High retention and viral suppression rates across all 27 HIV treatment centres in the Netherlands, but large variation in starting cART within one year after entry into care.

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Background

Data collected by Stichting HIV Monitoring track the outcomes for virtually all individuals infected with HIV cared for across the 27 Dutch HIV treatment centres.

We analysed scores of a number of outcome indicators and process indicators to gain insight into their variation between the 27 Dutch HIV treatment centres.

Methods

Indicators were derived from national HIV treatment and monitoring guidelines *(1)*.

Outcome indicators:

- Retention in care (% of patients in care on 1 January 2014 of those who entered care in 2012)
- Initiation of cART (% of patients starting cART within 12 months of those who entered into care in 2012 and 2013)
- Achieving viral suppression in 1. % of treatment-naïve patients with a HIV RNA level <400 copies/ml at 6 months after the start of cART, 2. % of all HIV-infected patients who received cART for at least 6 months with a HIV RNA level <100 copies/ml).

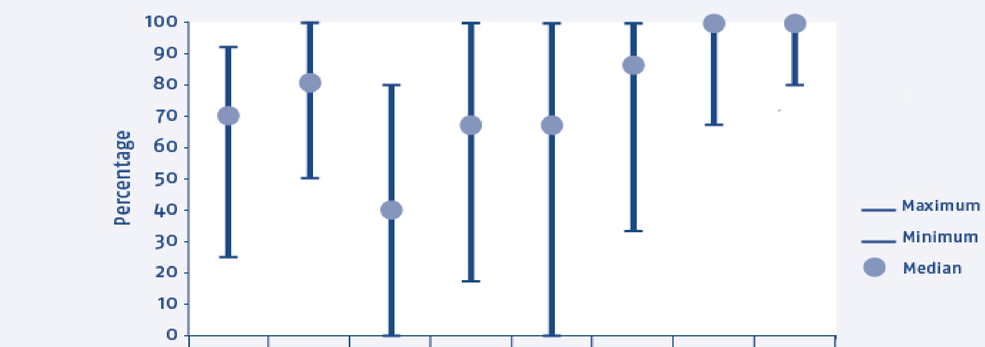
Proces indicators:

- % of patients who entered care in 2012, and in whom plasma HIV RNA, CD4 cell counts, total cholesterol, alanine transaminase (ALT) and creatinine had been assessed and screening for syphillis, hepatitis B (HBV) and C (HCV) has been carried out within 12 months following entry into care.
- % of repeat HCV screening among MSM who were HCV negative at entry in care in 2012, and repeat syphillis serology among all MSM who entered care in 2012 *(non-guidelines based)*.

Results

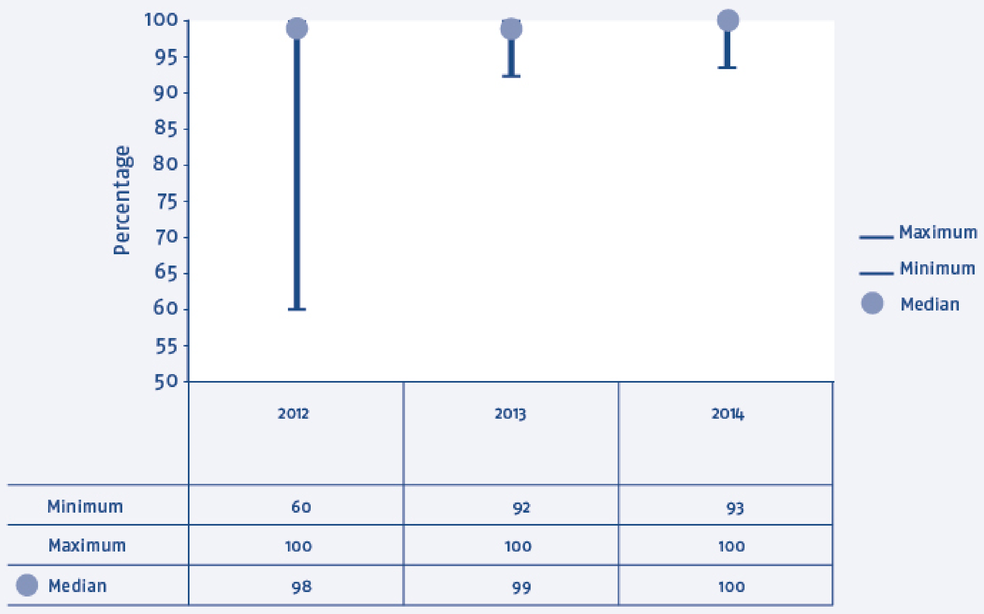
The median retention rate was 92%, retention rates varied between 81% and 100% across HIV treatment centres.

