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Conclusions: Real-life outcomes of PI-based dual ARV therapy appear broadly favourable in clinical practice. The ongoing utility of this paradigm in the advent of TAF and PI-sparing regimens is unclear.

P059

Long-term virological outcomes of replacing zidovudine or stavudine with tenofovir in the absence of routine virological monitoring in Kumasi, Ghana

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Introduction: Whilst access to ART is successfully expanding in Africa, long-term outcomes remain poorly investigated. This study addressed the outcomes of introducing tenofovir (TDF) in place of zidovudine (ZDV) or stavudine (d4T) among Ghanaian adults receiving HIV care in the absence of routine virological monitoring and determined the associated clinical and psychosocial dimensions.
Methods: The Hepatitis B Infection in Kumasi (HEPIK) study has prospectively followed HIV/HBV co-infected adults since 2010. This cross-sectional analysis comprised subjects that had previously started ZDV or d4T plus lamivudine and efavirenz or nevirapine, and at the time of HBV diagnosis (T0), replaced ZDV or d4T with TDF in the absence of virological monitoring. A median of 7.9 (IQR 6.0–9.2) years after starting ART and 4.0 (3.8–4.1) years after introducing TDF (T1, November 2015), patients were invited to attend for assessment, including HIV-1 RNA load, and offered a researcher-administered questionnaire about adherence (visual analogue scale and targeted questions); socio-economic, social support and disclosure status; and physical and mental health. Plasma viral load at T0 was determined retrospectively using stored (-80°C) samples.
Results: A total of 101/180 (56%) invited participants (66% females) attended the T1 assessment. Of the remaining, 47 (26%) were no longer contactable ($\geq$3 attempts), 17 (9%) declined to attend and 15 (8%) had died. At T1, mean age was 45 ($\pm$9) years; 90% were still receiving efavirenz (n = 87) or nevirapine (n = 4); 10% were on lopinavir/ritonavir (LPV/r). CD4 counts were median 572 (383–716) cells/mm^3. Suboptimal adherence was reported by 42% of participants; in univariable analysis, it was more prevalent among men ($p < 0.01$), those in a relationship ($p = 0.02$) and those with higher socio-economic status ($p = 0.04$). Moderate-to-severe depression/anxiety was reported by 27%; 64% described moderate-to-severe physical distress. HIV-1 RNA was detectable (>40 copies/mL) in 21%, and >1000 copies/mL in 14%, with median levels of 4.2 (2.1–5.1) $\log_{10}$ copies/mL. In univariable analysis, predictors of lack of virological suppression comprised the CD4 cell count at diagnosis ($p = 0.03$), T0 viral load ($p = 0.05$), suboptimal adherence ($p < 0.01$), lack of partner disclosure ($p < 0.01$) and LPV/r use ($p = 0.03$). Lack of virological suppression was also associated with lower T1 CD4 cell counts ($p < 0.01$). There was no association with socio-economic/social support status, or physical/mental health.
Conclusion: One in five subjects receiving long-term ART showed suboptimal virological suppression with reduced CD4 cell count recovery. The findings highlight the importance of viral load testing at key management time points, coupled with targeted interventions to support adherence and facilitate partner disclosure.

P060

Non-adherence in HIV patients is caused by specific reasons: results from the German adherence cohort study

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Introduction: Adherence to antiretroviral treatment (ART) in HIV patients plays a crucial role for treatment success. Our study aimed to identify reasons for non-adherence in a large HIV cohort, including known subjects with difficulties in ART adherence.
Methods: A cross-sectional, non-interventional, multicentre adherence study in treated HIV-infected patients from September 2014 to April 2015 in Germany was performed after ethic committee's approval. Study physicians were asked to recruit patients from all adherence levels and perform an adherence assessment for each subject (good, unstable or poor adherence). Questionnaires based on the SMAQ-MASRI-Hybrid [1] were given to the patient and treating physician to evaluate factors associated with poor adherence. Covariables of interest were age, sex, time since HIV diagnosis, time on ART, current ART regimen, transmission route, comorbidity, HIV-1 RNA viral loads (VLs) and CD4 cell count. Furthermore, specific reasons for non-adherence were assessed. For statistical analysis, extended Fisher's exact test and Kruskal–Wallis test were used.

Abstract P060–Table 1. Overview of questionnaire items and correlation with adherence levels

	"Good adherence" (n = 162)	"Unstable adherence" (n = 36)	"Poor adherence" (n = 17)	p-value (Fisher's exact test)
The ART intake reminds me of my disease	n = 7 (4.3%)	n = 4 (11%)	n = 5 (29%)	<0.01
I want to go out/I think my medication does not go well with alcohol/party drugs	n = 3 (1.9%)	n = 5 (14%)	n = 4 (24%)	<0.01
I'm afraid that others see me taking the ART medication	n = 4 (2.5%)	n = 4 (11%)	n = 2 (12%)	0.019
I think that the ART dose is too high	n = 3 (1.9%)	n = 4 (11%)	n = 1 (5.9%)	0.037
Sometimes the copayment fee to my ART is too much for me/other financial reasons	n = 2 (1.2%)	n = 3 (8.3%)	n = 1 (5.9%)	0.037