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ORIGINAL RESEARCH

European AIDS Clinical Society Second Standard of Care Meeting, Brussels 16–17 November 2016: a summary

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The European AIDS Clinical Society (EACS) organized a second meeting on Standard of Care in Europe on November 16-17 th, 2016. The aims of the meeting were to discuss and propose actions on three topics, namely: Adherence to guidelines for treatment initiation, treatment monitoring and outcomes, Retention in care and HIV and tuberculosis co-infection. Several actions need to be implemented in order to further improve quality of care and treatment of HIV in Europe. A common ground for standard of care, based on the EACS Guidelines should be established throughout Europe. EACS plans to interact with policy makers and other stakeholders to insure this common minimal level of standard of care, in particular for initiating of ART, accessibility of drugs and monitoring of ART with viral load. Progress should be made to monitor retention in care, prevent lost to follow and insure return to care. Improving integration of services and accessibility to care play a major role. Integration is also key for optimizing care of HIV-tuberculosis co-infection, as well as diagnosis and prevention of tuberculosis in population at risk. The Standard of Care meeting organized every other year by EACS provides a unique opportunity to monitor progresses and pitfalls in HIV patient care throughout Europe. It is also a forum for advocacy towards policy makers and other stakeholders to constantly improve HIV patient global management, aiming to provide the same level of quality on the whole continent.

Keywords: EACS, guidelines, retention in care, standard of care, tuberculosis

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The European AIDS Clinical Society (EACS) organized the Second Standard of Care Meeting in Europe on 16–17 November 2016 in Brussels after the first meeting held in Rome in 2014 [1]. Participating stakeholders were: members of EACS, the European Center for Disease Control (ECDC) and the US Centers for Disease Control and Prevention (CDC), and representatives from the Russian Federation, the European Union Commission, the World Health Organization (WHO) and the European AIDS Treatment Group (EATG).

The following aims were defined:

- to define how to improve and monitor quality of HIV care in the European region;
- to review the contribution of the EACS guidelines to quality of care;
- to discuss whether EACS guidelines could serve as a basis for broader quality-of-care standards, and
- to define partnerships with other societies, agencies and stakeholders to improve the standard of care in the European region.

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During the first day, a number of renowned lecturers presented cutting-edge data on a range of important issues including epidemiology, patient access to treatments, standard of care and public health. Panellists interactively discussed the data presented, took up important remarks from the audience and addressed key points for each topic. Panellists from Eastern Europe particularly felt that this meeting should trigger further regional activities in patient access and standard of care.

The meeting was introduced by Manuel Battegay, president of EACS (2012-2016), who stated that, with a view to treating all HIV-infected persons, physicians need to address broader determinants of health and access to treatment. Guidelines have an important role to play to advocate clinical standards.

Kevin De Cock, former Director of HIV for WHO, emphasized that the difficulty of bringing the HIV epidemic "down to zero" should not be underestimated. He underlined that HIV has acted as an amplifier of progress towards global health in many ways, even if the target of having 90% of all people with HIV infection diagnosed is proving frustratingly difficult to reach in some countries.

The outcomes of the "Euroguidelines in Central and Eastern Europe" Conference (ECEE) held in February 2016 in Warsaw were presented by Justyna Kowalska from Poland. This meeting brought together over 60 participants from 15 countries. A major emerging issue was the necessity for better surveillance prior to achieving improvements in standard of care. This was particularly true for the quality of data on the current prevalence of HIV, information on transmission and data on linkage and suppression rates. By 2016, progress had been made towards initiating antiretroviral therapy (ART) earlier. No Central and Eastern European (CEE) countries recommended starting treatment with a CD4 threshold of 200 cells/μL, six recommended starting treatment with a threshold of 350 cells/μL, nine with a threshold of 500 cells/μL and 11 with no threshold. Altogether, 58% of CEE countries had a defined CD4 threshold for treatment in their national guidelines.

Still, there were significant limitations in the choice of first-line ART, as not all antiretrovirals (ARVs) were available, mainly as a consequence of cost concerns. Also, registration of tuberculosis (TB), hepatitis C virus (HCV) infection and other comorbidities was delayed in most participating countries. Limitations in terms of access to laboratory services and the availability of well-trained staff to measure CD4 count, viral load and tropism and to perform resistance tests were also noted. Importantly, viral load testing is still not routine in many countries. TB and multidrug-resistant (MDR) TB are specific problems in the region, and TB services are poorly aligned with HIV services. Justyna Kowalska concluded that structural drivers of TB, especially poverty and poor housing, are rarely addressed in clinical settings [2].

On the second day of the meeting, three workshops addressed three topics, namely:

- adherence to guidelines for treatment initiation, treatment monitoring and outcomes;
- retention in care, and
- HIV and tuberculosis coinfection.

Adherence to guidelines for treatment initiation, treatment monitoring and outcomes

Andrea Antinori (Italy) and Nina Friis-Møller (Denmark)

In this workshop, harmonization of guidelines across Europe and evaluation of compliance with guidelines were discussed. It was noted that some international guidelines provide a grading for their recommendations. As a consequence, some countries follow non-European guidelines because they provide a grading. Hence, it was discussed whether guidelines issued by EACS should include a grading. The grading of guideline recommendations was criticized for being unpractical and, in overemphasizing randomized clinical trials, for neglecting the overview which is of particular importance in caring for HIV-infected persons.

