XIV CONGRESSO NAZIONALE
MILANO 29-30-31 ottobre 2025
PREVENZIONE E CURA DELLE DIPENDENZE
Traguardi raggiunti e nuove prospettive di intervento e di ricerca
Centro Congressi QUARK Hotel Milano
FeDerSerD
Federazione Italiana degli Operatori dei Dipartimenti e dei Servizi delle Dipendenze

Stefano
Rusconi

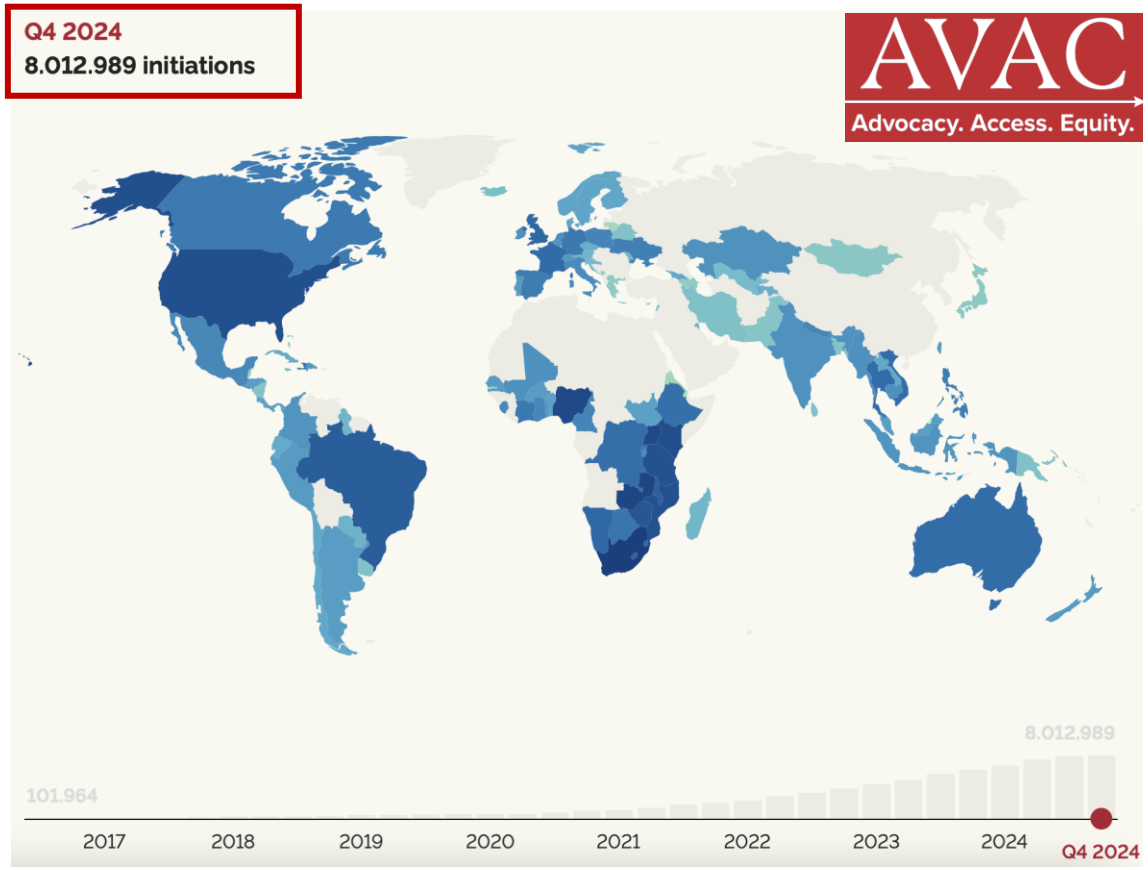
NOVITA' NEL MONDO DELLE PROFILASSI PRE- E POST-ESPOSIZIONE PER HIV

COI

AstraZeneca, Gilead Sciences, Menarini, MSD, ViiV Healthcare

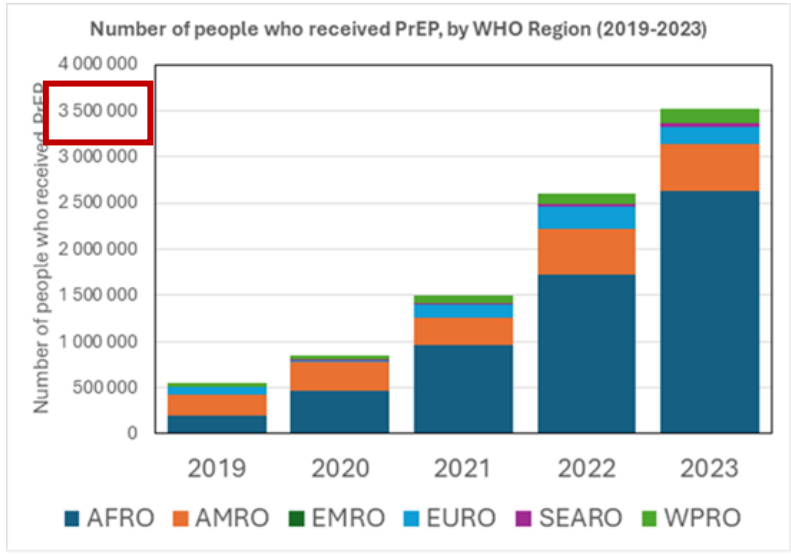
MEDICI CON L'AFRICA CUAMM

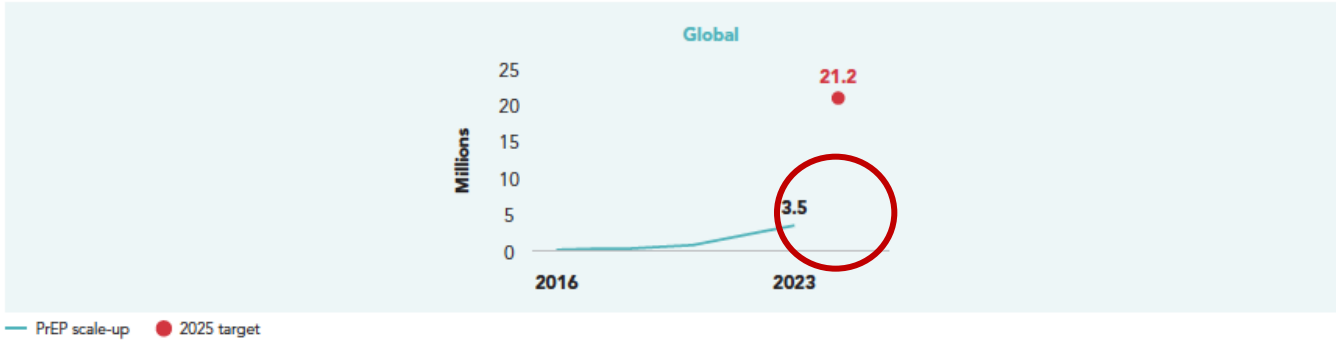
PrEP! Where are we? Where should we go?



