

# Optimal management of CHB patients with treatment failure

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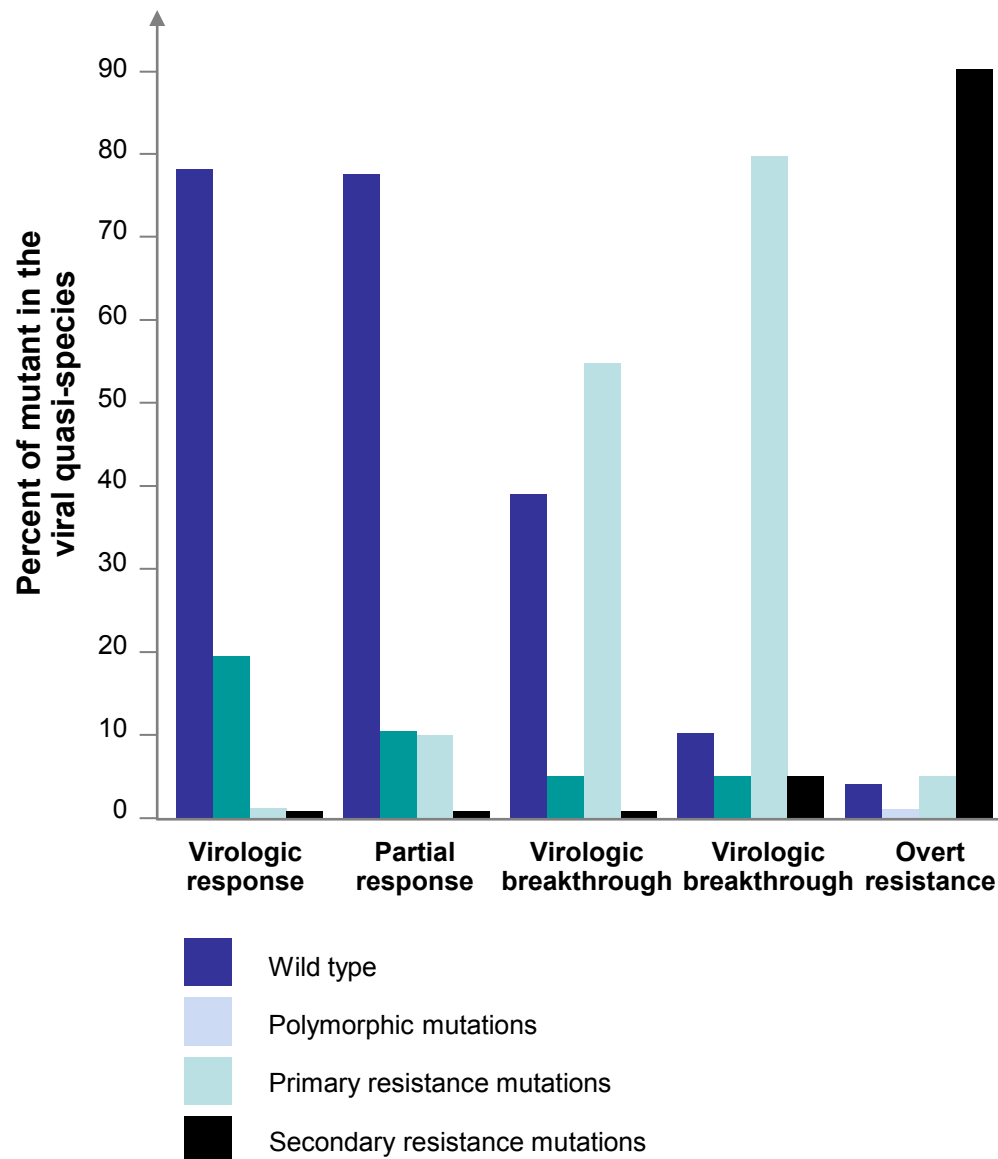
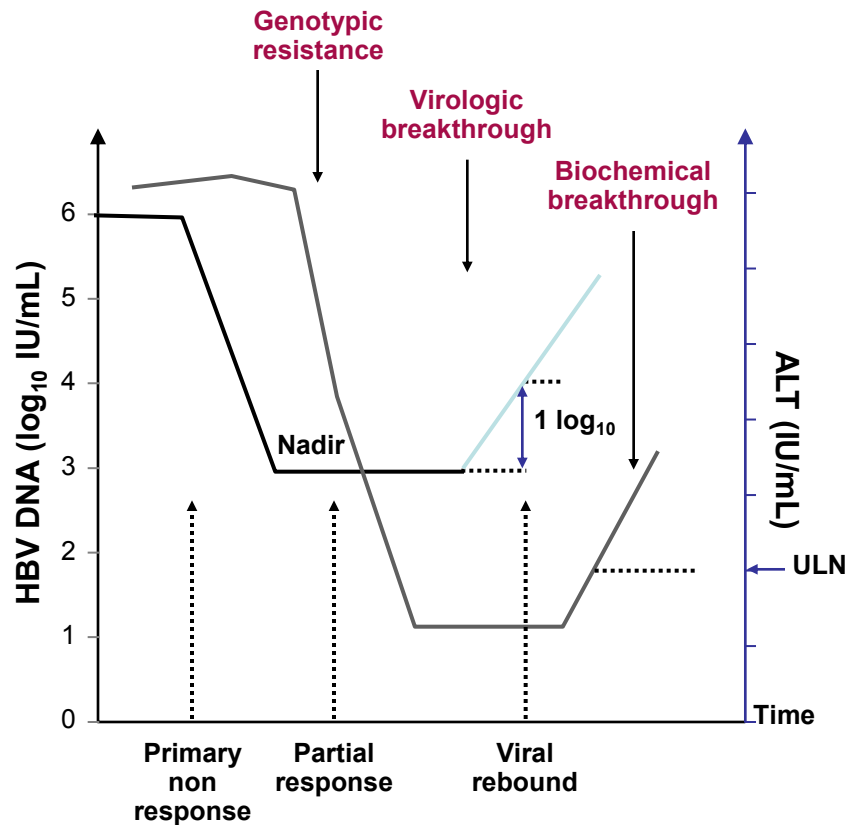
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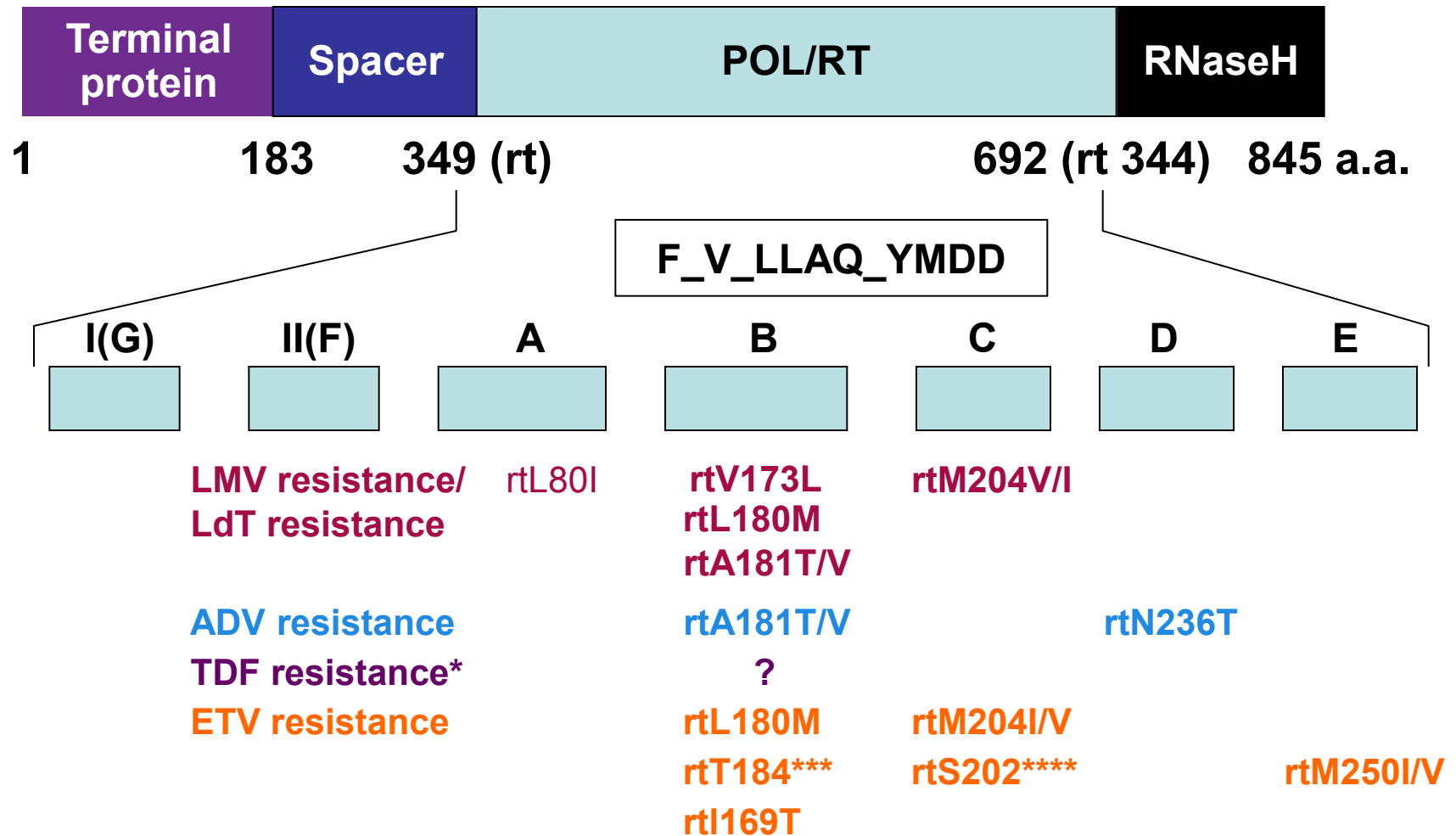


# Treatment failure

- **Primary non-response**
  - Viral load decrease  $< 1 \log_{10}$  IU/mL at M3
  - Mainly with ADV
- **Partial virological response**
  - Persistence of detectable viremia
    - At W24 for drugs with low barrier to resistance (LdT, LAM)
    - At W48 for high barrier to resistance drugs (ETV, TDF)
- **Virological breakthrough**
  - Rebound of viral load by  $> 1 \log_{10}$  IU/mL
- **The case of multidrug resistance**

## Antiviral drug





\*rtA181T/V and/or rtN236T cause reduced sensitivity

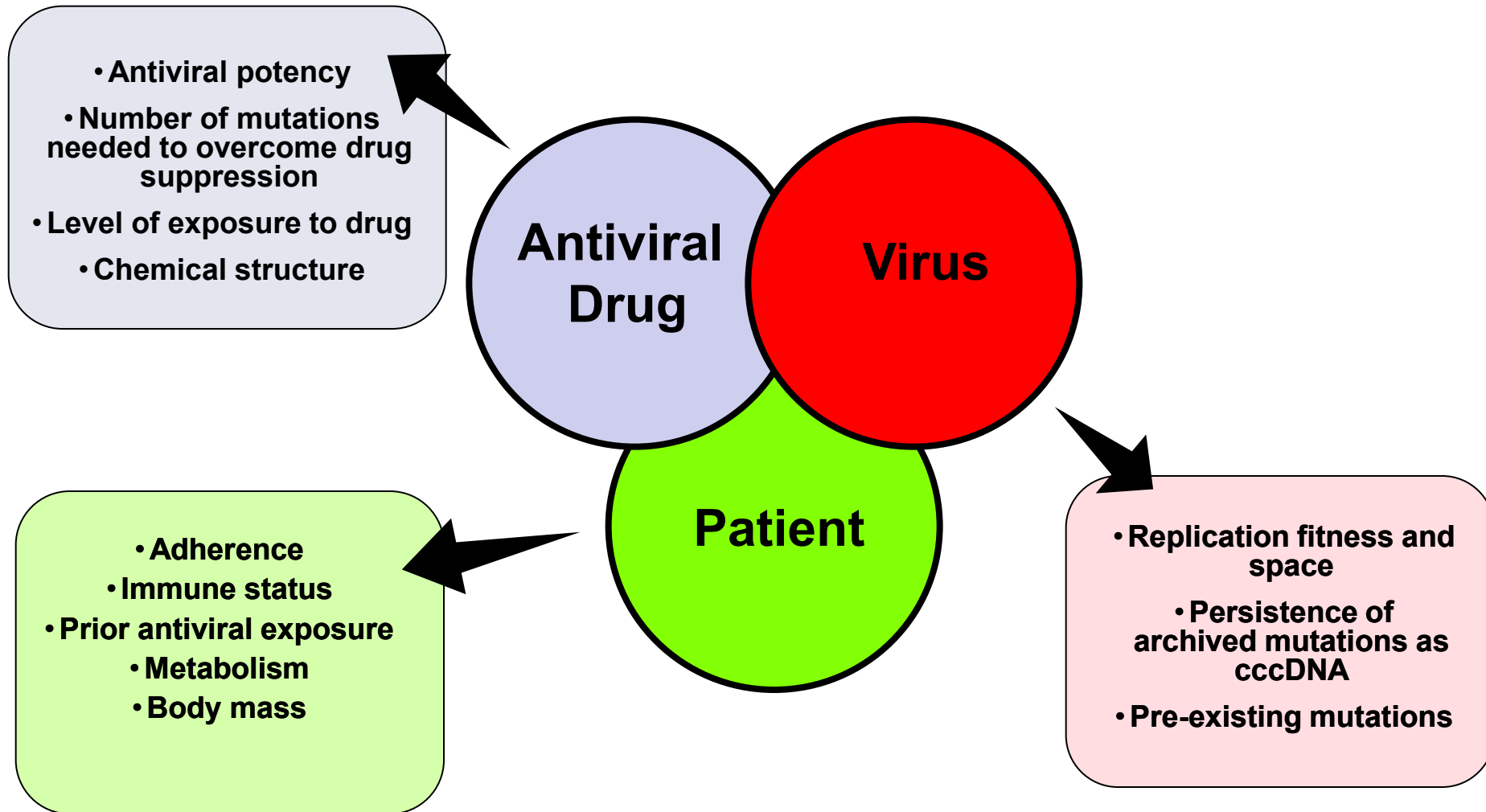
\*rtA194T association with rtL180M+rtM204V (to be confirmed)