Figure 1: Percentage of patients who entered care in 2012 and 2013 and started cART within one year after entry into care. Overall and categorised by CD4 cell count at entry are presented.

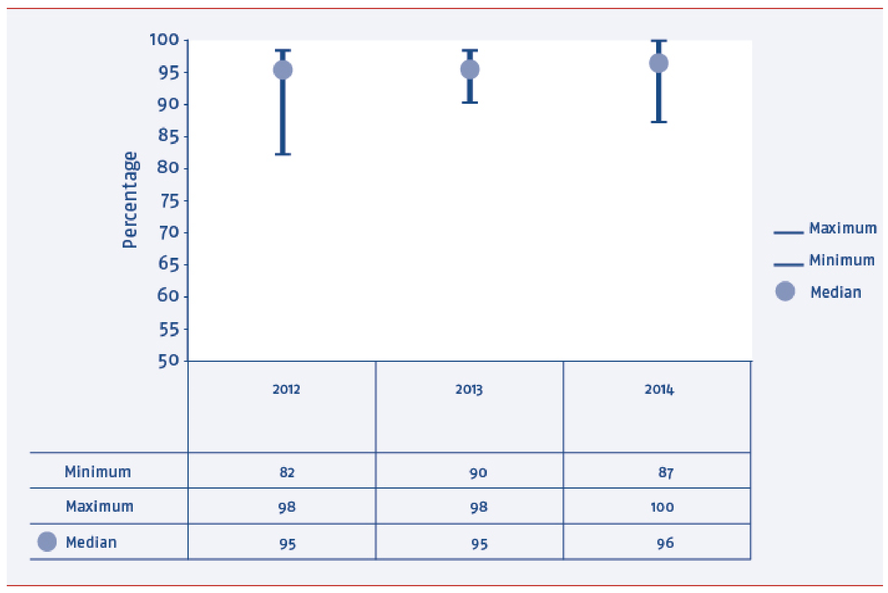


	overall 2012	overall 2013	CD4 >500 2012	CD4 >500 2013	CD4 350–500 2012	CD4 350–500 2013	CD4 ≤350 2012	CD4 ≤350 2013
Minimum	25	50	0	17	0	33	67	80
Maximum	92	100	80	100	100	100	100	100
Median	70	81	40	67	67	86	100	100

Figure 2: 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 cART.

