Background

Sofosbuvir (SOF) was approved in Europe in January 2014 with limited study data. In particular, interferon based triple therapy but also more relevant combination therapy with simeprevir and daclatasvir were studied in low patient numbers. HIV/HCV coinfected patients were not studied systematically with these regimens. For this real-life data are relevant to fill this gap. Here we present data on SOF-based treatments from a German multicenter cohort.

Methods

In this multicenter cohort, all consecutive patients who were started on the following treatment regimens were documented: SOF/ribavirin (RBV), SOF/daclatasvir (DCV), SOF/simeprevir (SMV), SOF/ledipasvir (LDV) and SOF/PegIFN/RBV. For the current analysis due to the limited number of HCV/HIV-coinfected patients with HCV genotype 2 and 3 only patients with genotype 1 and 4 were analysed (table 1). Due to the high association of SOF/RBV with genotype 2 and 3 this regimen was also excluded from the analysis. Data for SOF/LDV are not presented due to the limited follow up time.

Results

In total 518 patients are enrolled so far. Of those, 393 are HCV-monoinfected and 125 HCV/HIV-coinfected. Liver cirrhosis was present in about a third of the patients. Slightly more than half of the patients were pretreated for HCV. Most HCV/HIV patients had well controlled HIV infection and a high CD4+ cell count (table 1). Only 1/125 HCV/HIV-coinfected patients was not on antiretroviral therapy. The details for antiretroviral therapy are shown in table 2.

For patients with HCV genotype 1 or 4 there was no difference in vorologic response between SOF/PegIFN/RBV, SOF/SOF or SOF/DCV (Figure 1). HCV/HIV-coinfected patients responded as well as HCV-monoinfected patients (Figure 2). However patients with liver cirrhosis seem to respond slower to therapy and seem to have an approximately 10% lower SVR rate (p<0.05) (Figure 3 and 4). Premature discontinuation or lost to follow up were observed in 5% of patients counted as treatment failure, whereas relapse occurred in 7%.

Conclusion

In this ongoing cohort with a substantial proportion of cirrhotic patients probably liver cirrhosis, but not HCV/HIV-coinfection seems to be associated with a lower SVR. Premature discontinuation and lost to follow up compared to relapse almost equally contributed to patients considered as treatment failure.