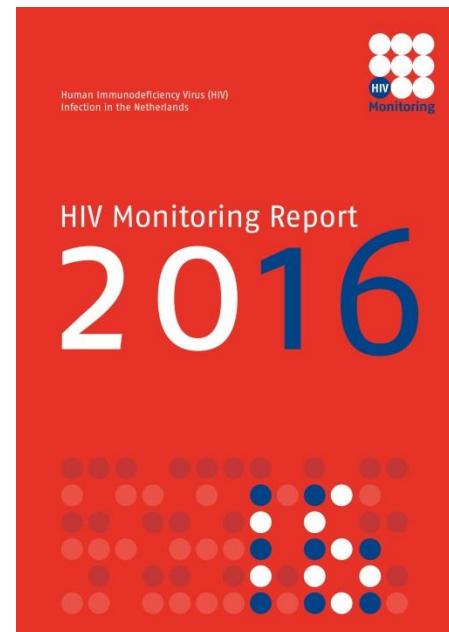


# An update on the HIV epidemic in the Netherlands

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## A selection of findings from the SHM Monitoring Report 2016

Peter Reiss  
NCHIV 2016  
22 November 2016



# A special thank you to:

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## **SHM**

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Mariska Hillebregt  
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# With thanks to colleagues at SHM and treatment centres

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**and all patients who allow us to collect and analyse data  
on the course and outcome of their infection**

# Topics

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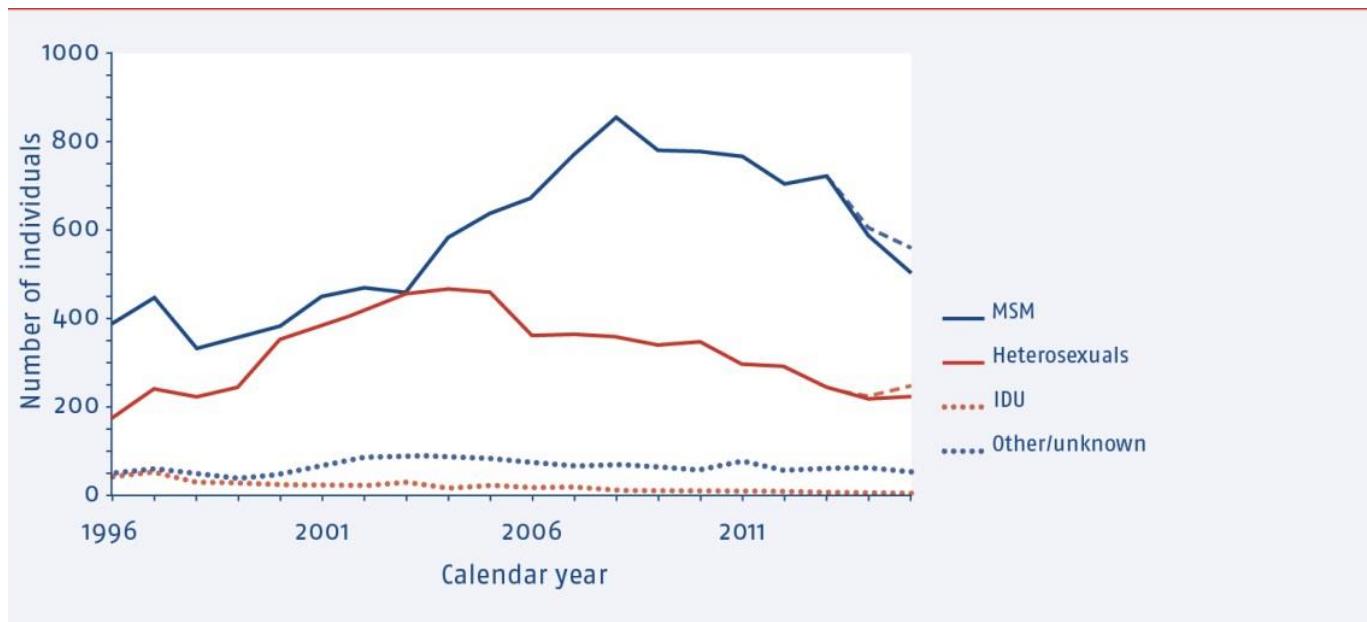
- **Epidemic trends in diagnosis and treatment initiation over time**
- **Treatment outcome and the continuum of care**
- **Initial treatment regimens**
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- **Conclusions**



# Annual number of new HIV diagnoses continues to decline, but only gradually

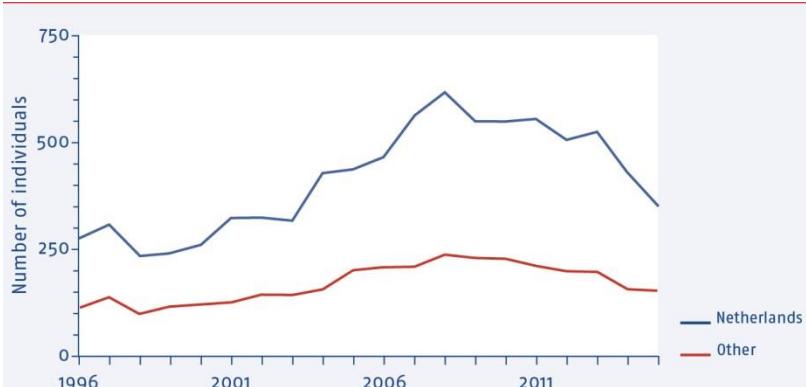
Around 900 new diagnoses in 2015

- 64% in MSM
- 28% through heterosexual contact
- 8% through other or unknown mode of acquisition



# Geographical region of origin of those newly diagnosed with HIV

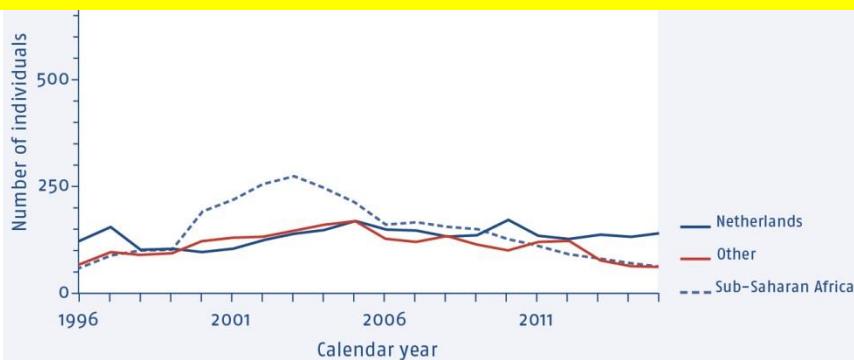
- MSM



	<2013	≥2013
NL	70.7%	71.4%
CE	1.9%	4.0%
CARIB	3.4%	4.6%

**About 25% of newly diagnosed persons in 2015 were > 50 yrs:**

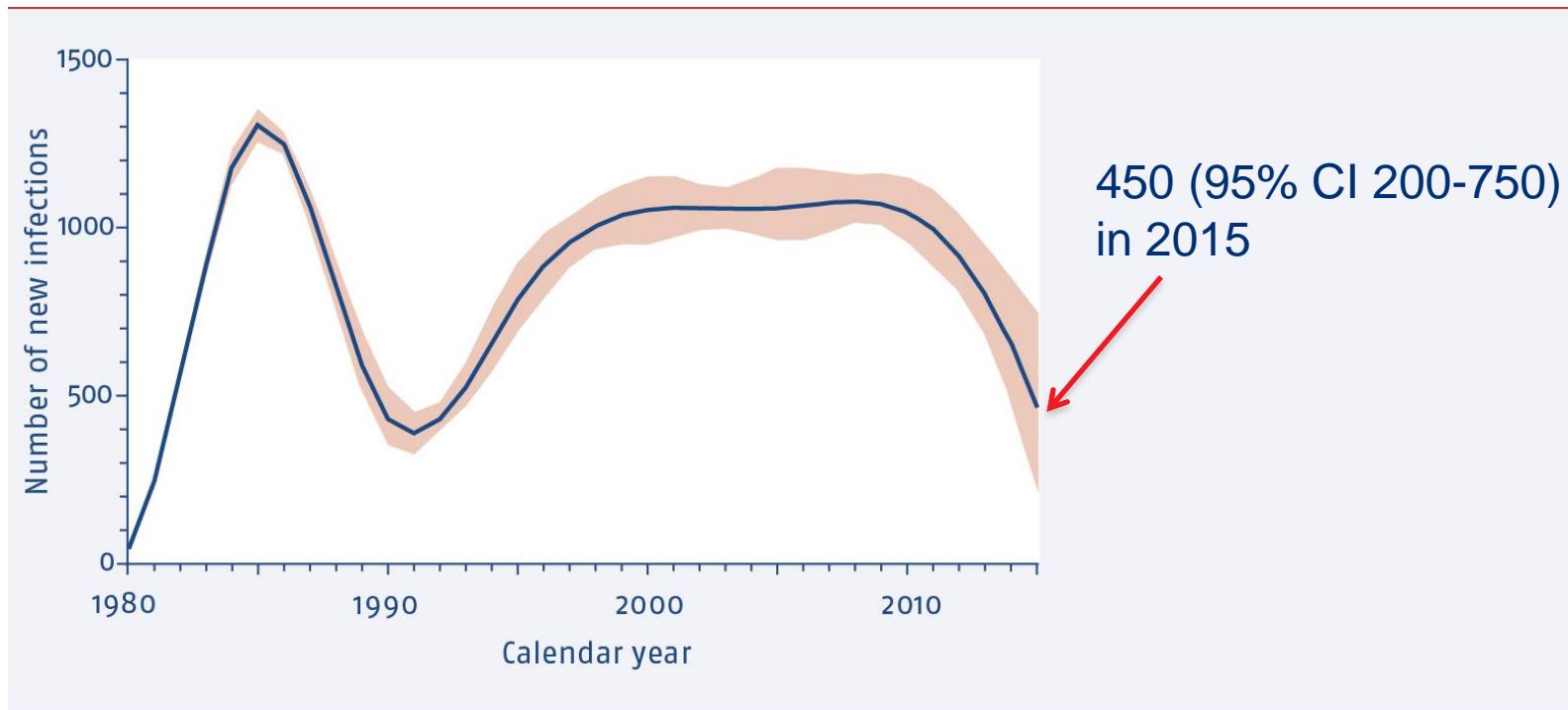
More often the case for Dutch MSM & other Dutch men and women than for those from other regions of origin than the Netherlands