\* **Role of complex mutants: rtA181T+rtN236T ?**

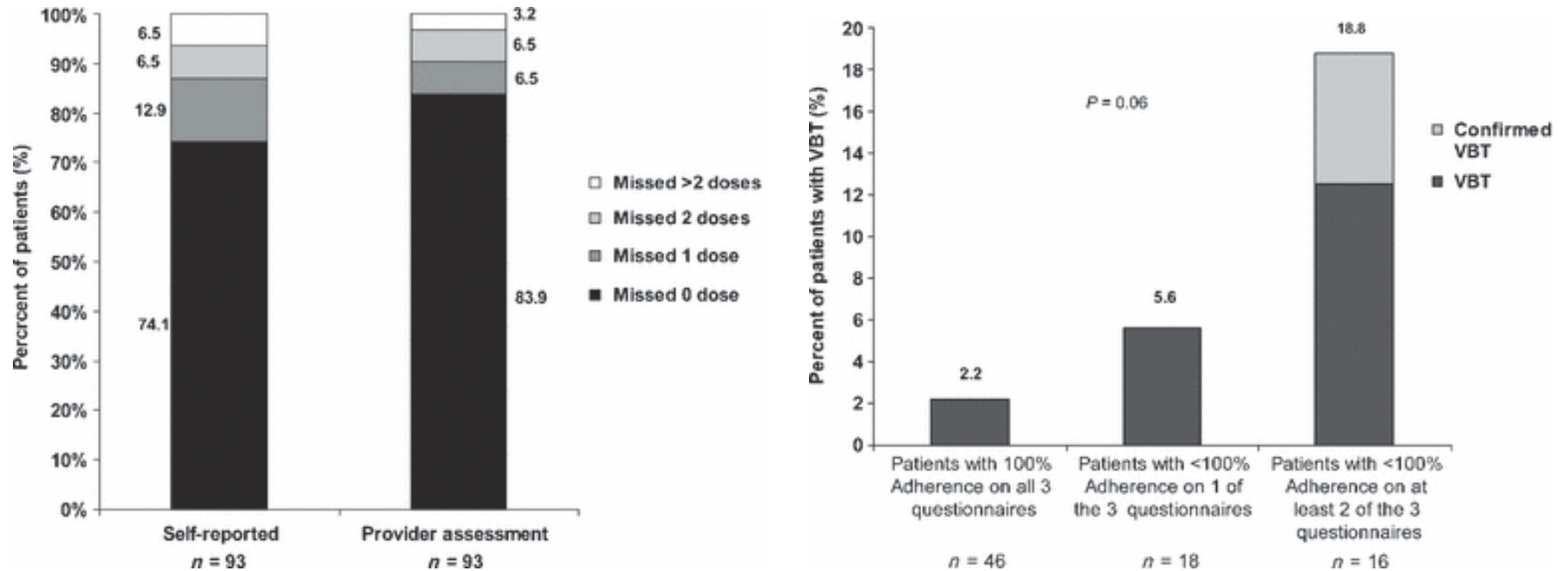
\*\*\*S/A/I/L/G/C/M

\*\*\*\*C/G/I

# Multiple factors are associated with the barrier of resistance



# Adherence to nucleos(t)ide analogues for chronic hepatitis B in clinical practice and correlation with virological breakthroughs

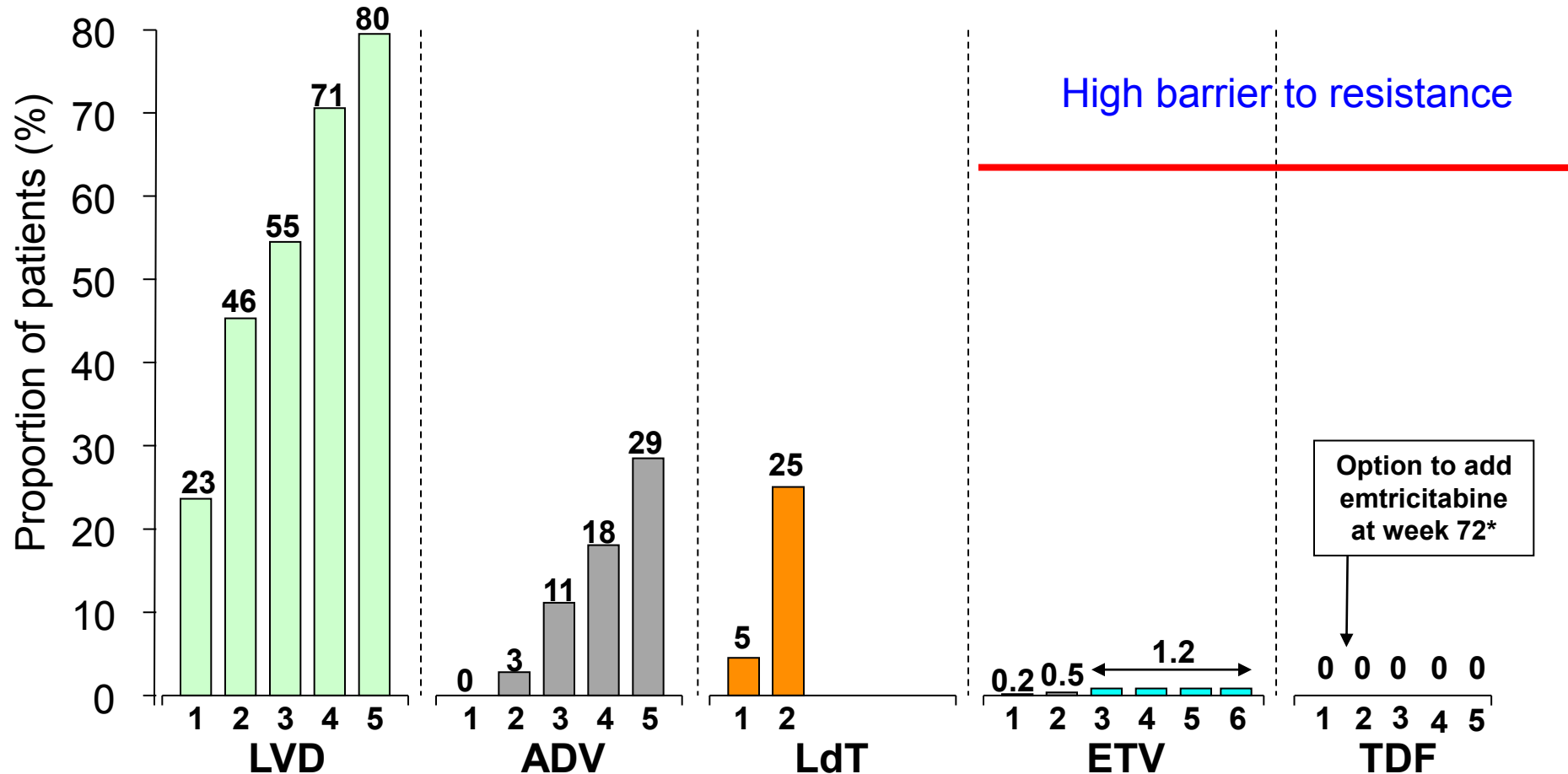


# **Prevention of resistance**

## **Impact of first line therapy**

- Choose an antiviral drug with
  1. A potent antiviral activity
  2. A high barrier to resistance

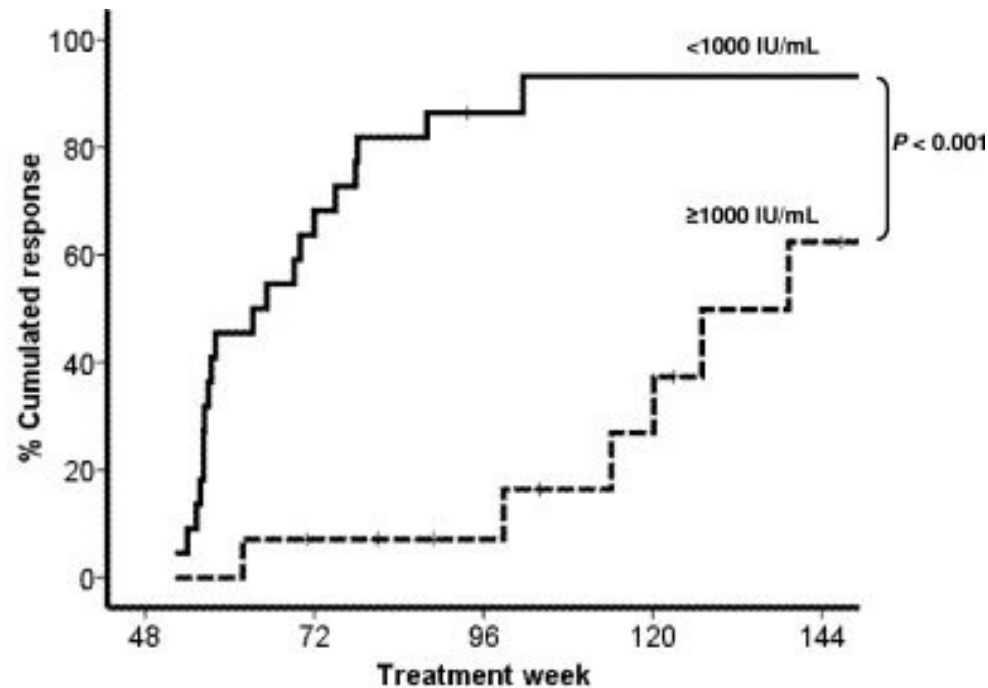
# Rates of resistance with lamivudine (LVD), adefovir (ADV), telbivudine (LdT), entecavir (ETV) and tenofovir (TDF) among NA-naïve patients



\*Patients confirmed to be viraemic at Week 72 or beyond could add emtricitabine to TDF at the discretion of the investigator. Clinical data on the safety and efficacy of emtricitabine and TDF in CHB are pending



# Entecavir treatment for chronic hepatitis B: Adaptation is not needed for the majority of naïve patients with a partial virological response



Number of patients without response					
<1000 IU/mL at week 48	22	8	2	1	1
≥1000 IU/mL at week 48	14 <sup>a</sup>	12	10	7	3
Total number of patients in follow up	36	31	23	16	9

.Kaplan-Meier curve for the probability of achieving a VR for NA-naïve patients with a PVR according to HBV DNA at week 48. Three patients were switched to TDF plus emtricitabine, and one patient received TDF add-on therapy. P value was determined using log-rank testing.