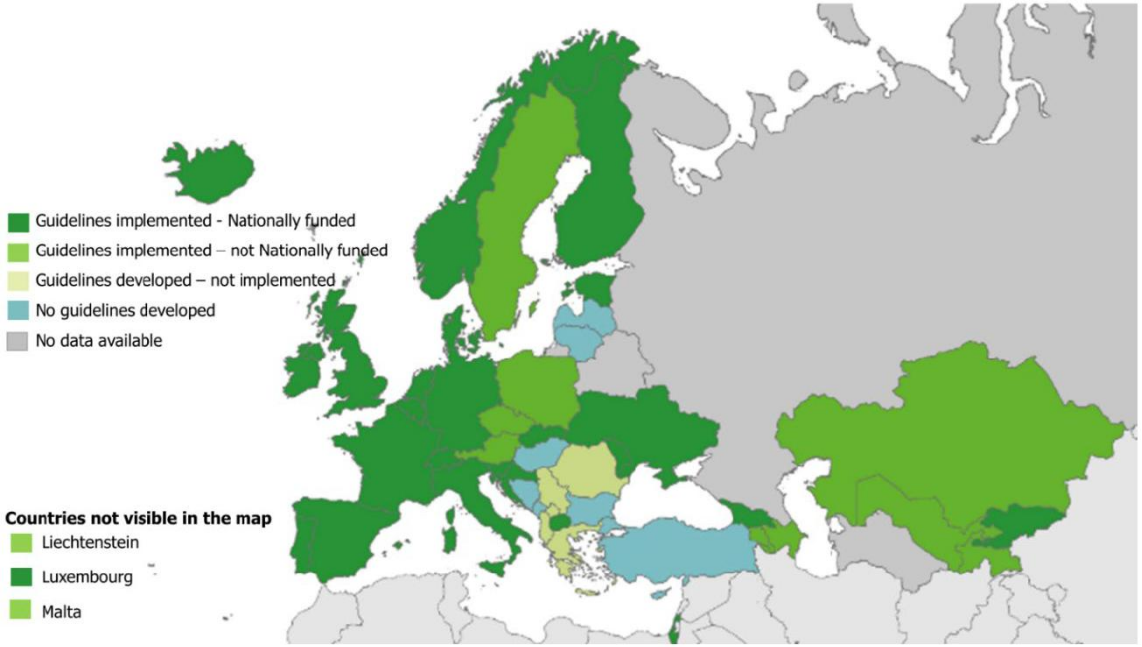
https://data.prepwatch.org

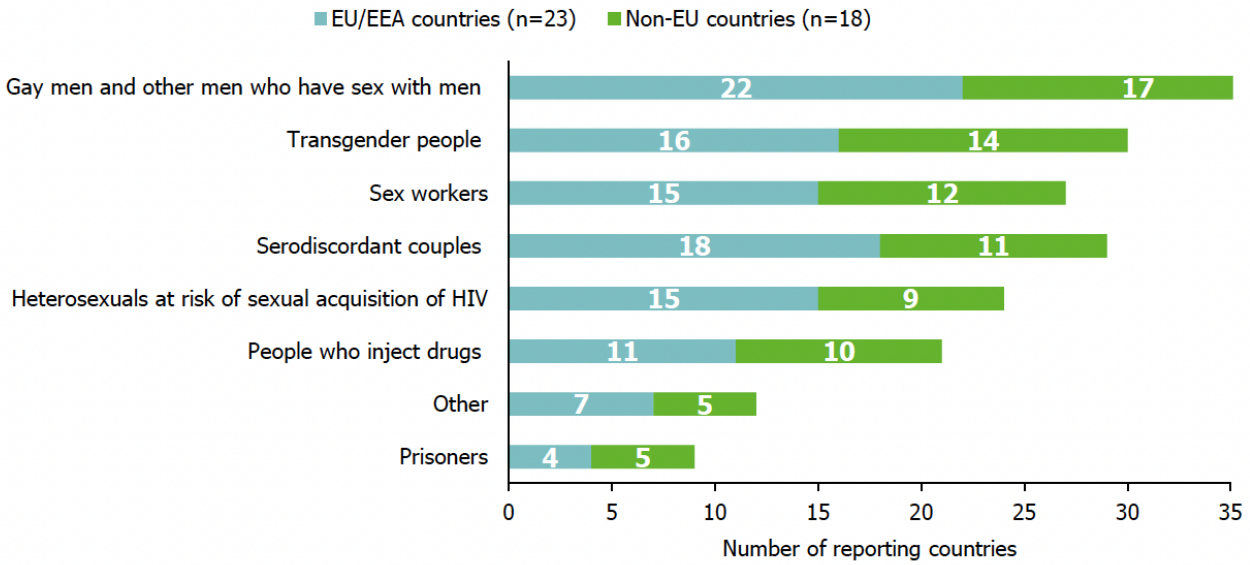
UNAIDS





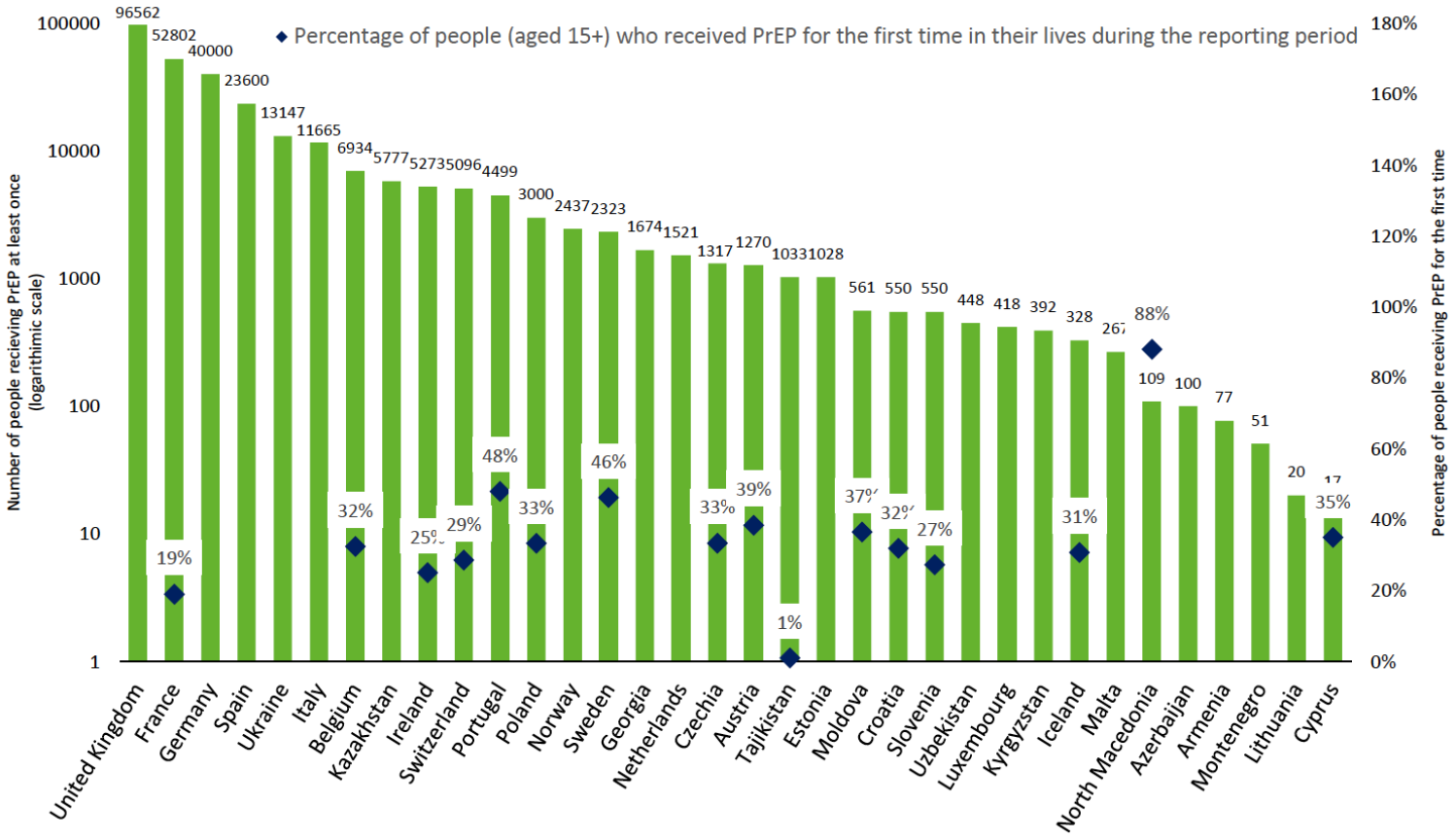
PrEP implementation and people eligible for PrEP according to national guidelines. Europe and Central Asia, end of 2023





Among the 52 countries in Europe and Central Asia that could provide data, 38 countries (23 EU/EEA countries) reported that PrEP guidelines had been developed and were being implemented

Number of people (aged 15+) who received PrEP at least once, Europe and Central Asia, end of 2023 (n=34)



In addition to understanding how many people are accessing PrEP, **it is important to identify gaps in access to PrEP**.

Six countries were able to estimate the proportion of MSM in need of PrEP who were receiving it: **Andorra (100%), France (33%), Germany (50%), Kyrgyzstan (1%), Slovenia (85%) and the United Kingdom (74%).**

However, **no country was able to provide an estimate of the unmet needs for PrEP in any other population group.**

European Centre for Disease Prevention and Control. PrEP for HIV prevention in Europe and Central Asia. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2024 progress report. Stockholm: ECDC; April 2025.

Which could be the PrEP target population in Italy?

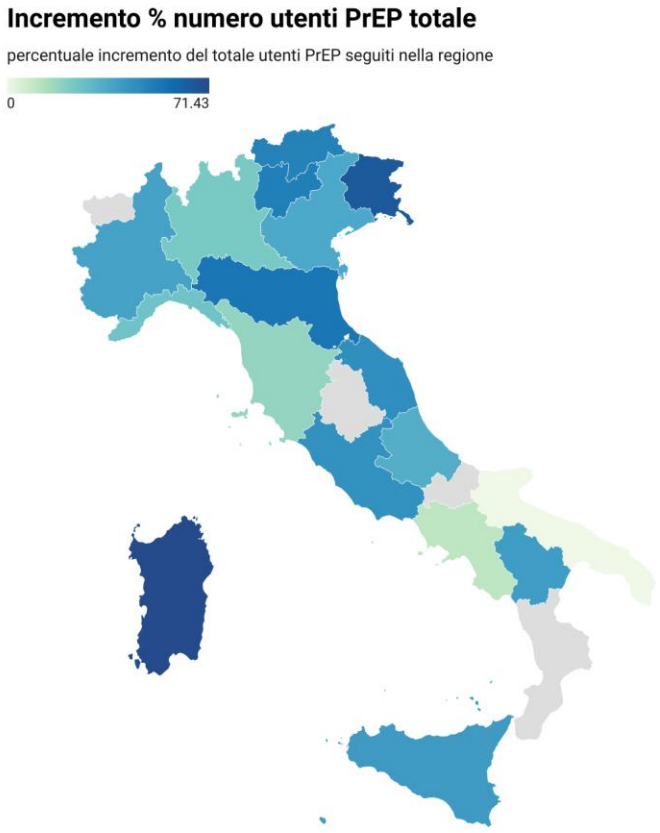
Country	PLWH°	New HIV diagnosis (2023)°	PrEP users (2023)°	PrEP-to-Need Ratio	Proportion of MSM in need of PrEP receiving it°
UK	95,932	6,402	96,562	15.08	74%
France	178,700	4,981	52,802	10.60	33%
Germany	90,800	3,321	40,000	12.04	50%
Italy	140,730	2,349	11,665	4.96	unknown*

*assuming a proportion of MSM in need of PrEP receiving it between 24% and 15%, the corresponding final population target in need of PrEP ranged from 49,000 to 77,000.

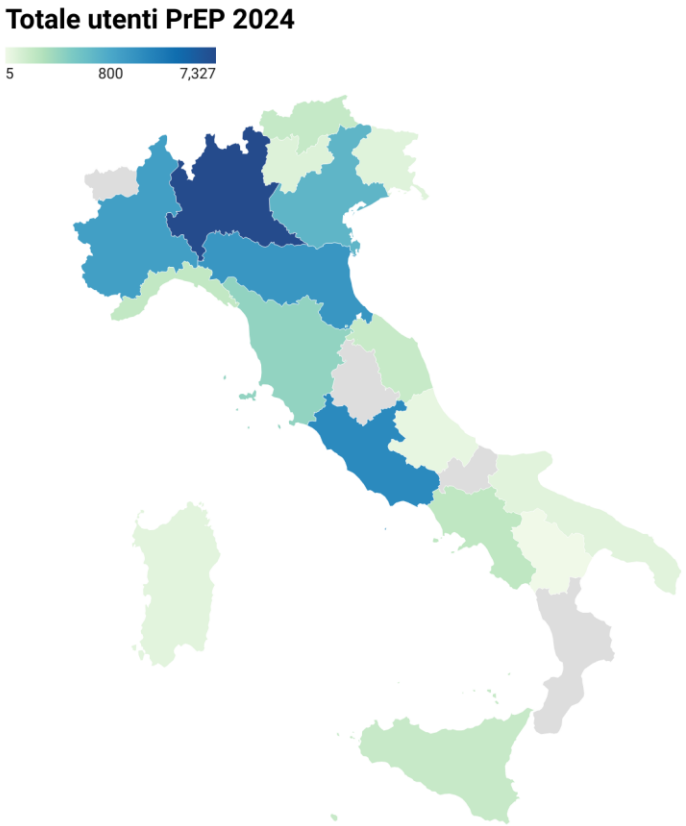
°Data on PLWH, new HIV diagnosis, number of PrEP users, and proportion of MSM in need of PrEP receiving it were derived from ECDC 2023 surveillance reports.

PrEP increase in Italy between 2023 and 2024

Regione	Total increase%	Total users 2024
Abruzzo	+33.33	45
Basilicata	+40.00	5
Bolzano	+50.00	200
Campania	+10.09	228
Emilia	+54.67	2,067
Friuli	+65.43	81
Lazio	+44.14	2,873
Liguria	+25.58	215
Lombardia	+23.17	7,327
Marche	+45.31	192
Piemonte	+37.72	1,445
Puglia	0.00	73
Sardegna	+71.43	70
Sicilia	+40.51	195
Toscana	+18.59	425
Trento	+51.09	92
Veneto	+35.37	687
Totale	+43.22	16.220



Rate of increase PrEP users from 2023 to 2024

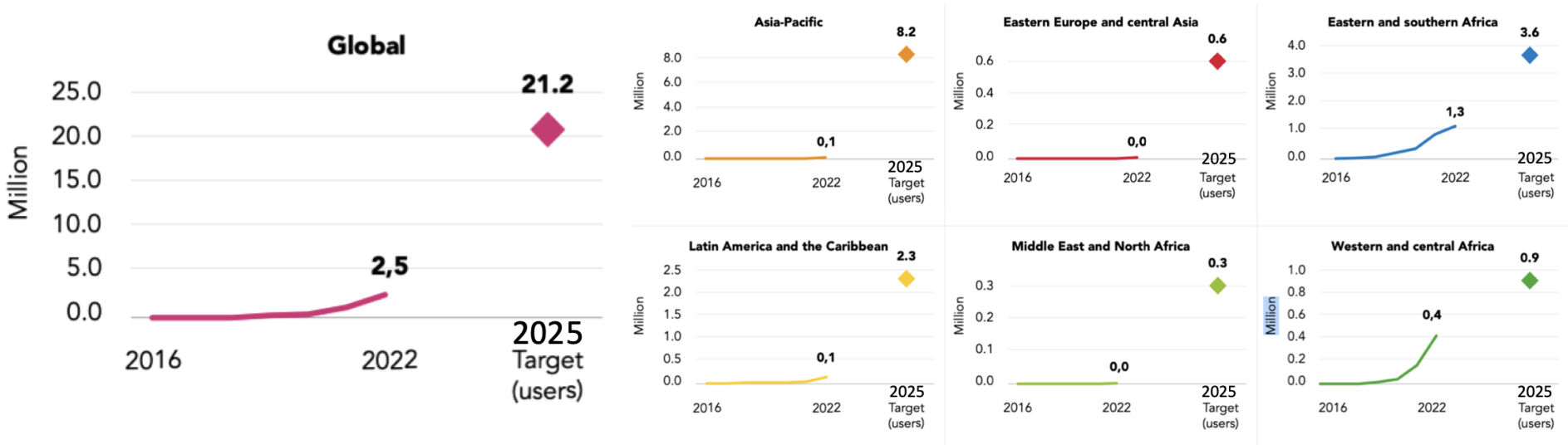


Total PrEP Users in Italian Regions in 2024

Nozza S, et al. ICAR, 2025; Poster #125

People need access to options so they can use what works for them

Number of people using HIV PrEP, relative to 2025 targets



1. We need to increase the number of people accessing HIV PrEP
   AND
2. We need more HIV PrEP options – so that people can choose what works for them