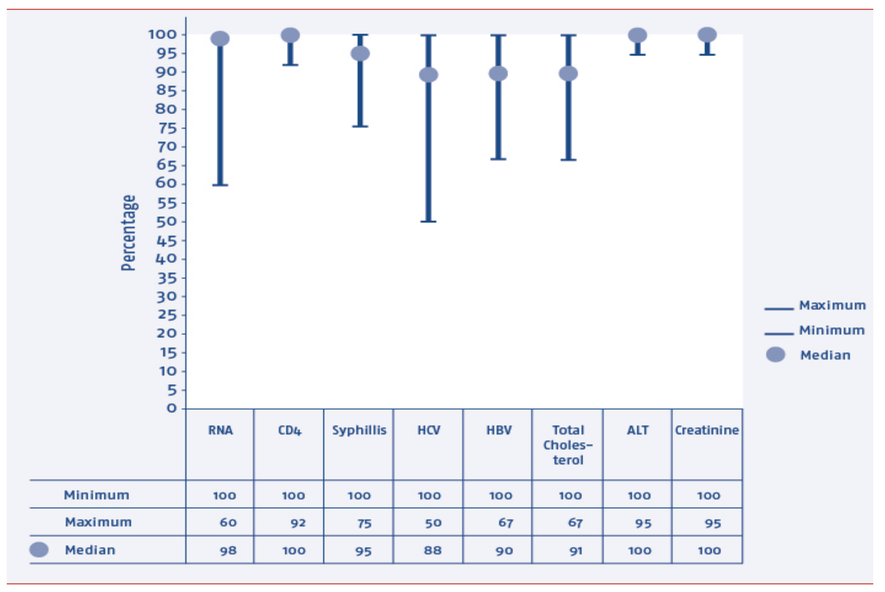


	2012	2013	2014
Minimum	60	92	93
Maximum	100	100	100
Median	98	99	100



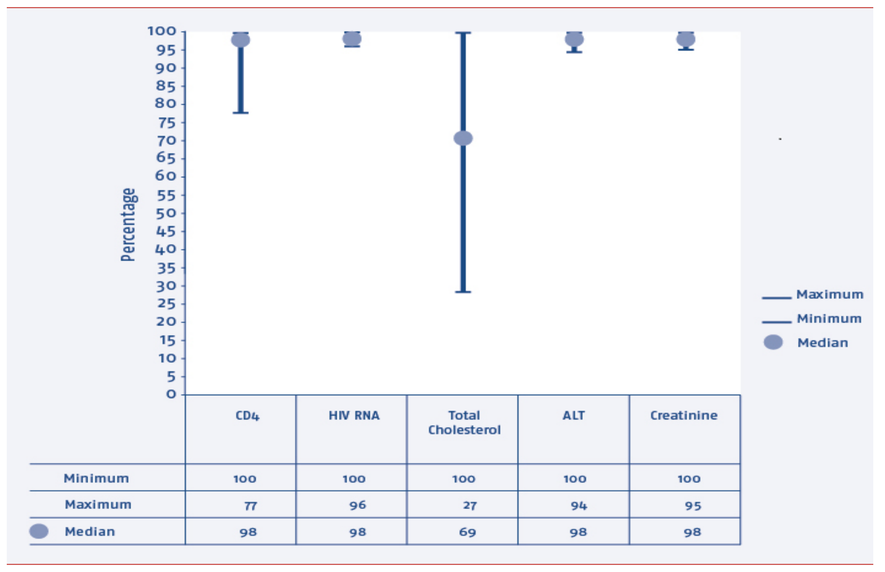
	2012	2013	2014
Minimum	82	90	87
Maximum	98	98	100
Median	95	95	96

Figure 3: Percentages of all HIV-infected patients in care who had received cART for at least 6 months and had a HIV RNA level <100 copies/ml.



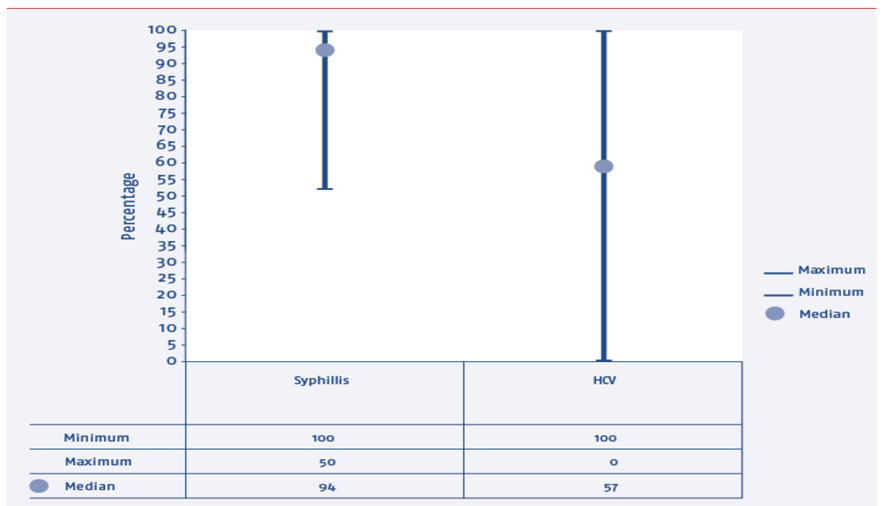
	RNA	CD4	Syphillis	HCV	HBV	Total Choles-terol	ALT	Creatinine
Minimum	100	100	100	100	100	100	100	100
Maximum	60	92	75	50	67	67	95	95
Median	98	100	95	88	90	91	100	100

Figure 4: Percentages of patients who newly entered care in 2012, and in whom plasma HIV RNA, CD4 cell count, total cholesterol, ALT and creatinine had been assessed and screening for HBV, HCV and syphillis has been carried out prior to starting cART.



	CD4	HIV RNA	Total Cholesterol	ALT	Creatinine
Minimum	100	100	100	100	100
Maximum	77	96	27	94	95
Median	98	98	69	98	98

Figure 5: Percentages of patients who initiated cART in 2012 and 2013 and in whom plasma HIV RNA, CD4 cell count,, total cholesterol , ALT and creatinine was assessed after the start of cART.



	Syphillis	HCV
Minimum	100	100
Maximum	50	0
Median	94	57

Figure 6: Percentages of repeat screening for HCV among MSM who were HCV negative at entry in care, and for repeat screening for syphillis among all MSM who entered care in 2012.

Conclusions

Retention in care and both short- and long-term viral suppression rates were high across Dutch HIV treatment centres.

Against the background of current guidelines recommending treatment for all patients regardless of CD4 count and screening for HBV and HCV, it is worth noting that in some HIV treatment centres initiating treatment among those entering into care with CD4 counts >350 cells/mm^3 may be improved.

Large variation in repeat screening for HCV in groups at risk may be explained by physicians applying a policy of targeted screening guided by the presence of elevated ALT levels.

Reference (1) Nederlandse Vereniging van HIV Behandelaren (NVHB). Richtlijn HIV. www.nvhb.nl/richtlijnhiv/index.php/Hoofdstuk_2._Therapie_bij_volwassenen. 2014.