# **Mangement of antiviral drug resistance**

- **Impact of second line therapy**
  - Early treatment adaptation to prevent accumulation of mutations
  - Choice always based on cross-resistance data
  - Add-on strategy versus switch ?
    - Good results with TDF switch
    - Some cases of suboptimal responses
    - Combination to increase the barrier to resistance

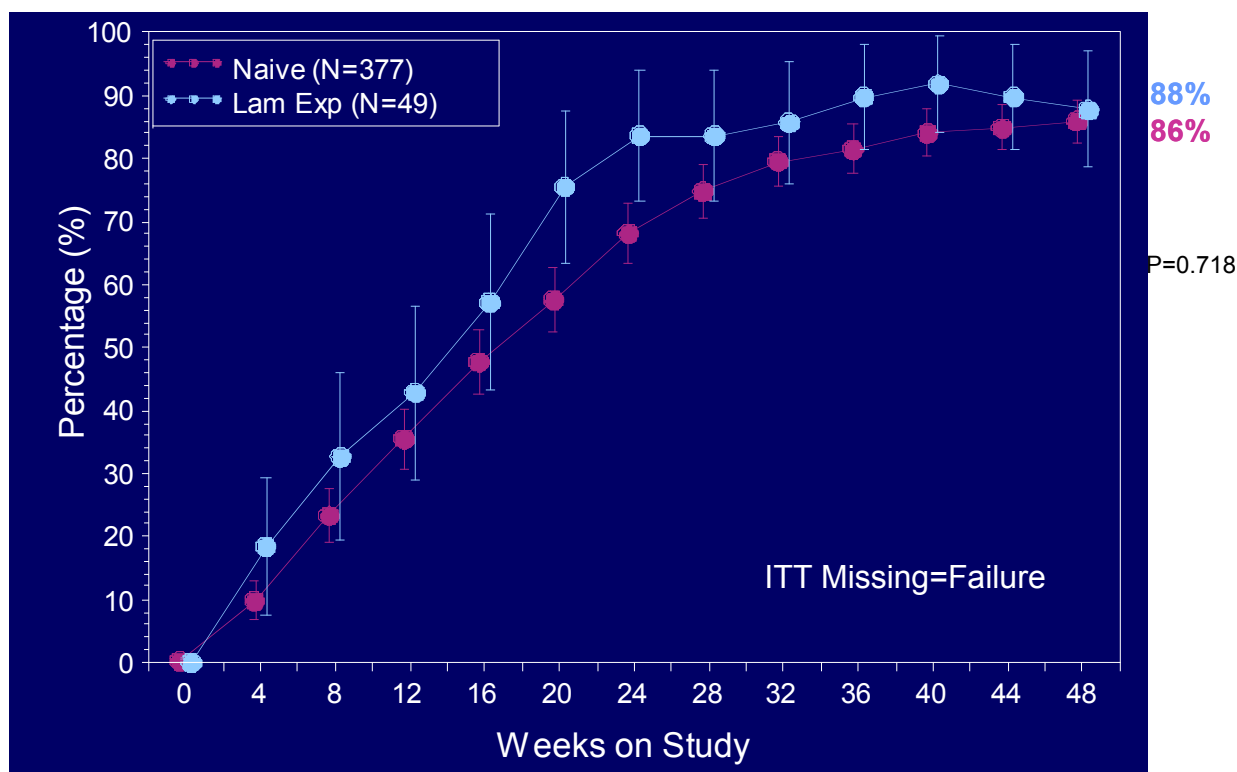
# Cross-resistance data for the main mutants and the commercially available drugs

Pathway	Amino Acid Substitutions in the rt Domain	LMV	LdT	ETV	ADV	TFV
	Wild-type	S	S	S	S	S
L-Nucleoside (LMV/LdT)	M204I/V	R	R	I	S	S
Acyclic phosphonate (ADV)	N236T	S	S	S	R	I
Shared (LMV, LdT, ADV)	A181T/V	R	R	S	R	I
Double (ADV, TFV)	A181T/V + N236T	R	R	S	R	R
D-Cyclopentane (ETV)	L180M+M204V/I ± I169 ± T184 ± S202 ± M250	R	R	R	S	S
Multi-Drug Resistance	A181T+N236T+M250V	R	R	R	R	R

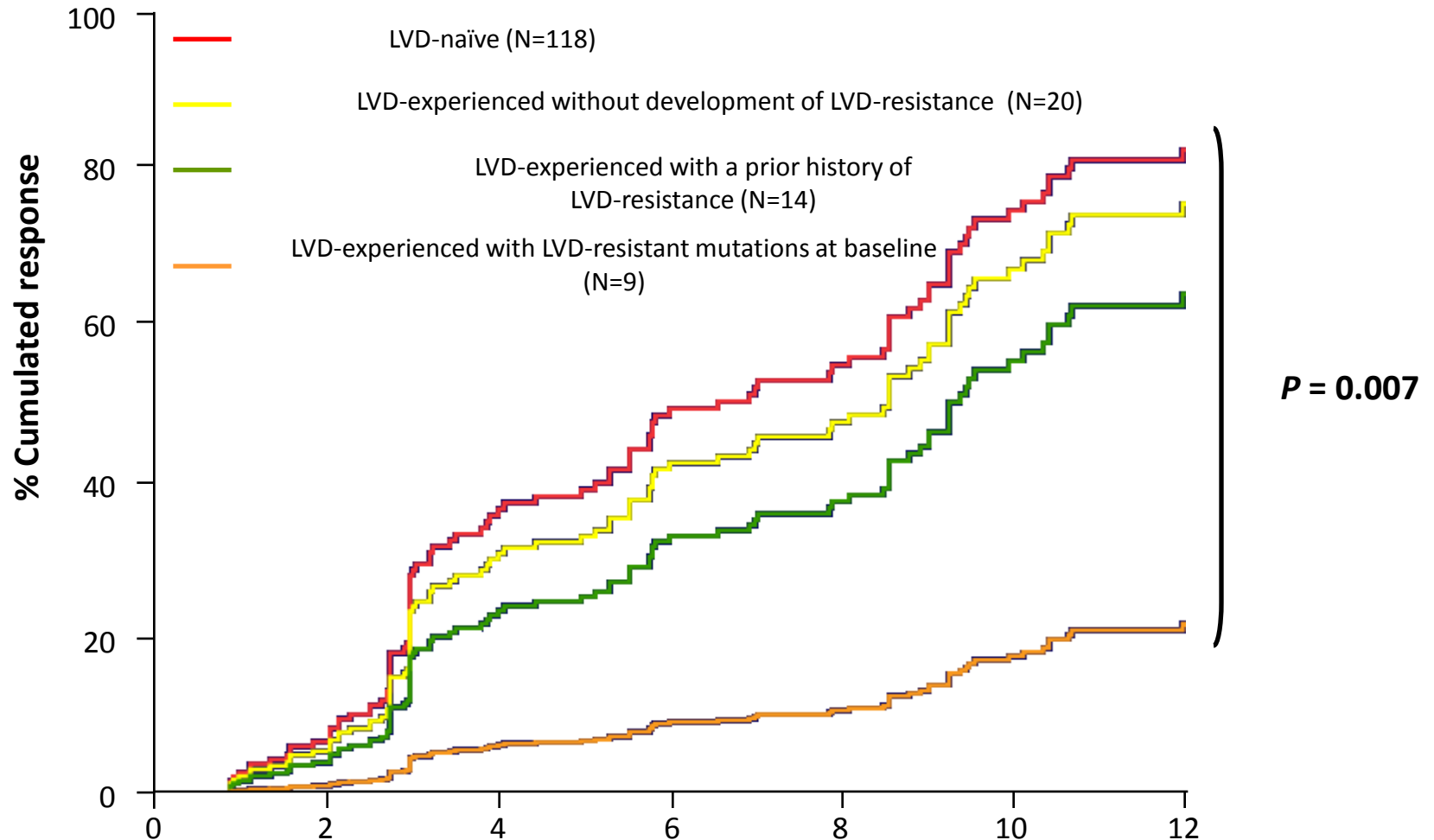
# Tenofovir efficacy in LAM Experienced vs. Naïve

	Study 103: N=176	Study 102: N=250	Total
LAM-Naïve, n	168	209	377
LAM-Experienced, n	8	41	49

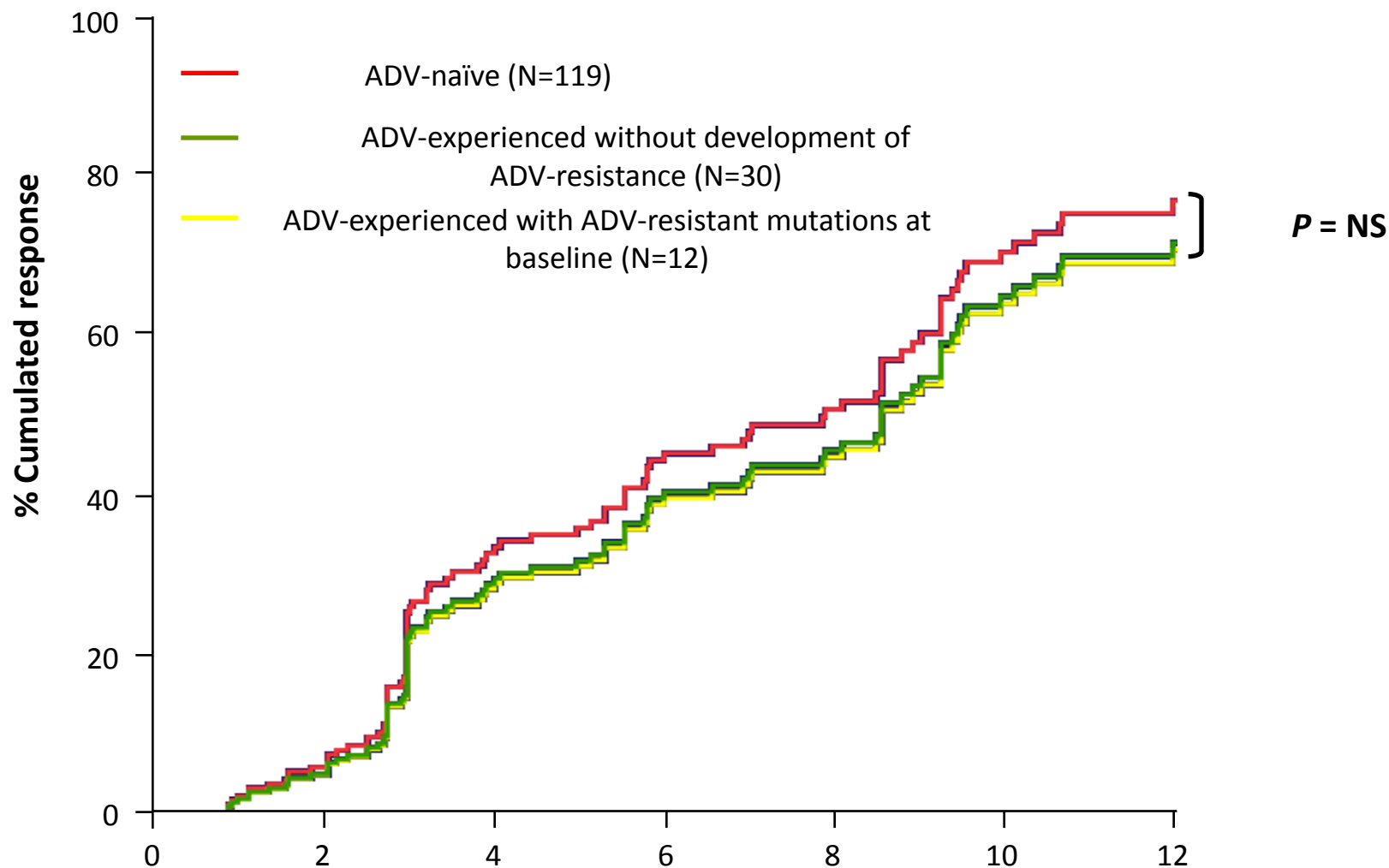
- Study 102 actively enrolled both LAM experienced and LAM-naïve patients
- Study 103 enrolled eight LAM experienced patients despite LAM-naïve inclusion criteria



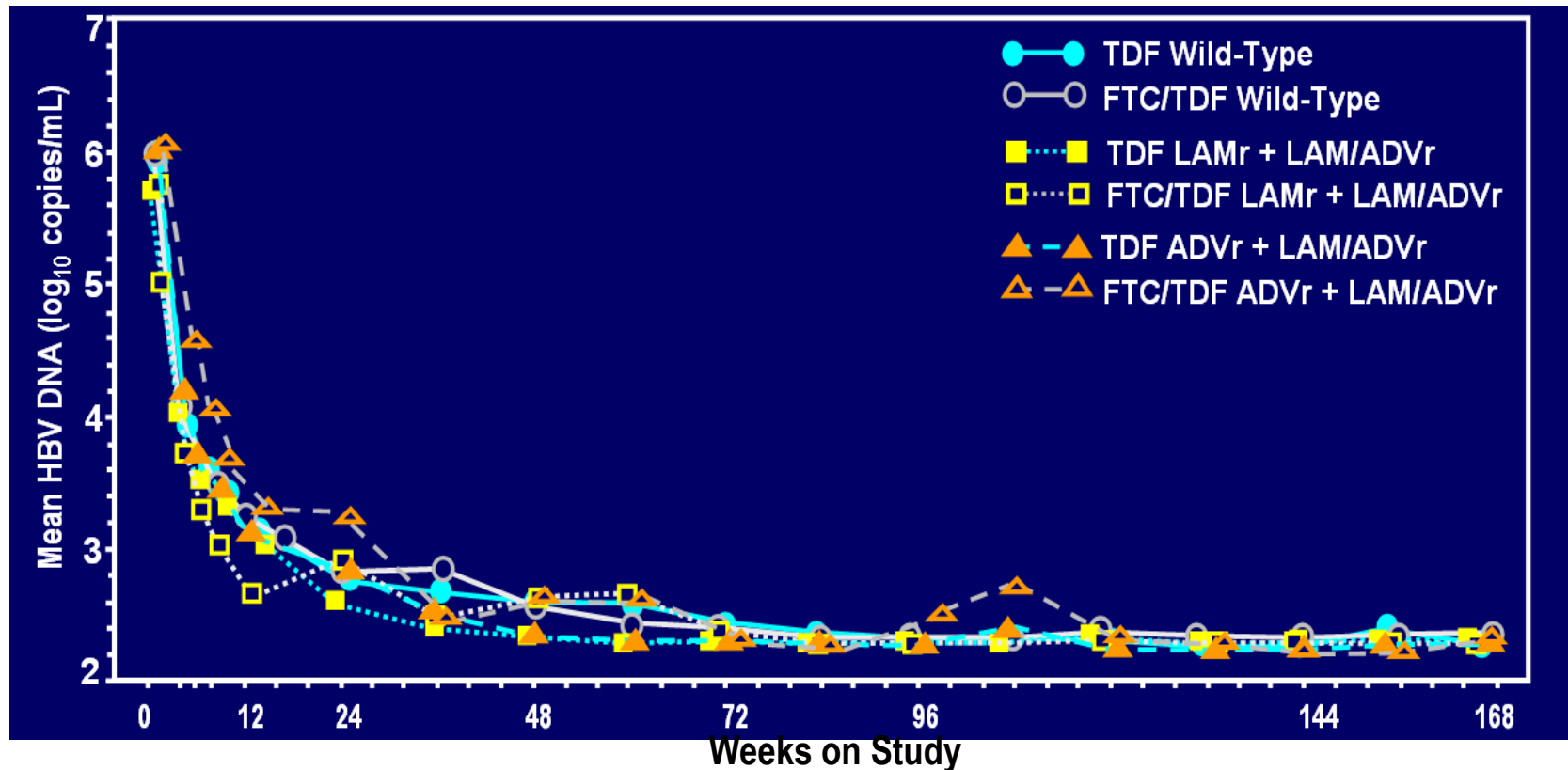
# Virologic response to Entecavir according to Lamivudine exposure



