British HIV Association
BHIVA

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Submitted online to www.nice.org.uk

Dear Mr Boysen

Thank you for allowing us to comment on the ACD 'Sofosbuvir for treating chronic hepatitis C'

The British HIV Association represents health-care professionals and community members involved in the care of people living with HIV-infection including those coinfected with HIV. The Advisory Committee had access to the BHIVA Guidelines for the management of hepatitis viruses in adults infected with HIV (*HIV Medicine* (2013), **14** (Suppl. 4), 1–71) and were advised of this at the time of the scope.

The British Association for Sexual Health and HIV membership includes medical practitioners, scientists in the field of medicine and other healthcare workers who have shown a commitment to the specialty.

We would like to make specific comments with regard to the management of chronic HCV and specific to Sofosbuvir use in HIV-infected patients for the Advisory Committee to take into consideration.

a) We acknowledge the Committee's notion that on the evidence presented, treatment responses in HIV-infected patients were similar to those seen in HCV mono-infected patients. We would like the Committee to note that recent Guidelines from AASLD[1] and EASL[2] also note this and make no distinction in terms of treatment regimens between these two groups of patients (talking into account potential drug-drug interactions). Indeed some studies have shown a higher response in the co-infected population[3].

b) The BHIVA Guidelines for HCV treatment in HIV+ patients will also shortly be updated to reflect this[4].

c) We would like the Committee to note that there is an exploratory study (study 1910, Torriani, et al, P714, IDWeek 2013, October 2013, San Francisco, USA) which confirms that in treatment naïve HCV/HIV co-infected patients, 12 weeks of therapy with Sofosbuvir plus Peg-IF plus weight-based ribavirin for G1, 2, 3 and 4 resulted in SVR12 rates very similar to those seen in mono-infected patients in the Neutrino study. This is the basis on which most experts would recommend 12 weeks of triple therapy with Sofosbuvir as a first-line treatment option for G1 to G4 treatment-naïve co-infected patients. The photon 2 study which looks at a European population treated with an interferon sparing approach of sofosbuvir and ribavirin will be available at the end of July and should also be considered when comparing the response of HIV infected and non-infected.

[1] http://www.aasld.org/practiceguidelines/Pages/default.aspx
[2] http://www.easl.eu/_clinical-practice-guideline
[3] DT Dieterich, et al. Similar Adjusted SVR12 Rates for HIV Co-Infected and HCV Mono-Infected Patients and No Dose or Population (Treatment-Naive/Relapser) Effect: Pooled Analysis of Faldaprevir Phase III Trials. Digestive Disease Week (DDW 2014). Chicago, May 3-6, 2014. Abstract 240
[4] http://www.bhiva.org/hepatitis-2013.aspx

d) We were more than a little perturbed by the statements from section 3.5 by the ERG:

"The ERG noted that people with HCV and HIV co-infection are likely to have a higher mortality rate than the population with HCV only regardless of sustained virological response and that this is currently not taken into account in the manufacturer's model"

Whilst no direct comparative data is available with HCV+ patients, there is now ample evidence of normalization of life expectancy amongst HIV+ patients successfully treated with antiretroviral therapy[5]. Moreover, there is now sufficient data from cohort studies that not only does an SVR with anti-HCV therapy reduce liver-related mortality but that it also significantly reduces non-liver related mortality and all-cause mortality in co-infected patients with both mild fibrosis and advanced fibrosis[6].

'The ERG noted that a study by Van Der Helm et al (2013) concluded that the effects of HCV treatment on HIV progression needed to be evaluated further."

This cohort study of HIV seroconvertors clearly showed an increase in death from AIDS in cART treated HCV-infected HIV seroconvertors compared to HCV-uninfected patients. There was no data available on HCV treatment, but the inference very clearly was that there is a negative influence of HCV on immune recovery and/or response to cArt in this group of patients and that effective anti-HCV treatment was urgently needed in this group of patients.

The authors' conclusion from this study was "Our findings highlight the importance of interventions to increase the uptake of HCV treatment in co-infected individuals".

e) Whilst we agree that the evidence to accurately evaluate the cost-effectiveness of sofosbuvir in the HCV and HIV co-infected individual may not be fully available, we highlight the importance of effective therapy for the treatment of HCV in HIV co-infected patients to reduce morbidity and mortality. Moreover, current rates of SVR in G1 patients with PegIFN and Ribavirin are only 16-33%.

We are also aware that the ERG (SHTA) have previously performed cost-effectiveness analyses for the treatment of co-infected patients with both PegIFN and ribavirin and in combination with Telaprevir and Boceprevir.

f) We would urge that a cost-effectiveness analysis in HCV/HIV co-infected patients takes into account the option of pegIFN, ribavirin and Sofosbuvir for 12 weeks.

g) We strongly disagree with the Committee's conclusion section 4.8 ".the benefits of treatment were likely to be lessened because of complications and higher morbidity associated with HIV infection". We are not aware of any evidence that suggests this and in fact, on the contrary, have shown from the cohort studies quoted above that effective anti-HCV treatment may be of greater benefit in the co-infected population.

h) We would strongly urge the Appraisal Committee to include clinical experts versed in the management of HIV-infected patients in future discussions.

Yours sincerely

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Chair, BHIVA Hepatitis Society Subcommittee

Dr Elizabeth Foley
BASHH General Secretary

[5] May, et al. AIDS 2014; Feb 19 [Epub ahead of print] PMID24556869
[6] Berenguer J, et al. Clin Infect Dis 2012;55 (5):728-36 and Berenguer J, et al. JAIDS 2014;66: 280-287