

HIV Vaccine Trials Network
GCAB Scientific Working Group Conference Call
Friday, Dec. 3, 2010 8 a.m. Pacific

Participant	Location	Participant	Location
Ian Maki, chair	Seattle CAB	Scott Hammer	Protocol Chair
Gloria Malindi	Soweto CAB	Magda Sobieszczyk	Protocol Co-chair
Kate Miller	Chicago CAB	Tamra Madenwald	HVTN Core
Victoria Chinnell	Seattle CAB	Shelly Karuna	HVTN Core
David Galetta	Cape Town CAB	Steve Wakefield	HVTN Core
Justin Barnes	Birmingham CAB	Carrie Schonwald	HVTN Core
Hamilton Richardson	Baltimore, GCAB at-large	Gail Broder	HVTN Core
Rick Church	New York City CAB	Cheryl Stumbo	HVTN Core
Gavin Morrow-Hall	San Francisco CER	Niles Eaton	HVTN Core
Adam Sherwat	DAIDS		

MINUTES

Introduction	<p>Niles Eaton: Thanks to everyone for allowing us to take over the agenda. A slide set and backgrounder were included.</p> <p>We at the HVTN and a subset of the HVTN 505 Protocol Team is keenly interested in what the iPrEx results mean to you and to HVTN 505. Turn over to Magda.</p>
	<p>Magda Sobieszczyk: Will review closely the slides we sent and our purpose here today is:</p> <ul style="list-style-type: none"> • To make you are aware of the iPrEx results; • To let you know the HVTN 505 study team is working to understand what the results mean to 505; • To ask: <ul style="list-style-type: none"> • what these results mean to you? • what these results mean to your communities? • what you think the results mean for HVTN 505? <p>Please see slide set here: http://www.hvtn.org/community/SWGiprexpresentation.pdf For background information, click here: http://www.hvtn.org/community/iprexbackground.pdf</p>
Questions?	<p>Ian Maki, Seattle CAB: Do we know about prevalence of virus in populations in cities where the studies were done? Scott Hammer: Circulating resistant strains is not known, but many of the countries participating in iPrEx are participating in the WHO</p>

	<p>surveillance of drug resistance in the treatment naive population. As I understand it, overall about <5% show resistance, again in treatment naive people. Magda: For those who are resistant, there are other treatment options available. The two in the iPrEx study who were identified were likely already infected, but not detectable, at baseline enrollment.</p> <p>Scott: The question is well placed, because in all PrEP studies this is, and will be, a major issue and will be looked at and followed carefully. There are also several new studies designed to detect lower levels of resistance viruses. More studies ahead on pharmacology and drug resistance issues as well.</p>
<p>What do the iPrEx results mean to you, your communities and HVTN 505?</p>	<p>Gavin Morrow-Hall in San Francisco: We recruited for the iPrEx study and we had a meeting with participants when the results came out. The first reaction was of great enthusiasm and joy. A big standing ovation. It was truly moving and exciting. But there was also concern: resistance, and the prospect, and effects, of taking the drug for a very long time. People out in the community are very keen to get more information, and there is a very strong interest in participating in any future iPrEx study. This was a very "big bang" event for our community. Quite exciting.</p> <p>Can you describe the meetings again:</p> <p>The first meeting included members from the Glaxo Institute and our site. The more recent meeting was with the participants we recruited. There will be a roll-over study to give participants open-label Truvada. There is great interest among participants about this, and when this all starts and what it all means.</p>
	<p>Hamilton Richardson, Baltimore: Can I play devil's advocate? This is good news, certainly something to add to our toolbox. But this is something that has to be taken everyday. But what about those communities who are already infected and are having trouble getting access to their meds. Will medical insurance fund it? Certainly there are people who will be able to afford access to Truvada to prevent infection, but what about those people already infected who can't get their meds? Or those who are uninfected, but at high risk, who won't be able to access or afford Truvada? Should we not focus on keeping the viral load in those who are infected down to help prevent further transmission of HIV? Am I being a downer?</p>
	<p>No. No. You are speaking realistically. These are very important points and issues. Who will benefit, when and for how long?</p>
	<p>Ian Maki: To change the subject briefly, I wanted to point out that all the risk reduction counseling we are doing seems very consistent with what was done in the iPrEx study. And it seem to me that another important takeaway message from the iPrEx results was that adherence was so low. Given this, it still points to the fact that a vaccine intervention would be preferable. So our work is not yet done!</p>
	<p>A question for Scott: I know you are going to be having some community consultation on HVTN 505. How are you going to get the answer we all want, statistically speaking, when everybody in the study is taking PrEP? Is that an accurate question? Wouldn't you need to enroll many more people to reach the endpoints?</p>

