



Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents

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Considerations for Antiretroviral Use in Patients with Coinfections

HIV/Hepatitis B Virus (HBV) Coinfection (Last updated January 10, 2011; last reviewed January 10, 2011)

Panel's Recommendations

- Prior to initiation of antiretroviral therapy (ART), all patients who test positive for hepatitis B surface antigen (HBsAg) should be tested for hepatitis B virus (HBV) DNA using a quantitative assay to determine the level of HBV replication (**AIII**).
- Because emtricitabine (FTC), lamivudine (3TC), and tenofovir (TDF) have activity against both HIV and HBV, if HBV or HIV treatment is needed, ART should be initiated with the combination of TDF + FTC or TDF + 3TC as the nucleoside reverse transcriptase inhibitor (NRTI) backbone of a fully suppressive antiretroviral (ARV) regimen (**AI**).
- If HBV treatment is needed and TDF cannot safely be used, the alternative recommended HBV therapy is entecavir in addition to a fully suppressive ARV regimen (**BI**). Other HBV treatment regimens include peginterferon alfa monotherapy or adefovir in combination with 3TC or FTC or telbivudine in addition to a fully suppressive ARV regimen (**BII**).
- Entecavir has activity against HIV; its use for HBV treatment without ART in patients with dual infection may result in the selection of the M184V mutation that confers HIV resistance to 3TC and FTC. Therefore, entecavir must be used in addition to a fully suppressive ARV regimen when used in HIV/HBV-coinfected patients (**AII**).
- Discontinuation of agents with anti-HBV activity may cause serious hepatocellular damage resulting from reactivation of HBV; patients should be advised against self-discontinuation and carefully monitored during interruptions in HBV treatment (**AII**).
- If ART needs to be modified due to HIV virologic failure and the patient has adequate HBV suppression, the ARV drugs active against HBV should be continued for HBV treatment in combination with other suitable ARV agents to achieve HIV suppression (**AIII**).

Rating of Recommendations: A = Strong; B = Moderate; C = Optional

Rating of Evidence: I = Data from randomized controlled trials; II = Data from well-designed nonrandomized trials or observational cohort studies with long-term clinical outcomes; III = Expert opinion

Approximately 5%–10% of HIV-infected persons also have chronic HBV infection, defined as testing positive for HBsAg for more than 6 months.¹ The progression of chronic HBV to cirrhosis, end-stage liver disease, and/or hepatocellular carcinoma is more rapid in HIV-infected persons than in persons with chronic HBV alone.² Conversely, chronic HBV does not substantially alter the progression of HIV infection and does not influence HIV suppression or CD4 cell responses following ART initiation.³⁻⁴ However, several liver-associated complications that are ascribed to flares in HBV activity, discontinuation of dually active ARVs, or toxicity of ARVs can affect the treatment of HIV in patients with HBV coinfection.⁵⁻⁷ These include the following:

- FTC, 3TC, and TDF are approved ARVs that also have antiviral activity against HBV. Discontinuation of these drugs may potentially cause serious hepatocellular damage resulting from reactivation of HBV.⁸
- Entecavir has activity against HIV; its use for HBV treatment without ART in patients with dual infection may result in the selection of the M184V mutation that confers HIV resistance to 3TC and FTC. Therefore, entecavir must be used in addition to a fully suppressive ARV regimen when used in HIV/HBV-coinfected patients (**AII**).⁹
- 3TC-resistant HBV is observed in approximately 40% of patients after 2 years on 3TC for chronic HBV and in approximately 90% of patients after 4 years when 3TC is used as the only active drug for HBV in

coinfected patients. Therefore, 3TC or FTC should be used in combination with other anti-HBV drugs **(AII)**.¹⁰

- Immune reconstitution after initiation of treatment for HIV and/or HBV can be associated with elevation in transaminases, possibly because HBV is primarily an immune-mediated disease.¹¹
- Some ARV agents can cause increases in transaminase levels. The rate and magnitude of these increases are higher with HBV coinfection.¹²⁻¹³ The etiology and consequences of these changes in liver function tests are unclear because continuation of ART may be accompanied by resolution of the changes. Nevertheless, some experts suspend the implicated agent(s) when the serum alanine transferase (ALT) level is increased to 5–10 times the upper limit of normal. However, in HIV/HBV-coinfected persons, increases in transaminase levels can herald hepatitis B e antigen (HBeAg) seroconversion due to immune reconstitution, so the cause of the elevations should be investigated prior to the decision to discontinue medications. In persons with transaminase increases, HBeAg seroconversion should be evaluated by testing for HBeAg and anti-HBe as well as HBV DNA levels.

