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Prevalence of resistance to nevirapine in mothers and children after single-dose exposure to prevent vertical transmission of HIV-1: a meta-analysis

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Accepted 16 April 2007

Background Single-dose nevirapine (NVP) is the main option for the prevention of mother-to-child transmission (PMTCT) of HIV-1 in countries with limited resources. However, the use of single-dose NVP results in HIV-1 viral resistance which could compromise the success of subsequent treatment of mother and child with antiretroviral combinations that include non-nucleosidic-reverse-transcriptase inhibitors. This systematic review and meta-analysis of summarized data aimed to estimate the proportion of mothers and children with NVP resistance mutations detected in plasma samples 4–8 weeks postpartum after single-dose NVP use for PMTCT.

Methods Systematic search of electronic databases (MEDLINE, PASCAL) and conference proceedings (1997 to February 2006). Inclusion of all studies, without design, place or language restrictions, meeting the following criteria: use of single-dose NVP; viral genotyping performed with standard sequence analyses, between 4 and 8 weeks postpartum, in plasma samples; available public report; report of mothers’ median baseline plasma HIV-1 RNA levels. Data extraction by two independent reviewers using a standardized form created for this purpose.

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† The study was presented in part at the Third IAS Conference on HIV Pathogenesis and Treatment (Rio De Janeiro) 2005: Abstract TuPe5.2P15.
Introduction

In 2006, an estimated 2.3 million children under 15 years were living with HIV/AIDS worldwide and at least 380,000 died of AIDS. In the same year, almost 530,000 infants became newly infected with HIV, 90% of them through mother-to-child transmission (MTCT) before, during or after delivery. Transmission around the time of delivery accounts for nearly half of overall MTCT in breastfeeding populations, and this peri-partum period has become the major focus of prevention of MTCT (PMTCT) strategies, especially with antiretroviral drugs (ARVs). Single-dose nevirapine (NVP) given to the mother and to the neonate within 72 h of birth has been proven to be a safe and effective intervention to prevent MTCT. The regimen is cheap and relatively easy to administer. Since 2000, single-dose NVP has been endorsed by the World Health Organization (WHO) as one of several recommended ARV regimens for PMTCT in resource-limited settings.

Single-dose NVP induces the selection of HIV-1 resistant mutants in mothers and infants. However, the extent of this problem is poorly quantified with estimated prevalence ranging from 1 to 69% for women and from 0 to 87% for neonates. 

Little is known about factors associated with the development of NVP viral resistance, but it is likely that high HIV-1 RNA levels in plasma, low CD4 cell counts, viral subtype and NVP plasma concentration play a role.

sources of between-study heterogeneity, including additional ARV interventions given post-partum.

Methods

Search strategy

MEDLINE and PASCAL were searched for published articles between 1997 and February 2006 using a combination of the terms ‘Resistance AND [(nevirapine OR NVP) OR NNRTI]’. Searches were complemented by perusing references of retrieved articles. Studies presented at conferences (US Conference on Retroviruses and Opportunistic Infections, International AIDS Conference, International HIV Drug Resistance Workshop, Conference on HIV Pathogenesis and Treatment; 2000–06) were also searched using NLM Gateway®, conference websites or conference proceedings.

Inclusion criteria

All studies, without design, place or language restrictions, were considered if they met the following four selection criteria: (i) a single-dose NVP had been given to HIV-1 infected women during labour, (ii) viral genotypic resistance assay had been performed with sequence analyses (detection limit ~20–30%), between 4 and 8 weeks post-partum, in mothers and children’s plasma samples, (iii) an abstract, an article or an oral or poster presentation was available and (iv) for the meta-analysis on mothers’ findings only, median baseline plasma HIV-1 RNA level was reported.

When a study had two or more intervention arms, only those where women had received single-dose NVP were included in the meta-analysis. When multiple communications were available for the same study, we included the most recent one and/or the one with the largest number of observations. The homogeneity relative to the genotypic assessment methods used in the included studies was checked by the virologists. Studies using sensitive drug resistance assays (detection limit <1%) in plasma sample were retained for a complementary analysis to estimate the prevalence of patients with NVP viral resistance mutations using these methods.

Results

The pooled estimate of NVP resistance prevalence was 35.7% [95% confidence interval (CI) 23.0–50.6] in women in 10 study arms using single-dose NVP ± other antepartum antiretrovirals and 4.5% (CI 2.1–9.4) in three study arms providing also postpartum antiretrovirals (adjusted odds ratio 0.08; CI 0.04–0.16). The corresponding estimates in children were 52.6% (CI 37.7–67.0) in seven study arms using single-dose NVP only and 16.5% (CI 8.9–28.3) in eight study arms combining single-dose NVP with other antiretrovirals.

Conclusions

Single-dose NVP is widely used for PMTCT in resource-poor settings, but the burden of viral resistance is high in both women and children. It is substantially lower in studies providing additional postpartum antiretrovirals. The clinical implications of these findings should be further investigated.

Keywords

PMTCT, HIV-1, nevirapine resistance, meta-analysis, systematic review

Logistic random effect models to obtain pooled estimates. Univariable and multivariable meta-regression to explore sources of heterogeneity.
Data extraction

Two independent observers (EA, DKE) independently assessed the eligibility of studies using a standardized form developed for this purpose. Disagreements between reviewers were resolved through discussion. Data extraction was done by the same reviewers using a standardized data extraction form created for this study and with help from others when needed (RT, BM, PVDP, CR). The following information was obtained from each study: first author's name, journal and year of publication/presentation and details on the principal study in case the resistance study was a substudy; patient inclusion and exclusion criteria in the primary study and in the resistance study; place of study; ARV intervention(s); methods used for resistance testing; median baseline plasma HIV-1 RNA viral load; and for all assessments, when available, number of available samples, number of successful analyses, number of study participants with NVP resistance mutations. We asked authors of primary studies to check the accuracy of extracted data and supply additional data if required.

