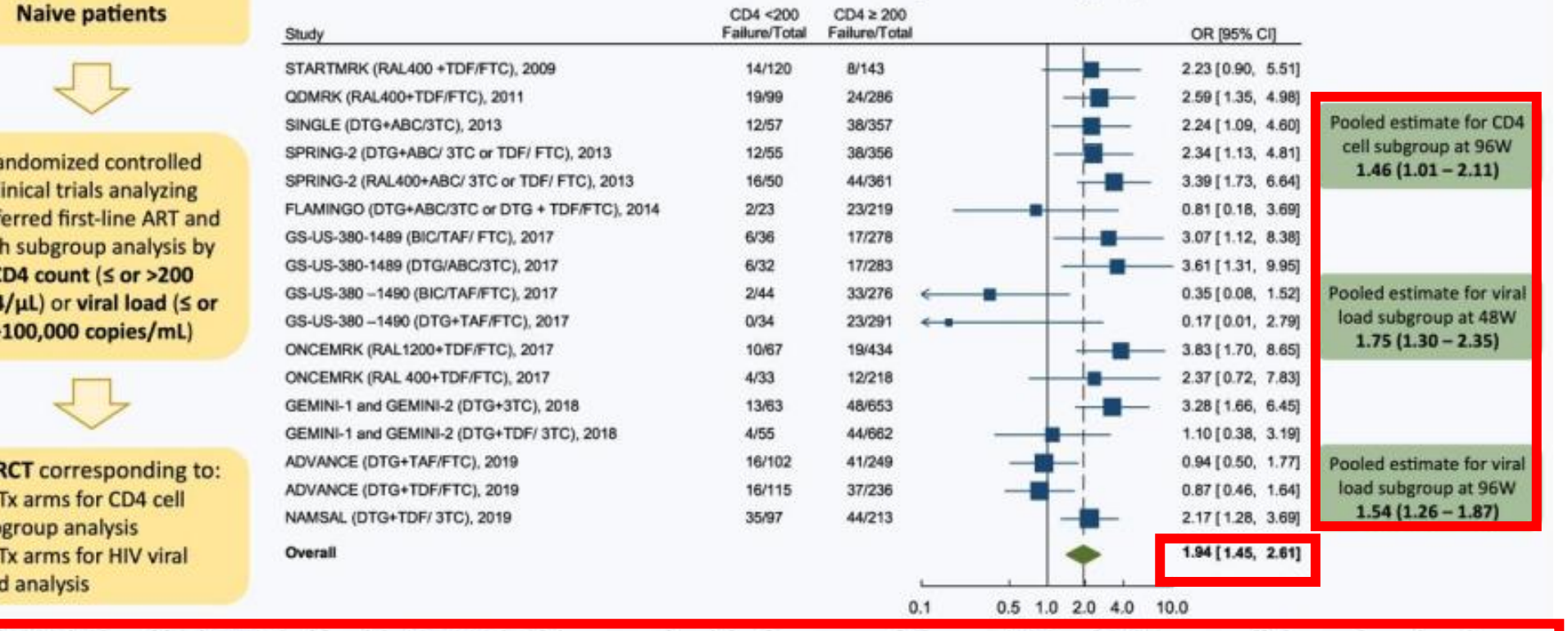
Naive patients

Randomized controlled clinical trials analyzing preferred first-line ART and with subgroup analysis by **CD4 count (≤ or >200 CD4/µL)** or **viral load (≤ or >100,000 copies/mL)**

12 RCT corresponding to:
- 17 Tx arms for CD4 cell subgroup analysis
- 21 Tx arms for HIV viral load analysis

We computed the OR of treatment failure (TF) for each subgroup and individual treatment arm

Pooled estimate of antiretroviral treatment failure rate by CD4 cell subgroups at 48 weeks



Pooled estimate for CD4 cell subgroup at 96W **1.46 (1.01 – 2.11)**

Pooled estimate for viral load subgroup at 48W **1.75 (1.30 – 2.35)**

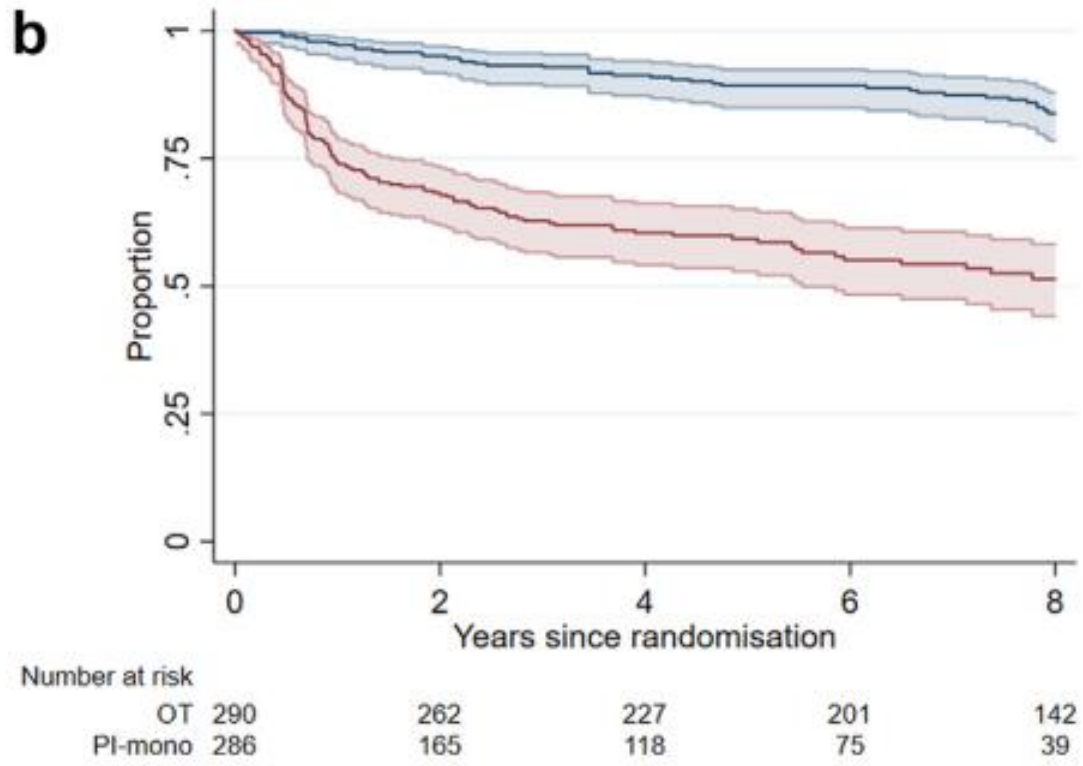
Pooled estimate for viral load subgroup at 96W **1.54 (1.26 – 1.87)**

Low CD4 cells (≤200/µL) and high HIV viral load (>100,000/mL) increase the risk of treatment failure at 48W and 96W across all the preferred regimens

Long-term efficacy and safety of a treatment strategy for HIV infection using protease inhibitor monotherapy: 8-year routine clinical care follow-up from a randomised, controlled, open-label pragmatic trial (PIVOT)

Nicholas I. Paton,[a,b,*] Wolfgang Stöhr,[a] Alejandro Arenas-Pinto,[a] Amanda Clarke,[c] Ian Williams,[d] Margaret Johnson,[e] Chloe Orkin,[f] Fabian Chen,[g] Vincent Lee,[h] Alan Winston,[i] Mark Gompels,[j] Julie Fox,[k] Karen Sanders,[a] and David T. Dunn,[a] for the Protease Inhibitor monotherapy Versus Ongoing Triple therapy (PIVOT) Trial Team[l]

eClinicalMedicine
2024;69: 102457



Kaplan–Meier estimates of the proportion of participants who remained on the treatment allocated by randomization who did not experience viral failure.