# Virologic response to Entecavir according to Adefovir exposure



# TDF vs. FTC/TDF for Treatment-Experienced Patients: Response by Baseline Resistance at Week 168



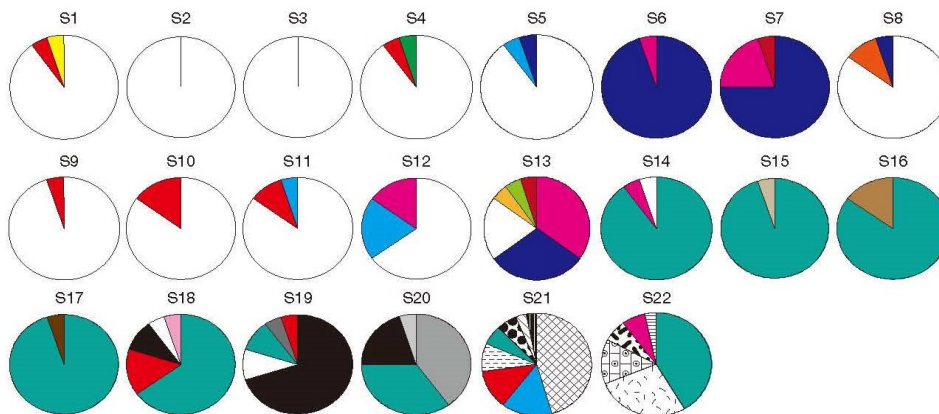
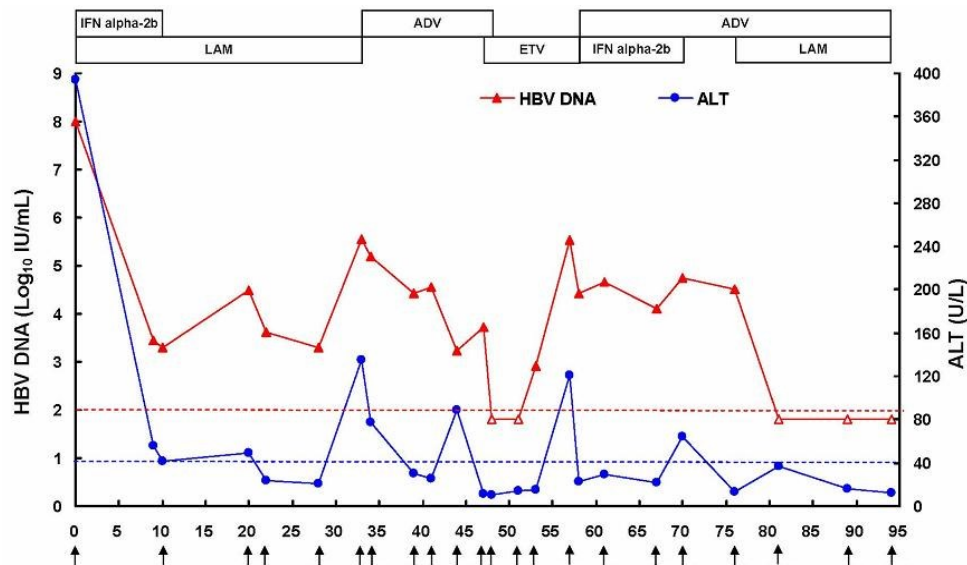
n =	●	29	29	29	29	27	26	24	24
n =	○	33	33	33	31	30	29	27	26
n =	■	14	14	14	14	14	14	14	14
n =	□	11	11	11	11	10	10	10	10
n =	▲	17	16	16	16	16	16	16	16
n =	△	12	12	12	12	12	11	10	10

## **Patients heavily exposed to NUCs with low barrier to resistance – Risk of MDR selection**

- Risk of multidrug resistance by sequential accumulation of resistance mutations
- Risk of partial response, even with the newest NUCs -> long-term impact ?

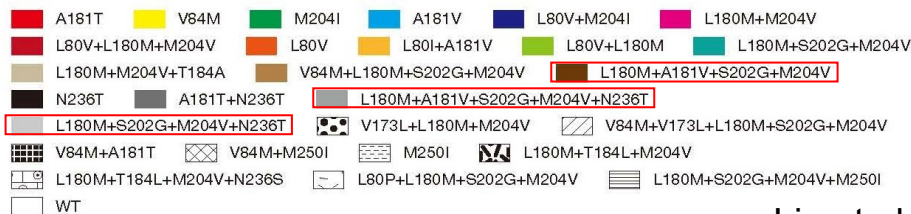


# Sequential therapy with NUCs and the risk of MDR



Accumulation of multiple mutations on the same viral genome

Complete change of the viral quasi-species



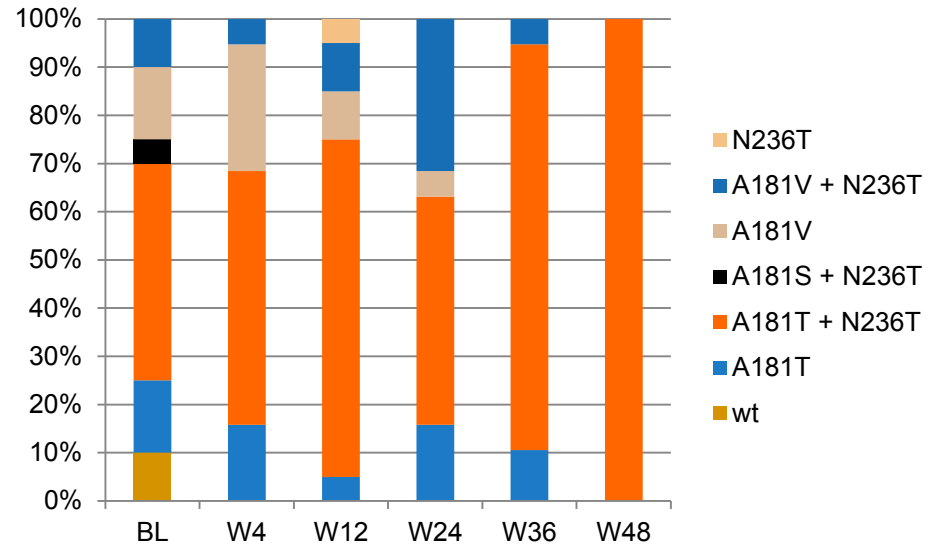
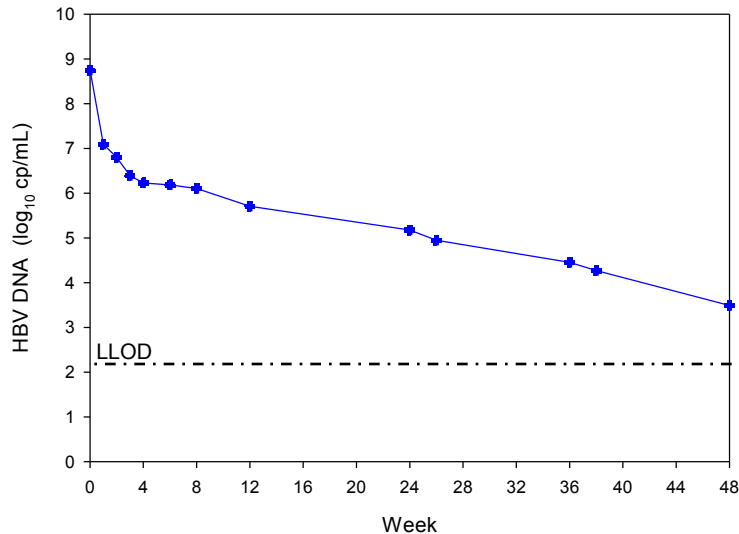
# Impact of rtA181 and rtN236 mutations on antiviral drug efficacy and cross-resistance

*In vitro* susceptibility to nucleos(t)ide analogs of the rtA181T, rtA181V, rtA181T+N236T, rtA181V+N236T, and rtN236T+N238T mutants isolated from patients with virological failure

Mutant	Patient	LAM FR	ADV FR	TDF FR	ETV FR
rtA181T	#2	$5.7 \pm 2.6$	$4.5 \pm 0.8$	$2 \pm 0.6$	nd
	#9	$8.7 \pm 4.2$	$3.2 \pm 1.6$	$2.8 \pm 1.6$	$1 \pm 0.08$
	#7	$10.8 \pm 2.9$	$2.1 \pm 1$	$2.9 \pm 1.5$	$1 \pm 0.5$
rtA181V	#9	$7.7 \pm 3.6$	$7.8 \pm 3.5$	$2.4 \pm 1.4$	$1 \pm 0.05$
	#4	$7.1 \pm 3.8$	$3 \pm 0.6$	$1.2 \pm 0.4$	$1.5 \pm 0.5$
	#5	$1.5 \pm 0.3$	$2.4 \pm 0.2$	$3.2 \pm 0.4$	$1.2 \pm 0.4$
rtA181T+N236T	#9	$35 \pm 5$	>10	$6.8 \pm 2.9$	$1 \pm 0.1$
rtA181V+N236T	#3	$43 \pm 10$	$4.5 \pm 2.7$	$1.2 \pm 0.2$	$1 \pm 0.05$
rtN236T+N238T	#4	$1.5 \pm 0.7$	$2.6 \pm 0.6$	$1.4 \pm 0.6$	$1.1 \pm 0.6$

# Evolution of viral genome during Tenofovir therapy in patients who previously failed ADV

Viral load



**Patient 1051 data:**  
BL viral load = 8.75log  
**Treatment: TDF**  
Adherence : 95.2%

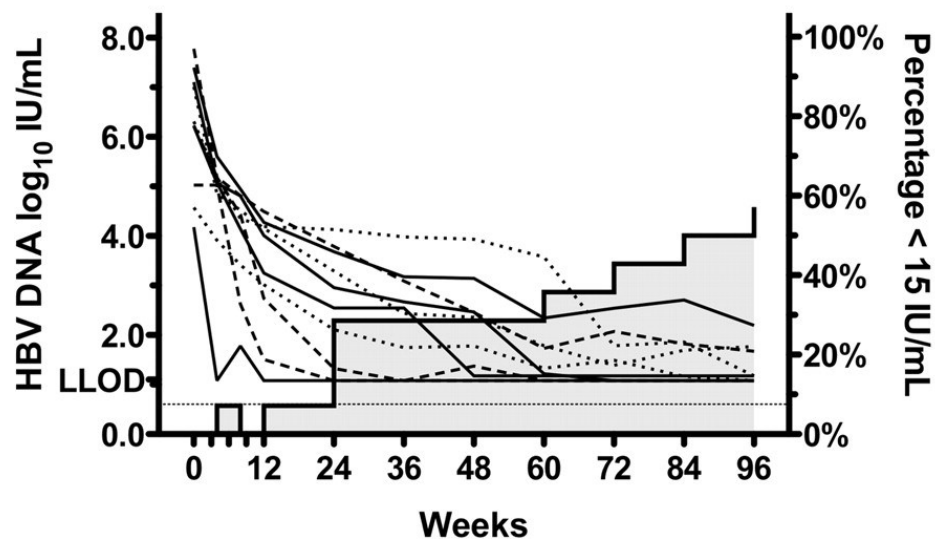
Impact of persisting low viremia levels on treatment outcome ?  
Impact of persisting resistant mutants ?