Source: Prepared based on 2023 prevention scorecards and Global AIDS Monitoring https://www.unaids.org/sites/default/files/media_asset/2023-global-hiv-prevention-coalition-scorecards-key-findings_en.pdf

UNAIDS

MarketScan Commercial Claims Database: Retrospective cohort study (US)

Low Rates of PrEP Prescriptions Among Youth

N=100,540

Youth aged 13–21 years meeting PrEP indication[a]

Outcomes

PrEP prescription fill (F/TDF, F/TAF, Q2M IM CAB)

January 2018–July 2023

Demographic and Clinical Factors Associated With PrEP Fill

		Adjusted HR (95% CI)
Sex	Male (Ref: Female)	15.6 (13.4–18.1)
Age, years	18–19 (Ref: 13–17)	2.82 (2.35–3.38)
	20–21 (Ref: 13–17)	3.38 (2.83–4.03)
Year PrEP indication met	2019 (Ref: 2018)	1.24 (1.07–1.43)
	2020 (Ref: 2018)	1.17 (1.00–1.38)
	2021 (Ref: 2018)	1.59 (1.36–1.86)
	2022 (Ref: 2018)	1.64 (1.39–1.94)
Sexual behavior with increased likelihood of HIV acquisition		2.36 (1.68–3.33)
Syphilis		4.52 (2.26–9.03)
Gonorrhea		2.47 (1.25–4.87)
Chlamydia		0.64 (0.32–1.27)
Number of prior STIs	1 (Ref: 0)	0.75 (0.36–1.56)
	2+ (Ref: 0)	0.63 (0.16–2.44)
Mental health condition		2.00 (1.80–2.21)
Substance use		0.66 (0.55–0.80)

Only 1.6% of youth with a PrEP indication **received PrEP**

PrEP utilization was **lower** for:
- People aged **<18 years** (vs. ≥18 years)
- **Females** (vs. males)

Time to PrEP fill was **longer** for:
- People aged **<18 years** (vs. ≥18 years)
- **Females** (vs. males)

PrEP prescription rates were **lower in the Midwest** and **South**, as well as in states with less progressive laws

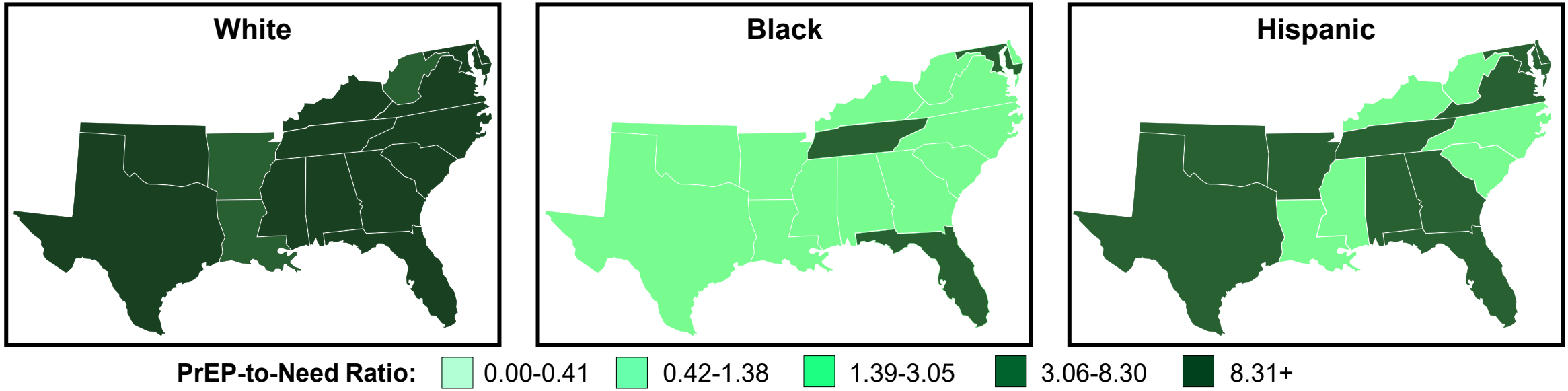
There are significant gaps in PrEP utilization among youth, especially in those aged under 18 years and in females

[a]PrEP indication defined as ICD-10 code for gonorrhea, chlamydia, syphilis or high-risk sexual behavior.

Venturelli N, et al. CROI 2025, Poster #1076

PrEP-to-Need Ratio Has Substantial Racial/Ethnic Disparities

- Substantially greater unmet PrEP need for Black and Hispanic vs White individuals in the South[1]



- US medical professionals are less likely to prescribe PrEP to Black and Hispanic people, contributing to substantial racial/ethnic and geographic disparities[2,3]

1. aidsvu.org/resources/deeper-look-prep/. 2. aidsmap.com/news/oct-2021/stark-disparities-seen-all-along-us-prep-continuum.
3. aidsmap.com/news/jul-2022/prep-inequities-have-worsened-us-over-last-decade-both-racially-and-regionally.

PrEP Preferences Among Transgender and Gender Diverse Adults

N=295

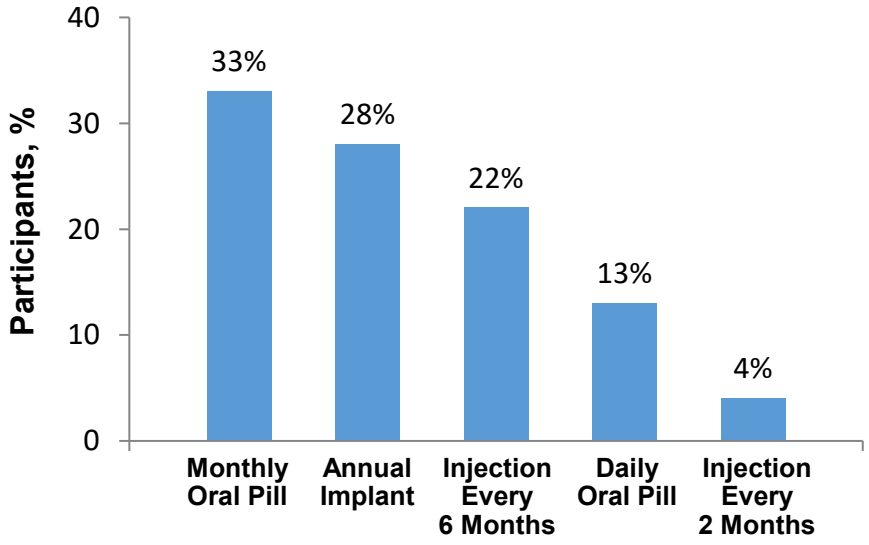
HIV-negative transgender and gender diverse adults

Outcomes

PrEP preferences; factors associated with reporting injectable PrEP administered every 6 months as the most preferred

April 2022–June 2022

Most Preferred PrEP Method



Factors Associated With Reporting Q6M Injectable PrEP as the Most Preferred

Race and ethnicity (Reference: Non-Latine White)	Unadjusted OR (95% CI) *P* value	Adjusted OR (95% CI) *P* value
Latine, any race	2.50 (1.19–5.24) *P*=0.02	2.39 (1.10–5.18) *P*=0.03
Non-Latine Black	2.41 (1.06–5.52) *P*=0.04	2.77 (1.10–6.98) *P*=0.03
Non-Latine, another race	1.24 (0.56–2.76) *P*=0.60	1.19 (0.53–2.69) *P*=0.67

Transgender and gender diverse adults preferred twice-yearly injections for PrEP compared with daily oral pills and Q2M injections

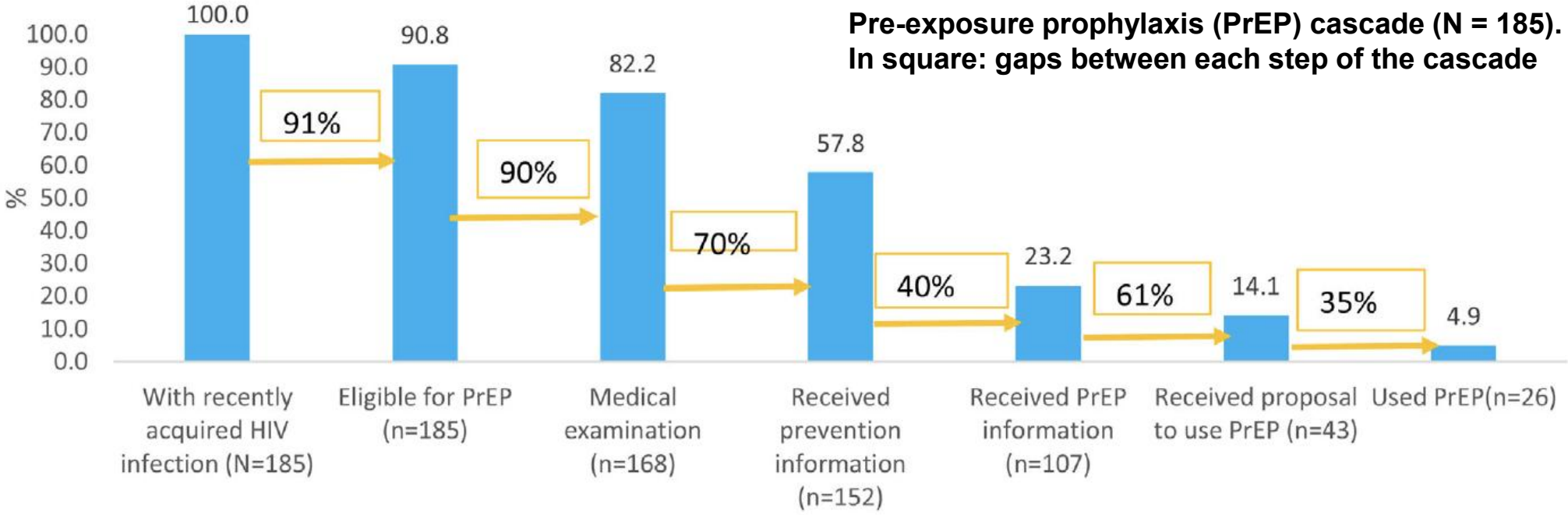
Watson DL, et al. CROI 2025, Poster 1353

French ANRS 95041 OMaPrEP study

Missed opportunities for HIV pre-exposure prophylaxis among people with recent HIV infection

French national cross-sectional multicentre study enrolling people diagnosed with recent HIV (incomplete Western blot or negative HIV , **analysing missed opportunities for PrEP use via a retrospective PrEP Cascade**.

Of the 185 enrolled patients, 168 (91%) were eligible for PrEP.