Participant	Drugs received during trial before date of resistance test	Reverse Transcriptase mutations	Protease mutations	Lost drug options
OT group				
1	ABC, 3TC, ATV	V118I, V179D, M184V	I84V	3TC, FTC, SQV, FPV, TPV
2	TDF, FTC, RPV, DRV	L100I, K103N, M184V	A71V	3TC, FTC, NVP, EFV, ETV, RPV
3	TDF, FTC, ETV, NVP, EFV	M184V/I, K65R, E138A, Y181C, H221Y, M230L	–	3TC, FTC, ABC, TDF, NVP, EFV, ETV, RPV
4	TDF, FTC, DRV	V106A	–	NVP[b], EFV[b]
5	ZDV, 3TC, TDF, FTC, NVP, DRV	V179D, M184LV	–	3TC
6	DDI, 3TC, ABC, EFV, DRV	K103N	–	NVP, EFV
7	ZDV, TDF, 3TC, FTC, EFV	V106M, Y188HY	–	NVP, EFV, DOR
PI-mono group				
1	ATV	–	K20T, I50L/I, A71T	ATV
2	DRV	–	L90M	SQV[a]
3	DRV	–	A71T, L90M	SQV[a]
4	DRV	K103N	–	NVP[b], EFV[b]
5	DRV	K103N	–	NVP[b], EFV[b]
6	DRV	M41L, T215D	–	ZDV[b]

Years since randomisation	Number (%) with viral load ≥200 copies/ml		P-value
	OT	PI-mono	
1	2/287 (0.7)	16/295 (5.4)	<0.001
2	3/284 (1.1)	6/290 (2.1)	0.51
3	2/293 (0.7)	3/287 (1.1)	1.00
4	3/261 (1.2)	7/250 (2.8)	0.21
5	3/243 (1.2)	8/219 (3.6)	0.13
6	3/230 (1.3)	3/213 (1.4)	1.00
7	1/217 (0.5)	3/206 (1.5)	0.36
8	4/214 (1.9)	1/196 (0.5)	0.37

Table 3: Proportion with HIV-1 RNA non-suppression (≥200 copies/ml) at annual time points from randomisation.

HIV treatment-as-prevention and its effect on incidence of HIV among cisgender gay, bisexual, and other men who have sex with men in Australia: a 10-year longitudinal cohort study

Lancet HIV 2023; 10: e385–93

Denton Callander, Hamish McManus, Richard T Gray, Andrew E Grulich, Andrew Carr, Jennifer Hoy, Basil Donovan, Christopher K Fairley, Martin Holt, David J Templeton, Siaw-Teng Liaw, James H McMahon, Jason Asselin, Kathy Petoumenos, Margaret Hellard, Alisa Pedrana, Julian Elliott, Phillip Keen, Jane Costello, Richard Keane, John Kaldor, Mark Stoové, Rebecca Guy**

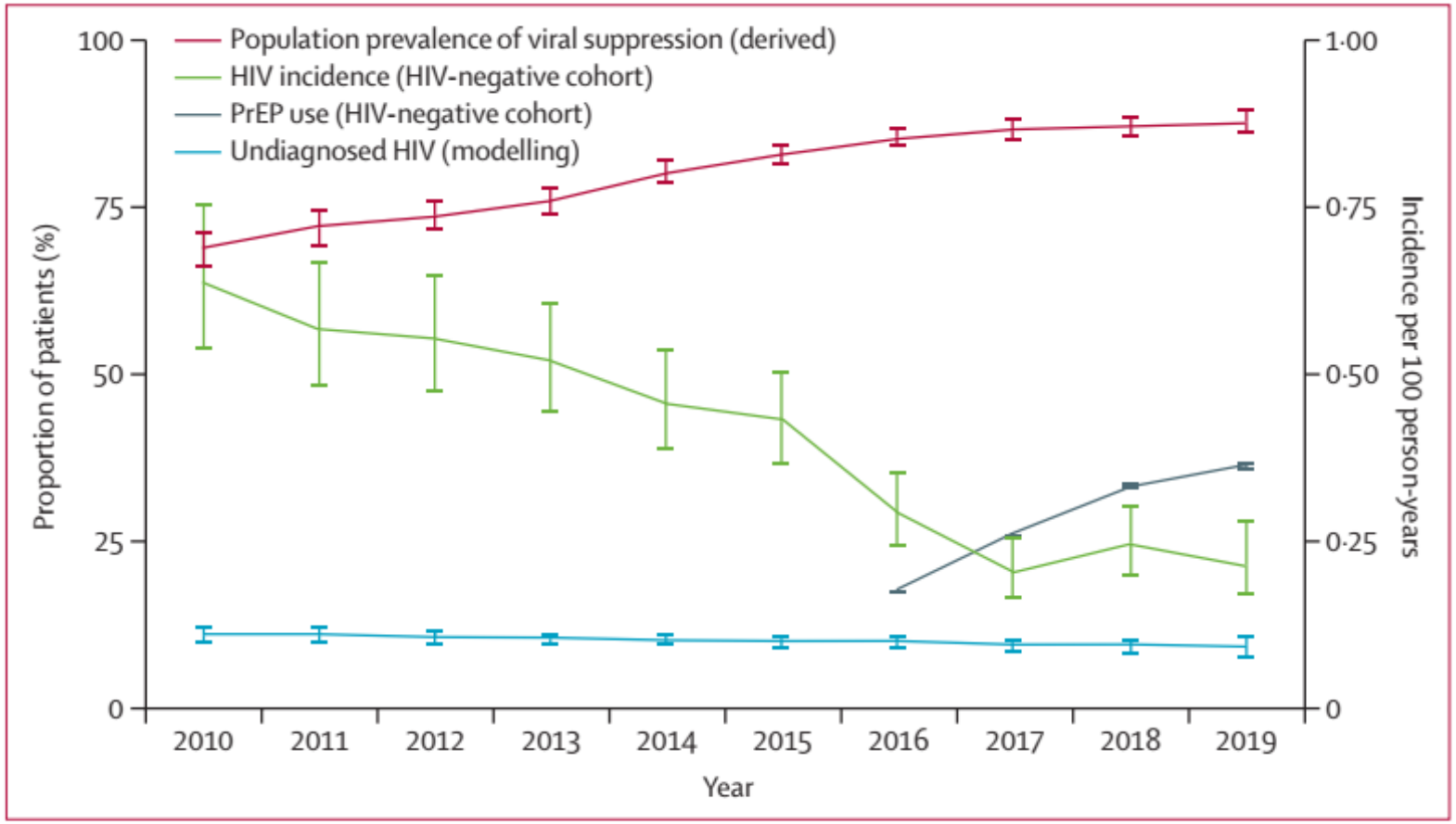
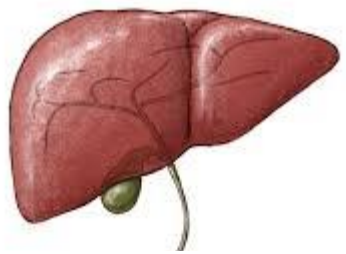