	<2013	≥2013
<b>Other men</b>		
NL	43.6%	56.8%
SSA	27.0%	19.7%
<b>Women</b>		
NL	26.5%	40.2%
SSA	43.3%	33.6%

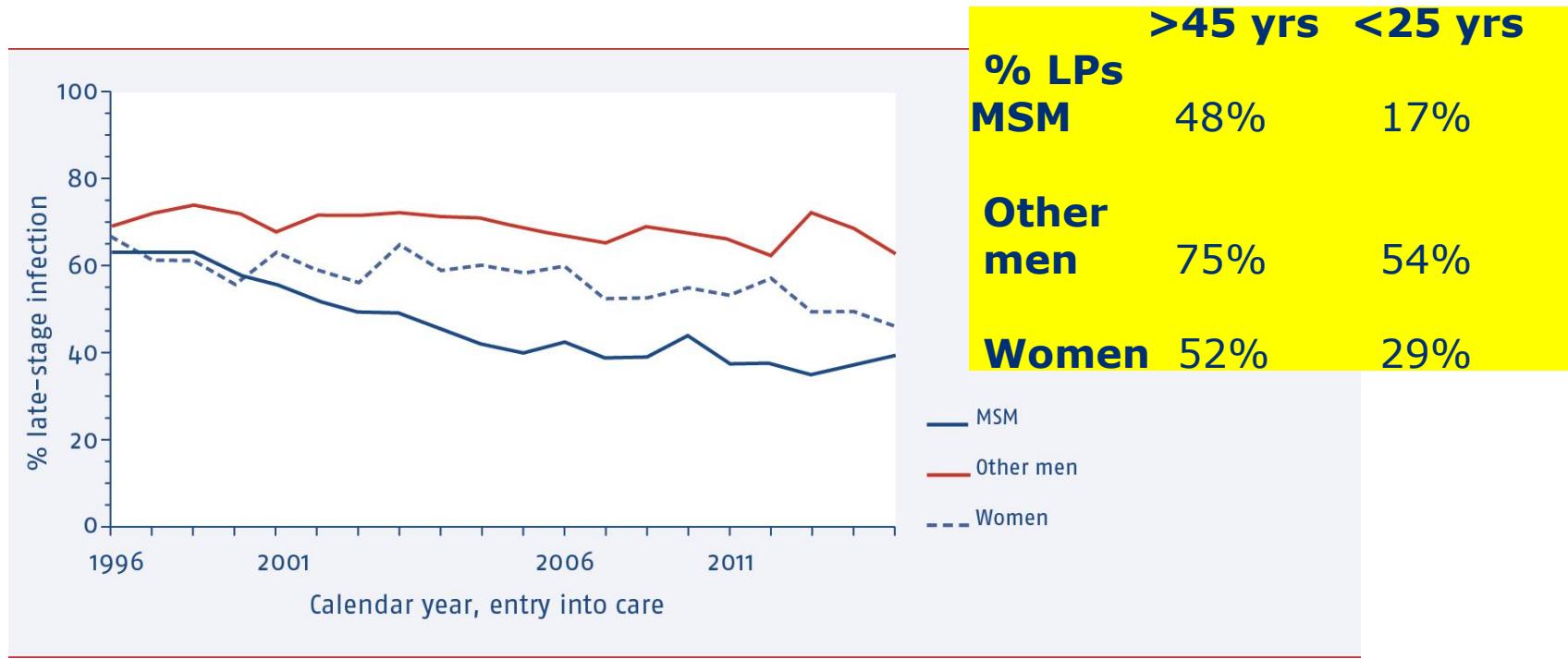
# Decline in new diagnoses includes a decline in the annual number of newly-acquired HIV infections

- Annual number of newly-acquired HIV infections as estimated using ECDC modelling tool



# However, at time of diagnosis many have likely already been infected much longer

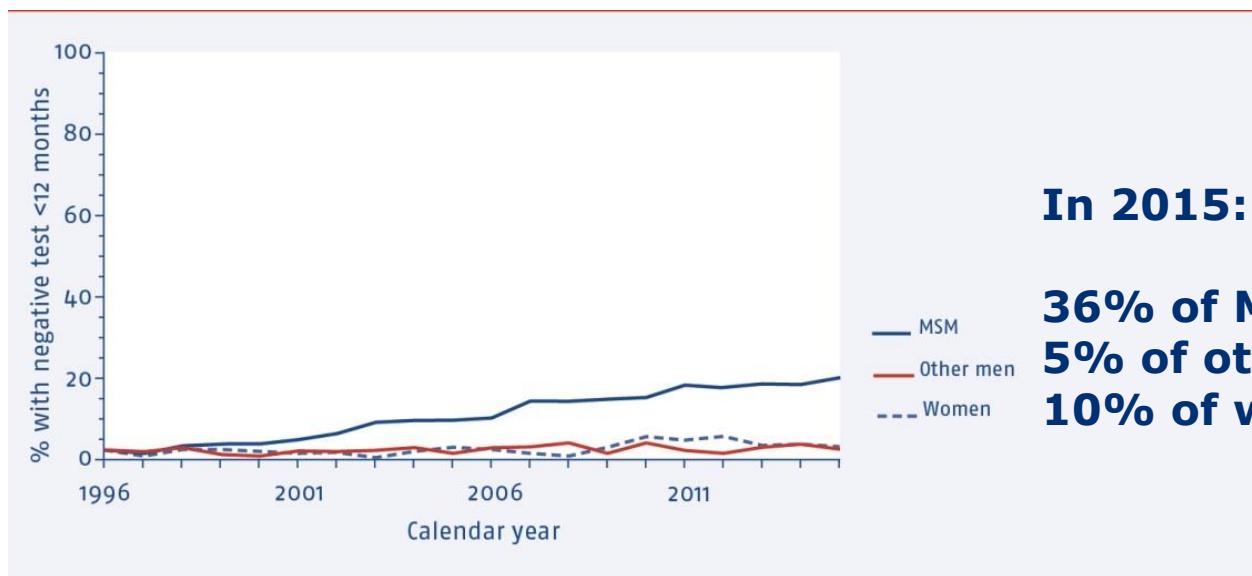
- 45 percent overall of newly-diagnosed individuals had AIDS and/or CD4 cells < 350/mm<sup>3</sup> when entering care
- Late presentation more common in those who enter care and are over 45 yrs of age



# Diagnosing “recent” HIV infection needs to be improved further

**Improving slowly in MSM,  
but not really in other men or women**

Proportion that had tested negative *at most 12 months before HIV diagnosis*



**In 2015:**

**36% of MSM  
5% of other men  
10% of women**

Expanding testing, including repeated testing in those at highest risk, is a prerequisite for further improvement in identifying people with recent infection