# Virologic response to TDF according to ADV resistance mutations at baseline

## The Australian Experience

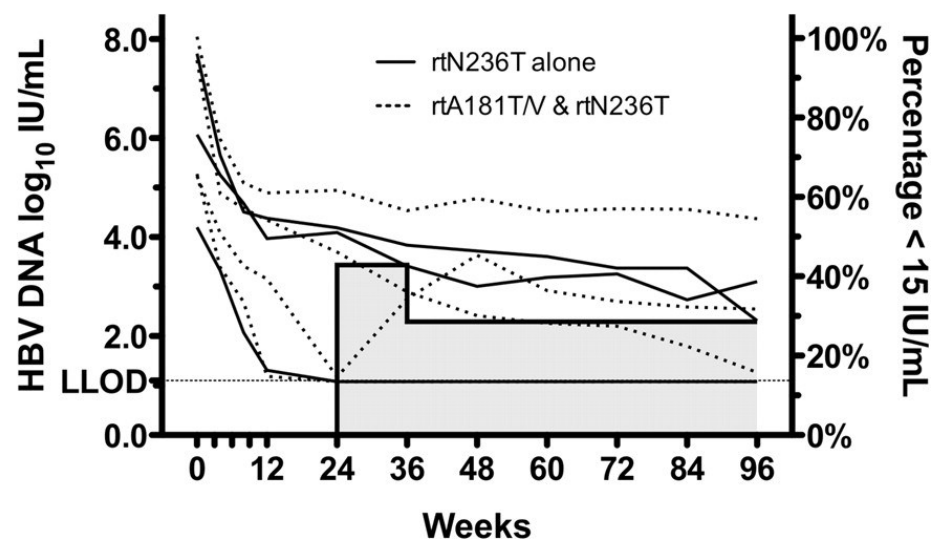
A

rtA181T/V without rtN236T (n=10)



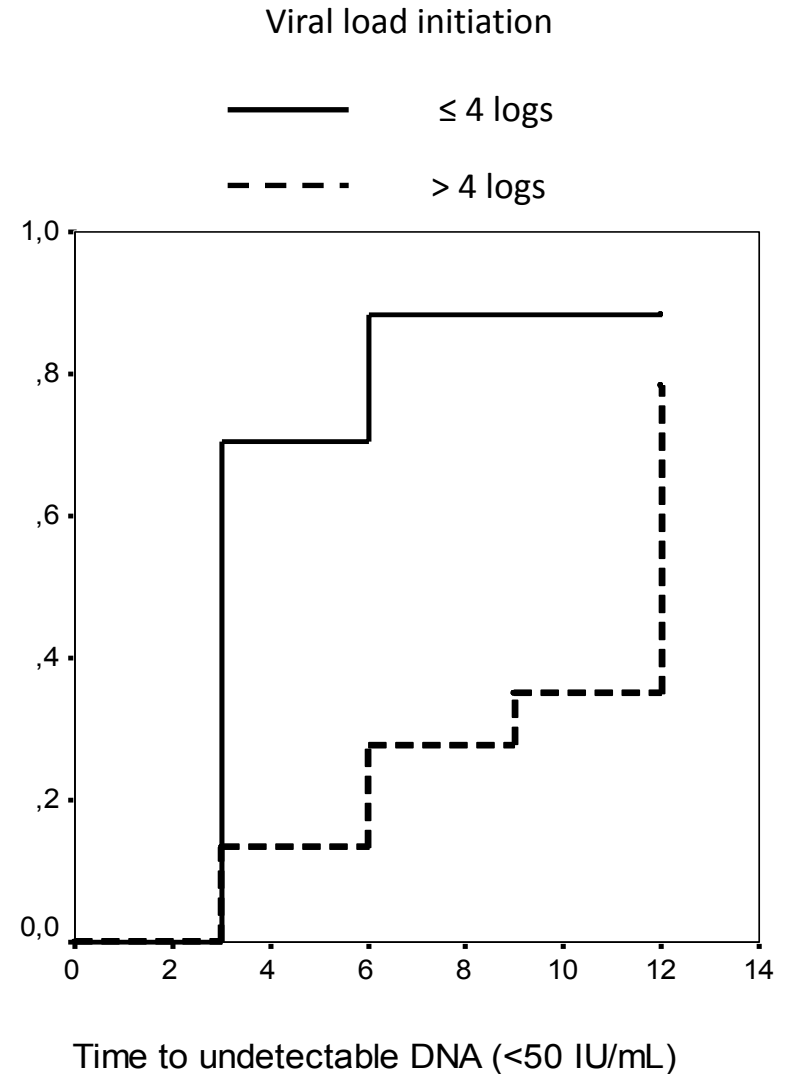
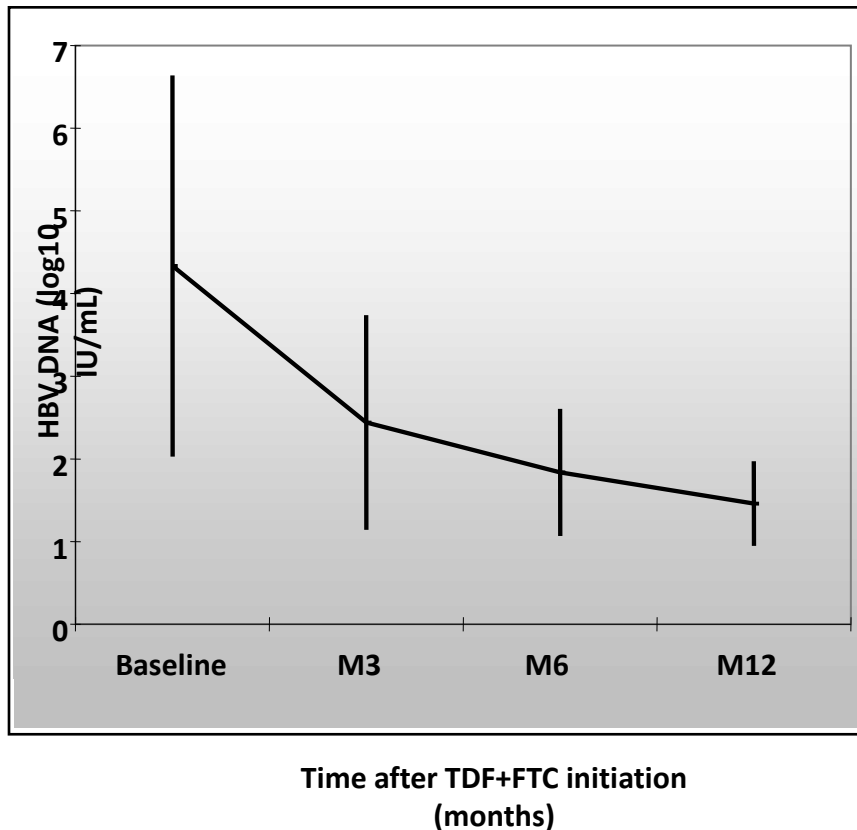
B

rtN236T patients (n=7, 3 alone, 4 with rtA181T/V)

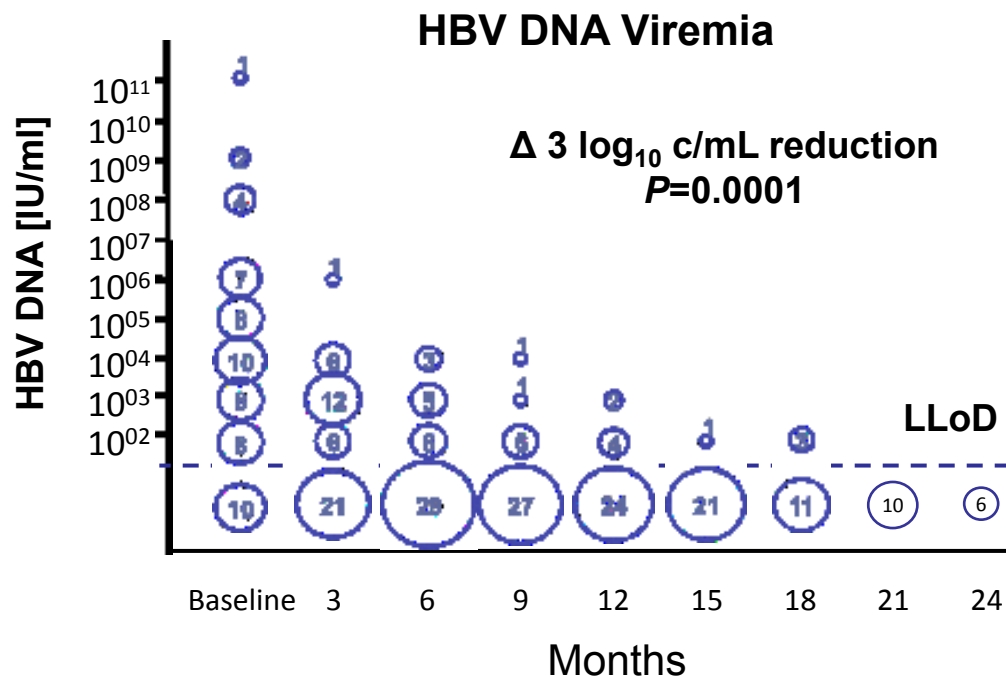


# Tenofovir + Emtricitabine in patients with treatment failure – treatment intensification

HBV DNA kinetics after TDF+FTC initiation in 59 patients with treatment intensification

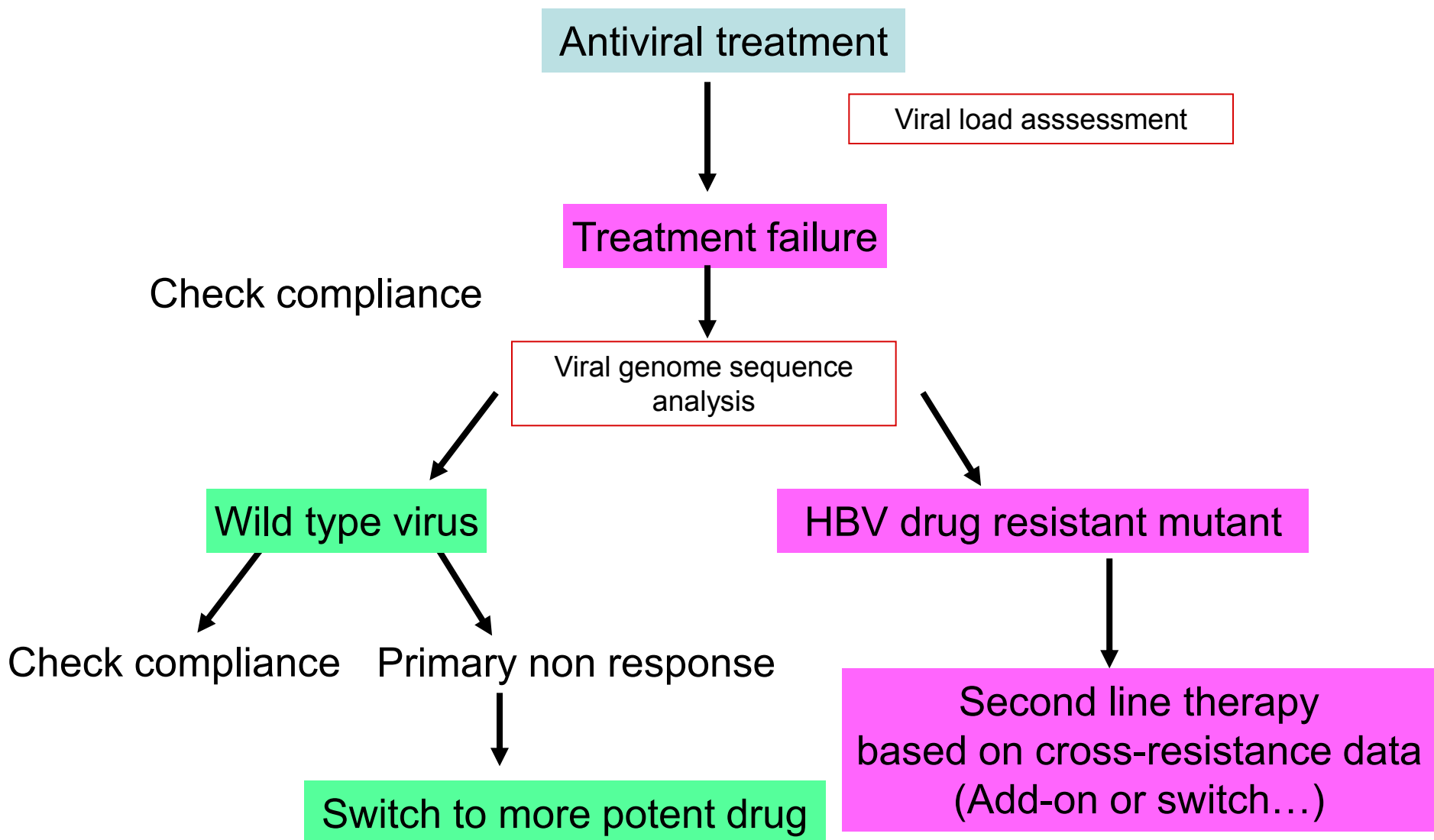


# ETV + TDF combination in patients with treatment failure



Rescue therapy with ETV + TDF in CHB patients with advanced liver disease and complex viral resistance patterns or showing partial antiviral responses to preceeding therapies (Virgil network)

# Management algorithm



# Suggested treatment adaptation in patients with treatment failure

Type of failure	Treatment adaptation
Lamivudine resistance	1) add TFV (add ADV if TFV not available) 2) a switch to TFV is also advised by some guidelines
Adefovir resistance	1) switch to TFV (if available) and a 2 <sup>nd</sup> drug 2) if no history of LMV, switching to ETV is also effective. 3) If rtN236T substitution, consider adding LMV, ETV, or LdT to the TFV or switch to TFV plus FTC 4) If rtA181V/T substitution, alone or in combination with rtN236T, switch to TFV plus ETV
Telbivudine resistance	1) add TFV 2) a switch to TFV has been considered in some guidelines 3) a switch to ADV is not recommended
Entecavir resistance	add TFV
Tenofovir resistance	1) not been confirmed so far 2) genotyping and phenotyping required 3) may add ETV



# Acknowledgements

## Hepatology Unit

### Clinical studies

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## Suggested treatment adaptation in patients with treatment failure

