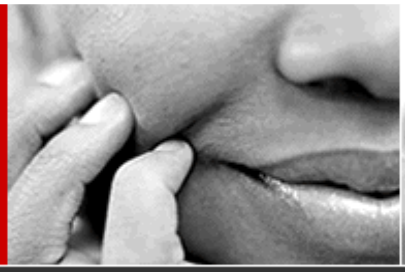

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# Healthcare Professional Newsletter

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## ART for Prevention

There have been several recent successes of antiretrovirals being used to prevent HIV infection. Infections in women were reduced by tenofovir vaginal gels and by pre-exposure prophylaxis with tenofovir plus emtricitabine in men having sex with men. The decision by the Data and Safety Monitoring Board of the HPTN 052 trial to discontinue the study early and release the positive preliminary findings of the study provides further evidence that antiretrovirals can reduce transmission of HIV.

This 13-site randomized controlled trial enrolled 1763 HIV-discordant couples, the HIV-infected partner having a CD4 count of 350-550 cells/mm$^3$. ART was either given immediately or was delayed until the CD4 count fell below 250 cells/mm$^3$ or the originally infected partner developed an AIDS-defining illness.

27 transmissions occurred within the 877 couples in the delayed ART group as opposed to 1 transmission in the immediate ART group (96% reduction in the risk of HIV transmission). Furthermore, 17 cases of extra-pulmonary TB occurred in the delayed ART group vs 3 in the immediate treatment group, demonstrating the role of early ART in reducing the incidence of opportunistic infections.

Publication of the full results of this study are awaited. The financial challenge for South Africa to adopt comprehensive treatment of all State Sector discordant couples with higher CD4 counts in addition to increasing coverage to all patients with counts <350 cells/mm$^3$ would be formidable. An early start of ART in discordant couples is already part of AfA's Clinical Guidelines 2010/2011 and now there is more robust evidence to support this policy to prevent transmission, the benefits of which are clear to all.

## Transnet Corporate HIV/AIDS Disease Management Programme - Change in Service Provider

Since 2004, all medically uninsured employees of Transnet have had access to an HIV/AIDS disease management programme through Qualsa. This **contract with Qualsa came to an end** on 30 April 2011.

We are delighted to announce, following a procurement process, **Transnet Ltd has appointed Aid for AIDS** to deliver disease management services in this regard. The new contract with AfA is in place as of 1 May 2011.

For doctors with any questions regarding a patient's treatment, please don't hesitate to contact our clinical staff on **0800 227 700.**

Should one of your patients require some assistance, they should ring **0860 100 646**. Alternatively, you can email us on afa@afadm.co.za.

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## Cryptococcal Antigen Screening in Patients with CD4 ≤ 100

In the 2010 edition of the AfA Clinical Guidelines the serum cryptococcal antigen (CRAG) test was added as one of the routine laboratory tests we advise be performed prior to starting ART in patients with a CD4 count ≤ 100. The rationale for this addition is discussed here.

Cryptococcal meningitis (CM) is one of the most common opportunistic infections in South Africa and even with optimal treatment the case mortality rate is very high. In clinical trial settings in South Africa using initial amphotericin B-based treatment 10-week mortality is 20-40%, whereas in routine care up to two-thirds of patients have died or are lost to follow-up within 3 months. With greater access to ART in SA, a substantial proportion of patients presenting with CM currently do so during the first months of ART (20% in one Cape Town study). As a result CM is an important cause of death among patients with advanced HIV during the early months of ART. Given these factors prevention of this life-threatening condition is a priority [1].

There is increasing evidence that CM cases that present after patients have started ART could be detected earlier and prior to the development of CNS disease. The presence of cryptococcal antigen (CRAG) in the blood has been shown to precede the development of CM by a median of 3 weeks, but it can be present for over 100 days prior to onset of symptoms [2]. Cryptococcal organisms first establish infection in the lung and this antigenaemia is thought to represent systemic dissemination prior to the invasion of the CNS and onset of meningitis.