# Overall the trend is moving towards earlier diagnosis

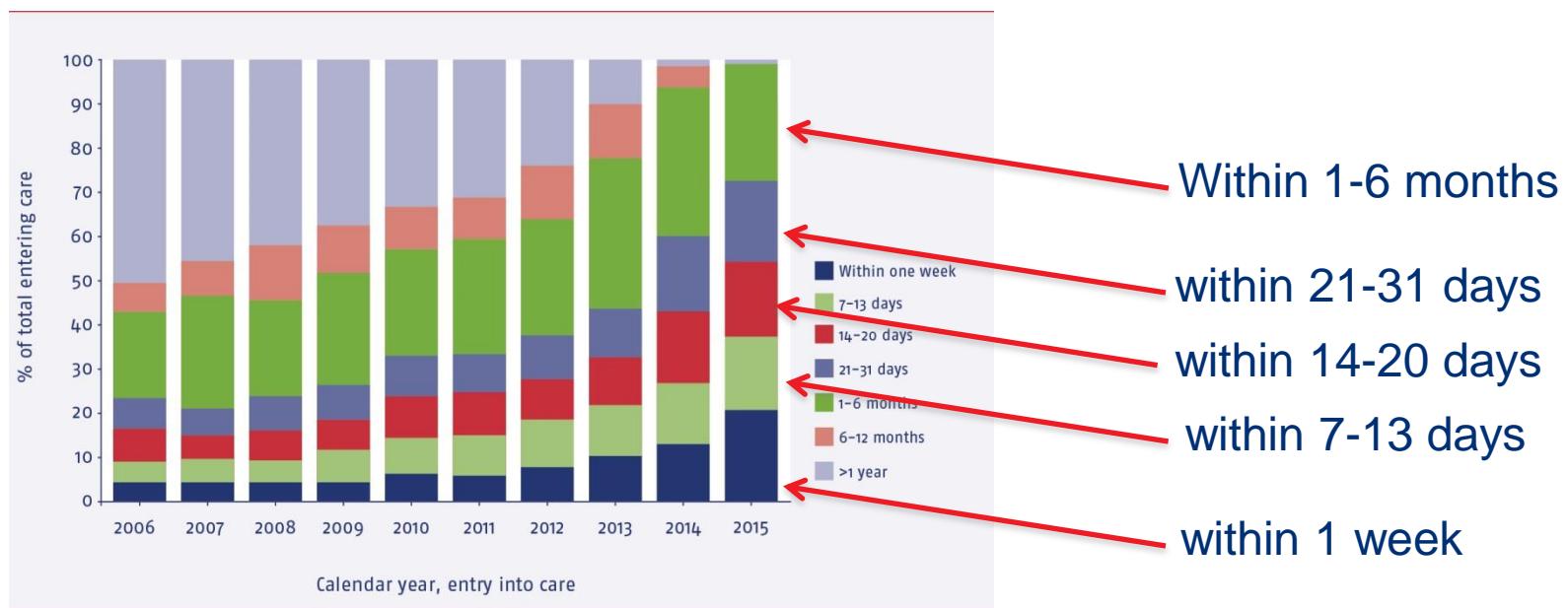
- Reflected in a gradual rise in CD4 count at time of diagnosis



...but room for improvement remains across the board, and more so among men & women with heterosexually acquired infection...

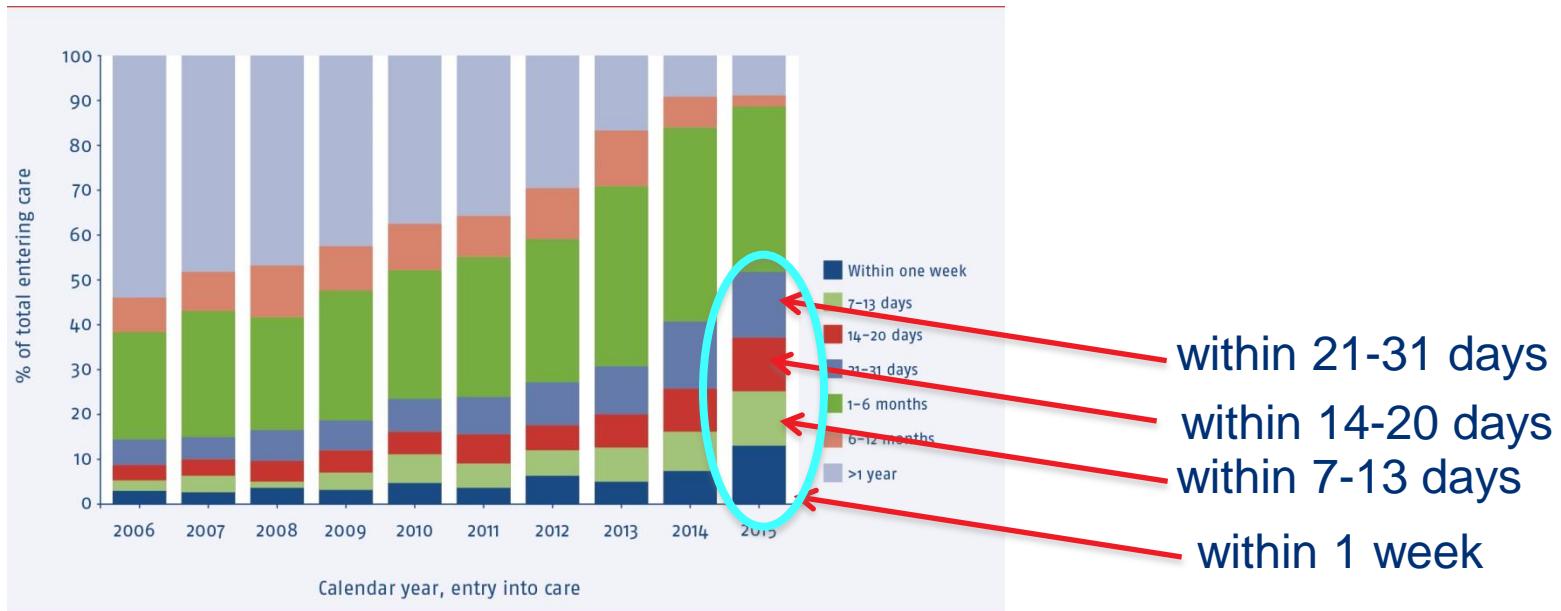
# Almost all those entering care in 2015 started treatment within 6 months

Time between *entry into HIV care* and initiation of combination antiretroviral therapy (cART) from 2006-2015.



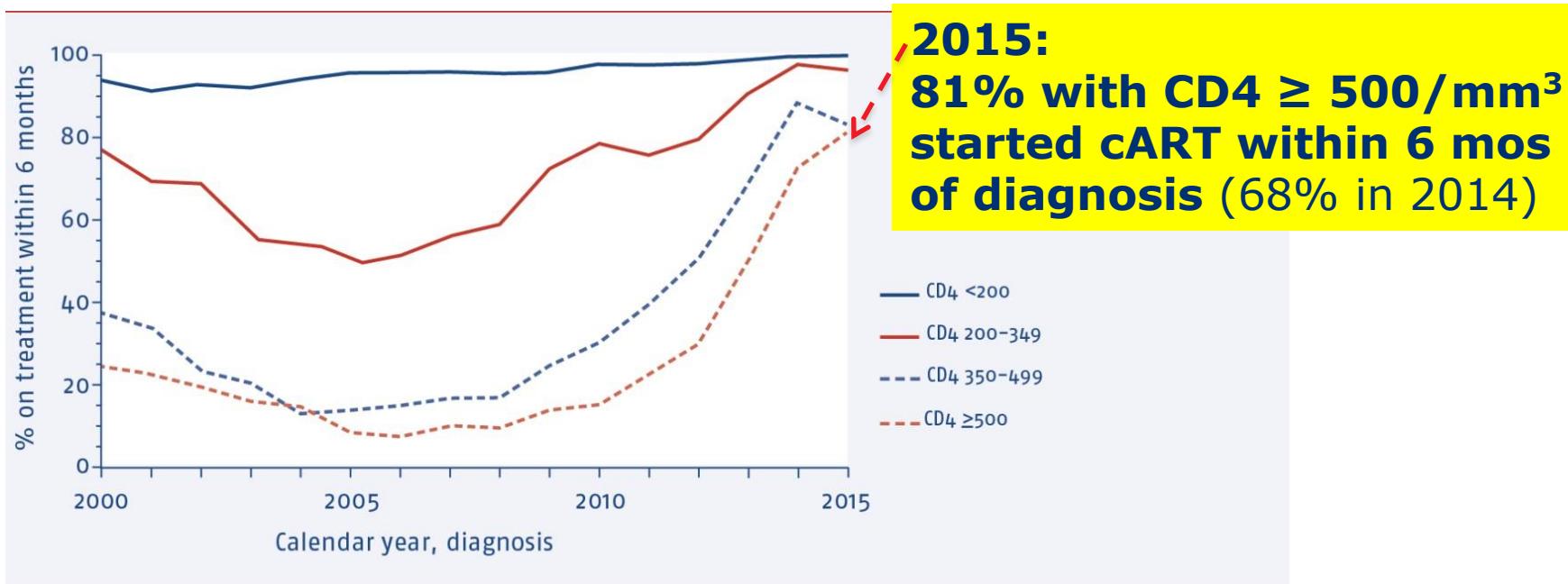
# ...and 50% started within 1 month after diagnosis

Time between *HIV diagnosis* and initiation of combination antiretroviral therapy (cART) from 2006-2015.