Type of failure	Treatment adaptation
Lamivudine resistance	<ol style="list-style-type: none"><li>1) add TFV (add ADV if TFV not available)</li><li>2) a switch to TFV is also advised by some guidelines</li><li>3) a switch to ADV is not recommended due to a high rate of resistance and its low potency</li></ol>
Adefovir resistance	<ol style="list-style-type: none"><li>1) switch to TFV if available and add a second drug without cross resistance.</li><li>2) if no history of LMV, switching to ETV is also effective.</li><li>3) If rtN236T substitution, consider adding LMV, ETV, or LdT to the TFV or switch to TFV plus FTC; if no history of LMV prior, consider switching to ETV</li><li>4) If rtA181V/T substitution, alone or in combination with rtN236T, switch to TFV plus ETV; as before, if no history LMV, consider switching to ETV;</li></ol>
Telbivudine resistance	<ol style="list-style-type: none"><li>1) add TFV</li><li>2) a switch to TFV has also been considered in some guidelines</li><li>3) a switch to ADV is not recommended</li></ol>
Entecavir resistance	add TFV
Tenofovir resistance	<ol style="list-style-type: none"><li>1) not been confirmed so far</li><li>2) genotyping and phenotyping required</li><li>3) may add ETV</li></ol>

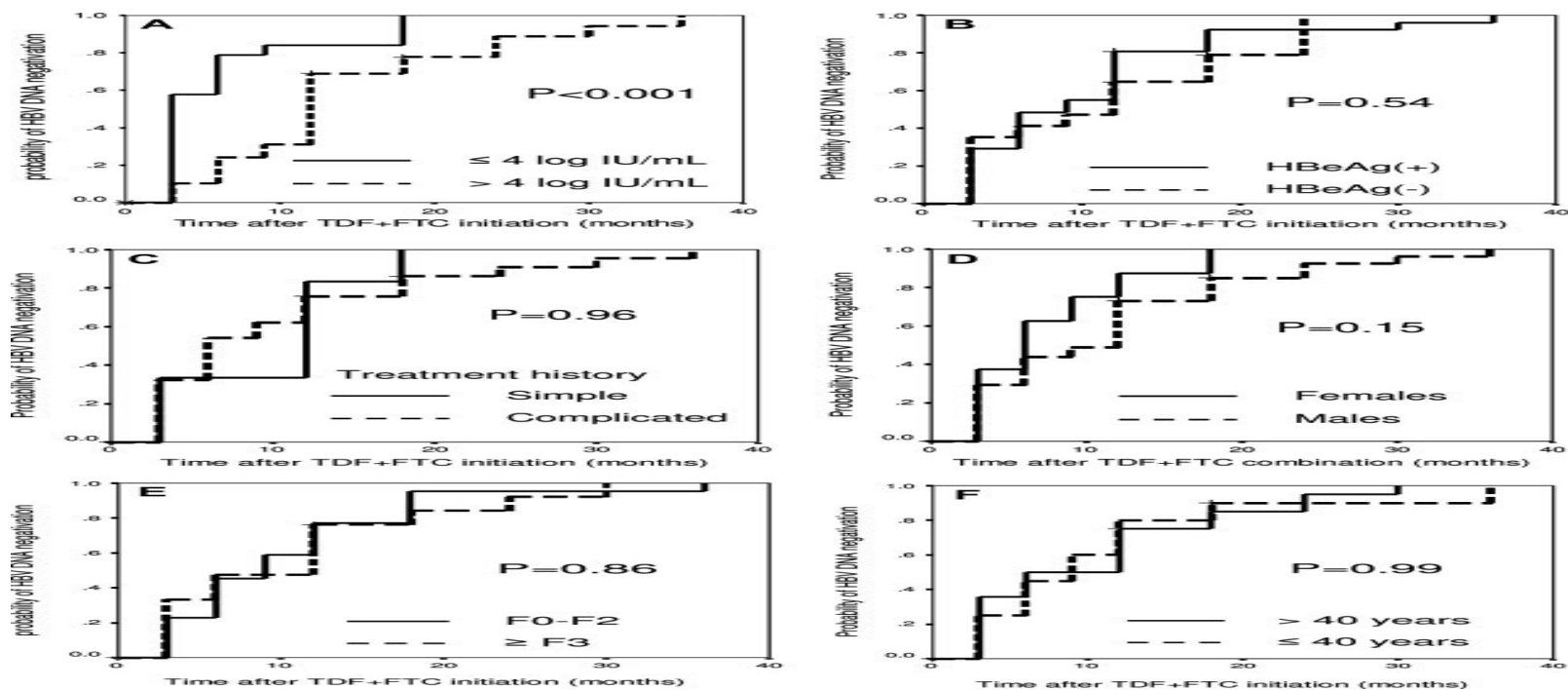


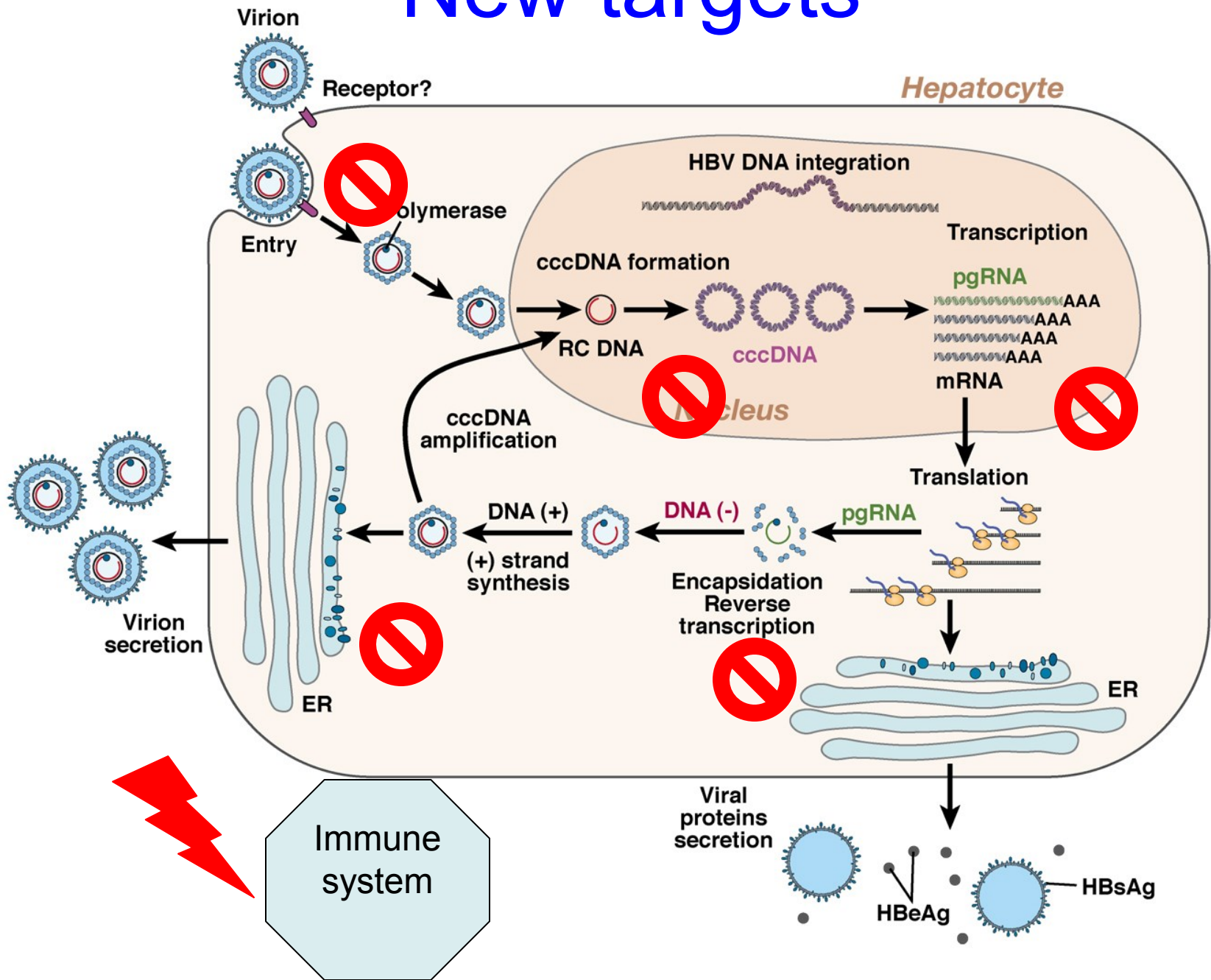
Fig. 2 Kaplan-Meier analysis giving the probability of HBV-DNA negativity according to HBV-DNA level at baseline (A), HBeAg status at baseline (B), previous treatment history (C), gender (D), fibrosis at baseline (E), and age (F).

Si-Nafa Si-Ahmed , Pierre Pradat , Roeland Zoutendijk , Maria Buti , Vincent Mallet , Claire Cruiziat , Katja Det...

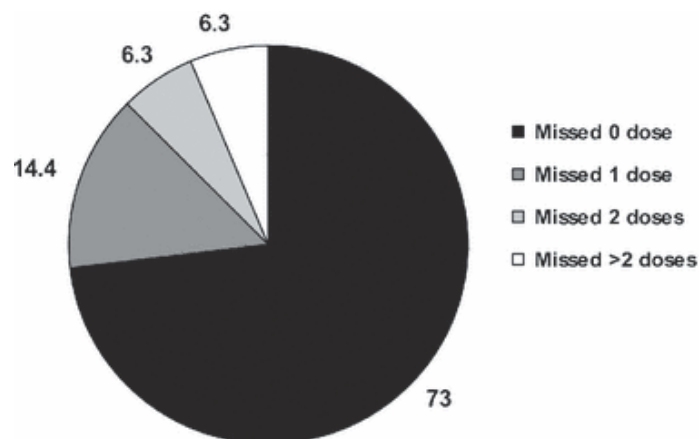
# **Efficacy and tolerance of a combination of tenofovir disoproxil fumarate plus emtricitabine in patients with chronic hepatitis B: A European multicenter study**

Antiviral Research Volume 92, Issue 1 2011 90 - 95

# New targets



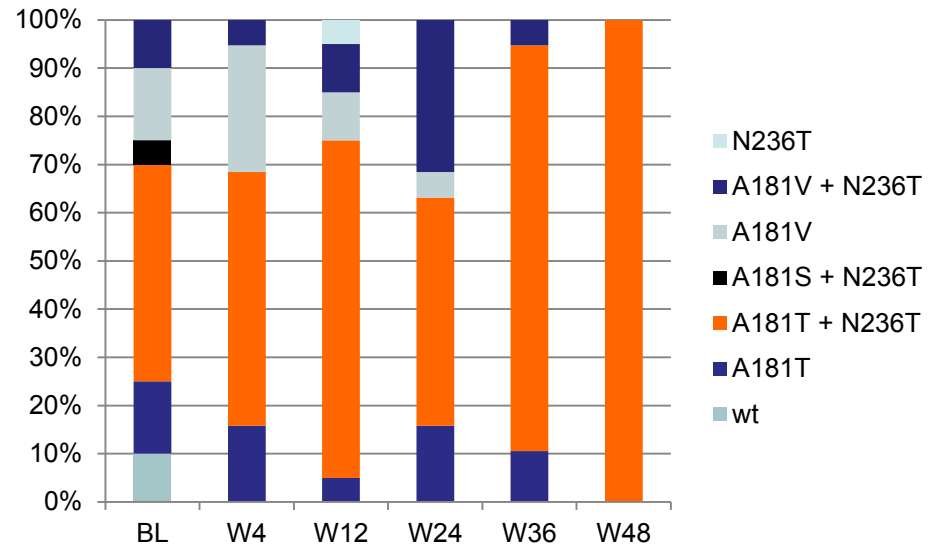
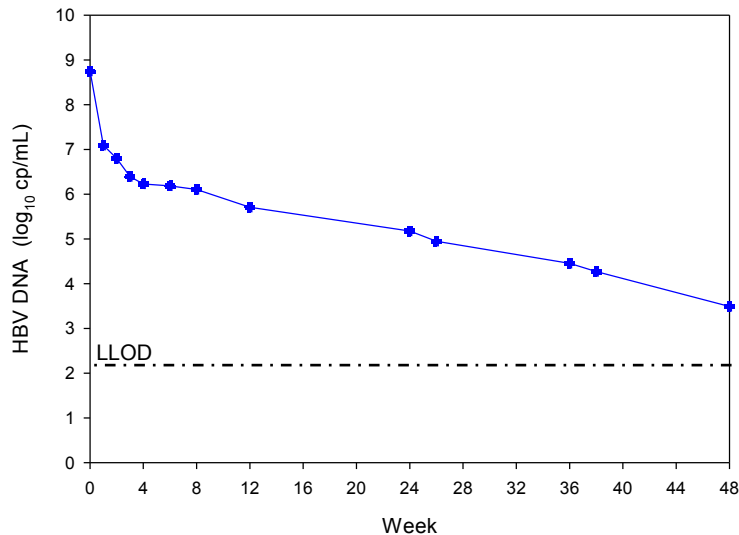
## Adherence to nucleos(t)ide analogues for chronic hepatitis B in clinical practice and correlation with virological breakthroughs