It has been stressed that many countries use their own national guidelines, which allows country-specific factors, for example in terms of health systems and drug availability, to be taken into account. EACS should work with country representatives to elaborate common ground for standard of care. Collaboration with international bodies such as ECDC and WHO, as well as nongovernmental organizations (NGOs), is needed to monitor access to "basic" standard of care recommendations in the different regions and countries of Europe. Available data should include drug unavailability and shortages, pricing issues, restrictions to access to treatment, issues regarding generics and untreated populations. This would allow EACS and other bodies to interact with policy makers to assure a common minimal basis for standard of care across the continent. There was a consensus to drop CD4 count monitoring if regular viral load tests show viral suppression. CD4 counts would still be performed on diagnosis, in the initial phase of treatment (first year), in people not on ART, in cases of virological and/or clinical progression, and when patients are treated with immunosuppressive agents, particularly cancer chemotherapy.

Retention in care

Sanjay Bhagani (UK) and Gerd Fätkenheuer (Germany)

It was noted that linkage to care after diagnosis is relatively easy to monitor. However, measurement of retention needs a clear definition of retention. Local and/or better national databases could be used to register data such as missed visits, appointment adherence (completed/scheduled visits in a given period), visit constancy (predefined time intervals with at least one visit), gaps in care (time intervals between visits), and a medical visit performance measure (whether a patient had more than two completed visits in 12 months) [3]. Few countries have provided data on retention in care. In Switzerland, linkage to care has been estimated to be around 98% [4]. Comparable figures have been generated in Sweden, Denmark and the UK [5-7]. Data from Belgium were slightly below these figures, with retention in care around 92% [8]. There was agreement on potential simple ways to measure retention in care, that is, viral suppression (undetectable viral load) and vital status. The timespan for the definition of loss to follow-up (LTFU) was discussed , and 6 months was considered to be too short. Populations particularly at risk of LTFU are people who inject drugs (PWID), individuals with psychiatric comorbidities, and persons with unstable social conditions.

Strategies that could restore linkage to care and prevent future LTFU episodes should be implemented. In particular, for people migrating, better surveillance would be valuable. A difficult issue to address is how to find LTFU patients. Some measures which were discussed were finding patients, especially highly mobile patients, via text messages to their mobile phones and inquiring about patients in other services, health facilities, centres and clinics. This would only be feasible if patients initially agreed to such measures. It was strongly suggested that the next issue of the EACS guidelines should include a short section defining retention and suggesting strategies for prevention of LTFU.

HIV and TB coinfection

Hansjakob Furrer (Switzerland) and Cristiana Oprea (Romania)

In Europe, it is estimated that 5% of TB patients are HIV-infected. Eastern Europe has the highest levels of MDR TB anywhere in the world and HIV is a driver of TB spread and drug resistance. Also, cases of HIV infection are being missed because of a lack of testing in TB patients and vice versa. Only 50% of people diagnosed with HIV infection in Europe are tested for latent TB and globally only 65% of TB patients are tested for HIV. There is a great difference among European countries in testing and treating latent TB. Participants in the workshop highlighted the fact that, especially in countries in Western Europe, physicians have stopped testing for latent TB following the advent of ART because the development of active TB in patients on ART is quite rare. However, migration could increase the number of MDR-TB cases in low-incidence countries in Western Europe. As TB in migrants is mainly associated with reactivation of latent infection, systematic screening strategies for migrants and refugees at arrival and post-arrival should be implemented.

The major challenges identified for TB management in Eastern Europe were: the overlapping risk groups for HIV and TB (especially in injecting drug users), the inadequate surveillance system and the lack of information for HIV/TB-coinfected patients, the lack of access to rapid drug susceptibility testing and integrated Directly Observed Therapy (DOT) program and the reduced availability of new anti-TB drugs TB. TB infection control is inadequate in some HIV facilities , carrying the risk of nosocomial transmission of TB among people living with HIV (PLHIV) in the region. There has been a substantial increase in triple coinfection [HIV/TB/hepatitis C virus (HCV)] in injecting drug users, especially in countries such as Ukraine, Russia and Romania.

There was a broad consensus on the need for data collection in order to evaluate the actual risk of TB in patients who are virologically suppressed and to scale up the management of Latent Tuberculosis Infection (LTBI) (especially in high-burden TB/HIV countries and for migrants).

Routine HIV testing should be scaled up for all patients with presumptive or diagnosed TB.

The three ‘i’s for HIV/TB [intensified TB screening, Isoniazide (INH) preventive therapy (IPT) and infection control] should be adopted by policy makers and implemented by all health facilities offering HIV care services. Early diagnosis and access to ART among PLHIV are essential to control TB and to reduce TB-associated mortality.

Enhanced Directly Observed Therapy (DOT), included as part of DOT support for other social and medical needs, might also increase the likelihood of TB treatment success.

In particular, for HIV/TB coinfection, integration of care is essential. HIV/TB-coinfected patients should be treated in a setting where the best isolation methods can be provided, preferably in the same health care facility. Treatment of active TB requires long-term adherence, and thus integration with other services such as drug addiction services would be very important to maintain patients on drugs, both (when indicated) TB drugs and ART.

Conclusions

Several actions need to be implemented in order to further improve quality of care and treatment of HIV

infection in Europe. Common ground for standard of care, based on the EACS guidelines, should be established throughout Europe. EACS plans to interact with policy makers and other stakeholders to ensure achievement of this common minimum level of standard of care, in particular for initiation of ART, accessibility of drugs and monitoring of ART using viral load.

Progress should be made in monitoring retention in care, preventing LTFU and ensuring return to care. Improving integration of services and accessibility to care will play a major role in this . Integration is also key for optimizing care of patients with HIV/TB coinfection, as well as diagnosis and prevention of TB in populations at risk.

The Standard of Care meeting organized every other year by EACS provides a unique opportunity to monitor progress and pitfalls in HIV-infected patient care throughout Europe. It is also a forum for advocacy targeted to policy makers and other stakeholders to constantly improve global management of HIV-infected patients, with the aim of providing the same level of quality throughout the continent.

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