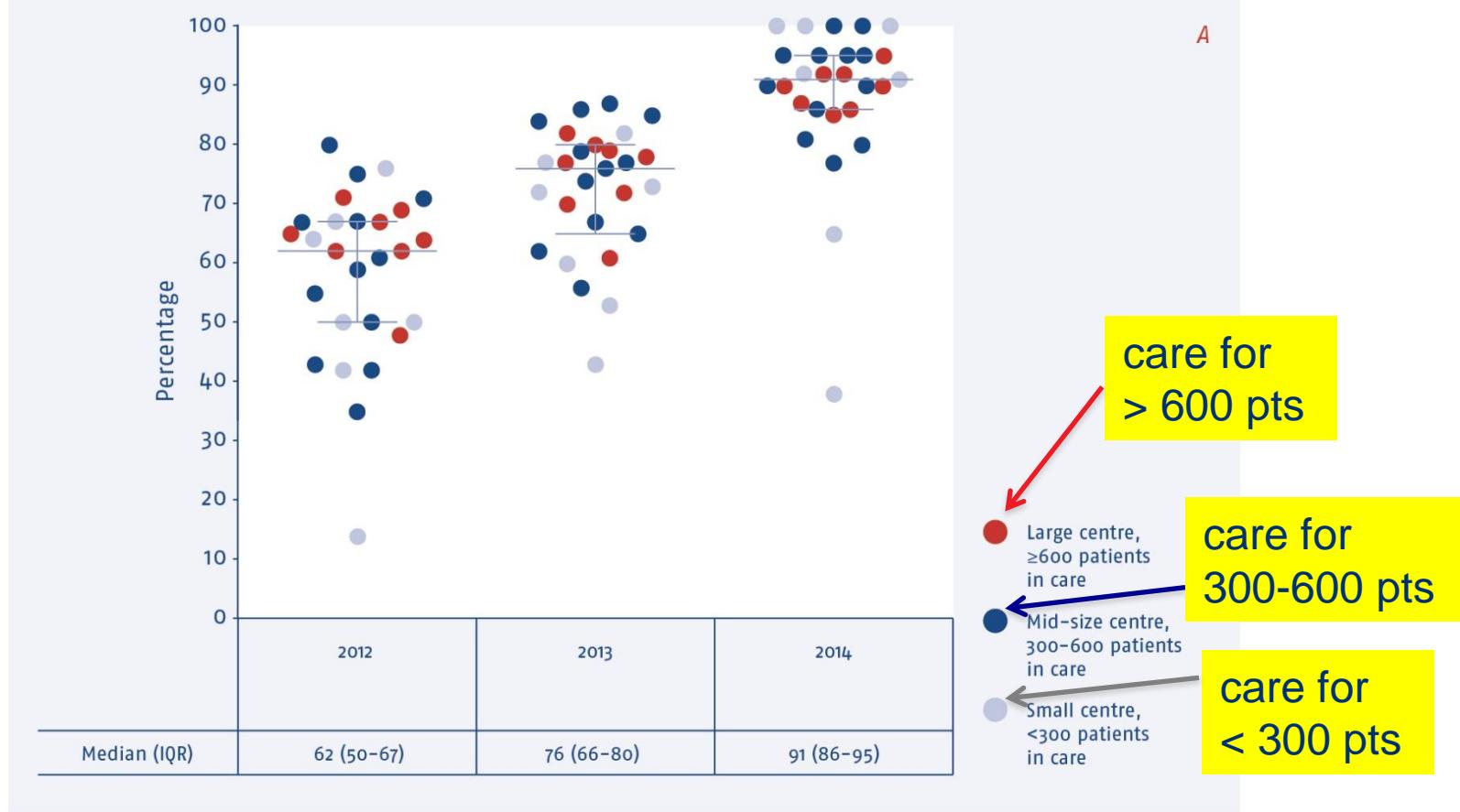
# Universal start of treatment, regardless of CD4 count, is increasingly the norm

Proportion starting cART *within 6months* after HIV diagnosis, according to CD4 count at time of diagnosis



# Universal treatment initiation fairly uniform across the 26 Netherlands treatment centres

Proportion of patients started on cART within 6 months after entering care, by year & treatment centre size



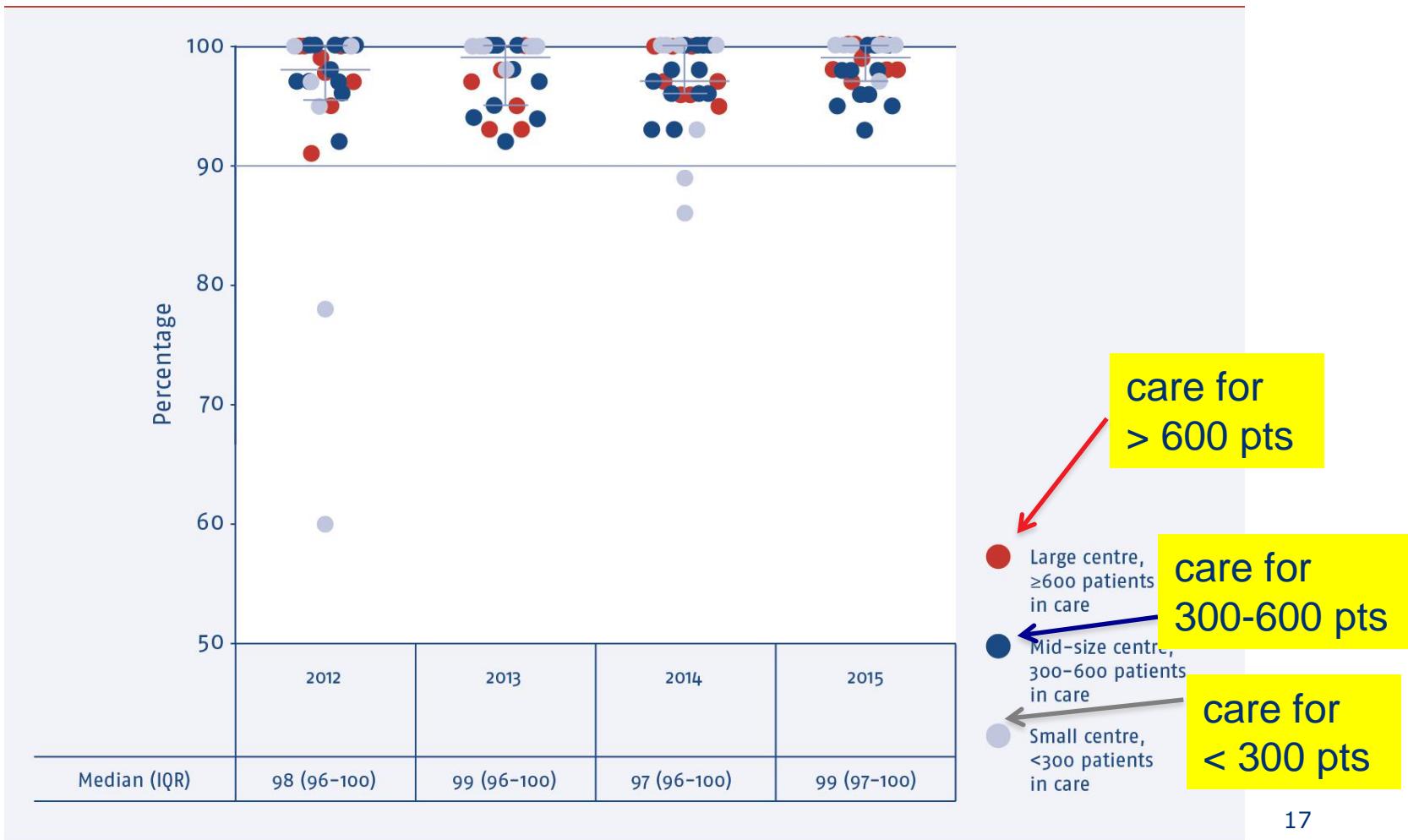
# Topics

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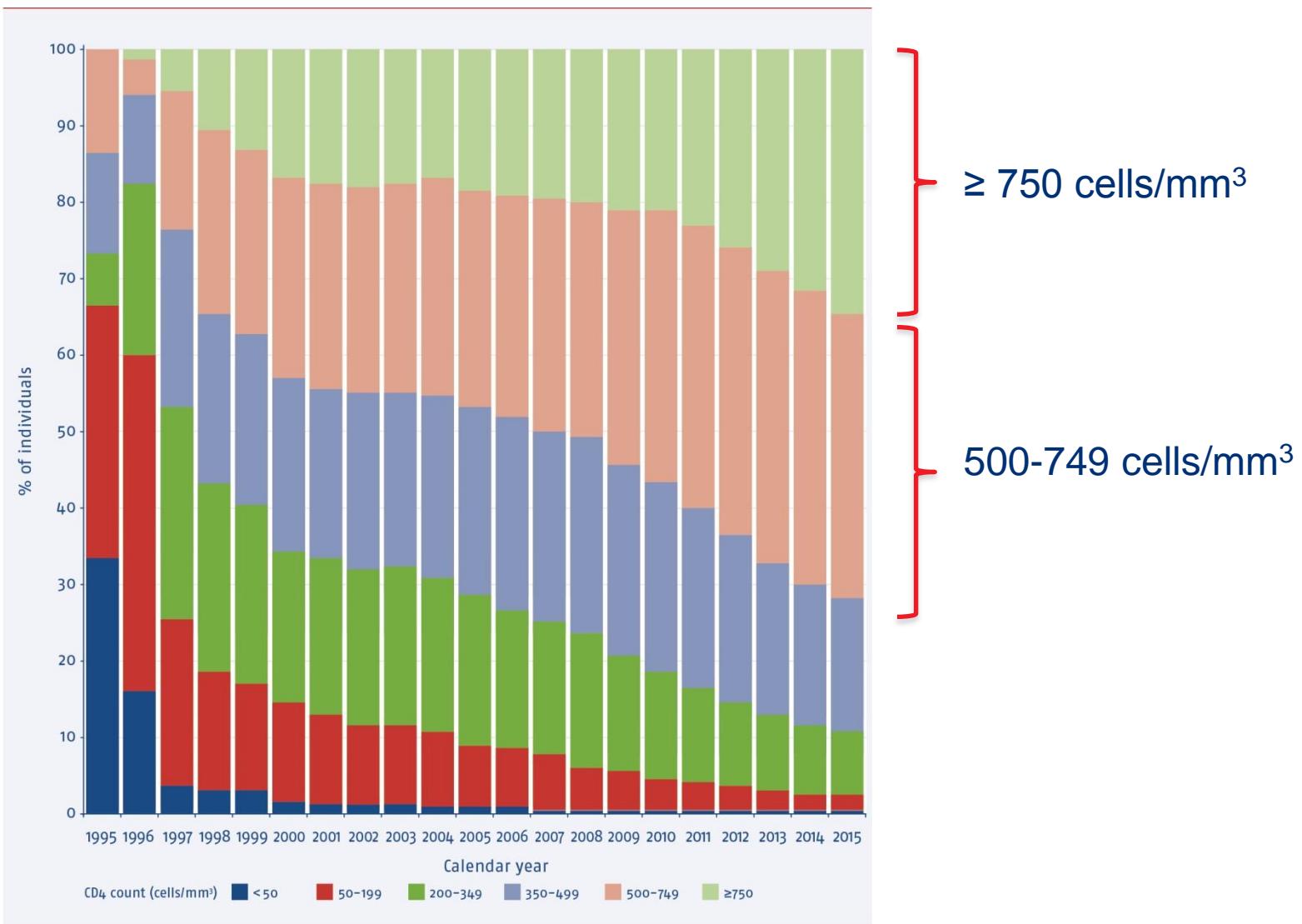
- Epidemic trends in diagnosis and treatment initiation over time
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# Viral suppression rates on cART are high across the 26 Netherlands treatment centres