	<p>Scott. Yes, a very good question. Let me just say a couple of things: 1) Most importantly, and overall, this is a very positive result. We welcome it. We have to monitor this positive outcome and the freedom our participants have to take this regimen. For there moment, from an HVTN 505 perspective, we are taking a passive approach and will simply tell our participants about the results, ask them if the will use PrEP and monitor their use. 2) If there is a large voluntary uptake of PrEP, this may affect the trial. As we gather this information, it will go confidentially to the DSMB and if there is a large uptake then we may need to expand the sample size. But for now our approach is to monitor this passively.</p>
	<p>But for our purposes today, our question to you all is: What's your equipoise? What do you think about all this? Should uptake be voluntary? We need, all of us, to talk through all the pros and cons of these results. And the impact to us.</p>
	<p>Gavin Morrow-Hall: when you say allow PrEP what do you mean exactly? Actually give PrEP to our HVTN 505 sites to give to participants? Scott: No, no. What we have to say participants is that this is out there. We want to know if they are taking it. We passively monitor their use. We are contemplating a more active role, but this hasn't been formulated yet. We really want to get your input and your feelings.</p>
	<p>Ian Maki: Another thing to remember, the STEP results took some time to make their way into the community. And in talking about the iPrEx results with the clinicians here in Seattle, it really appears that awareness is low. And "awareness" and "uptake" may be low for a while. This will vary, of course, across the country. This may take some time in cities like Seattle The prudent step to take will be to make sure people and participants are updated.</p>
	<p>Gail Broder: I'm curious about something-- One of the potential ways in which HVTN 505 could be modified would be to add an arm to include PrEP use. Correct? Scott: This is one option that is possible. This is something that would fall under the "active" as opposed to the "passive" approach described a few moments ago. The issue of what people feel in their gut, as well as their intellect about these results is what we want to know now. For these discussions, we have to be practical, we want to hear what people's thoughts are unencumbered by these details.</p>
	<p>Rick Church: One of the ethics issues I was thinking of is this: The difference between the iPrEx regimen and a vaccine. When we give a vaccine, we can't say at all that it works. But with the Truvada regimen, we can say it does work. For example, when Doctors Without Borders goes into a country to provide medications to people who need essential medications to treat HIV, they have an obligation to keep that medication going and available. Do we not have the same obligation with Truvada given these results?</p> <p>Gavin Morrow Hall: So you're saying that those who participated in iPrEx should be kept on Truvada, ethically-speaking</p> <p>Rick Church: Yes. Whatever the criteria was to take Truvada, there is an ethical obligation to continue to give it to those people. Unlike a vaccine, we have no evidence that it works so there is no ethical obligation to give or continue vaccine.</p>

	<p>Scott Hammer: This vaccine is not going onto the licensure path, but let's say for arguments sake: the vaccine was a home run and there was a 50% reduction in viral load among vaccine recipients. And let's say there was product available from the manufacturer. One could argue very strongly, with this result, that we should vaccinate placebos.</p> <p>The PrEP issue you raise is a very interesting one, because it is an approved drug. If we were to add an ARM into 505, what would be our obligation to provide this our participants?</p> <p>You've raised another interesting point: If we have efficacy in another trial, such as iPrEx and we want to incorporate it into 505. . . Are we obligated from the get-go, to give this drug to participants for a life time?</p> <p>These are very important and difficult to answer questions.</p>
	<p>Ian Maki: My first reaction when I heard the results, I thought: O my god: We'll never get another high risk MSM into a vaccine trial. When I think of the people I know, they will say "I would get the drug", I don't want to deal with an experimental vaccine that will never be licensed.</p> <p>Scott: And your reaction 9 days later? Ian: Um, well -- I think given the complexities of adherence, we may find more people who are motivated altruistically and may enroll. But I think these results will still make that harder.</p>
	<p>Gavin: One of the community education challenges is that this is just one study. And the reality check is that very few people will be able to walk into their local Kaiser and get PrEP. And we have heard from several physicians that they will not provide PrEP until more studies are done.</p>
	<p>Scott: These are very important points and they are very much related to the disparity in America in access to health care. An important illustrative example of this in the New York Times today. Medicaid patients will no longer be eligible for liver transplation in Arizona. And liver translation is a well established treatment for end stage liver disease. So the issue of resources and access are really hitting home. http://www.nytimes.com/2010/12/03/us/03transplant.html?_r=1&ref=health</p>
	<p>Gavin: It really has to be communicated to the community that this is not a reality now. We must really temper people's expectations.</p>
Other Calls Planned	<p>Niles: A number of calls just like this one are planned in the coming weeks. There will be some overlap between the members here today and other groups. So you will likely be receiving multiple invites. We will have quite a few of these calls moving forward.</p>
	<p>Scott adds: I would ask that if you have any comments or questions about the materials, we would love to know how to improve them. Please email us about this. Email any of us, Niles, Scott, Magda, etc.</p>

	Hamilton: When is the projected end of enrollment in HVTN 505? Answer: Approximately September 2011.
	This has been a very fruitful presentation for us.