Recommendations for HBV/HIV-Coinfected Patients

- All patients with chronic HBV should be advised to abstain from alcohol, assessed for immunity to hepatitis A virus (HAV) infection (anti-HAV antibody total) and vaccinated if nonimmune, advised on methods to prevent HBV transmission (methods that do not differ from those to prevent HIV transmission), and evaluated for the severity of HBV infection as outlined in the [Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents](#).¹⁴
- Prior to initiation of ART, all persons who test positive for HBsAg should be tested for HBV DNA using a quantitative assay to determine the level of HBV replication **(AIII)**. Persons with chronic HBV infection already receiving ART active against HBV should undergo quantitative HBV DNA testing every 6–12 months to determine the effectiveness of therapy in suppressing HBV replication. The goal of HBV therapy with NRTIs is to prevent liver disease complications by sustained suppression of HBV replication to the lowest achievable level.
- **If not yet on therapy and HBV or HIV treatment is needed:** In persons without HIV infection, the recommended anti-HBV drugs for the treatment of persons naive to HBV therapy are TDF and entecavir.¹⁵⁻¹⁶ In HIV-infected patients, however, only TDF can be considered part of the ARV regimen; entecavir has weak anti-HIV activity and must not be considered part of an ARV regimen. In addition, only TDF is fully active for the treatment of persons with known or suspected 3TC-resistant HBV infection. To avoid selection of HBV-resistant variants, when possible, these agents should not be used as the only agent with anti-HBV activity in an ARV regimen **(AIII)**.

Preferred regimen. The combination of TDF + FTC or TDF + 3TC should be used as the NRTI backbone of a fully suppressive ARV regimen and for the treatment of HBV infection **(AII)**.¹⁷⁻¹⁹

Alternative regimens. If TDF cannot safely be used, entecavir should be used in addition to a fully suppressive ARV regimen **(AII)**; importantly, entecavir should not be considered to be a part of the ARV regimen²⁰ **(BII)**. Due to a partially overlapping HBV-resistance pathway, it is not known if the combination of entecavir + 3TC or FTC will provide additional virologic or clinical benefit compared with entecavir alone. In persons with known or suspected 3TC-resistant HBV infection, the entecavir dose should be increased from 0.5 mg/day to 1 mg/day. However, entecavir resistance may emerge rapidly in patients with 3TC-resistant HBV infection. Therefore, entecavir should be used with caution in such patients with frequent monitoring (~ every 3 months) of the HBV DNA level to detect viral breakthrough. Other HBV treatment regimens include peginterferon alfa monotherapy or adefovir in combination with 3TC or FTC or telbivudine in addition to a fully suppressive ARV regimen;^{17, 21-22} however, data on these regimens in persons with HIV/HBV coinfection are limited **(BII)**. Due to safety concerns, peginterferon alfa should not be used in

HIV/HBV-coinfected persons with cirrhosis.

- **Need to discontinue medications active against HBV:** The patient's clinical course should be monitored with frequent liver function tests. The use of adefovir dipivoxil, entecavir, or telbivudine to prevent flares, especially in patients with marginal hepatic reserve such as persons with compensated or decompensated cirrhosis, can be considered.⁸ These alternative HBV regimens should only be used in addition to a fully suppressive ARV regimen.
- **Need to change ART because of HIV resistance:** If the patient has adequate HBV suppression, the ARV drugs active against HBV should be continued for HBV treatment in combination with other suitable ARV agents to achieve HIV suppression (**AIII**).

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