BHIVA guidelines for the management of HIV-2 2021

Public consultation comments

Compilation of all comments received via BHIVA website
28 May 2021

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	Name	Affiliation	Comments	Writing group response
1.	Graham P Taylor	Imperial College London	Enjoyed the HIV-2 guidelines. Thank you. 2 comments: 1) In the section on serological diagnosis there is specific mention that the laboratory should be UKAS accredited to ISO15189. This is not mentioned for other laboratory tests. What is the justification for this being a requirement for serology but not for molecular diagnostics? Secondly, if the intent is for ISO15189 standards to apply then perhaps should state that the HIV-2 serological diagnosis should be included in the UKAS accredited scope of the laboratory. 2) Do the neonatal post-exposure prophylaxis durations currently recommended for HIV-1 apply to HIV-2?	1) Thank you. UKAS accreditation is not possible for in-house assays. As noted in the text, the ACHIEVE collaboration aimed to compare and standardise the interpretation of HIV-2 viral load assays. 2) Thank you. Clarified that we suggest same neonatal post-exposure prophylaxis duration as stratified in HIV-1 guidance.
2.	Tristan Barber	Royal Free Hospital	This guideline is excellent. I have no further comments but would like to offer congratulations to the Chair and the writing group, thanks for all the hard work in pulling this together.	
3.	Steven Welch	University Hospitals Birmingham, CHIVA, Penta	Thankyou for comprehensive guidelines WRT pregnant women - it would be good to use the coincidence of this new version of the guideline and a current minor update of the pregnancy guideline to ensure that the 2 are completely congruent HIV2 guideline is recommending for initiation in pregnancy TDF /3TC with DRV/r, probably twice daily and says DTG is alternative from 6 weeks; pregnancy guideline says the same twice daily DRV/r regimen, with no mention of using INSTI. For neonatal PEP, HIV2 guideline is recommending consultation with an expert and likely raltegravir, 3TC, AZT if high risk, standard AZT if low or very low risk; the pregnancy guideline actually mentions neonatal PEP in both the pregnancy section, where it says may consider triple therapy with raltegravir, and in the	Thank you. Text amended to be consistent with HIV-1 guidance. Thank you. Neonatal PEP section has been amended to bring into line with HIV-1 guidance around lopinavir use.

			neonatal management section where we state that AZT for low or very low risk, and for high risk consultation with expert, same RAL/AZT/3TC if no advice available, consider LPV/r with caution instead of RAL if RAL not available. WRT management of paediatric HIV-2, there is never going to be enough evidence for a separate guideline; Penta and US DHHS guidelines for children are specifically on HIV-1 only. This does make it highly likely that anyone managing a child with HIV 2 in UK (and beyond) will refer to this guideline, and I note that the language throughout is helpful as refers to individuals with HIV2, not specifying adults. This guideline could therefore be used, and will remain appropriate eg where it recommends TDF "unless there is a clinical reason not to", pre-pubertal child could be managed with abacavir as age constitutes clinical reason to prefer abacavir over TDF. However I wonder if the HIV 2 guideline could include a paragraph on children as a special population in addition to pregnant women and neonatal PEP stating that absolutely no evidence, but that should be discussed in a national MDT and likely to be same choice of 3rd agent depending on age and formulation availability, and choice of NRTI according to age and basic recommendations in Penta guideline? The paragraph could alternatively be even more brief and say no evidence, consult an expert and use same principles of predicted drug susceptibility.	Agree – short section added.