20th EUROPEAN AIDS CONFERENCE
15-18 October 2025 | Paris, France
EACS European AIDS Clinical Society

High Effectiveness and Rare Virologic Failure in Treatment-Experienced Individuals on Long-Acting Cabotegravir + Rilpivirine Therapy Across Europe: Insights from the EuroSIDA Study

L. Peters[1], W. Bannister[1], G. Sridhar[2], M. Gardizi[1], M. van Frankenhuijsen[3], M-A. De Scheerder[4], I. S. Johansen[5], J-P. Viard[6], C. Duvivier[7,8,9,10], J. Bogner[11], O. Degen[12], A. Castagna[13], T. Staub[14], E. Martinez[15], P. Domingo[16], S. Moreno[17], D. H. Reikvam[18], M. Parczewski[19], B. Knysz[20], Y. Shivkar[21], K. Brown[2], J. van Wyk[21], V. Vannappagari[2]

1 Centre for Health and Infectious Disease Research, Department of Infectious Diseases, Rigshospitalet, University of Copenhagen, Copenhagen, Denmark; 2 ViiV Healthcare, Durham, NC, USA; 3 Institute of Tropical Medicine, Antwerp, Belgium; 4 Ghent University Hospital, Ghent, Belgium; 5 Department of Infectious Diseases, Odense University Hospital, Odense, Denmark; 6 Diagnostic and Therapeutic Center, Hôtel-Dieu, AP-HP, Paris, France; 7 AP-HP, Necker-Enfants Malades Hospital, Department of Infectious and Tropical Diseases, Necker-Pasteur Infectious Diseases Center; 8 IHU Imagine; 9 Institut Cochin - CNRS 8104 - INSERM U1016, Université Paris Cité; 10 Institut Pasteur, Medical Center, Paris, France; 11 Division of Infectious Diseases, Medizinische Klinik und Poliklinik IV, Ludwig Maximilian University of Munich, Munich, Germany; 12 University Clinic Hamburg Eppendorf, Hamburg, Germany; 13 Infectious Diseases, San Raffaele Scientific Institute, Milano, Italy; 14 Centre Hospitalier de Luxembourg, Service des Maladies Infectieuses, Luxembourg; 15 Infectious Diseases Service, Hospital Clinic, Barcelona, Spain; 16 Hospital de la Santa Creu i Sant Pau, Barcelona, Spain; 17 Servicio Enfermedades Infecciosas, Hospital Universitario Ramón y Cajal, Madrid, Spain; 18 Dep. of Infectious diseases, Oslo University Hospital, Oslo, Norway; 19 Department of Infectious, Tropical Diseases and Immune Deficiency, Pomeranian Medical University, Szczecin, Poland; 20 Wroclaw Medical University, Wroclaw, Poland; 21 ViiV Healthcare, London, England, UK

EuroSIDA

PURPOSE

- Cabotegravir + rilpivirine long-acting therapy (CAB+RPV LA) is the first complete long-acting regimen approved for treatment-experienced, virologically suppressed (HIV-RNA<50 copies/mL) people with HIV.
- We evaluated clinical outcomes of CAB+RPV LA in real-world settings across Europe.

METHODS

- All adults with HIV initiating CAB+RPV LA (baseline) between January 2021 and December 2023 in the pan-European EuroSIDA cohort were included.
- We describe their characteristics, adherence, discontinuation, and virologic outcomes during follow-up.
- On-time injections were those received within +/-7 days of their next scheduled injection; delayed injections were injections occurring >7 days after target date; missed injections were those missed without receiving oral bridging therapy.
- Confirmed virologic failure (CVF) was defined as two consecutive viral loads (VLs) ≥200 copies/mL or one VL ≥200 copies/mL followed by CAB+RPV LA discontinuation within 1 month.

CONCLUSIONS

- In this real-world European cohort, CAB+RPV LA demonstrated high rates of virologic suppression and no CVF among individuals virologically suppressed at initiation, with no missed injections and only few delays.
- Most individuals who were viraemic at CAB+RPV LA initiation achieved virologic suppression, with CVF seen in 2/7 individuals.
- Virologic suppression was consistent across BMI categories.
- The adverse events leading to discontinuation are in line with the safety profile described in the summary of product characteristics.
- These real-world data support prior studies demonstrating durable effectiveness and tolerability of CAB+RPV/LA.

ACKNOWLEDGEMENTS

EuroSIDA study group and funding available: https://chip.dk/research-areas/cohorts/studies-and-projects/eurosida/study-group/

This analysis was funded by ViiV Healthcare, who did not influence the analyses presented or the decision to publish study findings.

CONTACT INFORMATION

Wendy Bannister

CHIP, Rigshospitalet University of Copenhagen

Email: wendy.bannister@regionh.dk

RESULTS

Among 142 individuals who initiated CAB+RPV LA and were included in the analysis, median age was 52 years (IQR: 43-60), 79% males and 86% white (**Table 1**).

Most individuals (94%) had on-time injections, 8 (6%) had one delayed injection (median delay 9 days (IQR: 8-11)) after the target window and no individual missed any injections. Most (93%) remained on CAB+RPV LA over a median follow-up of 323 days (IQR: 204-466) at the time of analysis. Ten individuals (7%) discontinued CAB+RPV LA without resistance tests performed (**Figure 1**).

