# The need to harmonise management of HIV exposure in Europe

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Harmonised European recommendations for the management of HIV exposure have been needed for some time. Important and impressive work has been achieved by two groups of experts from a total of 14 countries, and their conclusions and recommendations are reported in the two papers from Jesús Almeda *et al* and Vincenzo Puro *et al* [1,2].

Two characteristic settings are specified, although the difference between each is debatable if the issue is to avoid or prevent an established infection after exposure to HIV (or, indeed, HCV or HBV). As the authors point out, post-exposure prophylaxis (PEP) is the standard of care for healthcare workers (HCW) in almost all countries including the United States, but not for the management of sexual, injecting drug use or other non-occupational exposures to HIV.

In the case of HCW occupational exposure, the authors' task was to standardise several national recommendations and strategies. For non-occupational exposure, the aim was to establish European guidelines, as very few national recommendations exist.

As these articles show, the rationale, background, management, and choice of treatment for PEP are very similar in both situations.

It is very important for healthcare workers to know that their institution has guidelines to protect them from occupational risks. In such situations, the source patient is usually accessible for rapid testing, which helps with risk evaluation and the therapeutic decision. Healthcare workers can also seek information and care on site immediately following exposure, which is very important for the outcome of the post-exposure care.

**The time elapsed between exposure and initiation of treatment is of major importance**

In cases of sexual exposure, access to the physician, and the physician's decision are more difficult and will take longer, since the source patient is often unknown or unavailable for testing. Moreover, the outcome (HIV status at 6 months) is frequently not properly assessed because patients are lost to follow up.

Despite these major differences, both type of exposure deserve the same multidisciplinary and comprehensive network of specialists for post-exposure care. Because the efficacy of PEP is linked to the delay of therapy initiation, it is important for medical teams and institutions to consider risk assessment as an emergency and to provide a ready accessibility to evaluation and PEP 24 hours a day. In our experience, sexually exposed patients frequently seek advice or care at night or at weekends, which are not the best times for a full assessment of the situation; in these cases we recommend starting PEP as soon as possible after counselling, with reassessment of the patient by a specialist the following morning so that the PEP indication can be reconsidered. It is preferable to stop antiretroviral treatment after one or two days than to realise that it is too late to start it if indicated.

Informing healthcare workers and the general public about the limitations of PEP: four weeks of therapy with potential side effects and toxicity, and a follow up with medical visits and blood test. PEP cannot be used as a 'morning after pill', as is sometimes requested by patients after risky sexual behaviour. On the other hand, it is important to know that PEP can be recommended for rape victims and should be available in these situations. For medical teams or physicians, these recommendations will help in giving adequate counselling and care or in referring the person to a specialist unit after a first evaluation. However, post-exposure care is time consuming for the specialist team, as it is not only the initial assessment and prescription that will contribute to the success of the PEP. Monitoring adherence to therapy, clinical tolerance and toxicity, psychological impact, and organising scheduled visits and testing are all mandatory for the success of the care. Recommendations on the choice of drugs will have to be updated regularly, as knowledge is moving quickly in the field of antiretroviral therapy. The most important point is that PEP is not indicated for an infected or sick person and that the risk-benefit ratio is therefore of major importance. In our institution we consider the assessment and the decision whether of not to treat to be the most important part of post-exposure care. The drugs have to reach the HIV target cells for replication before effective integration of the HIV genome, which is why the time elapsed between exposure and initiation of treatment is so important.

As the authors mention, a triple combination with two nucleoside analogues and a protease inhibitor are a good choice in terms of efficacy. We would also take the number of pills and the number of doses per day into consideration, as compliance is essential. In terms of risk and tolerance, we would not recommend nevirapine or abacavir (as recommended here) because of early toxicities such as hypersensitivity or hepatitis, but we do not use efavirenz either because of the dizziness and sleeping problems that may occur during the first days of therapy, and which would compromise the therapy in these anxious patients.

Finally, we will all benefit from these European recommendations which are both well documented and very informative. Little is known about the impact of NONOPEP on behaviour, or its efficacy, and so I would strongly support the idea, mentioned in the conclusion, of the need for a prospective evaluation of its use in the European countries.

## References

1. Almeda J, Casabona J, Simon B, Gerard M, Rey D, Puro V et al. Proposed recommendations for the management of HIV post-exposure prophylaxis after sexual, injecting drug or other exposures in Europe. *Euro Surveill* 2004;9:35-40
2. Puro V, Cicalini S, De Carli G, Soldani F, Ippolito G. Towards a standard HIV post exposure prophylaxis for healthcare workers in Europe. *Euro Surveill* 2004;9:40-3