Outcome measures

The outcomes of interest were the proportions of mothers and children with NVP resistance mutations in codons of the viral reverse transcriptase gene known to confer resistance to NVP (100, 103, 106, 108, 181, 188, 190).31 The proportion of study participants with NVP resistance mutations. We asked authors of primary studies to check the accuracy of extracted data and supply additional data if required.

Data synthesis and exploration of heterogeneity

The proportion of study participants with NVP resistance mutations from each selected study was graphically displayed descriptively in Table 1.

Outcome measures included:

(i) Administration of ante/intrapartum ARV regimen in addition to single-dose NVP
(ii) Administration of post-partum ARV regimen in addition to single-dose NVP
(iii) Study location: in Southern Africa vs other regions
(iv) Median baseline plasma HIV-1 RNA viral load, dichotomized at the median value
(v) Time of resistance assessment: at 4 weeks vs 6–8 weeks post-partum
(vi) Sample size, dichotomized at 30 study participants
(vii) Reported pre-NVP exposure resistance assessment
(viii) Exhaustivity of the sample with resistance assessment compared with the sample enrolled in the main study.

Report characteristics included:

(i) Publication type
(ii) Status of the reported results: final or preliminary.

Variables with P-value <0.20 in univariable models were examined in multivariable models using a forward stepwise procedure. When between-study variance failed to be calculated, no further independent variable was added in the random effect models and fixed effects models were used. All P-values were two-tailed.

Results

Prevalence of resistance in mothers

Among 74 reports identified from 20 investigators, 64 were excluded because they were either duplicates or met exclusion criteria (Figure 1). The investigators were contacted and eight responded. Seven reports could thus be updated, one still failing to meet every inclusion criterion. Answers from the other investigators would have allowed the re-evaluation for eligibility of four additional studies.

Ten reports were thus included in the final analysis, relating to nine studies reported between 2000 and 2006 and corresponding to 13 study arms and 1173 women overall. The arms of the studies included in the meta-analysis were described in Table 1.

Of the nine included studies, one (the TOPS trial)31 had three post-partum intervention arms, two [the ANRS (Agence Nationale de Recherche sur le Sida et les hépatites virales)]

1201 DITRAME (DIminution de la TRANsmission Mère-Enfant) Plus cohort7,8 and the South African PMTCT cohort9 had two intervention arms (Table 1). Four studies took place in Southern Africa (South Africa, Zimbabwe and Malawi), and two in Eastern Africa (Uganda). Published articles were available for six studies, as well as an unpublished report for one of them, poster/slides for two studies and an abstract for one. Results were reported as final for six studies.

Genotypic resistance assessment prior to single-dose NVP use in women with NVP resistance at 4–8 weeks post-partum or in a subset had been described for six studies. The median of the reported median baseline plasma HIV-1 RNA viral loads was 4.39 log_{10} copies/ml [interquartile range (IQR): 4.00–4.48].

In univariable meta-regression (Table 2), both the use of ante- and post-partum ARV regimens were associated with a lower NVP resistance prevalence, as was a higher median baseline plasma HIV-1 RNA viral load. The univariable inverse relation between baseline HIV-1 RNA viral load and occurrence of NVP resistance did not hold when this variable was adjusted for post-partum ARV intervention. Development of NVP resistance mutations was more frequent in studies in Southern Africa. In multivariable meta-regression (Table 2), no more than two independent variables could be added in the random effect model. Post-partum ARV regimen, study location and baseline median viral load remained strongly associated with the detection of NVP resistance mutations.
Potential relevant reports identified by literature search (n>1244)
- Pubmed/Pascal (1997-Feb 2006)*, n=549
- Gateway (2000-2006)*, n=629
- International HIV Drug Resistance Workshops (2000–2006), n=NA
- 12th CROI (2005)**, n=24
- 3rd IAS Conference (2005)**, n=29
- 13th CROI (2006)**, n=13

Reports retrieved for more detailed evaluation (n=74)

Figure 1 Flow chart of studies included in the meta-analysis on prevalence of viral resistance to nevirapine in mothers after single-dose exposure to prevent vertical transmission of HIV-1. "Terms of search: "Resistance AND ((nevirapine OR NVP) OR NNRTI)". NNRTI = non nucleosidic reverse transcriptase inhibitors. **Terms of search: "nevirapine" and "NVP". CROI = Conferences on Retroviruses and Opportunistic Infection. IAS = International AIDS Society. NA = not available. *See definition in the text.

Using univariable random effect models with the post-partum ARV regimen variable (Figure 2), the pooled estimate of NVP resistance prevalence in the 10 study arms using single-dose NVP ± other ante/intra-partum ARVs was 35.7% \( (n = 950; \text{CI: } 23.0–50.6) \), and 4.5% \( (n = 223; \text{CI: } 2.1–9.4) \) in three study arms providing also post-partum ARVs.

Complementary analysis from results using sensitive drug resistance assays in mothers
Five studies using sensitive drug resistance assays were identified (Table 3). We excluded from the analysis the women who received other ARV in addition to single-dose NVP (arms 2 and 3 of the TOPS trial). Using a random effect model with no explanatory variable, the pooled estimate of NVP resistance prevalence was 62.4% \( (n = 423; \text{CI: } 41.7–79.5) \).