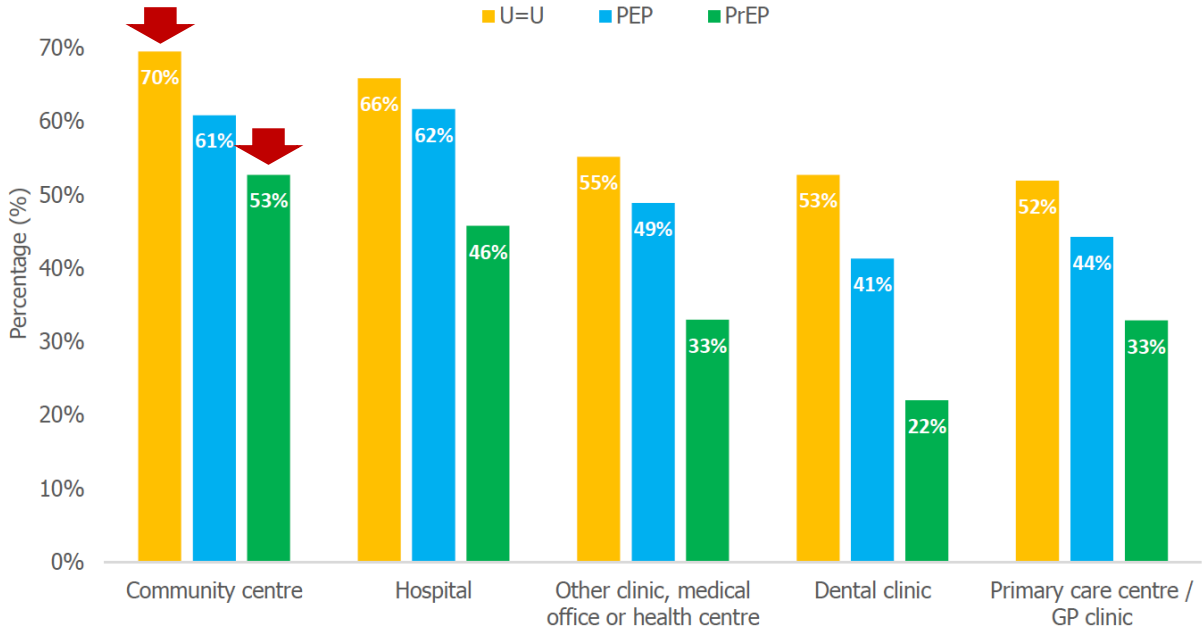


Lions C, et al. HIV Med. 2023;24:191–201.

May HCPs Approach Contributing to Loss to Follow-up from PrEP Care?

- PrEP persistence may be less about relationship to the drug than the **environment**
  - Among racially and sexually minoritized individuals, **stigma** is a barrier to PrEP persistence[1-3]
  - In a survey of 855 Black individuals in the US, more than one half reported **high levels of racism and discrimination** in their healthcare experiences[4]
  - Barrier to PrEP persistence could be **the healthcare providers (HCPs) and their approach**[1-6]
  - **Sexual prejudice** from HCPs was negatively associated with anticipated PrEP adherence[7]

In community centers highest (53%) proportion of respondents with correct knowledge of HIV prevention and transmission.



ECDC. HIV stigma in the healthcare setting. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia; 2024.

1. Golub. Curr HIV/AIDS Rep. 2018;15:190. 2. Rosengren. AIDS Behav. 2021;25:2054. 3. Jaiswal. Curr HIV Res. 2018;16:237. 4. Ojikutu. AIDS Behav. 2018;22:3576. 5. Cahill. AIDS Care. 2017;29:1351. 6. Calabrese. Am J Public Health. 2015;105:1960. 7. Calabrese. AIDS Behav. 2022;26:1393.

ANRS-PREVENIR cohort

Perception of PrEP-related stigma in PrEP users

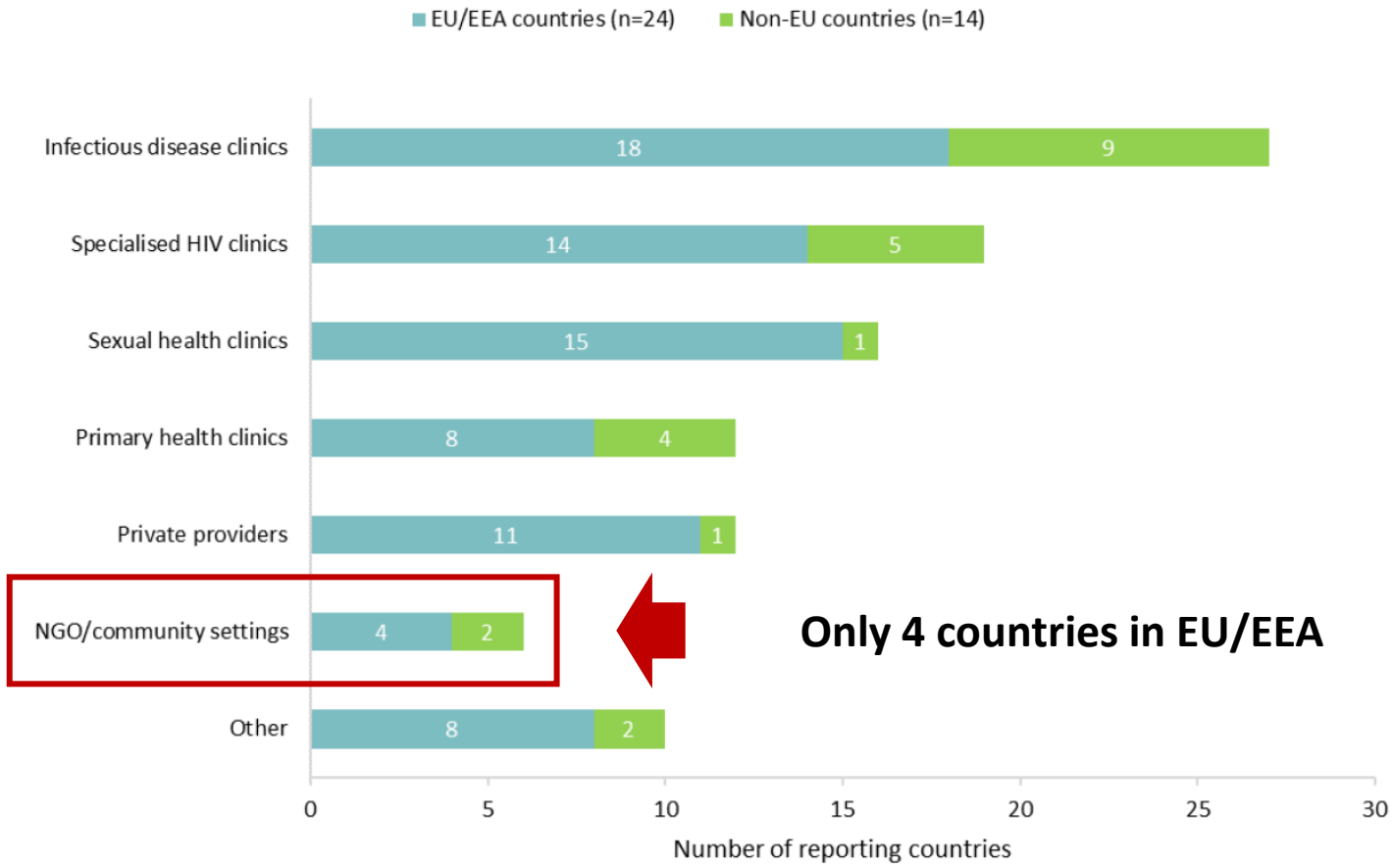
2,567 participants in the ANRS-PREVENIR study answered the outcome question. Almost **one-third of the sample** (comprising mostly cisgender men who have sex with men [94.3%]) considered that **taking PrEP could give others a negative image of them**.

Younger participants, **more psychologically vulnerable participants**, and **higher depression scores people** were also more likely to have this perception.

Characteristic	aOR	95% confidence interval		*p*-value
Age	0.98	0.97	0.99	0.002
Encouraged to take PrEP by main partner	0.67	0.51	0.88	0.004
Encouraged to take PrEP by friends	0.79	0.66	0.95	0.011
Knowing most recent sexual partner's HIV status	0.83	0.69	0.99	0.042
Sexual intercourse systematically protected during the previous 3 months	0.80	0.67	0.96	0.016
Center for Epidemiologic Studies Depression scale	1.02	1.004	1.03	0.009
Rosenberg self-esteem scale	0.98	0.96	0.99	0.045
Akaike information criterion	2791			

Protiere C, et al. HIV Med. 2023;24:938–945.

Settings in which PrEP is available, across Europe and Central Asia, end of 2023 (n=43)



The most frequently reported settings were **public health facilities (infectious disease clinics, specialised HIV clinics, sexual health clinics, and primary health clinics).**

The setting of infectious disease clinics was cited by 27 countries in Europe and Central Asia (19 EU/EEA countries), suggesting that **PrEP is still mainly provided in medicalised settings**.

European Centre for Disease Prevention and Control. PrEP for HIV prevention in Europe and Central Asia. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2024 progress report. Stockholm: ECDC; April 2025.

Resistance Among PLHIV Exposed to PrEP

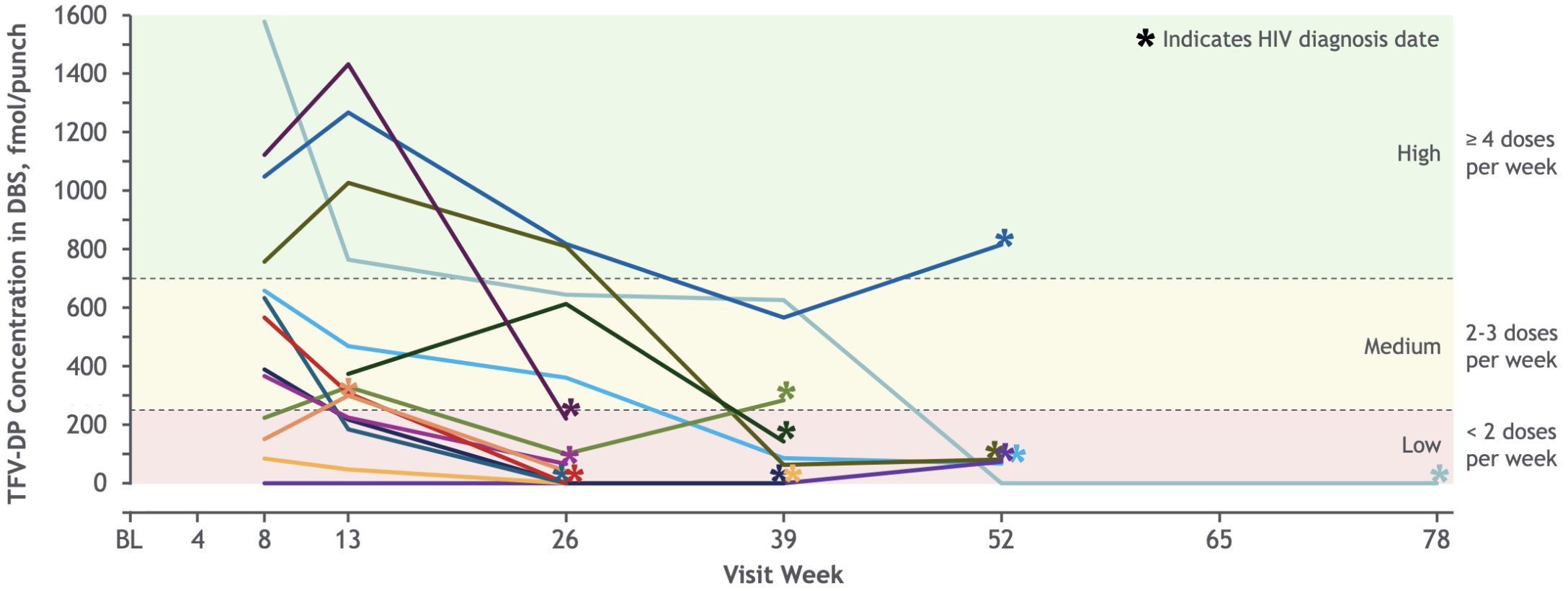
- Prevalence of major antiretroviral drug resistance mutation (ART-DRM) to emtricitabine (FTC) or tenofovir (TDF) (specifically K65REN,M184VI, K70E) was 24% (12/50; 95% CI:12%-36%)
- Five individuals thought they acquired HIV whilst taking PrEP and being fully adherent: 3 had major ART-DRMs to FTC/TDF, 1 did not have any detected and for one the resistance test was not available

	Prevalence (n/N)	95% confidence interval
Major antiretroviral drug resistance mutation to FTC or TDF detected with frequency above 15% (K65REN, M184VI, K70E)	24% (12/50)	(12% - 36%)
M184VI exclusively	10	
K103N exclusively	1	
L10I, L33I, E35D, N37S, R41K, L63T, A71T, I93L, A98S, D123E, E204A, Q207E, R211K, K277R	1	

- In our study, 1 in 20 new HIV diagnoses occurred in people who knew about PrEP and had previously used it
- The prevalence of resistance aligns with estimates from randomized controlled trials among individuals with acute HIV at enrolment

- Cambiano et al. HIV Glasgow 2024; Glasgow, Scotland. Poster P011.