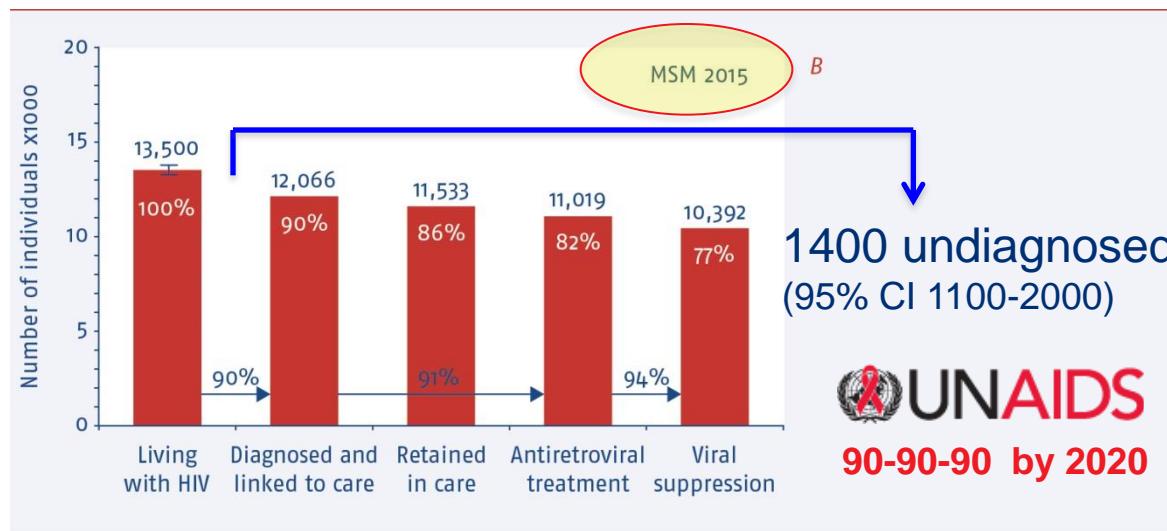
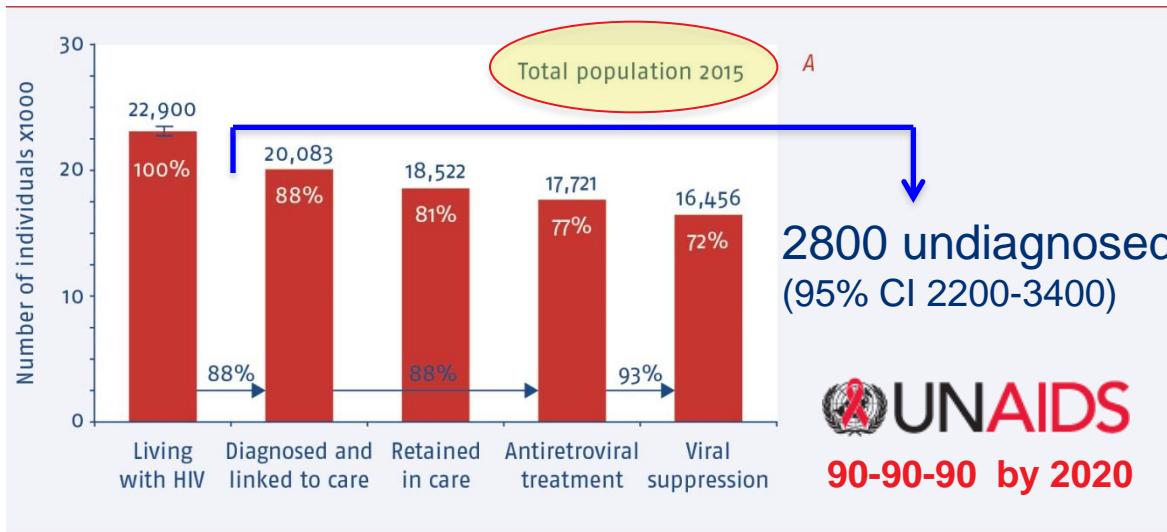
Percentages of treatment-naive patients with a plasma HIV RNA level <400 copies/ml at 6 months (minimum and maximum: 3-9 months) after the start of combination antiretroviral therapy (cART) across all HIV treatment centres.