Prevalence of resistance in offspring
Among 35 relevant reports, 24 were excluded because they were either duplicates or met exclusion criteria (Figure 3), giving 11 reports for inclusion in the final analysis, relating to 10 studies reported between 2000 and 2006, corresponding to 15 study arms and 339 children overall. Five of these studies were also included in the meta-analysis of NVP resistance in mothers. The arms of the studies included in the meta-analysis were described in Table 4.

Of the 15 study arms, four included both a maternal ante/intrapartum ARV intervention and an infant ARV prophylaxis with ZDV added to single-dose NVP.\(^7\)\(^8\)\(^13\)\(^22\) In one study arm, a second post-partum dose of NVP was provided\(^23\) and in two other arms, both maternal postpartum and neonatal ZDV + 3TC interventions were given\(^23\) (TOPS arms 2 and 3). Another arm provided ante/intrapartum and postpartum ZDV + 3TC plus infant ZDV prophylaxis\(^8\) and another one, infant ZDV prophylaxis only.\(^13\) Six studies took place in Southern Africa (South Africa and Malawi). All studies performed the genotypic assessment at 6–8 weeks post-natal. Median sample size was 23 (IQR: 10–29). An article was available for three studies, as well as an unpublished report for one of them, conference presentations (slides or posters) for four studies and abstracts for three.

In univariable meta-regression (Table 5), antepartum, post-partum and post-natal ZDV or ZDV + 3TC interventions were associated with lower NVP resistance prevalence in children. Location in Southern Africa was associated with higher NVP resistance. In multivariable analysis (Table 5), antepartum and post-partum ARV interventions remained strongly associated with lower NVP resistance prevalence in children, but not neonatal ARVs and geographical location.

Using a univariable random effect model, the pooled estimates of NVP resistance prevalence were 52.6% \( (n = 201; \text{CI: } 37.7–67.0) \) in the group of seven study arms using NVP only and 16.5% \( (n = 138; \text{CI: } 8.9–28.3) \) in the group of eight study arms combining NVP with ZDV or ZDV + 3TC interventions (Figure 4).

Discussion
We estimated that about one-third of women and more than half of children who became HIV-1-infected despite PMTCT, developed NVP resistance mutations after single-dose NVP intake, but this rate was reduced to about 4% and 16%, respectively, if additional short-course ARV regimens were given, post-partum ZDV and 3TC in particular. These pooled estimates should be interpreted with caution as the heterogeneity among the intervention groups remained important due to other factors assessed in the multivariable analyses.

A strength of our study is our effort to assess potential sources of between-study heterogeneity. Although we included only reported studies, our systematic review had a comprehensive coverage, thus limiting publication bias. Indeed, we believe that all NVP resistance studies which have been completed or are in progress, have been reported, whatever their results, at least as a conference communication.

The outcome of interest was standardized between studies, and we restricted our analysis to results of plasma samples acknowledging that NVP resistance mutations may differ between compartments (peripheral blood mononuclear cells or breast milk).\(^7\)\(^17\) The genotypic resistance assessment methods, all sequence analyses, were reasonably equivalent between studies included in the meta-analyses. We did not include studies using the more sensitive recent techniques\(^36\)–\(^40\) in the main analysis, partly because the clinical implications of
<table>
<thead>
<tr>
<th>References</th>
<th>Type</th>
<th>Place</th>
<th>Study name</th>
<th>Design</th>
<th>Arms with intervention of interest</th>
<th>Reported data</th>
<th>Exhaustivity</th>
<th>Method of genotyping assessment</th>
<th>Pre-NVP exposure genotypic assessment</th>
<th>Time of genotypic assessment</th>
<th>Median baseline viral load</th>
<th>% NVP</th>
<th>Notes</th>
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<tr>
<td>Martinson et al.</td>
<td>Slides</td>
<td>South Africa</td>
<td>PMTCT program</td>
<td>OS</td>
<td>Pre-NVP previously exposed naive</td>
<td>NI</td>
<td>Preliminary results</td>
<td>ViroSeq HIV-1 Genotyping system (Applied Biosystems)</td>
<td>In all women in the resistance study</td>
<td>6 weeks</td>
<td>4.51</td>
<td>45.1</td>
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<td>McIntyre et al.</td>
<td>Slides</td>
<td>South Africa</td>
<td>TOPS</td>
<td>RCT</td>
<td>Arm 1: Intrapartum sdNVP</td>
<td>Arm 1: sdNVP</td>
<td>Exhaustive sample</td>
<td>Sequencing analyses</td>
<td>In all women of the trial</td>
<td>6 weeks</td>
<td>6.57</td>
<td>60.6</td>
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<td>Malawi</td>
<td>NVAZ</td>
<td>RCT</td>
<td>Intrapartum sdNVP</td>
<td>Final results</td>
<td>NI</td>
<td>ViroSeq HIV-1 Genotyping system (Applied Biosystems)</td>
<td>In a subset of women</td>
<td>6–8 weeks</td>
<td>4.78</td>
<td>65</td>
<td>69.2</td>
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<td>Lee et al.</td>
<td>Article</td>
<td>Zimbabwe</td>
<td>HPTN 023</td>
<td>RCT</td>
<td>Intrapartum sdNVP</td>
<td>Final results</td>
<td>NI</td>
<td>TruGen HIV-1 kit (Visible Genetics)</td>
<td>NI</td>
<td>8 weeks</td>
<td>4.4</td>
<td>32</td>
<td>34.4</td>
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<td>Chaux et al.</td>
<td>Article and unpublished technical report</td>
<td>Côte d’Ivoire</td>
<td>ANRS 1201 DITRAME Plus 1.0 and 1.1</td>
<td>OS</td>
<td>1.0: Antenatal ZDV + intrapartum ZDV + sdNVP</td>
<td>sdNVP + 1 week ZDV</td>
<td>Final results</td>
<td>Selected sample</td>
<td>Sequencing reverse transcriptase gene + Sequence Navigator Software (Applied Biosystems PE)</td>
<td>In all women with NVP viral resistance detected in further assessment</td>
<td>4 weeks</td>
<td>4.64</td>
<td>63</td>
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<tr>
<td>Eshleman et al.</td>
<td>Article</td>
<td>Uganda</td>
<td>HIVNET 012</td>
<td>RCT</td>
<td>Intrapartum sdNVP</td>
<td>Final results</td>
<td>Exhaustive sample</td>
<td>ViroSeq HIV-1 Genotyping system (Applied Biosystems)</td>
<td>In a subset of women</td>
<td>6 weeks</td>
<td>4.4</td>
<td>279</td>
<td>25.1</td>
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<td>Jackson et al.</td>
<td>Article</td>
<td>Uganda</td>
<td>HIVNET 006</td>
<td>OS</td>
<td>Intrapartum sdNVP</td>
<td>+/- sdNVP</td>
<td>Final results</td>
<td>Exhaustive sample</td>
<td>ViroSeq HIV-1 Genotyping system (Applied Biosystems)</td>
<td>In all women with NVP viral resistance detected subsequently</td>
<td>6 weeks</td>
<td>4.36</td>
<td>15</td>
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<tr>
<td>Chalermbchok Abstract -charoenkit et al.</td>
<td>Abstract</td>
<td>Thailand</td>
<td>Thailand CDC</td>
<td>OS</td>
<td>Antenatal ZDV + Intrapartum ZDV + sdNVP</td>
<td>sdNVP + 4 weeks ZDV</td>
<td>NI</td>
<td>Exhaustive sample</td>
<td>TruGen HIV-1 kit (Visible Genetics)</td>
<td>NI</td>
<td>4 weeks</td>
<td>3.51</td>
<td>190</td>
</tr>
<tr>
<td>Cunningham et al.</td>
<td>Article</td>
<td>Multicountry (USA, Europe, Brasil)</td>
<td>PACTG 316</td>
<td>RCT</td>
<td>Non study ARV + Intrapartum ZDV +/- sdNVP</td>
<td>sdNVP or placebo</td>
<td>Final results</td>
<td>Selected sample</td>
<td>TruGen HIV-1 kit (Visible Genetics) + Sequence Navigator Software (Applied Biosystems PE)</td>
<td>In women with NVP viral resistance detected in further assessment</td>
<td>6 weeks</td>
<td>3.48</td>
<td>95</td>
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</table>