PrEP Failure… or Declining Adherence?



All partecipants in the F/TDF group of Purpose 1 who were diagnosed with HIV had evidence of low adherence or a decrease in adherence over time

Bekker et al, Glasgow 2024

Challenges with oral PrEP so far…

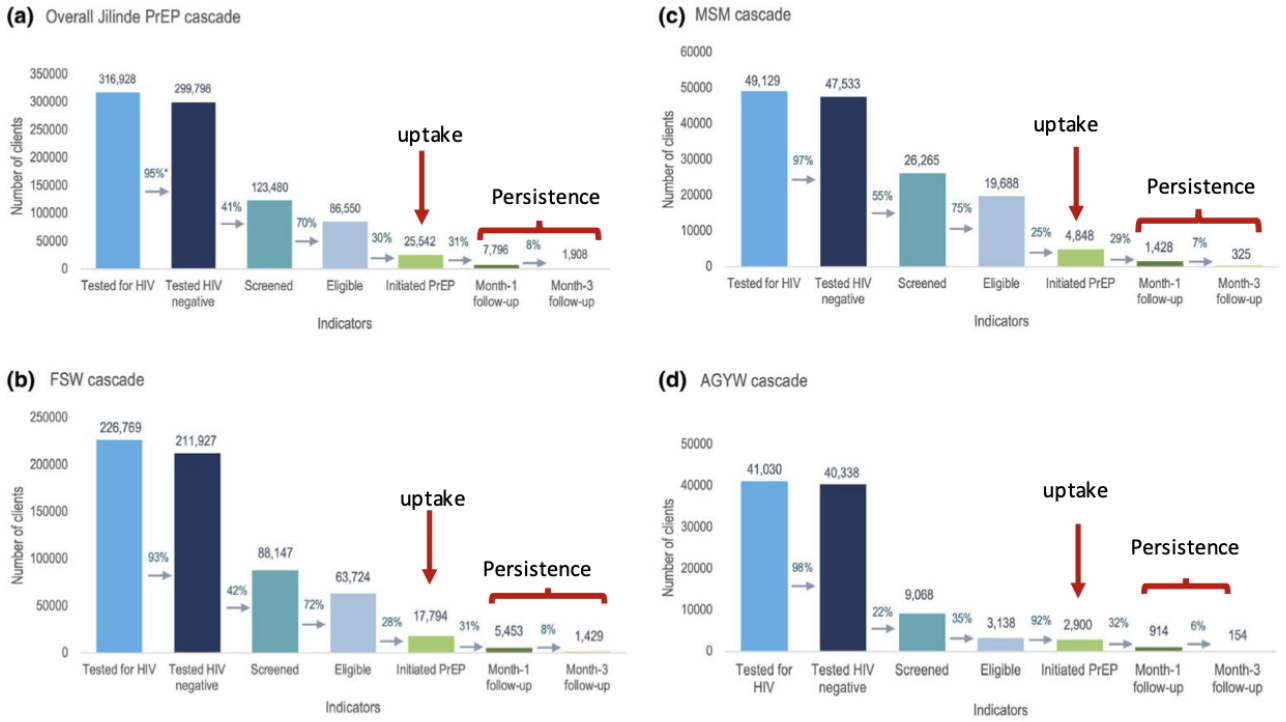


Figure 3. Overall Jilinde project (A) and population-specific (B, FSW; C, MSM; D, AGYW) PrEP cascades from February 2017 to December 2019.

Uptake, persistence…..impacting effective use.

Fogarty L, Were D, Reed, J et al Gates Open Res 2020

Long Acting PrEP

HPTN 083[1]

- N = 4566 MSM and TGW
- 13 incident infections with LA CAB vs 39 with oral FTC/TDF
  - **4 with on-time CAB injections**
  - 1 CAB infection later determined to be baseline infection
- HR for CAB vs FTC/TDF:
  0.34 (95% CI: 0.18-0.62)

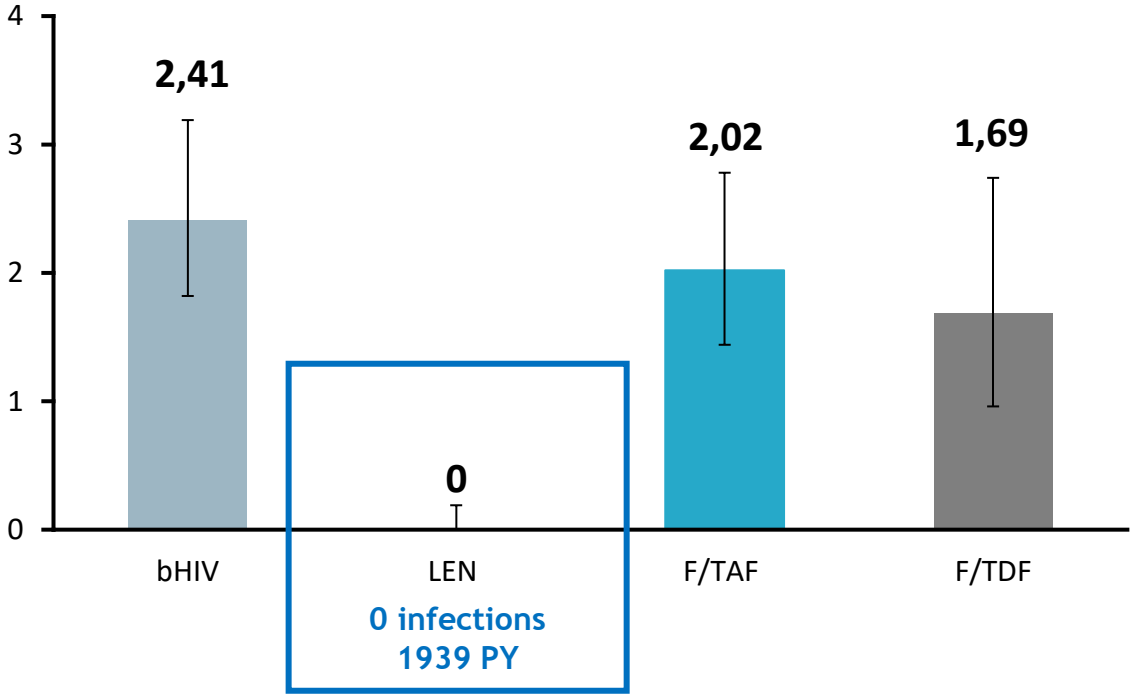
HPTN 084[2]

- N = 3224 cisgender women
- 4 incident infections with LA CAB vs 36 with oral FTC/TDF
  - **0 with on-time CAB injections**
  - 1 CAB infection later determined to be baseline infection
- HR for CAB vs FTC/TDF:
  0.12 (95% CI: 0.05-0.31)

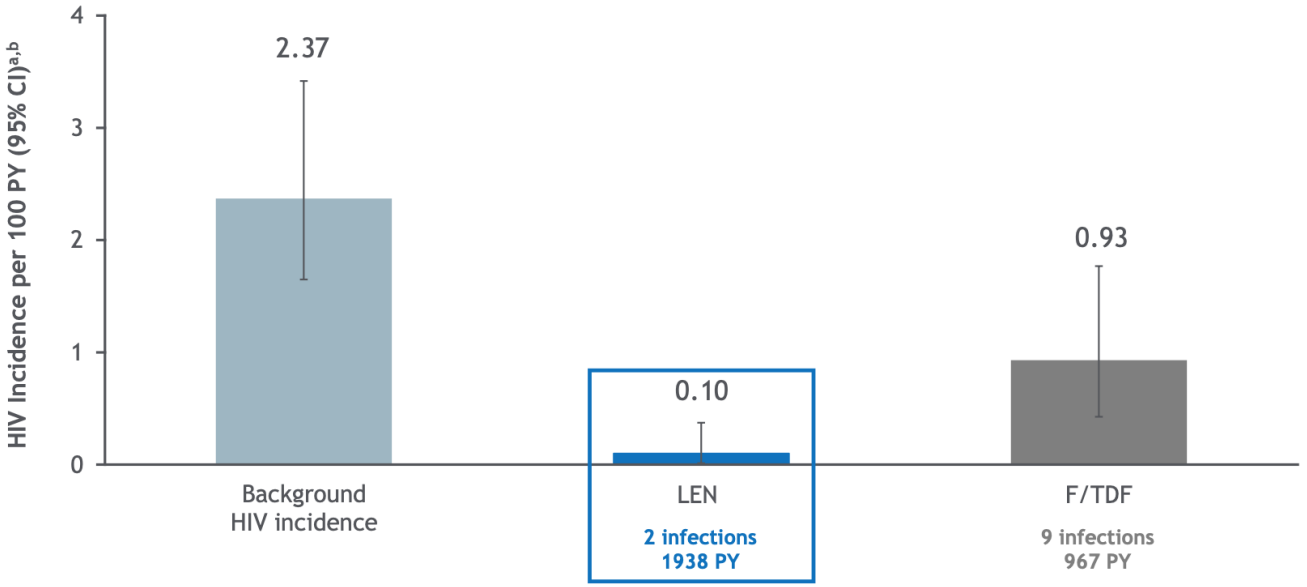
1. Landovitz. NEJM. 2021;385:595. 2. Delany-Moretlwe. Lancet. 2022;399:1779.

Long Acting PrEP

PURPOSE 1

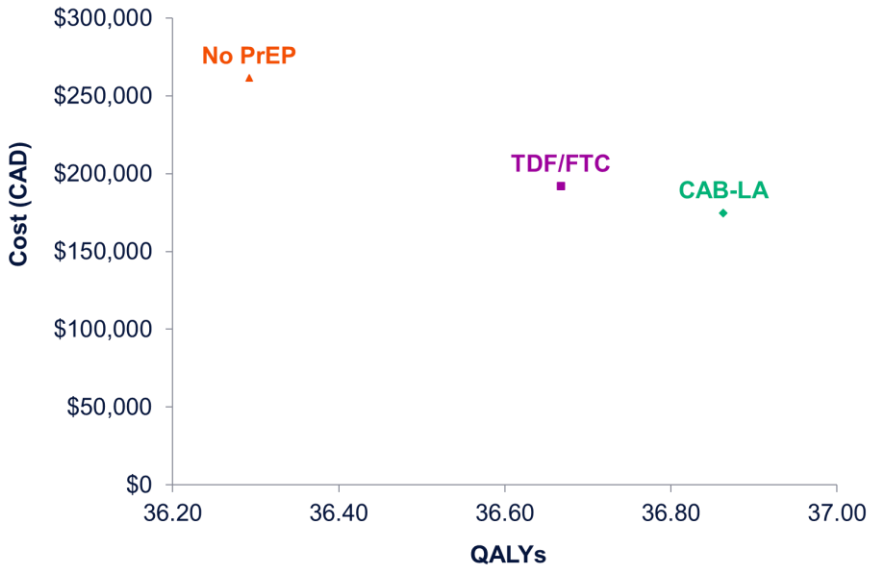


PURPOSE 2

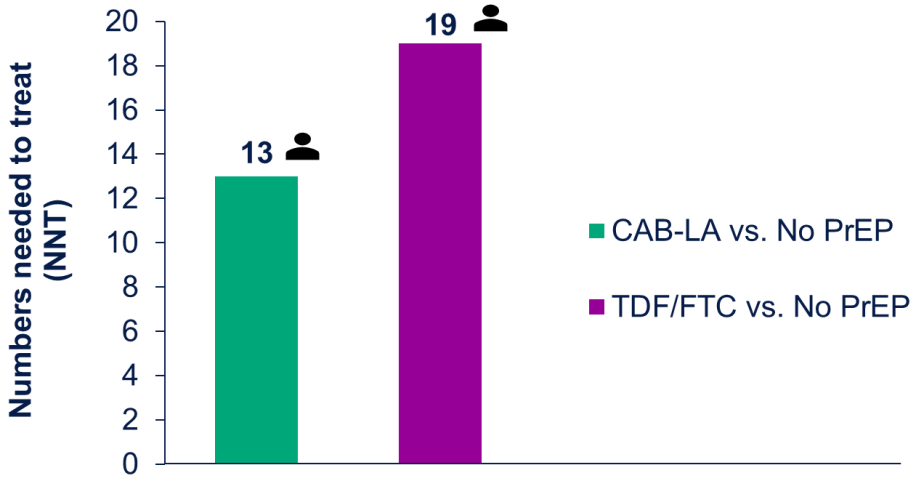


Cost-Effectiveness and Public Health Impact

At a willingness-to-pay threshold of $50,000 per QALY, 100% simulations showed CAB-LA cost-effective