# Increasing proportions of patients on cART are living with higher CD4 counts

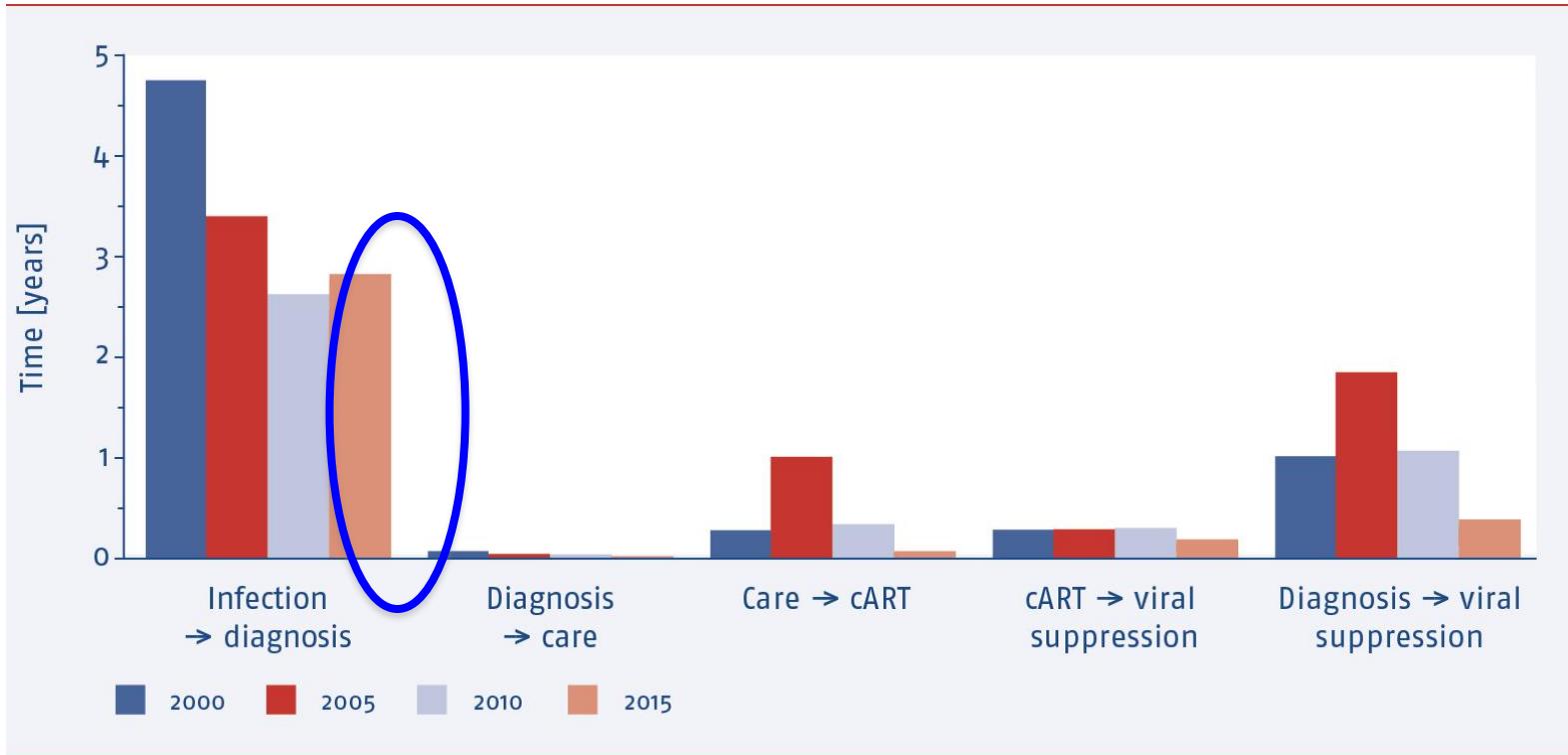


# Continuum of care: adults diagnosed, linked to care, retained in care, on cART, and suppressed



# The time to reaching each step in the continuum is shrinking

The major gap remains in the time between infection and diagnosis



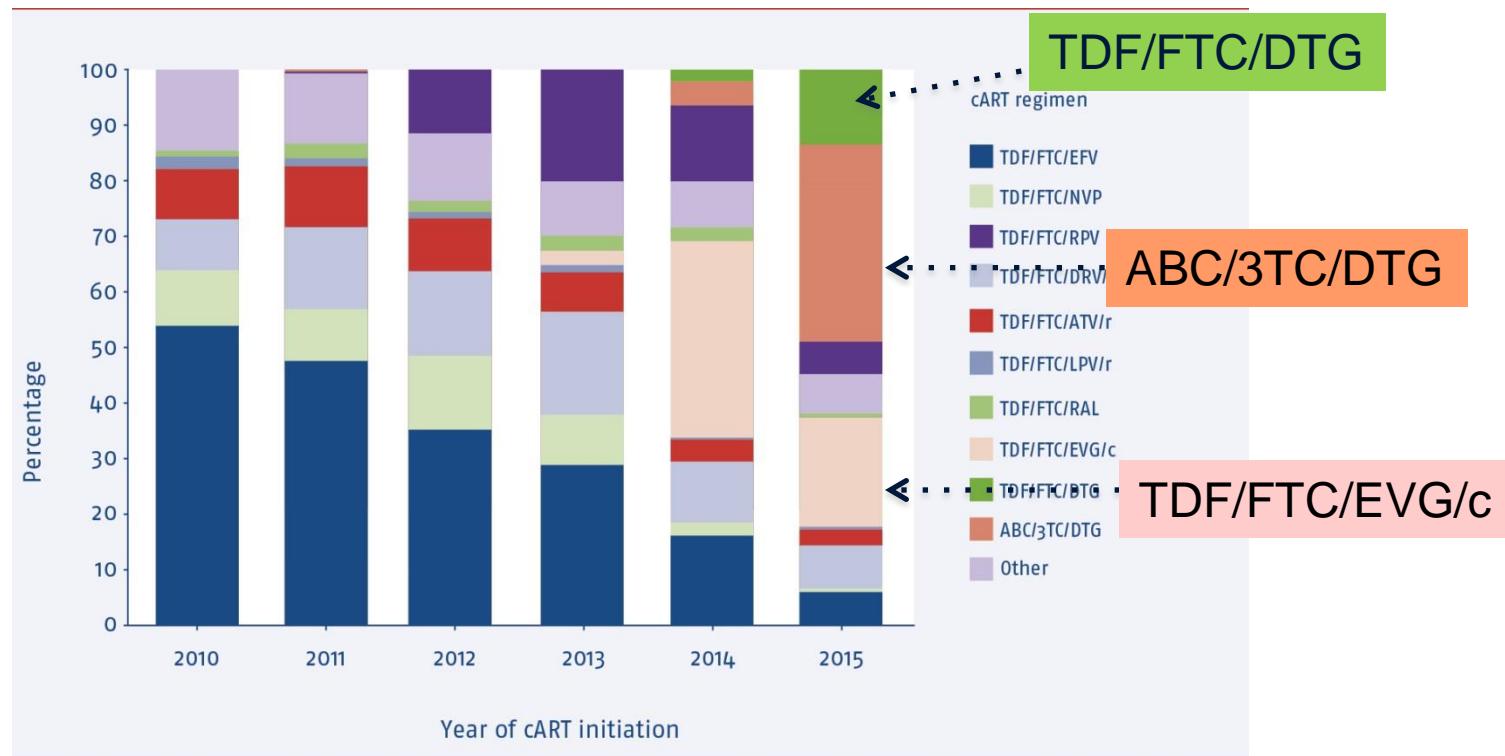
# Topics

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- **Treatment outcome and the continuum of care**
- **Initial treatment regimens**
- **Ageing and comorbidity, including hepatitis C co-infection**
- **Conclusions**