In a study conducted in Cape Town among 707 patients starting ART in whom CRAG was retrospectively tested on stored serum, 7% were found to be CRAG positive. Among those who were CRAG negative 0% developed subsequent CM in the first year of ART. Among those who were CRAG positive, and had not previously had CM, 28% developed CM on ART, the majority of whom had a baseline CD4 count < 100 [3].

Serum CRAG thus appears to be a valuable test for predicting risk of CM after starting ART in patients with a CD4 ≤ 100 and we advocate that it is performed in all such patients during work-up for ART, although it should not delay the initiation of ART. If the serum CRAG is positive, where possible patients should have a lumbar puncture performed and if the CSF demonstrates CM (Indian Ink, CSF CRAG and/or culture positive) then patients should be initially treated with amphotericin B as per AfA guidelines. However, if in serum CRAG positive patients without CNS symptoms LP is declined or facilities are unavailable or if the CSF shows no evidence of CM then we advocate treatment with fluconazole: 800mg for 2 weeks, then 400mg for 8 weeks and then 200mg daily for a further 10 months. Such patients should have ART started after 2 weeks of fluconazole therapy. This guideline is not based on prospective evidence as no studies have yet been completed and our guidance may be modified once prospective data becomes available.

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*Aid for AIDS is proud of the fact that we currently manage over **110 000** patients on our disease management programme.*

*We value the relationships we have in place with providers of care and treatment to our shared patients. We rely on your help in identifying HIV positive individuals and enrolling them onto the AfA programme.*

## Encouraging Enrollment on Aid for AIDS

Analysis of claims data has shown that a significant number of eligible medical scheme beneficiaries (currently over 36 000) are claiming for CD4 counts and viral loads on a regular basis, and thus are clearly HIV+, yet they are not enrolled on AfA.

The demographics of this group show a similar age and gender distribution to those already on AfA. Interestingly, the costs associated with the un-enrolled group are also similar to those on AfA, so these individuals are unlikely to all be at a very early stage of disease as was once thought. In fact, analysis of the costs indicates they are mostly related to hospitalization and treatment of opportunistic infections, suggesting antiretroviral therapy (ART) is probably already indicated and some may even be self-funding sub-optimal therapy.

Why are so many people reluctant to access a comprehensive and confidential benefit which is freely available to them and their dependents?

Possible explanations include:

- Lack of awareness about the existence of AfA and the benefits available on the part of both patients and doctors
- Lack of knowledge about how to join the programme
- Concerns about confidentiality
- A belief that treatment should be delayed as long as possible and that joining AfA offered no benefit until ART was considered essential
- Reluctance on the part of doctors to register patients because of the perception that this would be time-consuming and involve increased paperwork

AfA has embarked on a project to encourage as many HIV+ people as possible who belong to contracted medical schemes to enroll on the programme. This has mainly involved on-going efforts to educate medical scheme members about the benefits of enrolling on AfA and contacting practices linked to the individuals concerned to explain the advantages and outline the registration process.

In an attempt to simplify this process, AfA has made available both telephonic and on-line registration as alternatives to completing an application form. Doctors are requested to encourage all their patients who are HIV positive to enroll on AfA as early as possible, whether or not they require ART. This will ensure they gain access to regular treatment support and monitoring and can start ART at the most appropriate time.

## GEMS Communication – New DSP for HIV Medication

In line with the Scheme's commitment to service excellence and providing its members with the best possible experience, GEMS has appointed a courier pharmacy, namely **Medipost**, as the Designated Service Provider (DSP) of all chronic medication for their members. This is inclusive of medicines used to treat HIV. As the GEMS HIV Manager, AfA will continue to register, manage and care for members as normal. We will work alongside Medipost, in our capacity as the HIV Manager, to ensure that the delivery of approved medicines is a success.

As of 1 July 2011, purchasing chronic medication from any other pharmacy will attract a co-payment of 30%.

GEMS members have been advised of this new arrangement. We would however, appeal to you as the treating doctor to any GEMS members receiving chronic medication, to remind your patients of this change.

Medipost will be calling all relevant members in order to make the necessary arrangements. It is worth noting however, that members may also contact Medipost directly in this regard on the following number: 0860 00 4367