NNT to Prevent One New HIV-1 Infection



- CAB-LA is cost-effective compared to TDF/FTC and no PrEP
- Overall, compared to TDF/FTC and no PrEP, the results indicate the introduction of CAB-LA as PrEP in Canada would result in substantial public health and monetary benefits by preventing additional HIV infections and reducing the clinical and economic burden of HIV

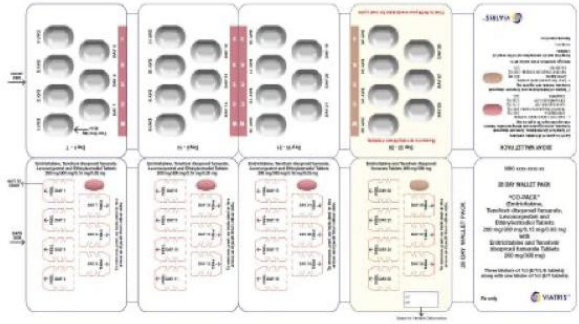
Adelakun et al. HIV Glasgow 2024; Glasgow, Scotland. Poster P264.

What's coming in the pill dept.....

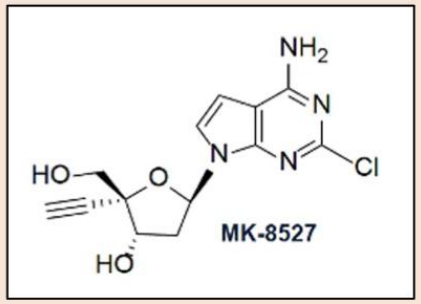
- **Multipurpose technology- Dual Prevention Pill :**
- Combines 2 already-approved products—oral PrEP (TDF/FTC) and oral contraception (ethinyl estradiol and levonorgestrel, or EE/LNG). **VIATRIS**
- **MK-8527: MONTHLY pill for HIV prevention**

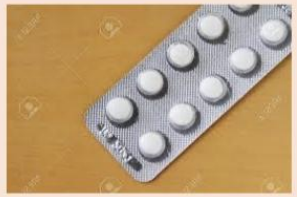
Figure 1: Proposed DPP tablet colors

Figure 2: Illustrative mock-up of DPP packaging by Viatris



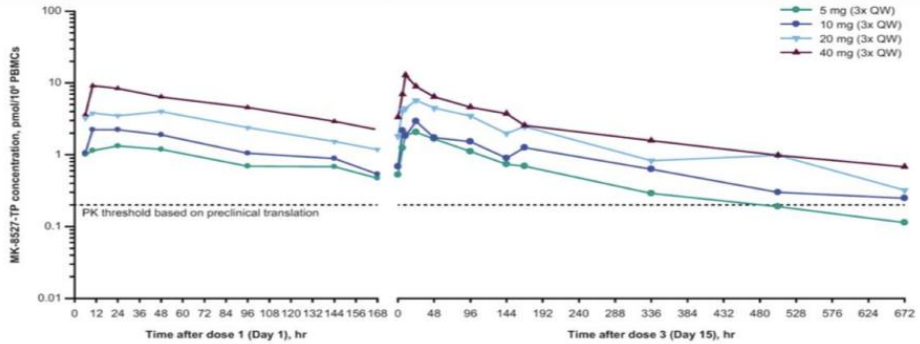
Agent class:
Nucleoside Reverse Transcriptase Translocation Inhibitor (NRTTI)





Long half life favours Monthly pill dosing

Mean MK-8527-TP concentrations after ascending multiple doses of MK-8527 (trial B)



- After multiple doses of MK-8527 (3x QW), the true geometric mean C_{168} of MK-8527-TP was >0.2 pmol/10^6 PBMCs for all dose levels
- Accumulation of intracellular MK-8527-TP was modest (range of C_{max} and AUC_{0-168} ratios was 1.1–1.6)
- Across all dose levels, the range of MK-8527-TP apparent terminal half-life was 216–291 hours

C_{168}, concentration at 168 hours post dose.

Pharmacokinetics (PK) data from multiple doses of MK8527 with potential once monthly (QM) for HIV pre-exposure prophylaxis (PrEP)

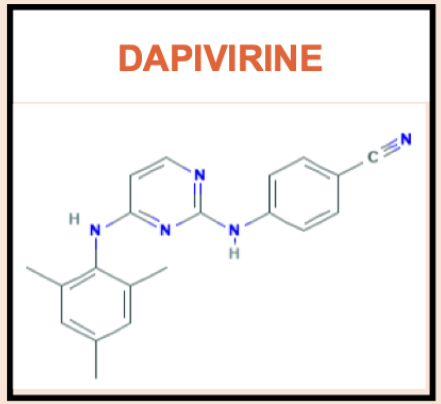
8

CROI 2024
Conference on Retroviruses and Opportunistic Infections
Denver, US | 3-6 March

Single (0.5–200 mg) and multiple (QW) doses (up to 40 mg) of MK-8527 administered to adults without HIV were generally well tolerated. The safety and pharmacokinetic profiles of MK-8527 support continued clinical investigation.

Dapivirine Ring: Use of a vaginal ring for HIV prevention

Agent class:
Non-nucleoside reverse transcriptase inhibitors (NNRTI)



Dosing Strategy:
Monthly dapivirine ring

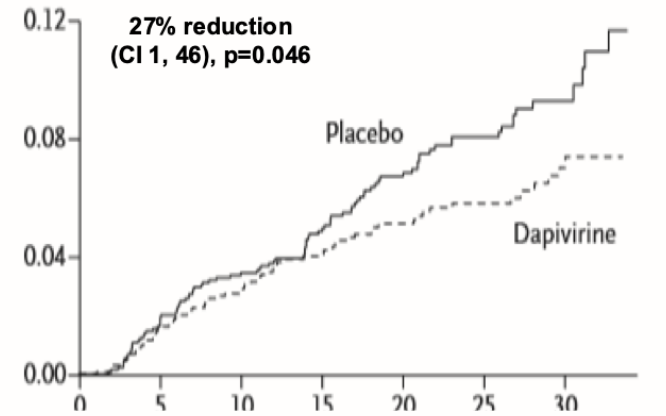
2016

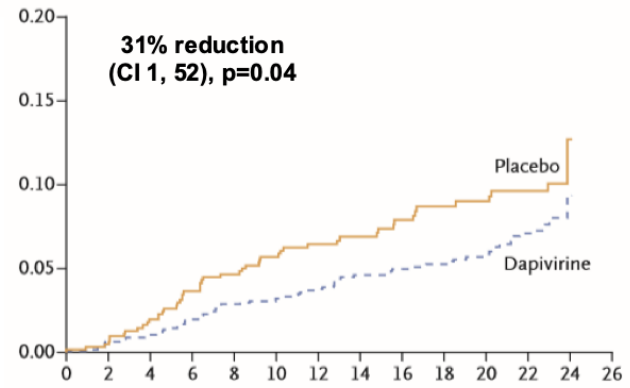
ASPIRE
A Study to Prevent Infection with a Ring for Extended Use

Trial sites in South Africa, Uganda, Zambia, Zimbabwe, Malawi

THE RING STUDY
Developing HIV Prevention for Women

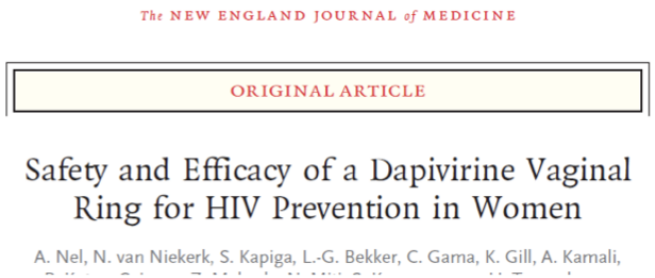
Trial sites in South Africa, Uganda





Use of a Vaginal Ring Containing Dapivirine for HIV-1 Prevention in Women

J.M. Baeten, T. Palanee-Phillips, E.R. Brown, K. Schwartz, L.E. Soto-Torres, V. Govender, N.M. Mgodi,



Safety and Efficacy of a Dapivirine Vaginal Ring for HIV Prevention in Women

A. Nel, N. van Niekerk, S. Kapiga, L.-G. Bekker, C. Gama, K. Gill, A. Karnali,

In both studies: Open label extension improved effectiveness - RR 0.50
EMA approved for section 58: (1) WHO recommendations, (2) Women in LMIC ; Second line to PrEP.

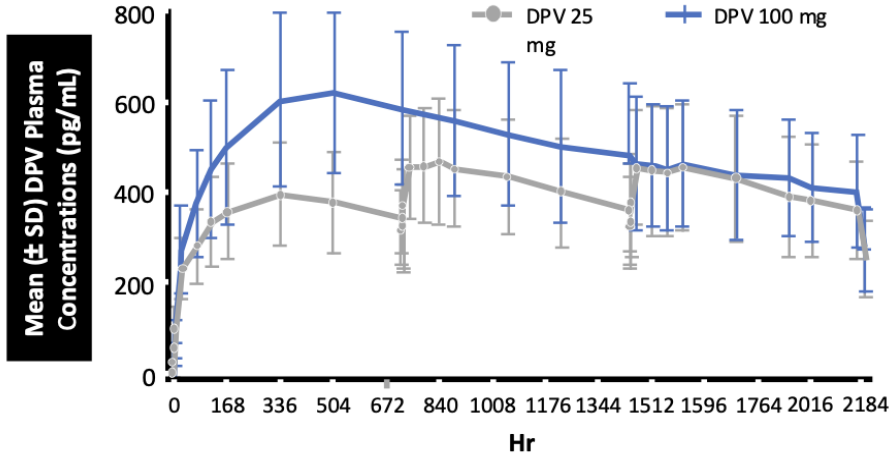
Longer acting (3 month) DapiRing

IPM 054: 1-Mo vs 3-Mo Dapivirine Vaginal Ring Pharmacokinetic Study in South Africa

Nuttal. HIVR4P 2024. Abstr OA0802LB.

- Monthly (25 mg) DPV ring approved for use in limited areas (not in US)
- **IPM 054:** open-label, randomized, crossover phase I study of 124 HIV-negative women
  - **Primary endpoint:** plasma DPV concentration at Day 90 (prior to removal) and exposure during last 30 days
    - Lower bound LS mean ratio 90% CI >0.95 (noninferiority) and >1 (superiority)

- 3-mo (100 mg) ring noninferior and **superior** to 1-mo (25 mg) ring
- **No differences** in treatment-emergent AEs (e.g., discharge, VVC and BV)



deliver
A Study of PrEP and the Dapivirine Ring in Pregnant Women

- No safety concerns were found in:
  - Cohort 1 (36+ weeks/8-9 months pregnant);
  - Cohort 2 (30-35+ weeks/7-8 months pregnant);
  - Cohort 3 (12-29 weeks/3-7 months pregnant).
- Follow up for cohort 3 concluded in mid 2023, babies followed up for an additional year after birth
- Final results anticipated late 2024 or early 2025

- Favourable safety profile and previous data showing low drug transfer to breastmilk supports updates of WHO to include breastfeeding women when recommending PrEP Ring as an HIV prevention option

What's coming in topical PrEP….