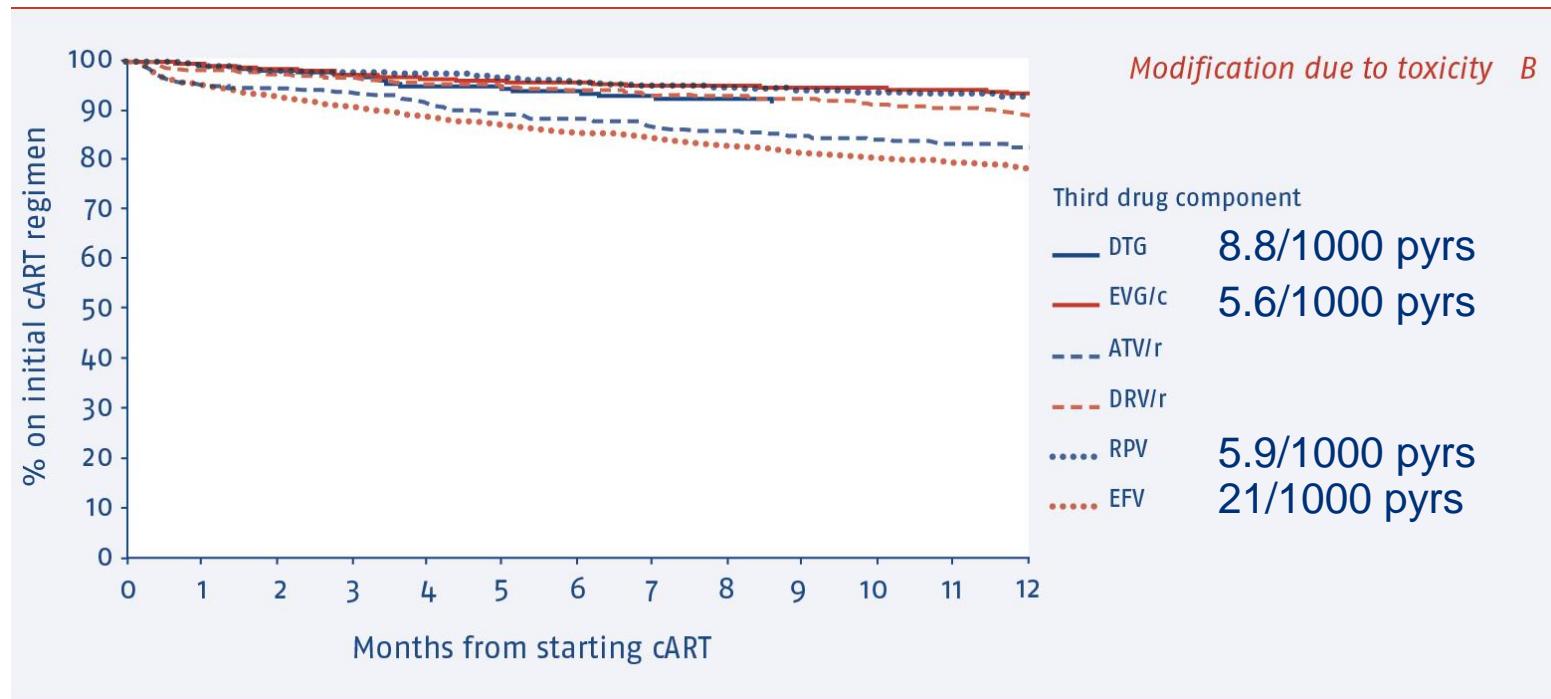


# Shifts in first-line cART regimens 2010-2015

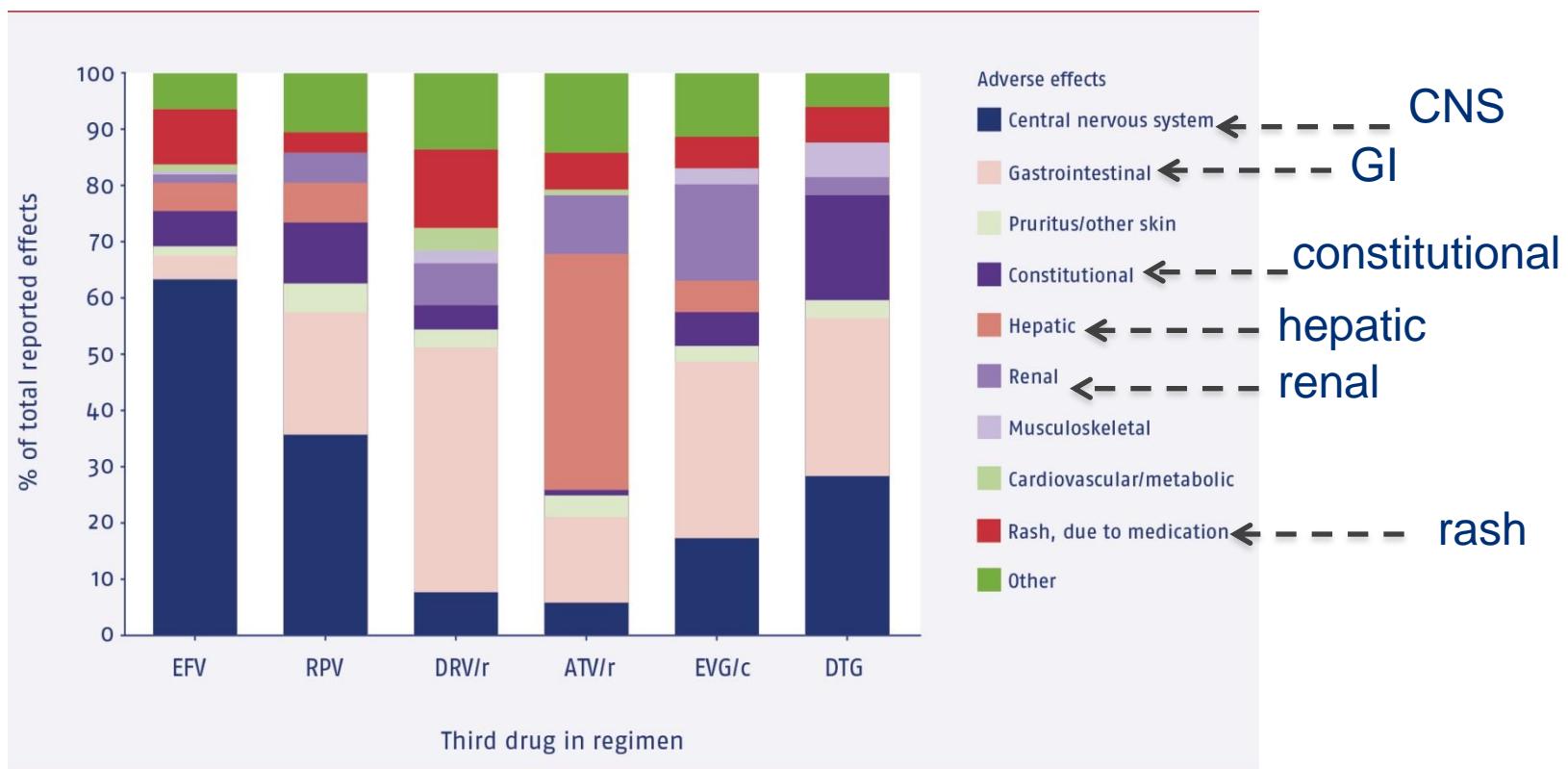


# Time to modification of recommended initial regimens for toxicity during first year of treatment

- 5,259 persons starting cART between 2010-2015
- 1,285 (24,4%) persons modified regimen within 12 mos
- Toxicity being the main reason in 758 of 1,285 (59%) persons



# Adverse effects in 758 individuals discontinuing their initial regimen due to toxicity during the first year of cART, by third drug component

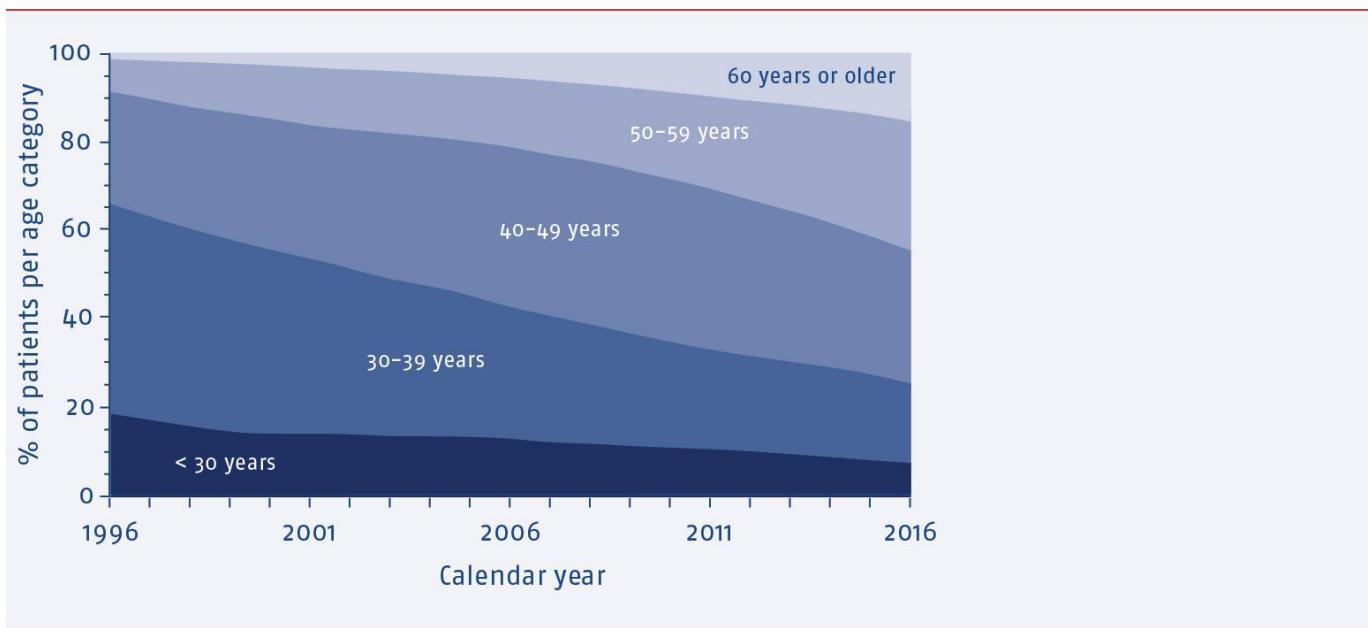


# Topics

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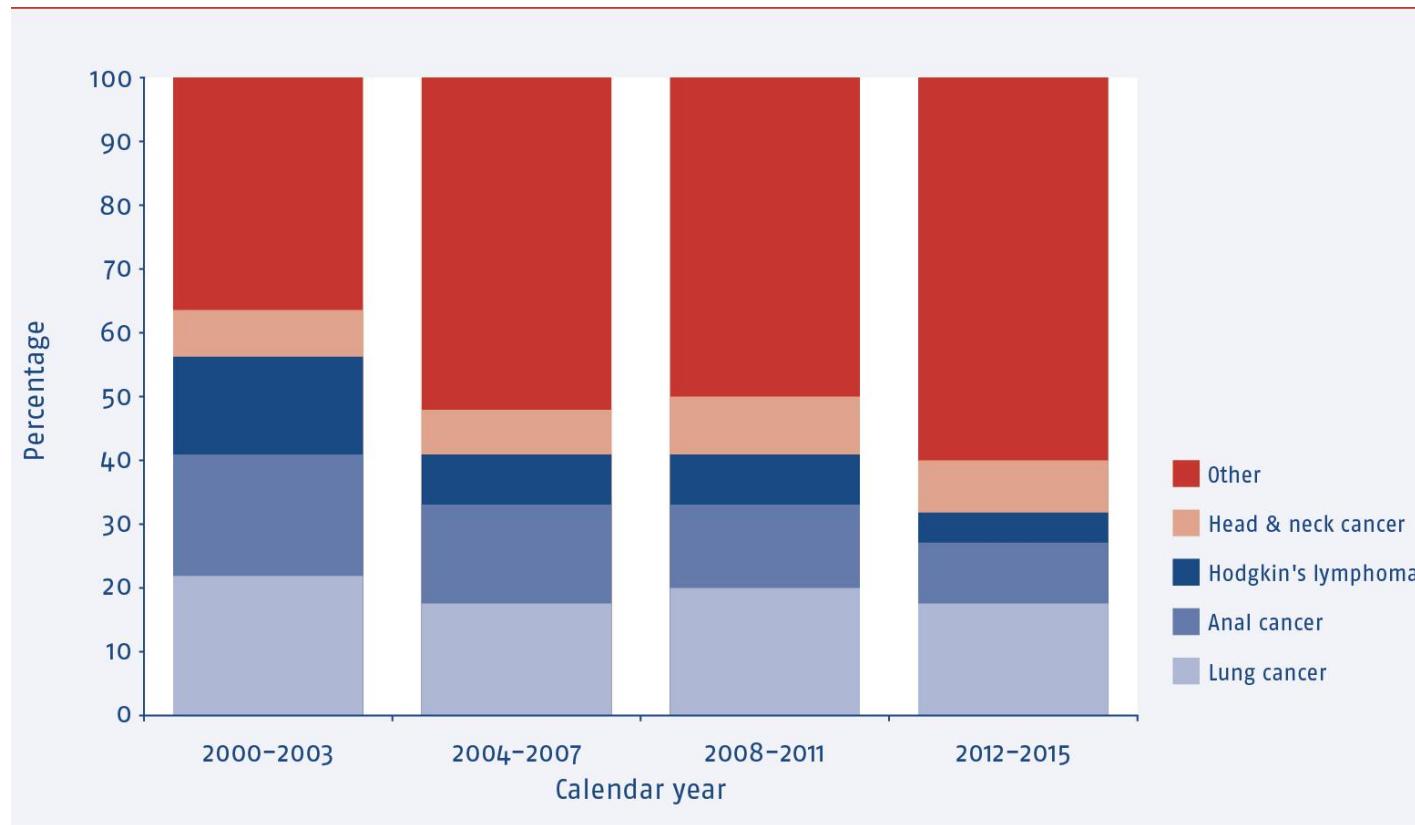
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# Increasing age of patients in care



- Median age of patients in care = 48 years
- 50 years or older
  - 1996: 9%
  - 2016: 45% (42% in 2015)  
15%  $\geq$ 60 years (14% in 2015)
- Increase in age-related comorbidities