RCT: randomised controlled trial; OS: Observational study; NI: no information; NVPR: NVP resistance; ZDV: Zidovudine; sdNVP: single-dose Nevirapine; 3TC: Lamivudine; CBV: Combivir® (ZDV + 3TC); For study arms with antepartum ARV intervention: plasma viral load performed at inclusion plasma viral load performed at delivery; PMTCT: Prevention of Mother-To-Child-Transmission; TOPS: Treatment Options Preservations Study; NVAZ:Nevirapine-AZT (zidovudine); HPTN: HIV Prevention Trials Network; ANRS: Agence Nationale de Recherches sur le Sida et les hépatites virales; DITRAME: Diminution de la TRAnsmission Mere-Enfant; HIVNET: HIV Network for Prevention Trial; CDC: Center for Diseases Control; PACTG: Pediatric AIDS Clinical Trials Group Protocol.

*Exhaustivity of the sample size with genotypic assessment compared with the number of participants included in the main study.
Table 2  Univariable and multivariable meta-regression on prevalence of nevirapine (NVP) viral resistance in women at 4–8 weeks postpartum after single-dose exposure to prevent vertical transmission of HIV-1

<table>
<thead>
<tr>
<th>Variables</th>
<th>Univariable Random effect models</th>
<th>Multivariable Random effect models</th>
<th>Multivariable Fixed effect model</th>
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<td>Postpartum ARV intervention</td>
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<tr>
<td>Yes vs No (Ref.)</td>
<td>0.07 [0.03–0.15]</td>
<td>&lt;10⁻⁴</td>
<td>0.08 [0.04–0.16]</td>
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<td>Ante/Intrapartum ARV intervention</td>
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<td></td>
<td></td>
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<tr>
<td>Yes vs No (Ref.)</td>
<td>0.29 [0.12–0.75]</td>
<td>0.016</td>
<td>0.6 [0.20–1.72]</td>
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<tr>
<td>Study location Southern Africa vs other regions (Ref.)</td>
<td>3.81 [1.73–8.40]</td>
<td>0.004</td>
<td>2.7 [0.97–7.46]</td>
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<tr>
<td>Median baseline median plasma viral load &gt;4.39 log₁₀ copies/ml vs ≤4.39 (Ref.)</td>
<td>0.11 [0.05–0.23]</td>
<td>&lt;10⁻⁴</td>
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<tr>
<td>Time of resistance assessment</td>
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<td></td>
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<tr>
<td>4 weeks vs 6–8 weeks postpartum (Ref.)</td>
<td>0.37 [0.10–1.32]</td>
<td>0.11</td>
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<tr>
<td>Exhaustivityb Yes vs No (Ref.)</td>
<td>1.81 [0.54–6.00]</td>
<td>0.298</td>
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<td>Status of the results Preliminary or no information vs final (Ref.)</td>
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<td>0.838</td>
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<td>Sample size &lt;30 vs ≥30 (Ref.)</td>
<td>0.56 [0.05–6.14]</td>
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<td>Pre-NVP exposure resistance assessment</td>
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<tr>
<td>Yes vs no information (Ref.)</td>
<td>0.74 [0.16–3.35]</td>
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<td>Publication type Articles vs other types (Ref.)</td>
<td>0.10 [0.02–0.41]</td>
<td>0.004</td>
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<tr>
<td>Between-study variance</td>
<td></td>
<td>–</td>
<td>&lt;10⁻³</td>
</tr>
</tbody>
</table>