MATRIX

MATRIX **Product Pipeline Overview**

Ngure K, Matrix

OneRing:
Antiviral peptide (non-ARV)
(protein fragment)

Non-hormonal contraceptive
A soluble Adenylate Cyclase (sAC) inhibitor; affects sperm's ability to move, fertilize eggs

Oak Crest Institute of Science
Matrix 003

TAF/EVG

Fast-dissolving vaginal insert
tenofovir alafenamide & elvitegravir

NRTI & integrase inhibitor (ARVs)

TAF has also shown activity against HSV, which could be added benefit. CONRAD also evaluating the insert's rectal use.

MATRIX 001

DAPIVIRINE VAGINAL FILM

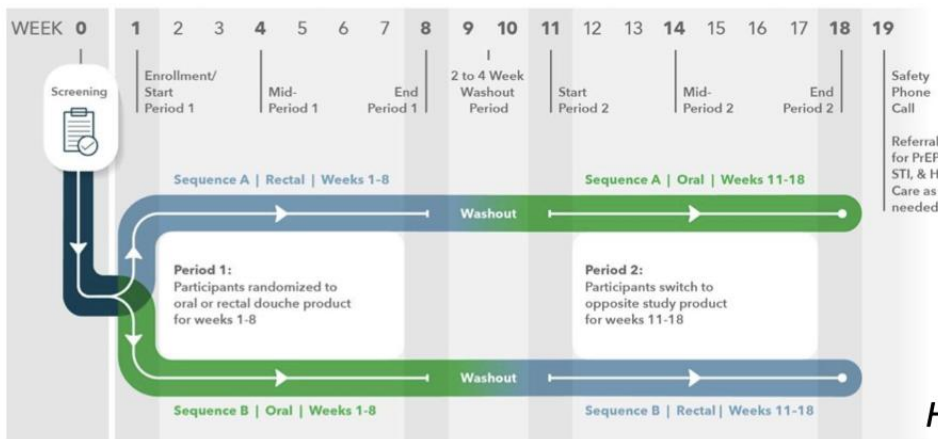
Film would slowly release drug until it completely dissolves (30 dys).

Also being developed as dual-purpose product

MATRIX 002

HPTN
HIV Prevention Trials Network

Phase 2: Rectal douche vs. Oral PrEP (HPTN 106)

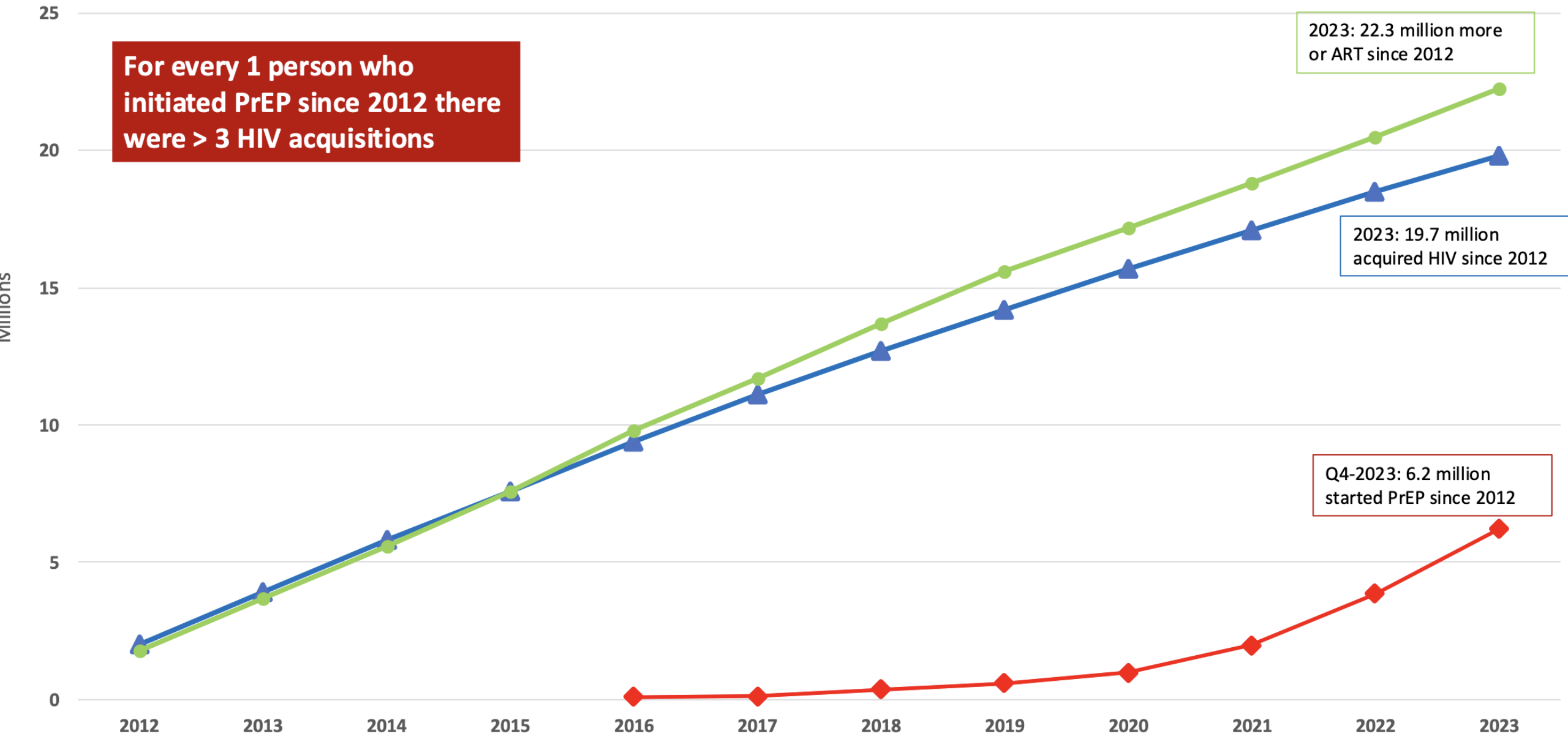


HPTN 106 REV UP
Rectal vs. Oral Use of On-demand PrEP

Hendrix C, HPTN

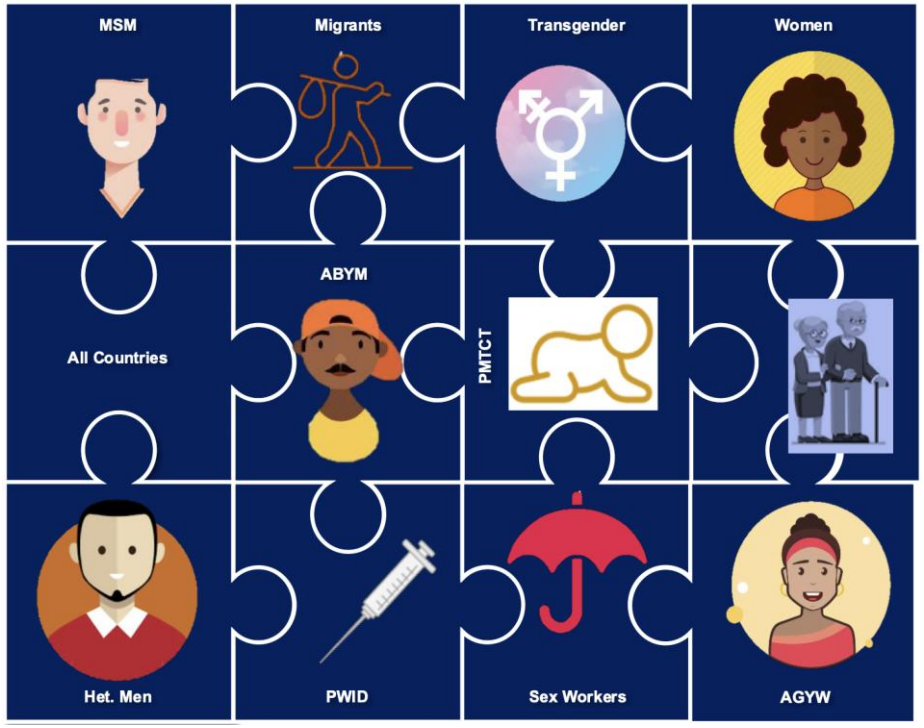
HIV/AIDS Key Numbers 2012-2023 – Global

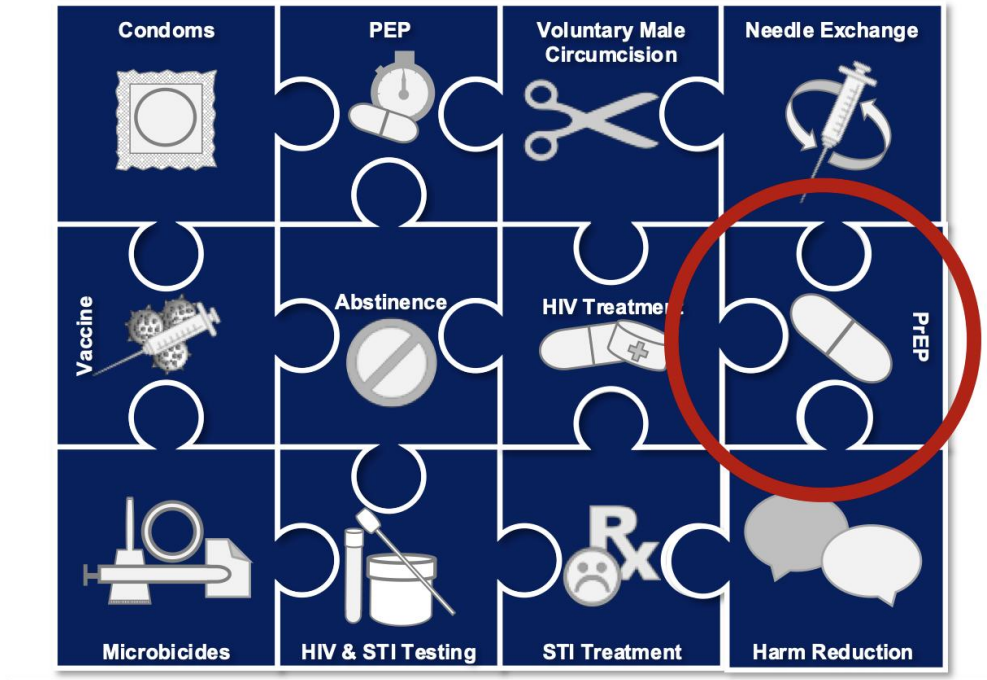
Huub Gelderblom, HVTN (personal comms)



Sources: AVAC PrEPWatch https://www.prepwatch.org/resources/global-prep-tracker/ and UNAIDS https://www.unaids.org/en/resources/fact-sheet

Humanity comes in many shapes and forms…





Prevention Should too…

Infusion Implant Injection Pill Vaginal ring Gels Insert Vaginal film Lube Douche

Sistema Sanitario Nazionale
Regione Lombardia

Protocollo per la Gestione della **Profilassi Post-Esposizione per HIV** a seguito di esposizione occupazionale e non-occupazionale nell'adulto

A Cura di

Dr. Davide Moschese
Ospedale "Luigi Sacco"
Milano

Regione Lombardia

INTRODUZIONE

Fattori di rischio per **fallimento della PEP**:

- Comportamenti ad alto rischio all'interruzione della profilassi
- Ritardo nell'inizio della profilassi
- Scarsa aderenza al regime prescritto
- Infezioni misconosciute all'inizio della profilassi
- Virus resistente ai farmaci impiegati nel regime

STIMA DEL RISCHIO

- Tipo di **esposizione** (occupazionale e non occupazionale)
- Rischio che la fonte sia **HIV positiva e viremica**
- **Fattori di rischio** della fonte e del soggetto esposto
  - Soluzioni di continuo delle mucose
  - Esposizione multiple in periodo di tempo limitato
  - IST concomitanti
  - Trauma profondo
  - Iniezione di bolo di sangue

Review > Lancet Infect Dis. 2004 Jul;4(7):456-66. doi: 10.1016/S1473-3099(04)01061-8.