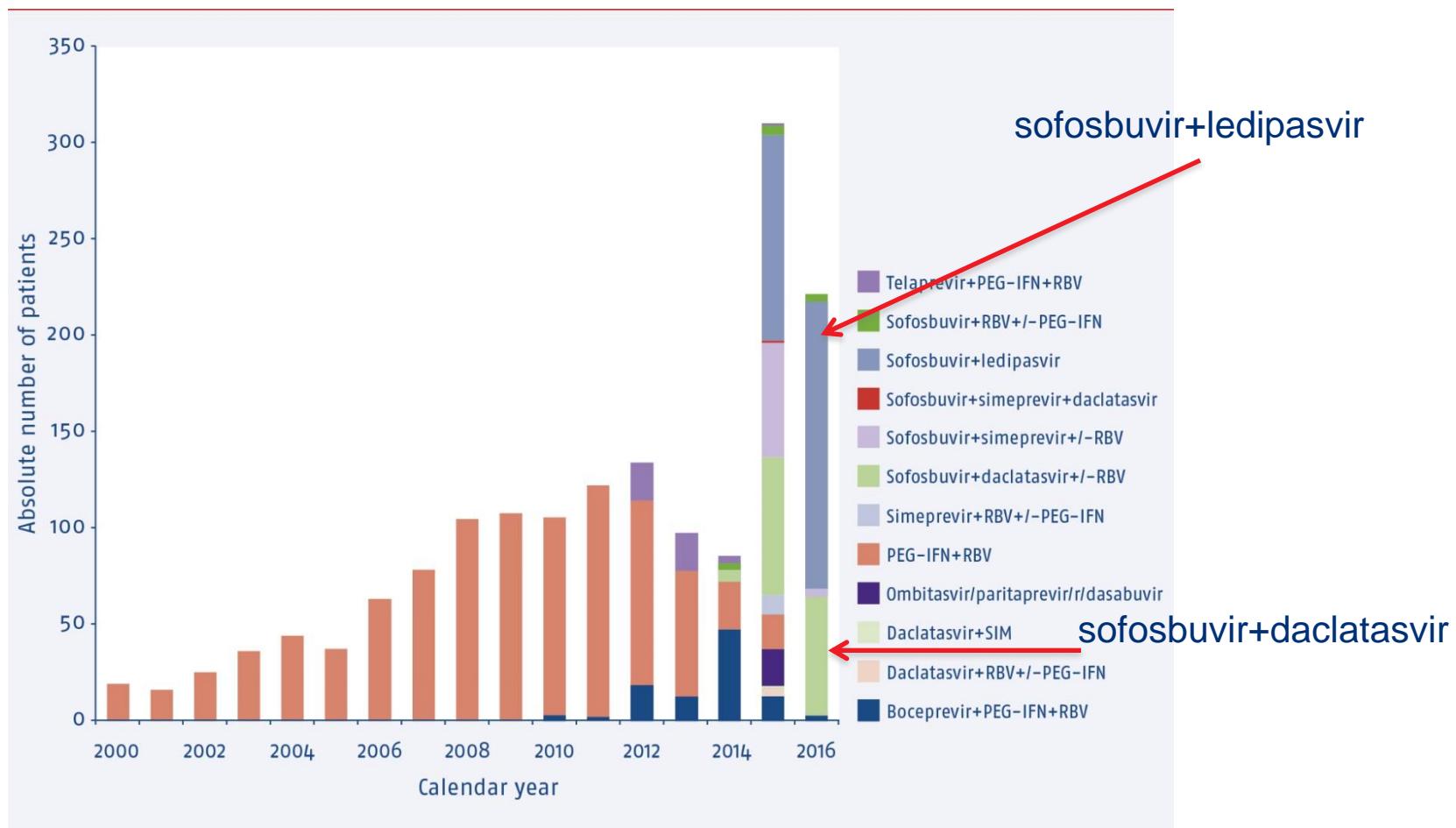
# Relative increase in cancers other than head & neck, Hodgkin's, anal, and lung as people in care with HIV age



# Treatment for HCV co-infection over time

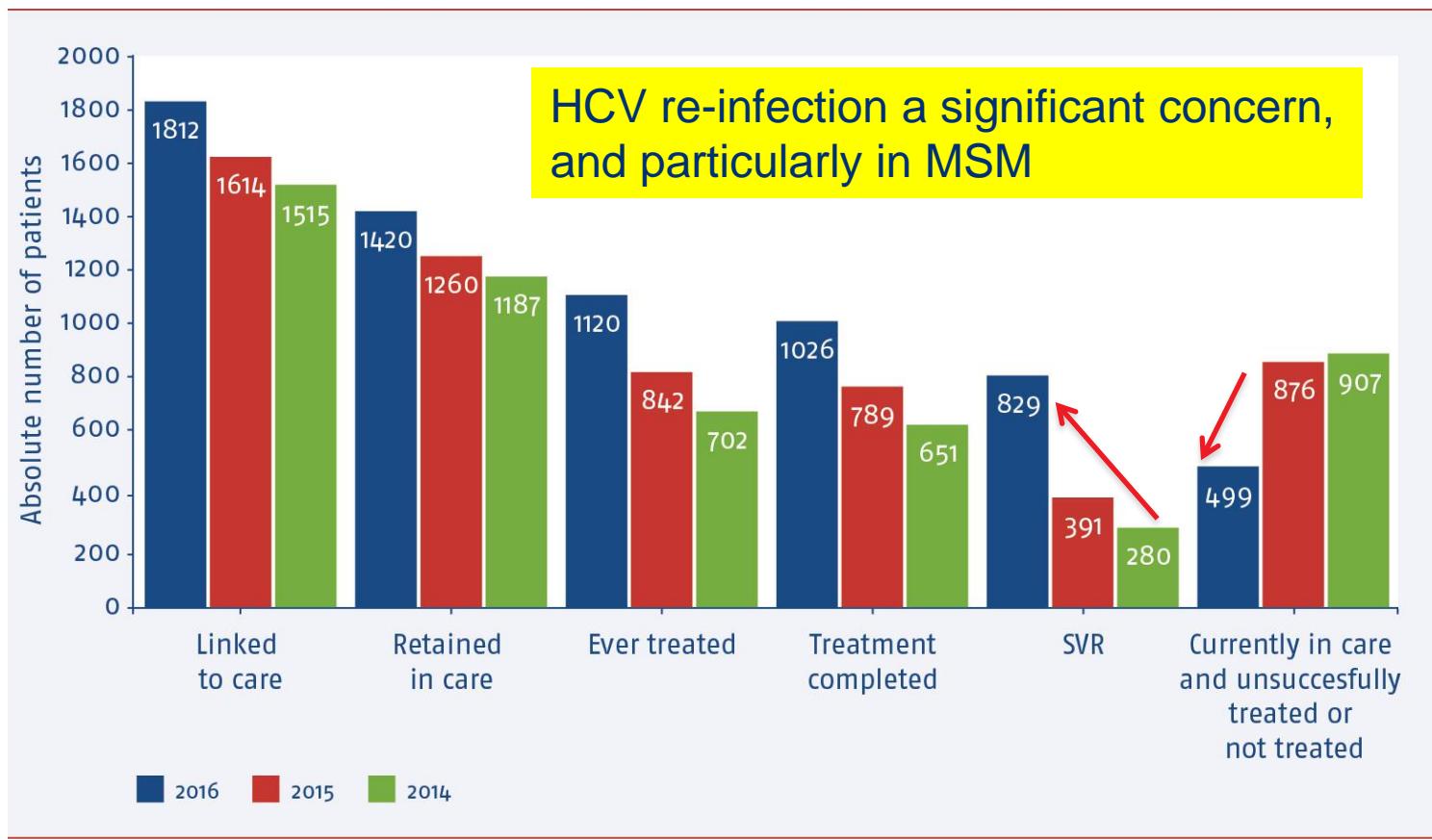
## Rapid uptake of new direct-acting antivirals

**SVR<sub>12</sub> rate 98% in 413 pts who completed treatment with one of the novel DAA regimens & sufficient follow-up post-treatment**



# HCV co-infection continuum of care

## Impact of new direct-acting antivirals comparing 2014, 2015, and 2016



# Conclusions

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## *Epidemic trends, continuum of care and antiretroviral treatment*

- We see a continued, but only gradual, decline in the annual number of newly diagnosed individuals, which includes a decline in newly-acquired HIV infections
- There is a general trend towards people being diagnosed and entering care earlier in infection
- Treatment is increasingly being started soon after diagnosis, and regardless of the CD4 count
- First-line treatment has largely shifted to include integrase inhibitors and the majority of patients achieves rapid viral suppression, regardless of where they receive care
- Nonetheless, late presentation remains far too common, and is particularly frequent in newly-diagnosed older individuals.

# Conclusions

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## *Ageing and comorbidity*

- Comorbidity, including cancer, will continue to increase as the population with HIV in care ages further and will increasingly affect health outcomes and clinical management
- The availability, regardless of liver disease-stage, of novel direct acting antiviral regimens against HCV, has resulted in rapid uptake of these regimens
- As a consequence, we are seeing a clear reduction in the number of co-infected individuals who remain in need of effective HCV treatment
- This could mark the beginning of eliminating HCV co-infection from the population with HIV in care in the Netherlands, but only when combined with other preventative interventions to turn the tide of HCV-reinfection

## For further information

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**Please visit our website ([www.hiv-monitoring.nl](http://www.hiv-monitoring.nl)) and read or download the new digital HIV Monitoring Report.**

- Fully searchable PDF, with appendix figures and tables included
- All figures available separately as powerpoint file at [www.hiv-monitoring.nl](http://www.hiv-monitoring.nl)
- Summary and Recommendations on website & in print (see NCHIV bag)