Figure 2: **Population prevalence of viral suppression, HIV incidence, undiagnosed HIV, and PrEP uptake among GBM, by year, 2010–19**

Effect of tenofovir-based HIV pre-exposure prophylaxis against HBV infection in men who have sex with men

Daisuke Mizushima[1] | Misao Takano[1] | Takahiro Aoki[1] | Naokatsu Ando[1] | Haruka Uemura[1] | Yasuaki Yanagawa[1] | Koji Watanabe[1] | Hiroyuki Gatanaga[1,2] | Yoshimi Kikuchi[1] | Shinichi Oka[1,2]



Hepatology. 2023;77:2084–2092

786 HSH suivis de janvier 2018 à juin 2021

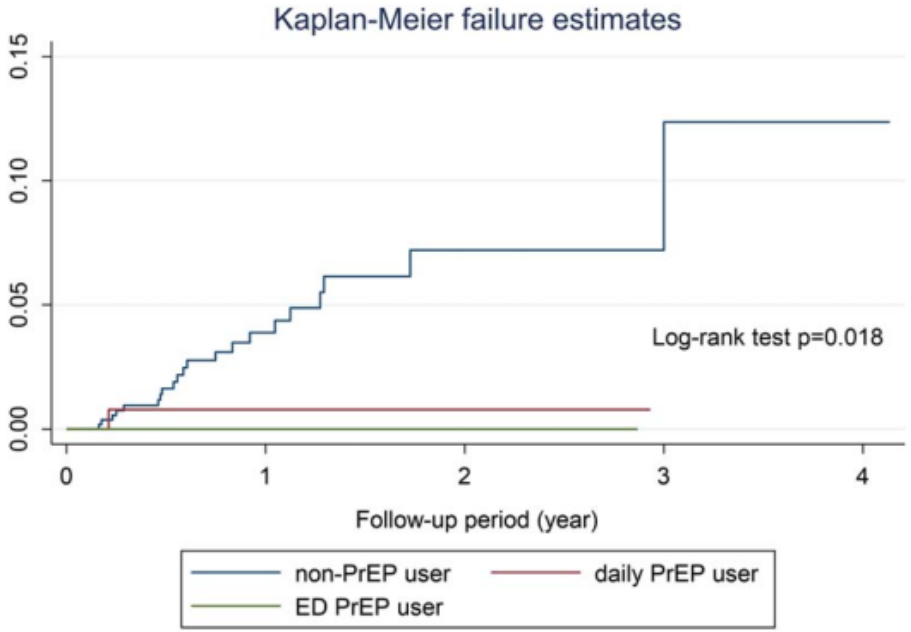


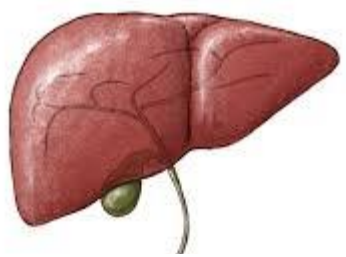
FIGURE 2 Kaplan–Meir curve to estimates incidence of HBV infection among MSM with and without PrEP. Abbreviations: ED, event-driven; MSM, men who have sex with men; PrEP, pre-exposure prophylaxis.

TABLE 2 Factors associated with acute HBV infection in the univariate analyses

	Univariate analysis		
Variables	**HR**	**95% CI**	***p*[a]**
Age, per year increase	0.94	0.883–0.996	0.037
Use of PrEP	0.13	0.017–0.938	0.043
Bacterial STI at enrollment	3.36	1.455–7.758	0.005
No. sexual partners at enrollment	1.01	1.001–1.010	0.011
Average rate of condom use at enrollment	1	0.988–1.015	0.855
Illicit drug abuse ever	0.78	0.183–3.353	0.742

Effect of tenofovir-based HIV pre-exposure prophylaxis against HBV infection in men who have sex with men

Daisuke Mizushima[1] | Misao Takano[1] | Takahiro Aoki[1] | Naokatsu Ando[1] | Haruka Uemura[1] | Yasuaki Yanagawa[1] | Koji Watanabe[1] | Hiroyuki Gatanaga[1,2] | Yoshimi Kikuchi[1] | Shinichi Oka[1,2]