# Evolution of viral genome during Tenofovir therapy in patients who previously failed ADV

Patient #1051

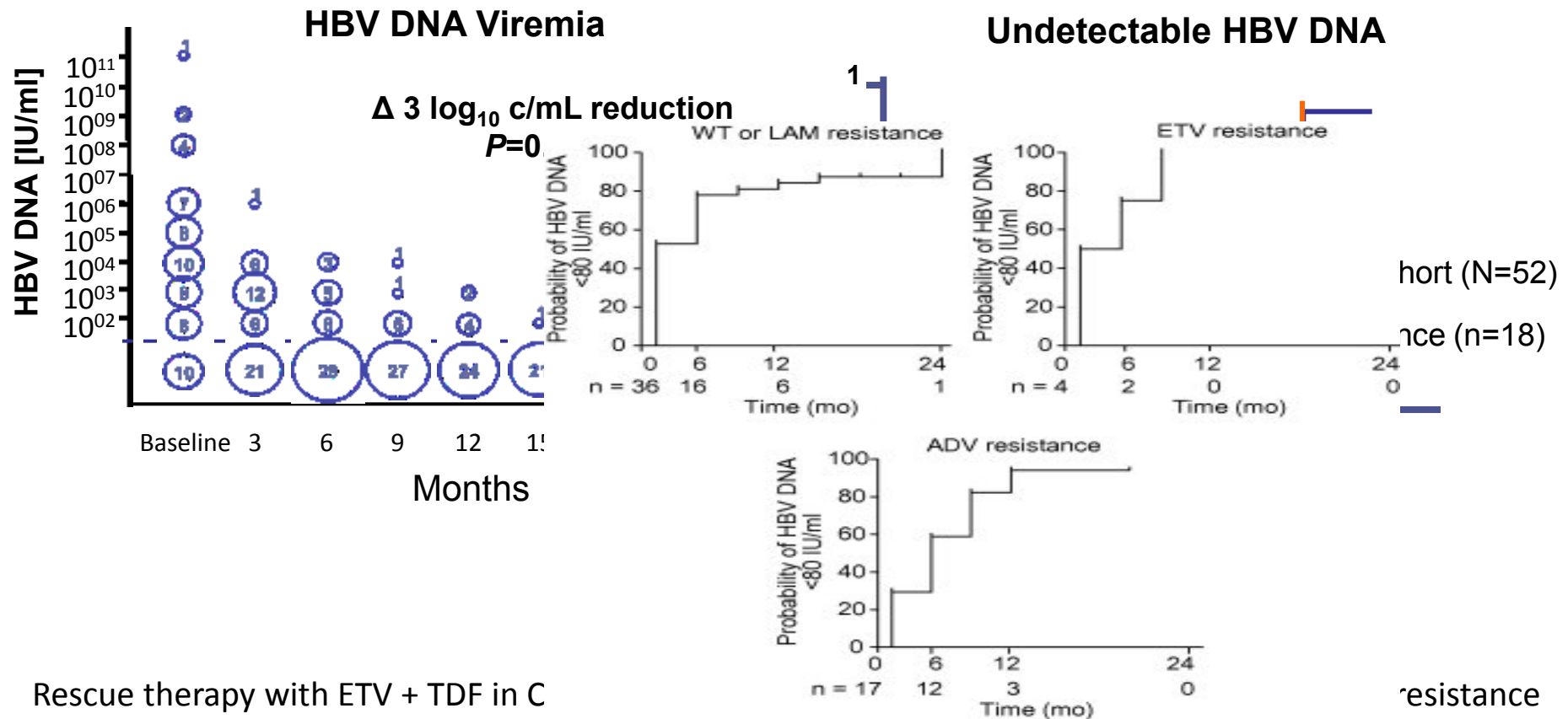
Viral load



**Patient 1051 data:**  
**BL viral load = 8.75log**  
**Treatment: TDF**  
**Adherence : 95.2%**

**Impact of persisting low viremia levels on treatment outcome ?**  
**Impact of persisting resistant mutants ?**

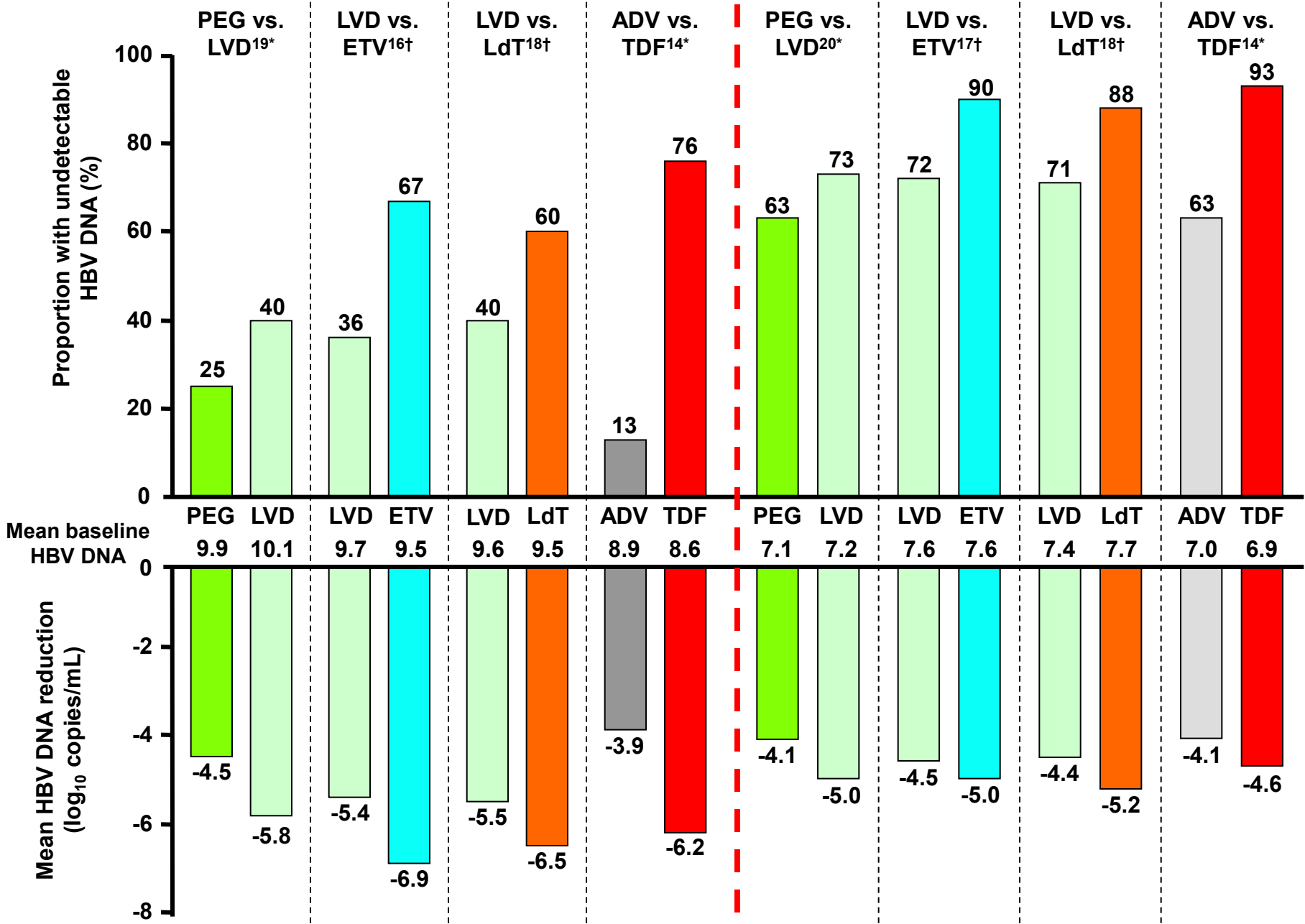
# ETV + TDF combination in patients with treatment failure



Rescue therapy with ETV + TDF in C patterns or showing partial antiviral responses to preceding therapies (Virgil network)

## HBeAg-positive

## HBeAg-negative





# Entecavir treatment for chronic hepatitis B: Adaptation is not needed for the majority of naïve patients with a partial virological response

Zoutendijk et al **Hepatology**

Volume 54, Issue 2, pages 443-451, 25 JUL 2011 DOI: 10.1002/hep.24406

<http://onlinelibrary.wiley.com/doi/10.1002/hep.24406/full#fig3>

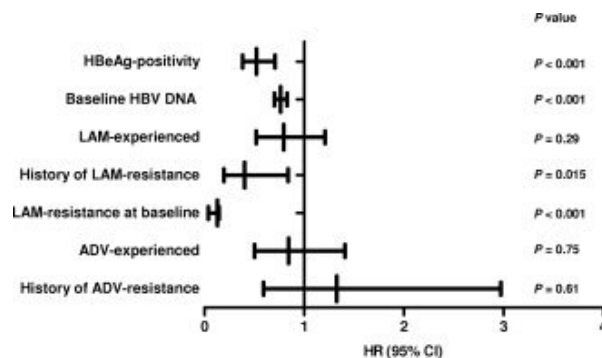
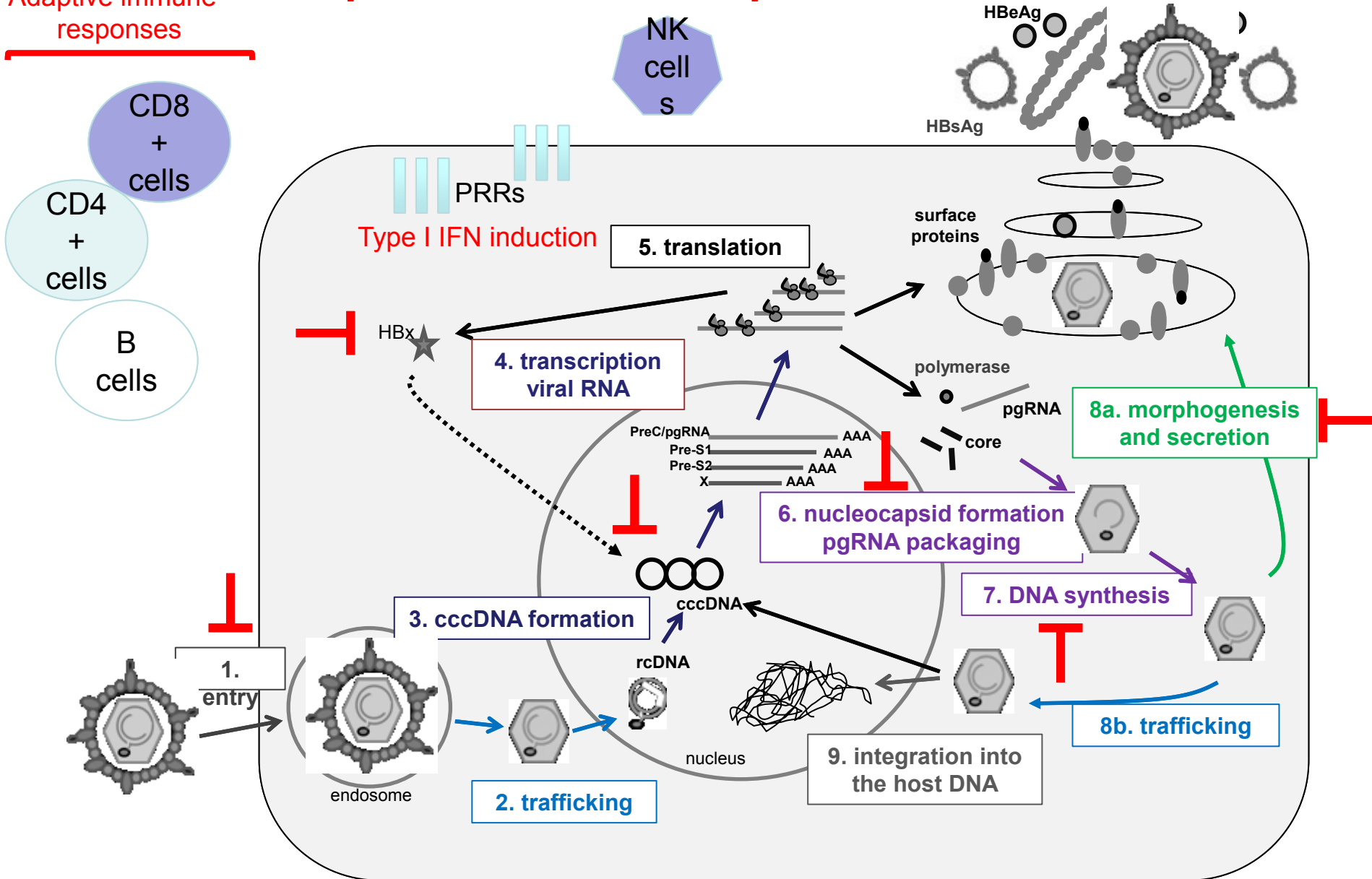


Figure 3. Adjusted HR of achieving a VR for both NA-naïve and NA-experienced patients. Based on the Cox model adjusted for HBeAg status, mean baseline HBV DNA, LAM experience, history of LAM resistance, LAM resistance at baseline, ADV experience, and history of ADV resistance.