aOdds Ratio [Limits of 95% confidence interval]. ARV: antiretroviral.
bExhaustivity of the sample size with resistance assessment compared with the number of participants included in the main study.
their results were unclear and partly because we did not want to introduce further heterogeneity and data overlap. However, complementary analysis of only studies using these more sensitive NVP-resistance assays showed a prevalence of resistance of 62%, and our results should thus be considered a minimum estimate of prevalence of NVP resistance. Finally, it has been previously reported that NVP resistance mutations could fade over time. The NVP resistance rates reported in this meta-analysis were all observed within a homogeneous short post-partum treatment period that ranged between 4 and 8 weeks. This increases the validity of our pooled estimates.

Our study has several limitations. First, reporting bias could have affected our findings. Because of lack of information, we were unable to adjust for treatment characteristics such as the percentage of women who received a second dose of NVP, after false or prolonged labour, or HIV-1 subtypes which have previously been identified to be associated with NVP resistance. However, we could adjust for study location, thus taking indirectly into account HIV-1 subtypes which are geographically distributed. In the meta-analysis in children, we could not evaluate the effect of duration of post-natal prophylaxis or that of regimen (ZDV only vs ZDV+3TC) due to the very limited number of reported studies. Some data were only available from abstracts or internal reports, although these were not yet peer-reviewed. However, most of them had already been presented at several occasions in international conferences, which provides some guarantee of quality. Secondly, although the indirect comparisons we have conducted could be subject to greater bias than a randomized design (especially selection bias), in the absence of such ‘ideal’ studies, the model we used was appropriately adapted to the complex nature of the data.

Exposure to antepartum ARVs was not associated with resistance risk in mothers in multivariable analysis. However, this may be due to the fact that it was administrated in one of the two studies providing also postpartum ARVs. Similarly, ZDV syrup was routinely given to neonates in studies where mothers were offered antenatal ARV intervention, before single-dose NVP and it was not possible to distinguish the effect of maternal and neonatal ZDV on the risk of NVP resistance in infants. Considering the different resistance profiles described

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**Figure 2** Forest plot of prevalence of viral resistance to nevirapine (NVP) in mothers at 4–8 weeks postpartum after single-dose exposure, grouped according to whether mothers received or not additional postpartum antiretroviral (ARV) therapy (univariable random effect model). Zidovudine or ARV combination. Zidovudine and lamivudine. TOPS: Treatment Options Preservations Study. NVAZ:Nevirapine-AZT (zidovudine). HPTN: HIV Prevention Trials Network. DITRAME: Diminution de la TRANsmision Mere-Enfant. HIVNET: HIV Network for Prevention Trial. PACTG: Pediatric AIDS Clinical Trials Group Protocol.

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**Table 1**

<table>
<thead>
<tr>
<th>Study</th>
<th>NVP resistance prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eshleman et al. (NVAZ/dNVP; n=65) [12]</td>
<td></td>
</tr>
<tr>
<td>McIntyre et al. (TOPS Arm 1; n=68) [21]</td>
<td></td>
</tr>
<tr>
<td>Martinson et al. (Naive Arm; n=51) [20]</td>
<td></td>
</tr>
<tr>
<td>Martinson et al. (Exposed Arm; n=92) [20]</td>
<td></td>
</tr>
<tr>
<td>Lee et al. (HPTN 023; n=32) [17]</td>
<td></td>
</tr>
<tr>
<td>Chaix et al. (DITRAME Plus 1.0; n=63) [7]</td>
<td></td>
</tr>
<tr>
<td>Eshleman et al. (HIVNET 012; n=279) [11]</td>
<td></td>
</tr>
<tr>
<td>Jackson et al. (HIVNET 006; n=15) [16]</td>
<td></td>
</tr>
<tr>
<td>Chalermchokkanakit et al. (n=190) [9]</td>
<td></td>
</tr>
<tr>
<td>Cunningham et al. (PACTG 316; n=95) [10]</td>
<td></td>
</tr>
<tr>
<td><strong>Summary estimate</strong> 35.7 [23.0; 50.6]</td>
<td></td>
</tr>
<tr>
<td>McIntyre et al. (TOPS Arm 2; n=67) [21]</td>
<td></td>
</tr>
<tr>
<td>McIntyre et al. (TOPS Arm 3; n=68) [21]</td>
<td></td>
</tr>
<tr>
<td>Chaix et al. (DITRAME Plus 1.1; n=88) [8]</td>
<td></td>
</tr>
<tr>
<td><strong>Summary estimate</strong> 4.5 [2.1-9.4]</td>
<td></td>
</tr>
</tbody>
</table>
in mothers (K103N) and children (Y181C) in most studies included in this meta-analysis, the acquisition of resistant virus may be more likely to be due to a sub-optimal neonatal prophylaxis than to the transmission of such virus by the mother. In one study, the K103N was the most common mutation observed in children and the authors suggested this could be in relation with the pressure of ZDV prophylaxis on the CRF01_AE subtype.