Hepatology. 2023;77:2084–2092

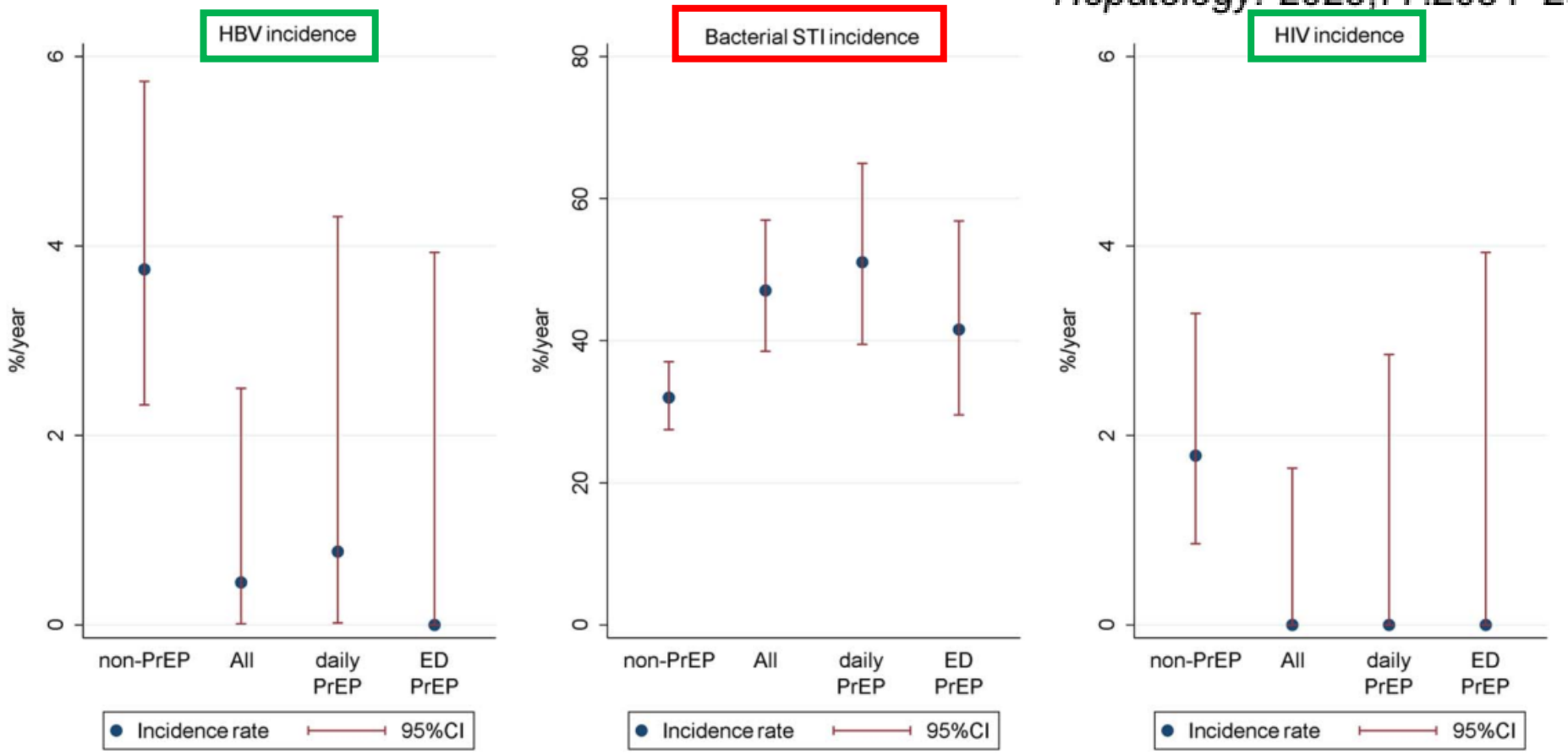
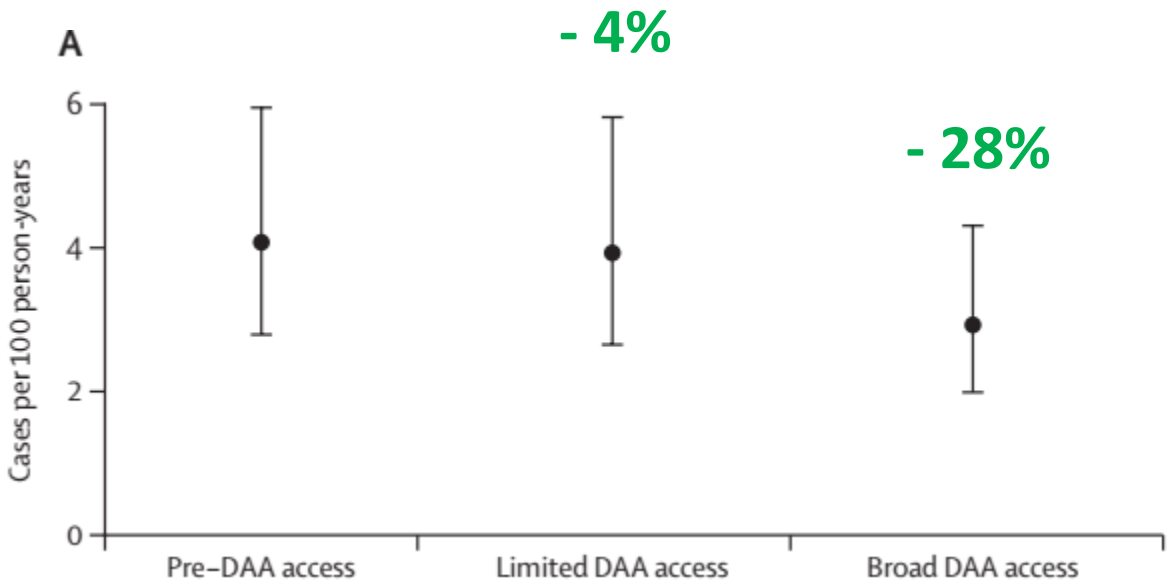


FIGURE 3 Incidence rate of HBV, HIV, and bacterial STIs with and without PrEP use. Abbreviations: PrEP, pre-exposure prophylaxis; STI, sexually transmitted infection.

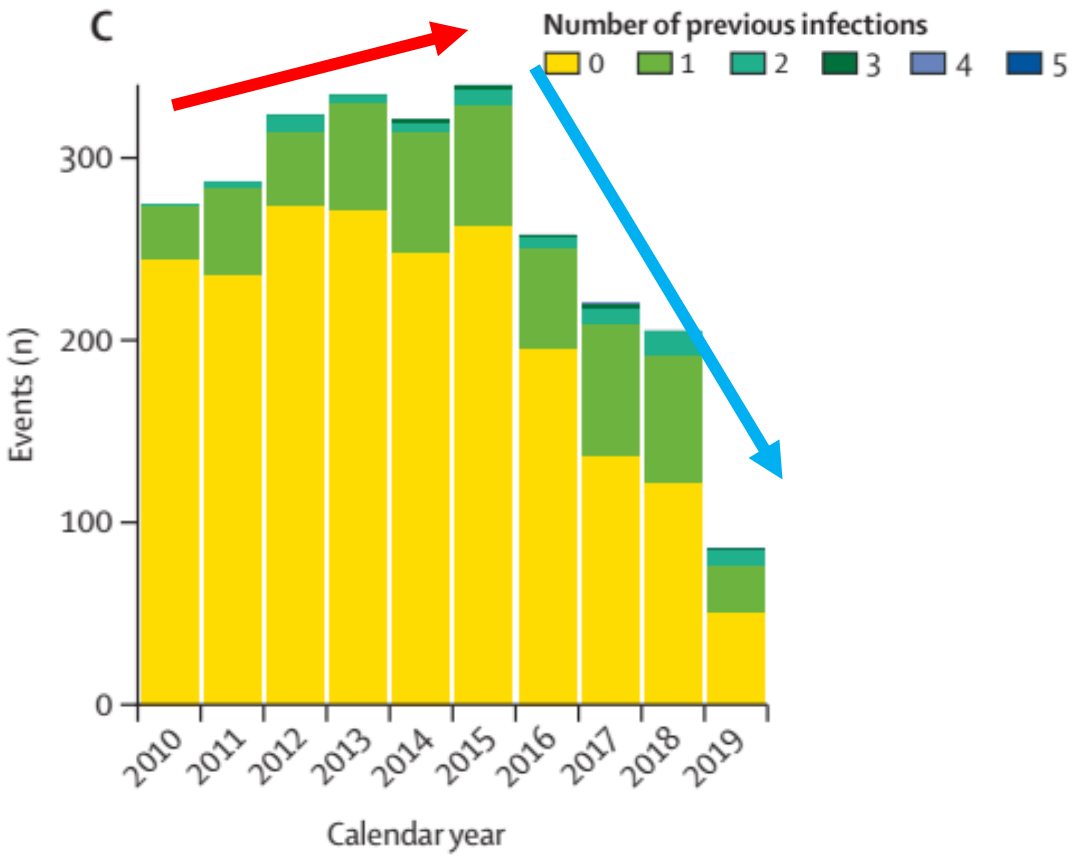
Changes in incidence of hepatitis C virus reinfection and access to direct-acting antiviral therapies in people with HIV from six countries, 2010–19: an analysis of data from a consortium of prospective cohort studies