## Innate responses

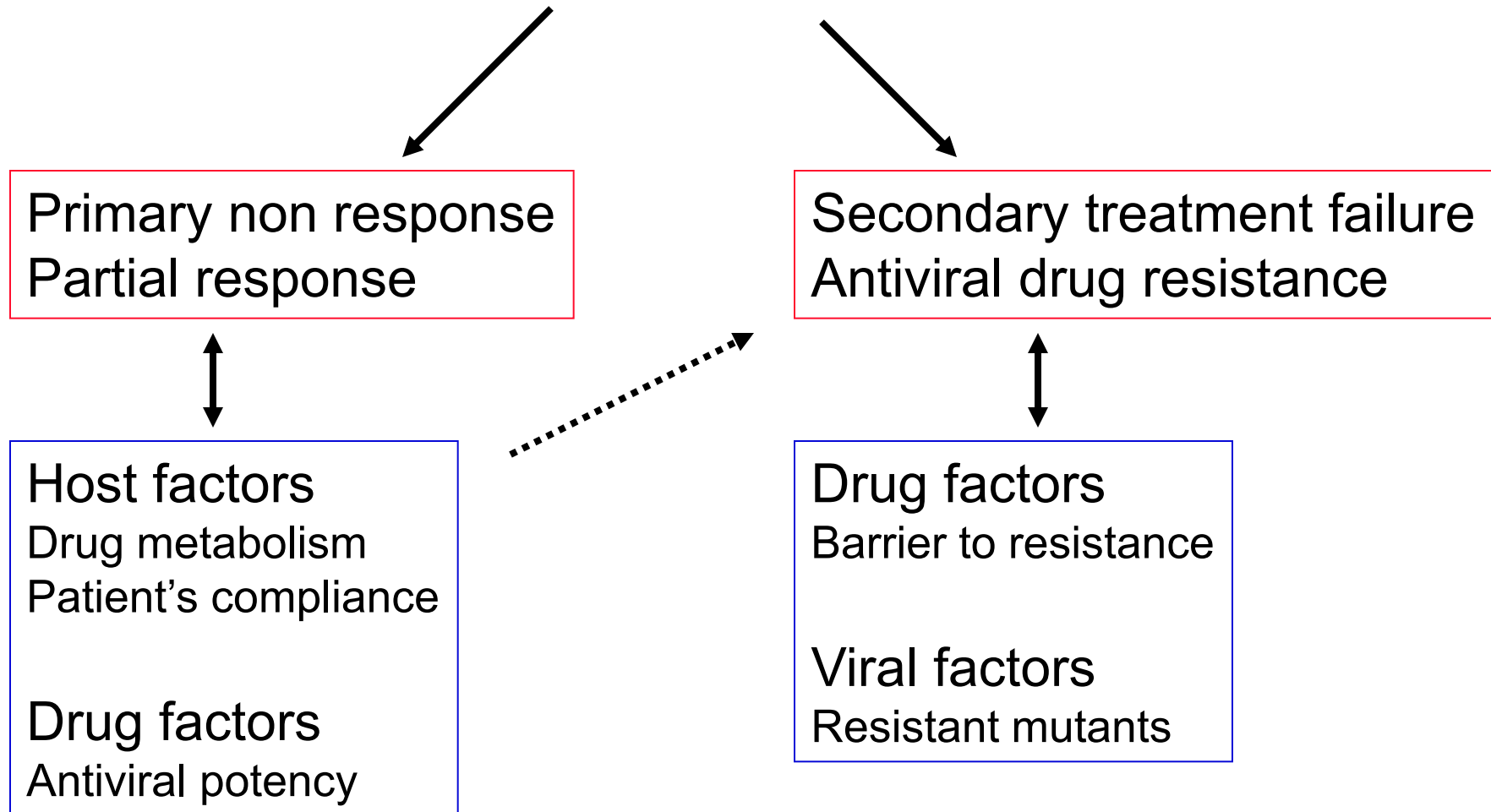
## Adaptive immune responses



# HBV resistance: new challenges

- Poorer response in second or third line therapy
  - Persisting low viremia levels
- Risk of selection of MDR mutants
- Potential risk of transmission of mutants
- Early detection of mutants (UDP sequencing)
- Identification of new targets for true combination therapy, prevention of resistance, and finite duration therapy

# Treatment failure



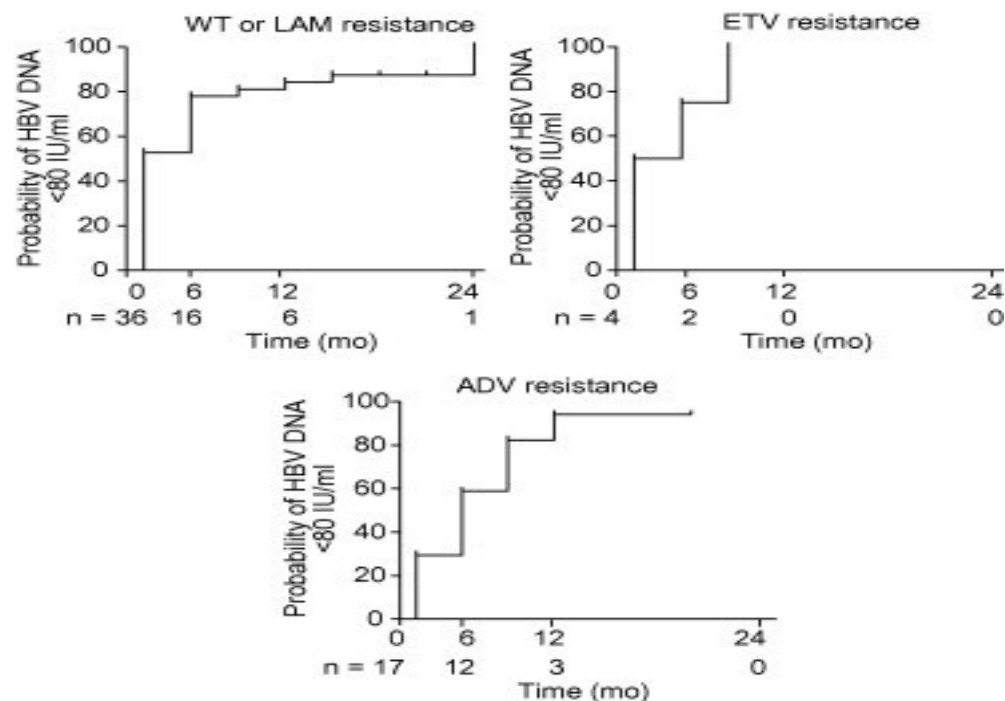


Fig. 2 Probability of HBV DNA below LLoD (80 IU/ml) . A Kaplan-Meier analysis was used to analyze the probability of reaching HBV DNA undetectability. For the entire cohort, the median time to HBV-DNA undetectability was 6 months.

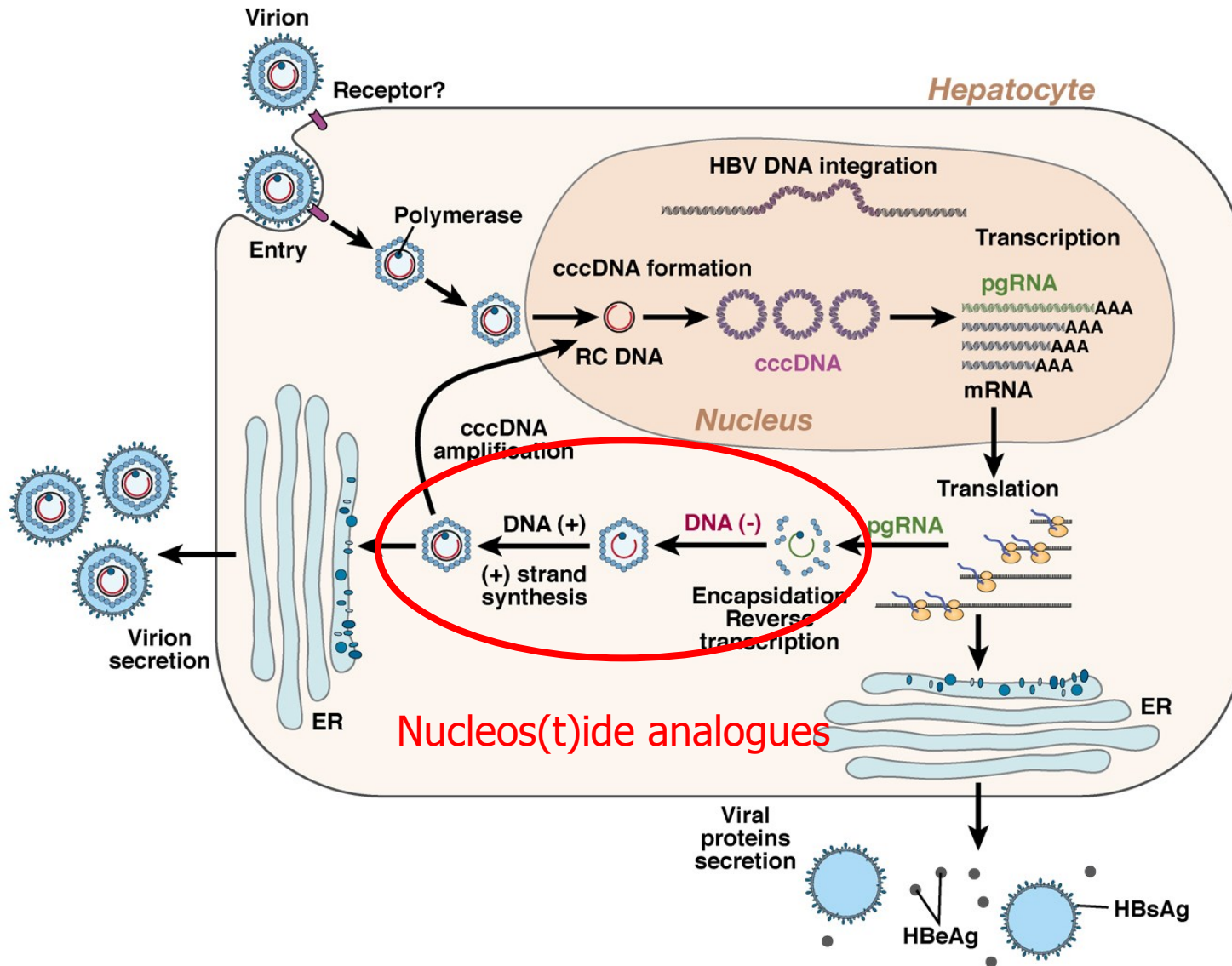
Jorg Petersen , Vlad Ratziu , Maria Buti , Harry L.A. Janssen , Ashley Brown , Pietro Lampertico , Jan Schollmeyer...

# Entecavir plus tenofovir combination as rescue therapy in pre-treated chronic hepatitis B patients: An international multicenter cohort study

Journal of Hepatology Volume 56, Issue 3 2012 520 - 526

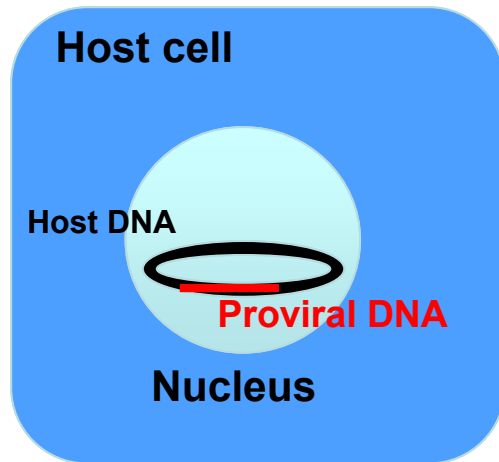
<http://dx.doi.org/10.1016/j.jhep.2011.09.018>

# The target of nucleos(t)ide analogues



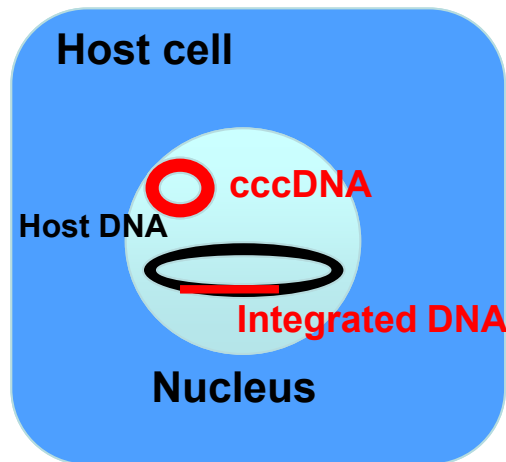
# The main differences between HIV, HBV and HCV

## HIV



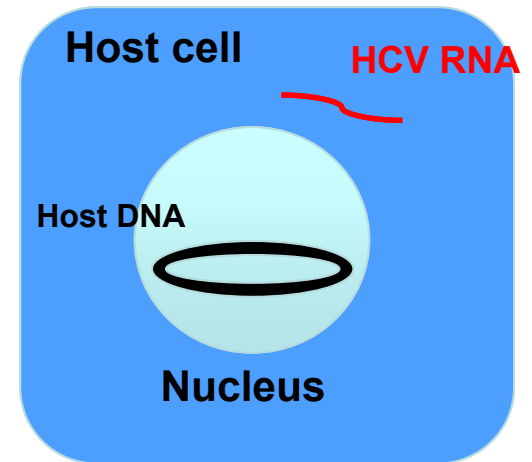
Lifelong suppression  
of viral replication

## HBV



Longterm suppression  
of viral replication

## HCV



Definitive viral clearance  
and SVR