Syphilis and HIV: a dangerous combination

W A Lynn [1], S Lightman

ESPOSIZIONE OCCUPAZIONALE

Contatto dell'**operatore** con **fluidi corporei o tessuti** che espongono al rischio di trasmissione di HIV

sangue, sperma, secrezioni sessuali, latte materno e altri fluidi visibilmente contaminati con sangue

- **Ferite percutanee**
- **Membrane mucose** o **cute non intatta**
- **Morsi profondi o multipli** (se fonte molto probabilmente HIV positiva e sangue visibile nella bocca)

ESPOSIZIONE NON O

- Attività **sessuale**
- Utilizzo di **droghe ini**

Esposizione	Rischio
Rapporto anale recettivo • con eiaculato • senza eiaculato	 1:70 1:155
Rapporto anale insertivo • non circonciso • circonciso	 1:160 1:900
Rapporto vaginale recettivo	1:1250
Rapporto vaginale insertivo	1:2500
Fellatio	Trascurabile
Cunnilingus	Trascurabile
Membrane mucose/cute non intatta	1:1000
Cute intatta	Trascurabile
Morso di umano	Trascurabile
Condivisione di presidi endovenosi	1:125
Puntura accidentale occupazionale	1:440
Puntura accidentale con ago abbandonato non-occupazionale	Trascurabile*
Trasfusione di sangue	1:1

suale quando il soggetto fonte

on **stabile soppressione**

ca

di droghe iniettive (e per

occupazionale)

VALUTAZIONE CLINICA

1. Informazioni sulla **fonte**, quando identificabile (status HIV e HBV)
2. Informazioni sull'**esposizione** (data e ora, tipo di esposizione)
3. Informazioni sulla **persona esposta**
   - Ultimo test HIV eseguito, pregresso uso di PEP, attuale utilizzo di
   - Esposizioni a rischio negli ultimi 3 mesi
   - Sintomi di IST concomitanti
   - Status vaccinale per HBV
   - Eventuale stato di gravidanza o allattamento e uso di contraccettivi
   - Anamnesi patologica e farmacologica
4. Acquisizione del **consenso informato scritto** per test HIV e PEP

INDICAZIONI

	Fonte HIV positiva		Fonte HIV non noto
	HIV-RNA>50 cp/ml	HIV-RNA <50cp/ml	
Esposizione sessuale			
Sesso anale recettivo	PEP	NR	PEP
Sesso anale insertivo	PEP	NR	PEP **
Sesso vaginale recettivo	PEP	NR	PEP***
Sesso vaginale insertivo	PEP	NR	PEP **
Fellatio	NR*	NR	NR
Cunnilingus	NR	NR	NR
Contatto sperma e occhio	NR	NR	NR
Esposizioni occupazionali o altre			
Condivisione di presidi per iniezioni endovenose	PEP	PEP	PEP
Puntura con ago o altro tipo di tagliente (occupazionale) contaminato da liquido potenzialmente infettante	PEP	PEP	PEP
Contatto tra mucose e liquidi corporei infettanti	PEP	NR	PEP
Morso di umano	NR#	NR	NR#
Puntura con ago (ambientale)	NR	NR	NR

QUANDO E COME PRESCRIVERE LA PEP

- Preferibilmente **entro le 24 ore** dall'esposizione e **non oltre le 72 ore** (massima efficacia entro le 4 ore)

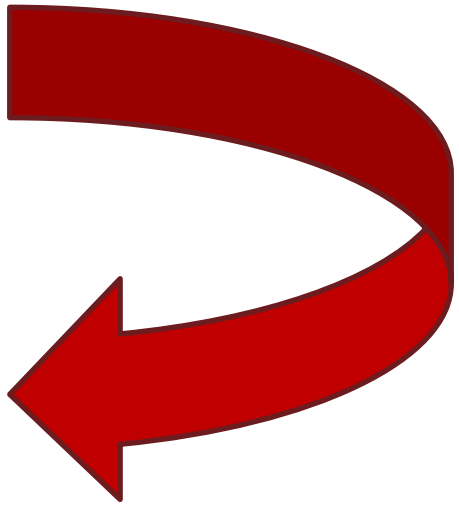
Efficacia fortemente tempo-dipendente

- Regimi di prima scelta a base di **2 NRTI + 1 INSTI** (TDF o TAF + FTC + RAL o DTG o BIC), preferibilmente in ***single-tablet regimen***
- Durata di **28 giorni** (possibilmente con immediata fornitura di farmaco per l'intero ciclo di PEP)

Efficacia fortemente aderenza-dipendente

INTERRUZIONE PRECOCE DELLA PEP

- **Fonte** identificabile
  - HIV Ag/Ab negativo
  - Non esposizioni a rischio nelle precedenti 6 settimane
- **Individuo esposto** informato e d'accordo



FOLLOW-UP

Test	Baseline (BL)	Settimana 4-6	Settimana 12
HIV (Ag/Ab)	X	X	X
Epatite B (HBsAg, Anti-HBs and Anti-HBc)	X		X *(se non vaccinato o noto)*
Epatite C (Ab, e in caso di positività anticorpale ricerca di HCV RNA Qual PCR)	X	X	X
Chlamydia e gonorrea (NAAT o colturale)			X*
Sifilide (anticorpi o RPR/VDRL o TPHA/TPPA)	X	X	X
Test di **funzionalità renale**	X	X	
Test di **funzionalità epatica**	X	Solo se alterato a BL o sintomi	
Test di **Gravidanza**	X	X	

DO NOT DELAY

FOLLO

Interp

- ne
- ezione

Transiz

- rEP al

Immediate PrEP after PEP: Results from an Observational Nurse-Led PEP2PrEP Study

Journal of the International Association of Providers of AIDS Care
Volume 19: 1-7

DOI: 10.1177/2325958220939763
journals.sagepub.com/home/jia
SAGE

Patrick O'Byrne, RN-EC, PhD[1,2], Lauren Orser, RN, MScN[1,2], and Amanda Vandyk, RN, PhD[1]

Abstract

Patients who use post-exposure prophylaxis (PEP) are at ongoing risk for HIV acquisition after completing PEP. While the Centers for Disease Control and Prevention recommends pre-exposure prophylaxis (PrEP) use immediately after PEP, some practitioners are hesitant to offer PEP-to-PrEP (PEP2PrEP). We began offering PEP2PrEP in the sexually transmitted infection clinic in Ottawa, Canada on August 5, 2018. During the first 16 months of PEP2PrEP, 61 patients requested PEP and 46 were initiated; 30 of these patients agreed to PEP2PrEP and 26 followed through. None of our PEP patients had confirmed HIV exposures; all fulfilled the initiation criterion of condomless anal sex with a male partner of unknown HIV-status. During the study, the number of PEP requests and initiations was statistical unchanged, yet the seroconversion rate among patients who used PEP decreased from 1.7% pre-PEP2PrEP to 0% post-PEP2PrEP. Regarding follow-up, most discontinuations occurred between the PrEP intake and 1-month follow-up visit.

NON SOLO HIV

HBV

Precedentemente immunizzati	HBsAb > 10 UI/L dopo ciclo vaccinale oppure pregressa infezione	Nessun ulteriore follow-up
Non immunizzati	HBcAb e HBsAb negativi	Vaccinazione e follow-up a 6 mesi; eventualmente Ig specifiche se fonte HBsAg positiva
HBV positivi	HBsAg positivi	Valutazione epatologica per presa in carico

HCV

Non disponibile alcuna profilassi post-esposizione

ESPOSIZIONE A RISCHIO TRASCURABILE

Richiesta **insistente** di accesso alla PEP:

- Stato particolarmente **ansioso** del soggetto esposto
  - Inizio di **PrEP** con duplice attività di profilassi (TDF/FTC 2 cp, quindi 1 cp ogni 24 ore)
  - Screening per HIV con HIV Ag/Ab e HIV-RNA al baseline e dopo 30 giorni dall'inizio

- **Comportamento a maggior rischio** che il soggetto esposto non ha riferito (**stigma**)
  - Inizio di **PEP**

NUOVE ESPOSIZIONI DURANTE LA PEP

MSM cisgender	Ultima esposizione nelle **ultime 48 ore** prima delle fine della PEP	Proseguire la PEP per **48 ore** dopo l'ultima esposizione a rischio
Donne cisgender, uomini e donne transgender e di genere non binario	Ultima esposizione nell'**ultima settimana** prima della fine della PEP	Proseguire la PEP per **7 giorni** dopo l'ultima esposizione a rischio
Utilizzatori di sostanze per via endovenosa	Esposizione in **qualsiasi** momento del ciclo di PEP	Proseguire la PEP per ulteriori **28 giorni** dopo l'ultima esposizione a rischio

TRANSIZIONE A PEP IN CORSO DI PrEP

Tipo di esposizione	**Aderenza a PrEP***	**Raccomandazione§**
Rapporto anale recettivo/insertivo	Almeno 4 dosi	Continuare schema PrEP
	Meno di 4 dosi oppure Aderenza incompleta a schema On Demand# prima o dopo il rapporto	Transizione a PEP
Sesso vaginale/neovaginale/organo genitale frontale recettivo	Almeno 6 dosi	Continuare schema PrEP
	Meno di 6 dosi	Transizione a PEP
Sesso vaginale/neovaginale/organo-genitale-frontale-recettivo insertivo	Almeno 4 dosi	Continuare schema PrEP
	Meno di 4 dosi oppure Aderenza incompleta a schema On Demand# prima o dopo il rapporto	Transizione a PEP

LO STILE DI COMUNICAZIONE D

- Chiedere il **nome scelto dal** rmini che preferiscono utilizzare per descrivere i propri organi
- Spiegare la necessità di cono
- Utilizzare **domande aperte**
- Informare che i regimi PEP r **erazioni farmacologiche con le terapie ormonali** di afferma

ABSTRACT

Objectives HIV postexposure prophylaxis (PEP) is indicated after sexual exposure with high risk of transmission. Men who have sex with men (MSM) are the main target of PEP. The aim of our study was to investigate the experience and shortcomings of PEP among people with a high risk of HIV exposure.

Design and methods Subjects with ongoing follow-up for HIV infection and PEP history were selected for the qualitative study. Semistructured interviews were conducted at the patients' homes. They were audio-recorded, transcribed and deidentified before data analysis, double coding and thematic analysis with an inductive approach.

Results Twenty-three patients were eligible for the qualitative study. Thirteen interviews were carried out. All patients were 20-60-year-old MSM. The median time between PEP and HIV diagnosis was 3.3 years (interquartile range $(IQR)_{25-75}$=0.9-4.9). Many participants reported negative PEP experiences: awkward access to the PEP clinic, uneasiness and shame in the hospital setting, unpleasant interaction and moral disapprobation from the medical staff, treatment intolerance and prevention messages that were 'inconsistent with real life'

Conclusion Our data highlight PEP management failures among its target population that may have compromised any subsequent attempts to seek out PEP. Practitioners should be more aware of MSM sexual contexts and practices. PEP consultations should provide the opportunity to discuss prevention strategies with highly exposed HIV-negative subjects, which may include pre-exposure prophylaxis.