Reply to Zimmer

To the Editor—We thank Dr Zimmer for contributing his personal reflections about how to improve access to and completion of human immunodeficiency virus (HIV) post-exposure prophylaxis (PEP) [1]. With respect to the evidence supporting the recent World Health Organization (WHO) recommendation to provide a full 28-day course of PEP at first visit, Dr Zimmer raises 3 main concerns: a false premise that starter packs are designed to improve adherence; information bias resulting from study misclassification and noninclusion of unpublished data; and the issuance of recommendations based on low-quality evidence.

We agree that starter packs are not primarily designed to improve adherence, although this has been stated by providers as a reason for using starter packs, on the assumption that interim visits provide an opportunity to assess adherence and toxicity [2]. The concern that led to the WHO guideline group to consider the benefits and risks of starter packs was that multiple reports from a diversity of settings show that over a quarter (28%) of individuals provided with starter packs fail to return for their subsequent PEP course and are therefore lost to care with no possibility to complete the full 28-day course [3]. In the United States, low rates of PEP completion following referral from emergency departments have led to calls for provision of full courses of PEP to allow patients an opportunity to take PEP even if they do not adhere to scheduled clinic follow-up [4]. There was also some evidence that people offered a full course at first visit were 11% less likely to refuse PEP and 16% more likely to complete the full course [3].

Information bias is an important concern for any systematic reviews. In our review, we included one study, PEPdar [5], for assessment of drug tolerability but excluded it from the analysis of PEP dispensing because it was reported only as an abstract and provided insufficient details regarding PEP dispensing. Publication bias is an ever present concern, in particular for implementation science research where not all healthcare providers document and publish their experiences. It is therefore important to consider the extent to which the published data is representative of broader experience. Overall we were able to identify 97 studies reporting outcomes among 21 462 PEP initiations, and considering the heterogeneous and generally poor outcomes reported by most studies which were carried out in routine program settings, we have no basis for believing that published outcomes will differ greatly from general practice.

There is a pressing need to improve the adherence and completion rates for PEP. Multiple studies, summarized by at least 3 systematic reviews [6–8], have highlighted the fact that rates of PEP completion are poor, with only 57% of eligible individuals completing a full course of PEP, falling to below 40% for adolescents and victims of sexual assault [7]. Dr Zimmer suggests that occupational cases often suffer from over adherence, whereas nonoccupational cases often suffer from under adherence. However, the evidence base to date does not appear to suggest any important difference between these 2 groups: globally, rates of treatment completion between occupational and nonoccupational exposures (56%, 95% confidence interval, 45%–68% vs 66%, 56%–76%) are similarly suboptimal [7]. Efforts are needed to improve PEP adherence and completion across all groups.

Otherwise, the current guidelines will continue to offer too little, and much too late.

Notes

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