Rachel Sacks-Davis, Daniela K van Santen*, Anders Boyd, Jim Young, Ashleigh Stewart, Joseph S Doyle, Andri Rauch, Catrina Mugglin, Marina Klein, Marc van der Valk, Colette Smit, Inmaculada Jarrin, Juan Berenguer, Karine Lacombe, Maria-Bernarda Requena, Linda Wittkop, Olivier Leleux, Fabrice Bonnet, Dominique Salmon, Gail V Matthews, Rebecca Guy, Natasha K Martin, Tim Spelman, Maria Prins, Mark Stoove, Margaret Hellard, on behalf of the InCHEHC Collaboration†*



Predicted incidence of first HCV reinfection in 6144 participants of InCHEHC cohorts before and after the introduction of direct-acting antivirals

Lancet HIV 2024

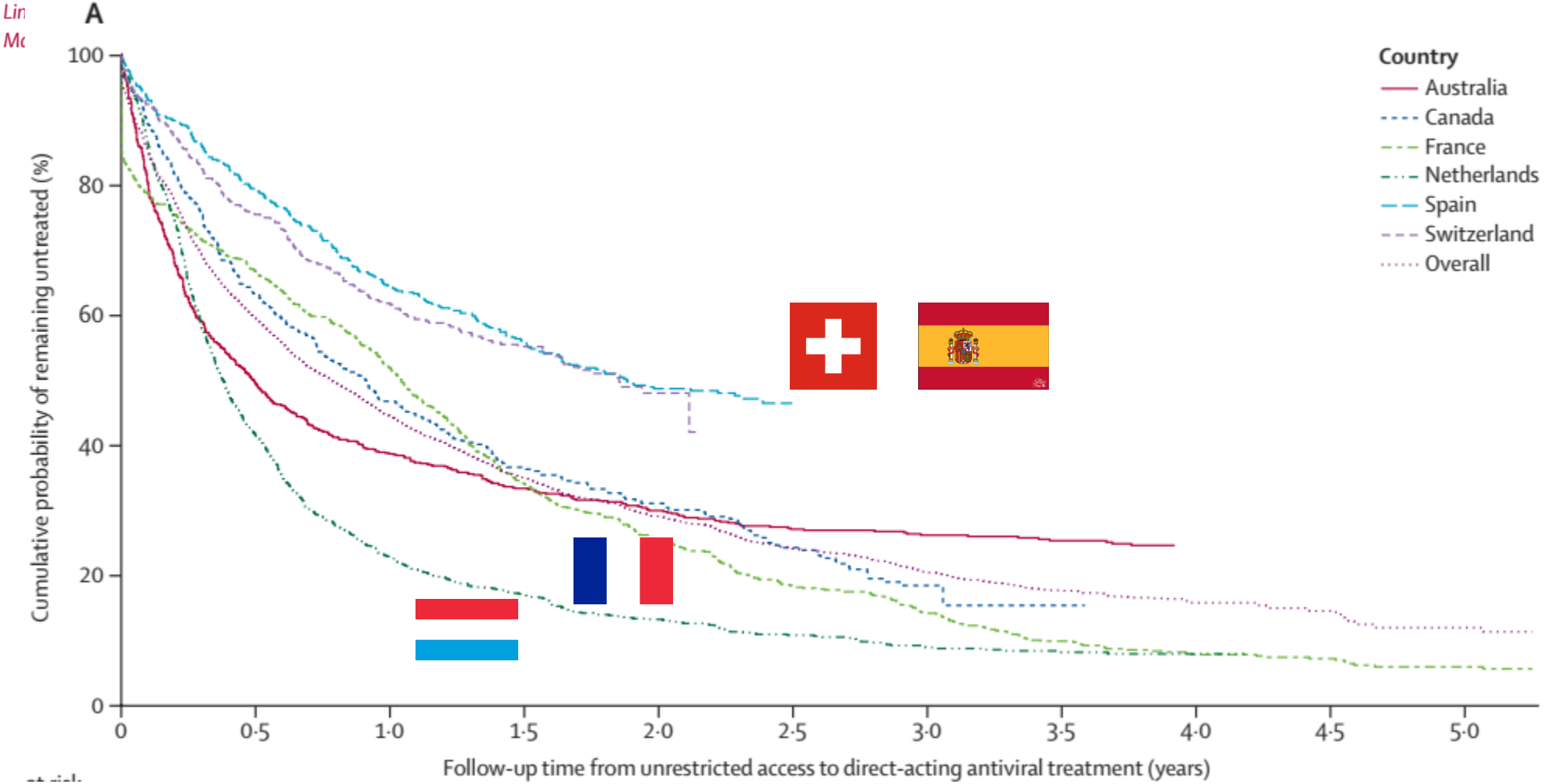


Combined HCV *(infection)* incidence among people with HIV by calendar year

Reasons for not commencing direct-acting antiviral treatment despite unrestricted access for individuals with HIV and hepatitis C virus: a multinational, prospective cohort study

Lancet Public Health 2023; 8: e294–304

Cas J Isfordink, Anders Boyd, Rachel Sacks-Davis, Daniela K van Santen, Colette Smit, Marianne Martinello, Mark Stoove, Juan Berenguer, Lin Mc



- Un tiers des patients non traités
- Par rapport à HSH: femmes+++ et hétérosexuels plus à risque

(+ être « bien » dans une filière de soin)

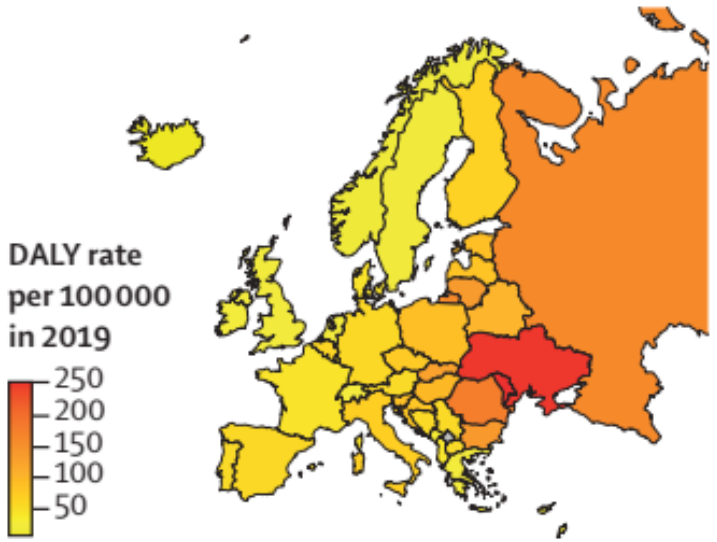
Hepatitis B and C in Europe: an update from the Global Burden of Disease Study 2019