In the meta-analysis on NVP resistance in mothers, study location in Southern Africa was independently associated with a higher NVP resistance prevalence, which could be, in part, to the high prevalence of viral subtype C. In Côte d’Ivoire, where the prevalence of NVP resistance prevalence was lowest and where women received additional antepartum and post-partum ARVs, the main subtype is CRF02-AG. However, other studies have shown resistance frequencies similar to those observed in other countries where other variants predominate: 33.3% in a group of women receiving additional ante/intra-partum ARVs and 20.7% in a group of women receiving single-dose NVP only (publication not included in our analysis due to the lack of availability of baseline plasma RNA viral load).

Allowing for study location and post-partum intervention, we also confirmed that the prevalence of NVP resistance increased with higher baseline HIV-1 RNA viral load. Although this finding should be interpreted with caution due to the risk of aggregation bias, this result raises a potential case management problem as these women are likely to become resistant.

### Table 3: Characteristics of resistance studies using sensitive drug-resistance assays on prevalence of resistance to nevirapine in mothers after single-dose nevirapine to prevent vertical transmission of HIV-1

<table>
<thead>
<tr>
<th>Reference</th>
<th>Type</th>
<th>Place</th>
<th>Study</th>
<th>Arms with intervention</th>
<th>Exclusivitya</th>
<th>Exhaustivity</th>
<th>Method of assessment</th>
<th>Limit of detection</th>
<th>Sub-type</th>
<th>Time of genotypic assessment</th>
<th>Sub-type</th>
<th>Size</th>
<th>%</th>
<th>NVPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnson et al.</td>
<td>Article</td>
<td>South Africa</td>
<td>PMTCT program</td>
<td>Intrapartum sNVP</td>
<td>NI</td>
<td>NI</td>
<td>Subset Alle-specific real-time PCR for K103N and Y181C</td>
<td>0.2%</td>
<td>C</td>
<td>6-36 weeks</td>
<td>50</td>
<td>64.9</td>
<td>23.3</td>
<td>4.36</td>
</tr>
<tr>
<td>Palmer et al.</td>
<td>Abstract</td>
<td>South Africa</td>
<td>TOPS</td>
<td>Arm 1: Intrapartum sNVP Arm 2/3: Intrapartum sNVP + 4/7 days CBV</td>
<td>NI</td>
<td>NI</td>
<td>Subset Alle-specific real-time PCR for K103N and 181C</td>
<td>0.1%</td>
<td>C</td>
<td>6 weeks</td>
<td>10</td>
<td>75.0</td>
<td>27.3</td>
<td>3.26</td>
</tr>
<tr>
<td>Loubser et al.</td>
<td>Abstract</td>
<td>South Africa</td>
<td>PMTCT program</td>
<td>Intrapartum sNVP</td>
<td>NI</td>
<td>NI</td>
<td>Subset Alle-specific real-time PCR for K103N</td>
<td>0.2%</td>
<td>C</td>
<td>6 weeks</td>
<td>NI</td>
<td>14</td>
<td>41.7</td>
<td>14.6</td>
</tr>
<tr>
<td>Flys et al.</td>
<td>Article</td>
<td>South Africa</td>
<td>Uganda</td>
<td>HIVNET</td>
<td>Intrapartum sNVP</td>
<td>NI</td>
<td>NI</td>
<td>Lig/Amp for K103N and 181C</td>
<td>0.1%</td>
<td>C</td>
<td>6 weeks</td>
<td>6 weeks</td>
<td>6 weeks</td>
<td>6-8 weeks</td>
</tr>
<tr>
<td>Lehman et al.</td>
<td>Article</td>
<td>Kenya</td>
<td>PMTCT program</td>
<td>Intrapartum sNVP</td>
<td>NI</td>
<td>NI</td>
<td>Alle-specific RT-PCR for K103N</td>
<td>0.1%</td>
<td>C</td>
<td>6-8 weeks</td>
<td>6-8 weeks</td>
<td>6-8 weeks</td>
<td>6-8 weeks</td>
<td>6-8 weeks</td>
</tr>
</tbody>
</table>

NI: no information; PMTCT: prevention of mother-to-child transmission; NVPR: NVP resistance; sNVP: single-dose Nevirapine; CBV: Combivir (Zidovudine+lamivudine); TOPS: Treatment Options Preservations

Terms of search: "Resistance AND ((nevirapine OR NVP) OR NNRTI)". NNRTI = non nucleosidic reverse transcriptase inhibitors. Terms of search: "nevirapine" and "NVP". CROI = Conferences on Retroviruses and Opportunistic Infection. IAS = International AIDS Society. NA = not available. $See definition in the text

### Figure 3
Flow chart of studies included in the meta-analysis on prevalence of viral resistance to nevirapine in children after single-dose exposure to prevent vertical transmission of HIV-1. Terms of search: "Resistance AND ((nevirapine OR NVP) OR NNRTI)". NNRTI = non nucleosidic reverse transcriptase inhibitors. Terms of search: "nevirapine" and "NVP". CROI = Conferences on Retroviruses and Opportunistic Infection. IAS = International AIDS Society. NA = not available. $See definition in the text.