In a subset of 115 individuals with baseline and follow-up VL assessments:

- 108 individuals had **VL <50 copies/mL** at initiation and follow-up VLs, of which 105 (97%) had most recent VL <50 copies/mL, 97 (90%) had all follow-up VLs <50 copies/mL, and no individuals experienced CVF. Virologic suppression was consistently high at 6, 12, and 24- months with rates above 95% (**Figure 2**).
- 7 individuals had **VL ≥50 copies/mL** at initiation and follow-up VLs, of which 6 (86%) had most recent VL <50 copies/mL and 3 (43%) had all follow-up VLs <50 copies/mL. Two individuals experienced CVF with no resistance testing, switched to boosted darunavir-based regimens, and resuppressed to VL<50 copies/mL (**Figure 3**).
- 84 had baseline BMI <30 kg/m^2 and 12 had baseline BMI ≥30 kg/m^2 (19 unknown BMI). Most recent VL was <50 copies/mL in 81 (96%) and 12 (100%) individuals, respectively. Virologic suppression was sustained in all follow-up assessments by 74 (88%) and 10 (83%) individuals, respectively.

Table 1 Baseline demographic and clinical characteristics of individuals initiating CAB+RPV LA between January 2021 and December 2023

		Total (N=142)
Age at initiation (years), n (%)	≥50	77 (54)
	Median (interquartile range, IQR)	52 (43-60)
Sex, n (%)	Male	112 (79)
	Female	29 (20)
	Transgender woman	1 (1)
White ethnicity, n (%)		122 (86)
Body mass index (BMI) (kg/m^2), n (%)	<18.5	3 (2)
	18.5-<25	62 (43)
	25-<30	33 (23)
	30+	12 (8)
Mode of HIV acquisition, n (%)	Men who have sex with men	89 (63)
	Heterosexual	27 (19)
	People who inject(ed) drugs	21 (15)
	Other/unknown	5 (4)
Region of Europe, n (%)	Central West	44 (31)
	Central East	43 (30)
	North	42 (30)
	South	13 (9)
	East	0 (0)
Viral load at initiation (copies/mL), n (%)	<50	127 (89)
	≥50	8 (6)
	Unknown	7 (5)
	Median (IQR)	19 (19-42)
No. of years since HIV diagnosis, median (IQR)		18 (10-27)
No. of years since antiretroviral therapy initiation, median (IQR)		15 (9-24)
History of previous virological failure*, n (%)		64 (45)
History of AIDS defining events, n (%)		25 (18)
People with both HIV and hepatitis C virus, n (%)		3 (2)
People with both HIV and hepatitis B virus**, n (%)		1 (1)

*Previous virological failures included 19 on NNRTI-based regimen and 2 on INSTI-based regimen.
**Hepatitis B surface antigen positive, no HBV-DNA results, started HBV therapy.

Figure 1 Reasons for discontinuation in 10 individuals who discontinued CAB+RPV LA

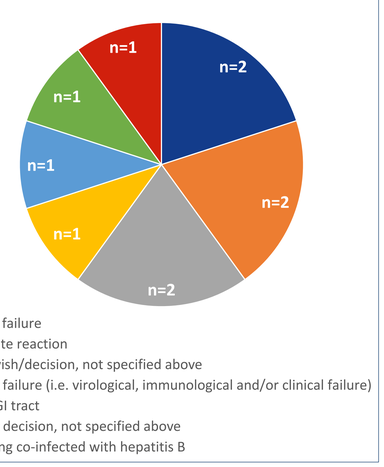


Figure 2 Percentage (and 95% CI) of VL <50 copies/mL at 6, 12, and 24 months after initiating CAB+RPV LA in 108 individuals with VL <50 copies/mL at initiation

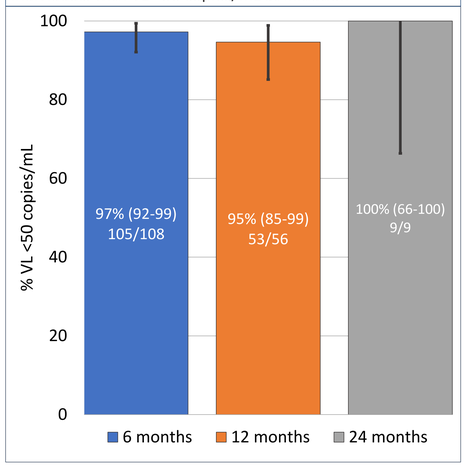
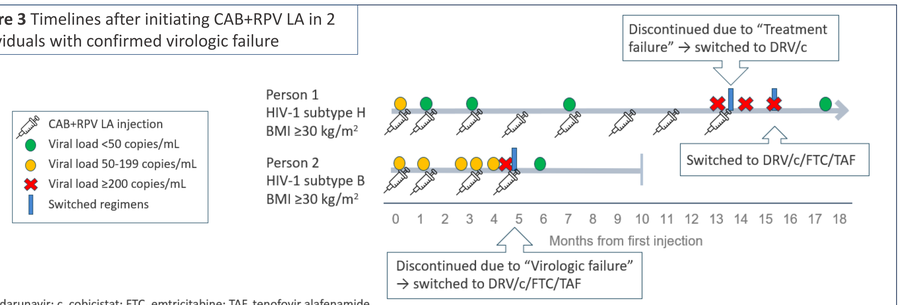


Figure 3 Timelines after initiating CAB+RPV LA in 2 individuals with confirmed virologic failure



DRV, darunavir; c, cobicistat; FTC, emtricitabine; TAF, tenofovir alafenamide

Disclaimer

This content was acquired following an unsolicited medical information enquiry by a healthcare professional. Always consult the product information for your country, before prescribing a ViiV medicine. ViiV does not recommend the use of our medicines outside the terms of their license. In some cases, the scientific Information requested and downloaded may relate to the use of our medicine(s) outside of their license.