Lancet Public Health 2023; 8: e701–16

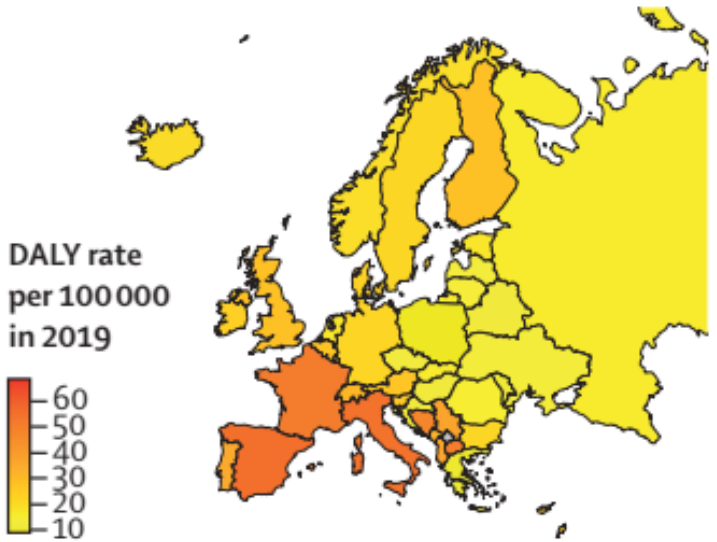
*GBD 2019 Europe Hepatitis B & C Collaborators**

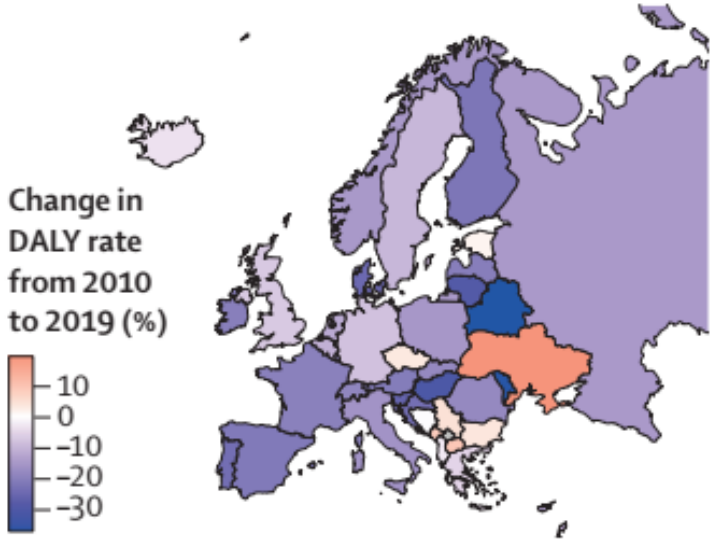
VHC

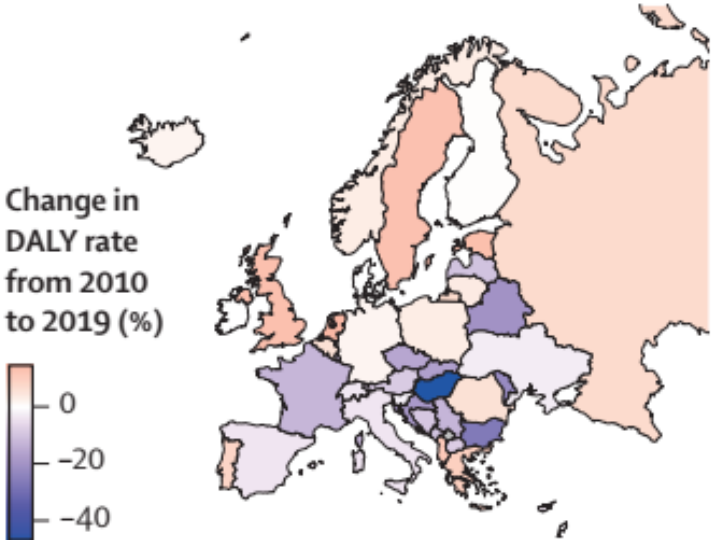
HCV-related cirrhosis and other chronic liver diseases



HCV-related liver cancer





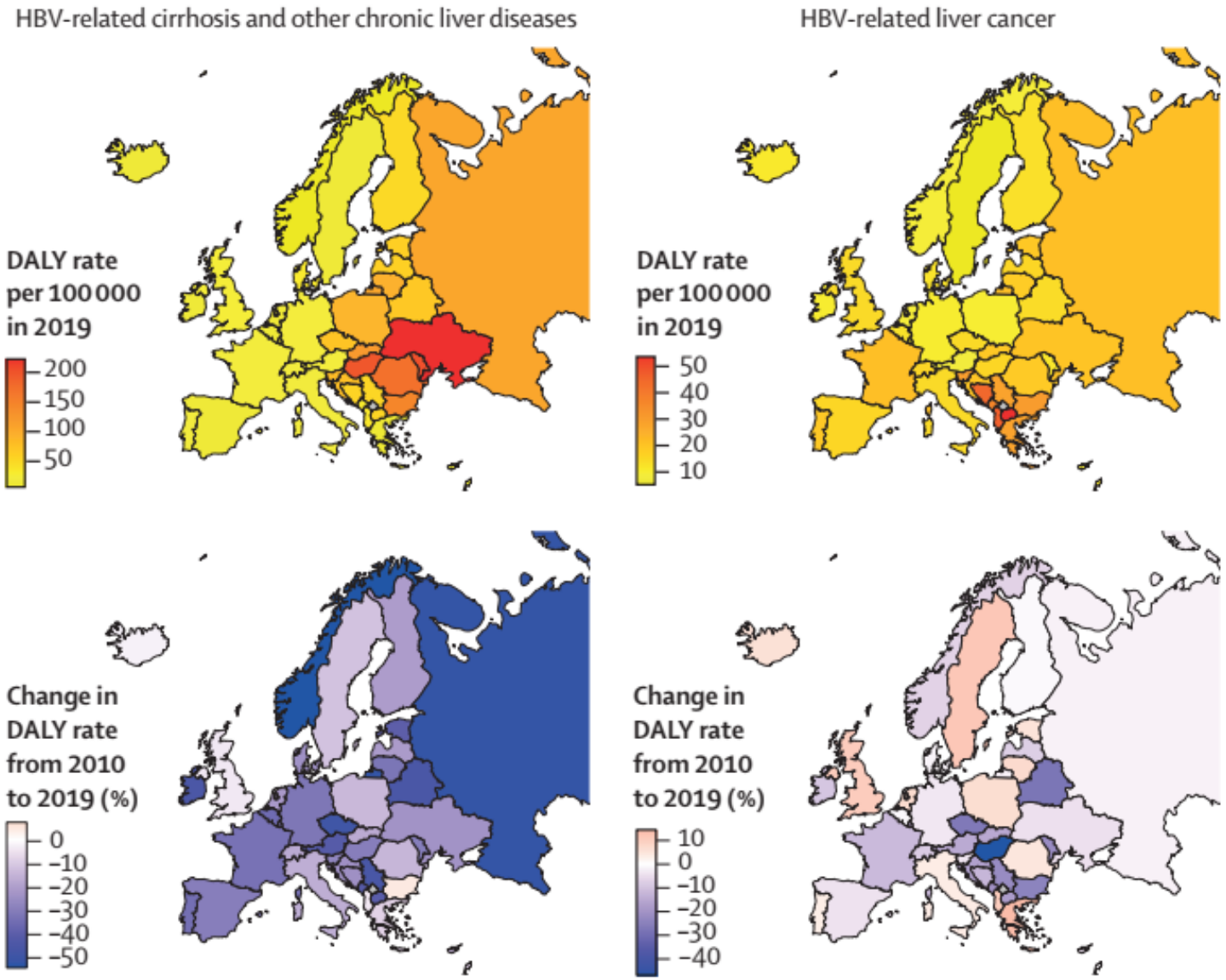


Hepatitis B and C in Europe: an update from the Global Burden of Disease Study 2019