Potential relevant reports identified by literature search (n>1244)
- Pubmed/Pascal (1997–Feb 2006)*, n=549
- Gateway (2000–2006)*, n=629
- International HIV Drug Resistance Workshops (2000–2006), n=NA
- 12th CROI (2005)**, n=24
- 3rd IAS Conference (2005)**, n=29
- 13th CROI (2006)**, n=13

Reports retrieved for more detailed evaluation (n=35)
- duplicates (n=17)
- meeting exclusion criteria (n=7)

Reports included in the meta-analysis (n=11)
Table 4  Characteristics of resistance studies included in the meta-analysis on prevalence of resistance to nevirapine in children after single-dose nevirapine to prevent vertical transmission of HIV-1

<table>
<thead>
<tr>
<th>References</th>
<th>Type</th>
<th>Place</th>
<th>Study</th>
<th>Design</th>
<th>Arrows with intervention of interest</th>
<th>Reported data</th>
<th>Exhaustivity</th>
<th>Method of assessment</th>
<th>Time of genotypic assessment</th>
<th>Size</th>
<th>% NVPR</th>
</tr>
</thead>
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<tr>
<td>McIntyre et al.</td>
<td>Slides</td>
<td>South Africa</td>
<td>TOPS</td>
<td>RCT</td>
<td>Mothers: Arm 1: Intrapartum sdNVP</td>
<td>Infants: Arm 1: sdNVP</td>
<td>Preliminary results</td>
<td>Exhaustive sample</td>
<td>6 weeks</td>
<td>9</td>
<td>77.8</td>
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<td></td>
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<td>Arm 2: Intrapartum sdNVP + 4 days CBV</td>
<td>Arm 2: sdNVP + 4 days CBV</td>
<td>NI</td>
<td>NI</td>
<td></td>
<td>8</td>
<td>12.5</td>
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<td></td>
<td>Arm 3: Intrapartum sdNVP + 7 days CBV</td>
<td>Arm 3: sdNVP + 7 days CBV</td>
<td>NI</td>
<td>NI</td>
<td></td>
<td>7</td>
<td>0</td>
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<tr>
<td>Sullivan et al.</td>
<td>Abstract</td>
<td>South Africa</td>
<td>SAINT</td>
<td>RCT</td>
<td>Intrapartum sdNVP + Postpartum sdNVP</td>
<td>sdNVP</td>
<td>NI</td>
<td>NI</td>
<td>4-6 weeks</td>
<td>40</td>
<td>52.5</td>
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<tr>
<td>Eshleman et al.</td>
<td>Article</td>
<td>Malawi</td>
<td>NVAZ</td>
<td>RCT</td>
<td>Intrapartum sdNVP</td>
<td>sdNVP</td>
<td>NI</td>
<td>NI</td>
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<td>20</td>
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<td>Loubser et al.</td>
<td>Poster</td>
<td>South Africa</td>
<td>PMTCT</td>
<td>OS</td>
<td>sdNVP</td>
<td>sdNVP</td>
<td>NI</td>
<td>NI</td>
<td>RT-PCR and DNA sequencing</td>
<td>6 weeks</td>
<td>25</td>
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<tr>
<td>Gordon et al.</td>
<td>Abstract</td>
<td>South Africa</td>
<td>KZN</td>
<td>OS</td>
<td>sdNVP</td>
<td>sdNVP</td>
<td>NI</td>
<td>NI</td>
<td>ViroSeq HIV-1 Genotyping system (Applied Biosystems®)</td>
<td>6 weeks</td>
<td>30</td>
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<tr>
<td>Martinson et al.</td>
<td>Slides</td>
<td>South Africa</td>
<td>PMTCT</td>
<td>OS</td>
<td>sdNVP</td>
<td>sdNVP</td>
<td>Final results</td>
<td>Exhaustive sample</td>
<td>Sequence analysis</td>
<td>6 weeks</td>
<td>50</td>
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<tr>
<td>Chalermchok-charoenkit</td>
<td>Article</td>
<td>Coûte d’Ivoire</td>
<td>ANRS 1201</td>
<td>OS</td>
<td>1.0: Antenatal ZDV + Intrapartum ZDV + sdNVP + 4 weeks ZDV</td>
<td>sdNVP + 1 week ZDV</td>
<td>Final results</td>
<td>Exhaustive sample</td>
<td>Sequencing reverse transcriptase gene + Sequence Navigator Software (Applied Biosystems PE®)</td>
<td>4 weeks</td>
<td>26</td>
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<tr>
<td></td>
<td>and unpub-</td>
<td></td>
<td>DITRAME Plus 1.0 and 1.1</td>
<td>1.1</td>
<td>Antenatal ZDV + Intrapartum ZDV + 3TC + Intrapartum ZDV + 3TC + sdNVP + postpartum 3 days ZDV + 3TC</td>
<td>sdNVP + 1 week ZDV</td>
<td>Final results</td>
<td>Exhaustive sample</td>
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<td>16</td>
<td>6.25</td>
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<tr>
<td>Eshleman et al.</td>
<td>Article</td>
<td>Uganda</td>
<td>HIVNET 012</td>
<td>RCT</td>
<td>Intrapartum sdNVP</td>
<td>sdNVP</td>
<td>Final results</td>
<td>Not exhaustive sample</td>
<td>ViroSeq HIV-1 Genotyping system (Applied Biosystems®)</td>
<td>6 weeks</td>
<td>24</td>
</tr>
<tr>
<td>Chalermchok-charoenkit</td>
<td>Abstract</td>
<td>Thailand</td>
<td>CDC</td>
<td>OS</td>
<td>Antenatal ZDV + Intrapartum ZDV + sdNVP</td>
<td>sdNVP + 4 weeks NI ZDV</td>
<td>Exhaustive sample</td>
<td>TruGen HIV-1 kit (Visible Genetics®)</td>
<td>4 weeks</td>
<td>10</td>
<td>20</td>
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<tr>
<td></td>
<td>et al.7,8</td>
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<tr>
<td>Ngo-Giang-Huong et al.</td>
<td>Poster</td>
<td>Thailand</td>
<td>PHPT-2/Cohort</td>
<td>RCT/OS</td>
<td>(1) Antenatal ZDV + sdNVP</td>
<td>Arm 1: sdNVP + 7 days ZDV</td>
<td>NI</td>
<td>NI</td>
<td>ViroSeq HIV-1 Genotyping system (Applied Biosystems®)</td>
<td>6 weeks</td>
<td>29</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>(2) Antenatal ZDV + Intrapartum saNVP</td>
<td>Arm 2: sdNVP + 6 weeks ZDV</td>
<td></td>
<td></td>
<td></td>
<td>21</td>
<td>4.5</td>
</tr>
</tbody>
</table>

