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Location	England
Organisation	HIV i-Base
Conflict	N/A
Declaration of interest	
Comments on individual sections of the ACD:	
	1/4 HIV i-Base is a national HIV treatment information and activist organisation. We are concerned that evidence to the committee has not included specific references to people living with both HIV and HCV coinfection. Approximately 9% of HIV positive people also have HCV (compared to 0.4% in the general population) with rates varying by HIV acquisition risk group. [1] Until the recent data from DAA clinical trials, HIV/HCV coinfection has involved separate management guidelines to HCV monoinfection. This was largely due to poorer treatment outcomes and it is now significant that the efficacy and safety of DAAs appears no longer require this distinction for treatment in key treatment guidelines. [2, 3] However, the move to consider HIV as no longer a specific management issue is dependent on universal access to DAAs and until they are freely available there are several important reasons why HIV/HCV coinfection requires specific consideration. 1) In the absence of universal access to DAA treatment, HCV progresses significantly more rapidly in people with HIV/HCV coinfection compared to HCV monoinfection with HCV directly related to high mortality. [4, 5] HCV viral load levels are higher, progression to fibrosis is faster and hepatic cell carcinoma occurs at a higher rate, faster and at a younger age than in HIV negative people. [6, 7, 8, 9] References 1. Turner J, Bansi L, Gilson R et al. for the UK Collaborative HIV Cohort (UK CHIC) Study. The prevalence of hepatitis C virus (HCV) infection in HIV-positive individuals in the UK ‘ trends in HCV testing and the impact of HCV on HIV treatment outcomes. J Viral Hepat 2010; 17: 569’577. 2. British HIV Association (BHIVA). Guidelines for the Management of Hepatitis Viruses in Adults Infected with HIV 2013. Revised June 2014). http://www.bhiva.org/documents/Guidelines/Hepatitis/2013/hiv_v14_is4_New.pdf 3. European Association for the Study of the Liver (EASL). EASL Recommendations on Treatment of Hepatitis C 2014. (April 2014). http://files.easl.eu/easl-recommendations-on-treatment-of-hepatitis-C.pdf 4. Weber R, Ruppik M, Rickenbach M et al. for the Swiss HIV Cohort

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	2/4) Despite higher risk of HCV progression, previous HCV treatment consisting of pegylated interferon plus ribavirin are so unacceptable due to the treatment duration and side effect profile that a larger proportion of people actively choose HCV progression over treatment - even though chronic HCV considerably reduces quality of life in numerous other ways (including chronic fatigue). Part of the decision to avoid older treatment is likely related to higher rates of psychological co-morbidity in HIV positive people compared to the general population, and the risk that these will be exacerbated from having to take PEG-IFN plus ribavirin for 48 weeks (or longer). We are concerned that, for example, that one of the committee's key conclusions still refers to "adverse reactions associated with sofosbuvir plus peginterferon alfa and ribavirin" as being "generally tolerable" (Section 4.9). This statement is based on data from a clinical trial setting, and although the context is to highlight the tolerability of sofosbuvir, outside of the context of research, peginterferon alfa and ribavirin have unacceptable tolerabilty, especially given extended duration of treatment required in coinfection.
	3/4) That sexually transmitted HCV has rapidly become a personal and public health issue in HIV positive gay men. [10] A recent study estimated the rate of acute HCV at 7.8’11.8 per 1000 patient-years in HIV positive gay men compared to 1.4 per 1000 patient-years in HIV negative gay men. [11] The exact mechanism for why these rates are higher than rates reported for heterosexual HIV negative people is unclear and limits the ability to provide accurate information to prevent further transmission. It is notable that many cases men have specifically chosen potential partners with the same HIV status as a strategy to reduce the risk of further HIV transmission. Higher rates of heterosexually transmitted HCV are also reported when the HCV negative partner is HIV positive. References 10. Vogel M, Boesecke C, Rockstroh JK. Acute hepatitis C infection in HIV-positive patients. Curr Opin Infect Dis 2011; 24: 1’6. 11. Yaphe S, Bozinoff N, Kyle R, Shivkumar S, Pai NP, Klein M. Incidence of acute hepatitis C virus infection among men who have sex with men with and without HIV infection: a systematic review. Sex Transm Infect 2012; 88: 558’564.

	4/4) Until universal access to DAA is available in the UK, we argue that HIV/HCV coinfection remain a criteria for access to DAA therapy, including sofosbuvir. We strongly recommend that the NHS value the importance of the broad opportunity to cure HCV in this population. People living with HIV/HCV coinfection should not be forced to wait until advanced progression of liver disease in order to access treatment that is both tolerable and effective. In the broader context, we urge the NHS to rapidly find solution ensue that all people living with HCV, irrespective of HIV status, are able to benefit from these dramatic medical advances. With more that 200,000 people likely to have chronic HCV in the UK, only 25% or who are diagnosed, access to effective and tolerable treatment will change the urgency and willingness for people to test and then treat, It is unacceptable for access to be limited to 500 people with the most severe HCV progression. We also note that this situation is driven by the decision by Gilead's decision to price sofosbuvir at an excessively marked up price compared to the manufacturing costs, such that while on an individual patient this this might be cost effective on a population level this will never be affordable to people in the UK.
Date	2014 07 04