Lancet Public Health 2023; 8: e701–16

*GBD 2019 Europe Hepatitis B & C Collaborators**

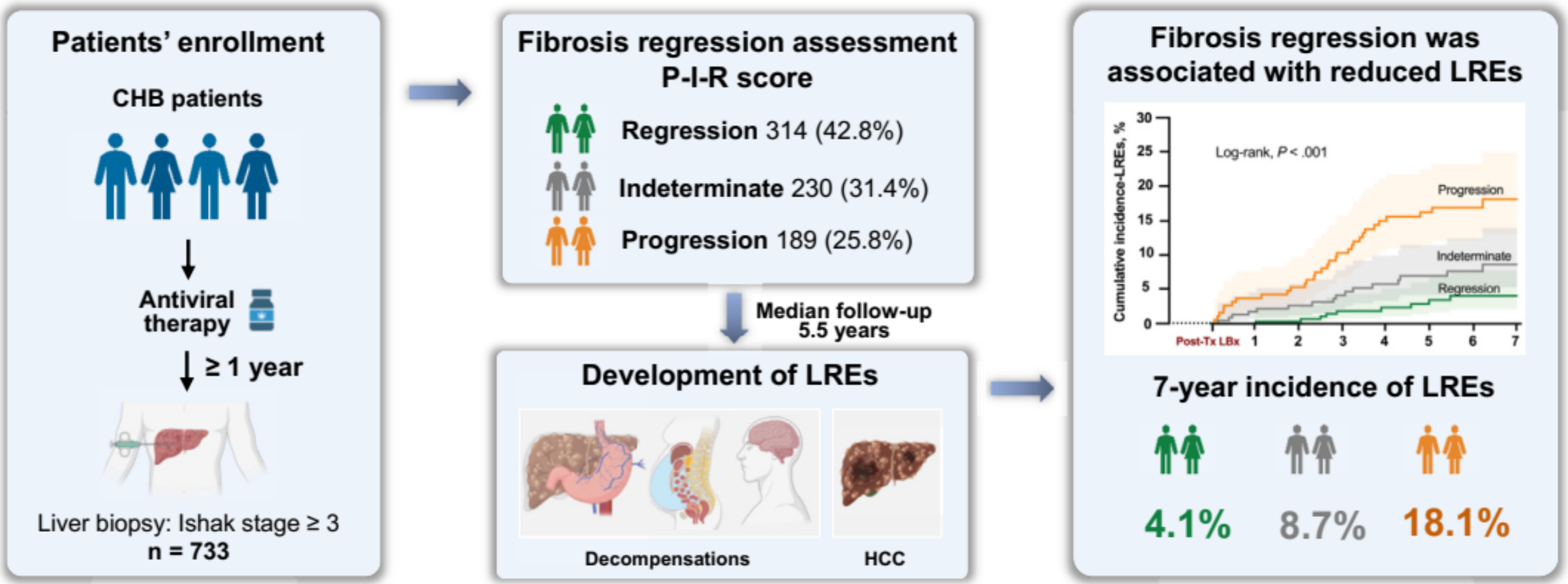
VHB



Regression of Liver Fibrosis in Patients on Hepatitis B Therapy Is Associated With Decreased Liver-Related Events

Yameng Sun,[1,*] Wei Chen,[2,*] Shuyan Chen,[1,*] Xiaoning Wu,[1] Xinxin Zhang,[3] Lingyi Zhang,[4] Hong Zhao,[5] Mingyi Xu,[6] Yongpeng Chen,[7] Hongxin Piao,[8] Ping Li,[9] Lei Li,[10] Wei Jiang,[11] Xiaodong Li,[12] Huichun Xing,[13] Xudong Liu,[14] Yuxi Zhang,[15] Bingqiong Wang,[1] Jialing Zhou,[1] Tongtong Meng,[1] Xinyan Zhao,[1] Chen Shao,[16] Yuanyuan Kong,[17] Xinyu Zhao,[17] Xiaojuan Ou,[1] Chenghai Liu,[18] Jidong Jia,[1] and Hong You[1]

Clinical Gastroenterology and Hepatology 2024;22:591–601



Hepatocellular carcinoma risk in patients with chronic hepatitis B receiving tenofovir- *vs.* entecavir-based regimens: Individual patient data meta-analysis

Won-Mook Choi, **Terry Cheuk-Fung Yip**, Grace Lai-Hung Wong, …, Jung Woo Shin, Yao-Hsu Yang, Young-Suk Lim

J. Hepatol. 2023, 78, 534–542

Objective

To compare the risk of HCC development associated with tenofovir disoproxil fumarate (TDF) *vs.* entecavir (ETV) treatment in patients with CHB, using individual patient data (IPD)

Methods

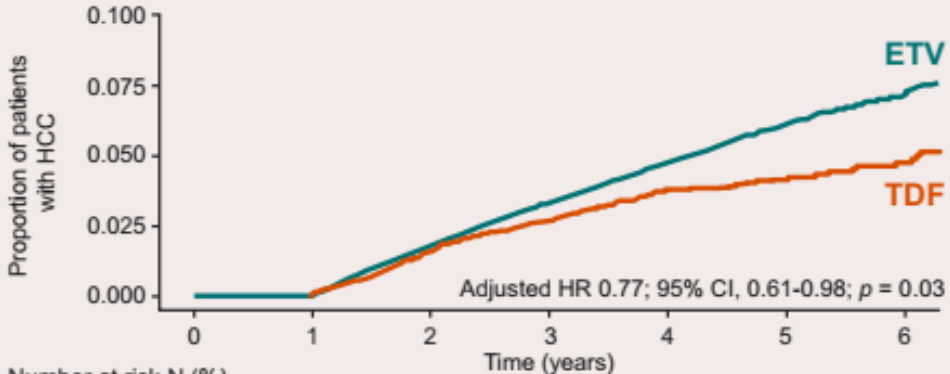
Systematic literature review (SLR) of published SLRs, electronic databases and key congress proceedings

20 eligible studies identified; **11 studies from 3 countries contributed IPD** to the meta-analysis

Meta-analysis performed using IPD from **42,939 eligible patients with CHB** treated with **TDF or ETV**

Findings

Patients receiving TDF had a significantly lower risk of developing HCC than those receiving ETV, with risk diverging after 2.5 years



Number at risk N (%)

ETV	35,960 (100)	35,960 (100)	29,679 (83)	24,642 (69)	19,749 (55)	13,046 (36)	4,383 (12)
TDF	6,979 (100)	6,979 (100)	5,792 (83)	4,387 (63)	2,927 (42)	1,730 (25)	751 (11)

Conclusions

Patients with CHB receiving treatment with TDF were significantly less likely to develop HCC than those receiving ETV