RCT: randomised controlled trial; OS: Observational study; NI: no information; NVPR: NVP resistance; ZDV: Zidovudine; sdNVP: single-dose Nevirapine; 3TC: Lamivudine; CBV: Combivir® (ZDV + 3TC); TOPS: Treatment Options Preservations Study; SAINT: South African Intrapartum Nevirapine Trial; NVAZ:Nevirapine-AZT (zidovudine); PMTCT: Prevention of Mother-To-Child-Transmission; KZN: KwaZulu-Natal; ANRS: Agence Nationale de Recherches sur le Sida et les hépatites virales; DITRAME: Diminution de la TRAnsmission Mere-Enfant; HIVNET: HIV Network for Prevention Trial; CDC: Center for Diseases Control; PHPT: Perinatal HIV Prevention Trial.

*Exhaustivity of the sample size with genotypic assessment compared with the number of participants included in the main study.
eligible for treatment sooner after the delivery than women with lower baseline HIV-1 RNA viral load. This was highlighted by Lockman et al.\textsuperscript{25} who demonstrated that virological suppression was less frequent in women who initiated NVP-based ART <6 months from single-dose NVP exposure and among infants while this association was not found among women initiating the same kind of treatment 6 months or more from sdNVP exposure. Results from recent studies did not suggest a difference in terms of clinical or immunological response to NVP-containing ARV treatments\textsuperscript{26,29} or efficacy of NVP-containing regimens for PMTCT in subsequent pregnancies\textsuperscript{20,44} in women previously exposed to single-dose NVP. However, it cannot be excluded that NVP-resistant viruses following single-dose NVP exposure, even below the threshold of detection of conventional assays or archived in biological reservoirs may impair response to subsequent NNRTI-containing regimens.\textsuperscript{24,25}

In conclusion, we confirm a substantial reduction in the prevalence of NVP resistance after single-dose NVP to prevent MTCT with the addition of a short course of dual ARV regimen (ZDV + 3TC) given to the mother post-partum. Given the high likelihood of viral resistance associated with single-dose NVP use alone, here estimated at 35.7% in mothers and 52.6% in children and the uncertain clinical implications in settings where NVP is included in first-line ARV treatment regimen, we suggest that a short-course post-partum ARV regimen should be routinely recommended.\textsuperscript{6} This is of particular importance in settings where sub-type C is predominant. For women with high baseline HIV-1 RNA viral load and more advanced disease, fully suppressive ARV therapy, instead of single-dose NVP containing PMTCT regimens, is already recommended, partly to reduce the risk of resistance to NVP.\textsuperscript{6} Further studies are needed to assess the association between single-dose NVP exposure, not only in the proportion of resistant mutants in plasma but also in the different compartments and subsequent response to NNRTI-based treatment in mothers and children. Furthermore, alternative regimens to prevent MTCT need urgent evaluation.

**Acknowledgements**

This study was funded by ISPED, University Victor Segalen, Bordeaux 2, Bordeaux, France and Institute of Child Health, University College, London, UK. We acknowledge the women and children enrolled in the studies included in our meta-analysis and the participating study teams, especially those who responded to our request for providing extra information: Susan Eshleman, Brooks Jackson, David Katzenstein, Mary Culnane, Neil Martinson and Lynn Morris. We also thank the following members of the Ghent Group on HIV in women and children (www.ghentgroup.org) for their encouragement and support to conduct the study; Philippe Lepage, Nicolas Meda, Marleen Temmerman, Joep Lange, Katherine Luzuriaga, James McIntyre, Philippe Msellati, Ruth Nduati and John Sullivan. We acknowledge ANRS and EDCTP for their indirect support to the study by supporting EA and DE, respectively.

**Conflict of interest:** None declared.
KEY MESSAGES

- Single-dose NVP administrated to the mother and the neonate is the most common regimen used to prevent MTCT of HIV, as it is cheap, effective and easy to use.
- However, the burden of viral resistance after single-dose NVP to prevent MTCT of HIV-1 is high in both women and children (pooled estimates of nevirapine resistance prevalence was 35.7% and 52.6%, respectively).
- This prevalence can be substantially reduced by adding short-course post-partum antiretroviral therapy to standard prophylaxis (4.5% and 16.5%).

References


21 McIntyre JA, Martinson N, Gray GE et al. Addition of short course Combivir (CBV) to single dose Viramune (sdNVP) for the prevention of mother to child transmission (pMTCT) of HIV-1 can significantly decrease the subsequent development of maternal and paediatric NNRTI-resistant virus. In: Program and abstracts of the Third Conference on HIV Pathogenesis and Treatment (Río De Janeiro) International AIDS Society, 2005:Abstract TuFo1204.


39 Palmer S, Boltz V, Maldarelli F et al. Short-course combivir (CBV) single dose nevirapine reduces but does not eliminate the selection of nevirapine-resistant HIV-1: improved detection by allele-specific PCR. *Antiviral Ther* 2005;10(Suppl.1):55.


