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Response to treatment of hepatitis C in HCV/HIV co-infected patients is not influenced by either abacavir or tenofovir with weight-based ribavirin

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Background

Approximately 30% of HIV-infected patients are co-infected with hepatitis C (HCV). The current treatment standard of care for HCV, pegylated interferon and ribavirin (RBV), has demonstrated a sustained virologic response (SVR) in less than 50% of HCV/HIV co-infected patients, and only 17-35% in HCV genotype 1 patients. It has been previously shown that using a weight-based RBV dose results in favorable SVR rates. Prior studies suggest that HCV/HIV co-infected patients receiving a HAART regimen that included tenofovir (TDF) had higher SVR rates than those who received abacavir (ABC) in their nucleos(t)ide analogue (N(t)RTI) backbone.

Purpose of the study

At our specialty clinic for the treatment of HCV/HIV co-infected patients, we re-examined the efficacy of HCV treatment in patients receiving either agent in their regimen with weight-based ribavirin doses.

Methods

Patients with HIV/HCV co-infection (HCV genotype 1) met with a multidisciplinary team before therapy initiation for education and teaching. HCV treatment consisted of weekly injections of 180 mcg pegylated interferon subcutaneously and weight-based dosing of RBV (13mg/kg/day to maximum of 1200 mg/day). Treatment duration was 48 weeks with longer treatment in slow responders; side effects and adverse events were treated promptly. The HAART regimen consisted of a N(t)RTI backbone with either ABC or TDF and a protease inhibitor or non-NRTI. We retrospectively compared SVR rates in patients being treated with either ABC or TDF.

Results

Thirty-four patients met the inclusion criteria. In an ITT analysis, 20 of 34 (59%) patients receiving HAART demonstrated SVR with no significant differences between races (p=0.31). Among those twenty HAART patients with SVR, 9 patients were being treated with ABC and 11 were being treated with TDF (p=0.13). The length of treatment between ABC and TDF treated groups did not differ significantly (49.6 and 49.5 weeks, p=0.001). No significant difference in SVR rates was shown between the two groups.

Conclusions

The rate of SVR in patients with HIV/HCV genotype 1 dosed with weight-based RBV was significantly higher than generally reported. There was no difference in SVR rates in HIV/HCV co-infected patients receiving ABC or TDF in their HAART regimen with weight-based RBV. These results may give providers flexibility in their selection of N(t)RTI backbone while receiving treatment for HCV.

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