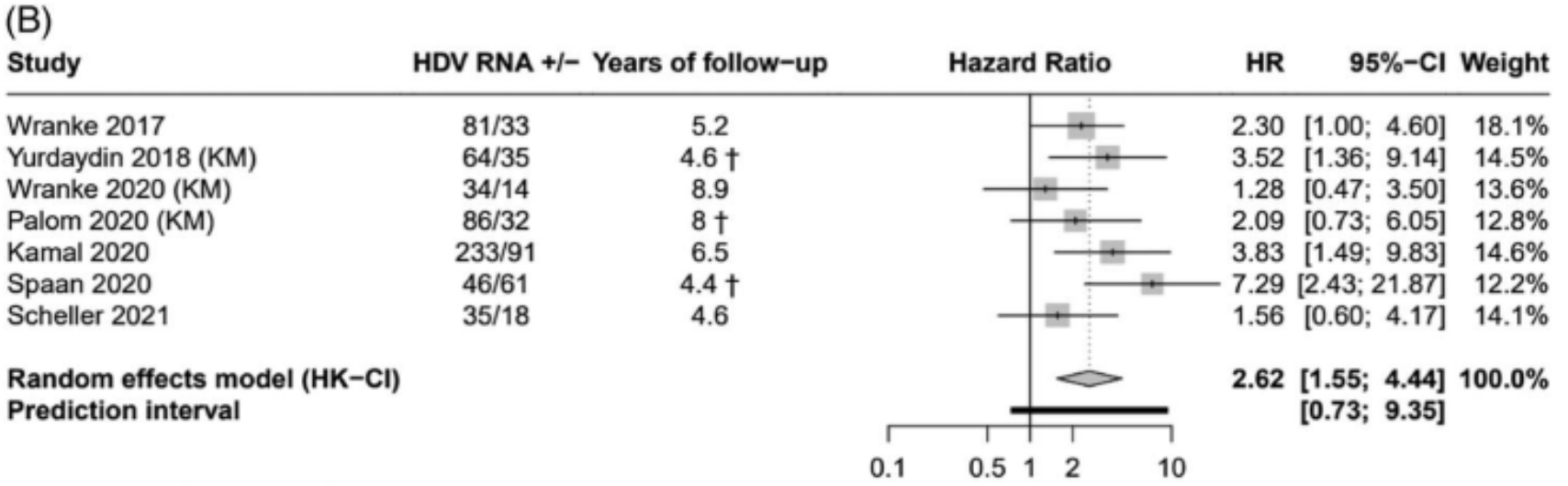
These findings should be considered in determining the treatment course to achieve the best long-term outcomes in patients with CHB

Association of hepatitis delta virus with liver morbidity and mortality: A systematic literature review and meta-analysis

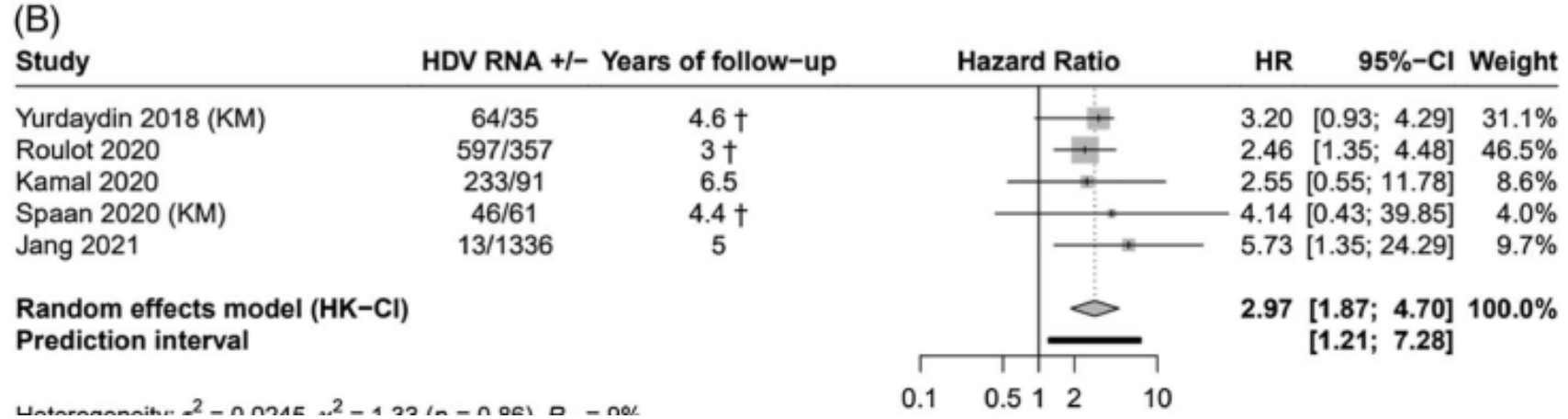
Robert G. Gish[1] | Robert J. Wong[2] | Gian Luca Di Tanna[3] | Ankita Kaushik[4] | Chong Kim[4] | Nathaniel J. Smith[5] | Patrick T.F. Kennedy[6]

Hepatology. 2024;00:000–000.

Risque évènement hépatique



Risque CHC



Association of hepatitis delta virus with liver morbidity and mortality: A systematic literature review and meta-analysis

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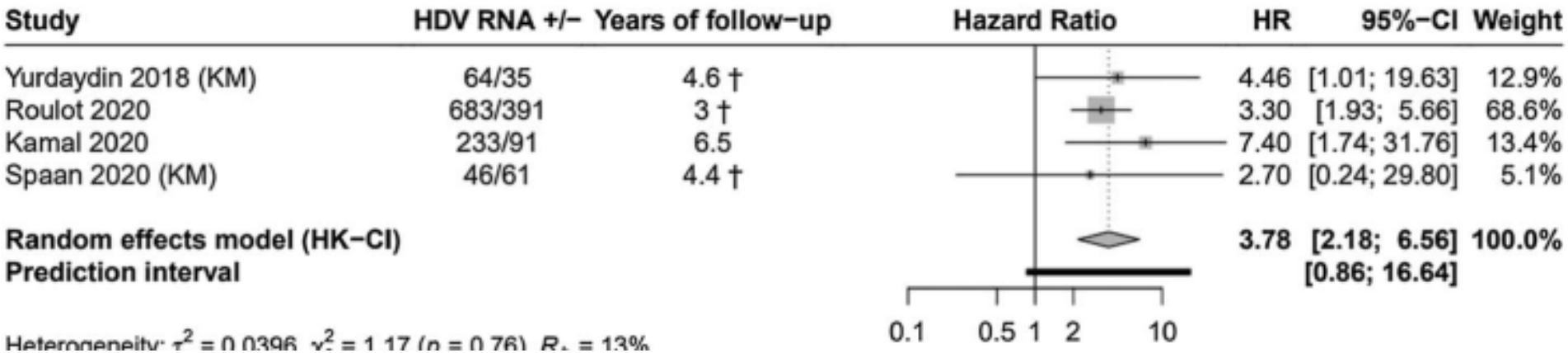
Mortalité



Merci de votre attention