

Limiting cumulative HIV viremia copy years by early treatment reduces risk of AIDS and death

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Background: Viremia copy-years (VCY), a time-updated measure of cumulative HIV exposure predicts AIDS/death; although its utility in deciding when to start combination antiretroviral therapy (cART) remains unclear. We aimed to assess the impact of initiating versus deferring cART on risk of AIDS/death by levels of VCY both independent of and within CD4 cell count strata ≥ 500 cells/mm³.

Methods: Using CASCADE data, we created a series of nested –‘trials’ corresponding to consecutive months for individuals ≥ 16 years at seroconversion (SC) after 1995 who were cART-naïve and AIDS-free. Pooling across all ‘trials’, time to AIDS/death by CD4 and VCY strata was compared in those initiating vs. deferring cART using Cox models adjusted for: country, sex, risk group, SC year, age, time since last HIV-RNA, and current CD4, VCY, HIV-RNA, and mean number of previous CD4/HIV-RNA measurements/year.

Results: Of 9,353 individuals, 5312 (57%) initiated cART and 486 (5%) acquired AIDS/died. Pooling CD4 strata, risk of AIDS/death associated with initiating vs. deferring cART reduced as VCY increased. In patients with high CD4 cell counts, ≥ 500 cells/mm³, there was a trend for a greater reduction for those initiating vs. deferring with increasing VCY ($p = 0.09$) with the largest benefit in the VCY $\geq 100,000$ copy-years/mL group (HR (95% CI)= 0.41 (0.19, 0.87)).

Conclusions: For individuals with CD4 ≥ 500 cells/mm³, limiting the cumulative HIV burden to $<100,000$ copy-years/mL through cART may reduce the risk of AIDS/death, supporting recent START trial results suggesting immediate cART initiation vs. waiting until CD4 <350 cells/mm³.

Introduction

While CD4 cell counts are used routinely to monitor adults with HIV infection, viral loads also have an important role in the monitoring and staging of adults with HIV [1, 2]. One or two values of an individual's viral load are often used to determine antiretroviral therapy (cART) failure, their risk of transmitting HIV to others, and to tailor first-line cART regimens [3-5]. However, assessment of an individual's viral load at a single point in time fails to capture cumulative exposure to HIV replication which may have been over a period of 10 years or more. Several investigators have proposed that a measure of cumulative viral burden might provide useful additional information and, in particular, a measurement of viremia copy-years (VCY) has been proposed [6]. VCY is akin to cigarette pack-years when assessing exposure to tobacco; A VCY of 1,000 copy-years/mL is the equivalent to an individual having a viral load of 1,000 copies/mL for an entire year or a viral load of 500 copies/mL for two years. The measurement of VCY has been shown to predict death and AIDS in both the absence [6] and presence [7, 8] of cART, independently of the individual's most recent CD4 count and viral load. This independent association suggests that cumulative HIV burden is associated with an increased risk of development of clinical events through mechanisms other than immunodeficiency.

United States guidelines recommend immediate cART initiation, regardless of CD4 cell count [5, 9] due to evidence that exposure to uncontrolled viremia is associated with an increased risk of death, AIDS, and non-AIDS events [5, 10-12]. The START trial has recently reported that waiting to initiate cART until CD4 <350cells/mm³ increases the likelihood of serious illness or death compared to immediate initiation [13]. VCY serves as a measurement of cumulative exposure to HIV and so it is important to determine if VCY contributes to the likelihood of illness and death and whether cART initiation prior to the accrual of viremia copy-years could help optimise clinical and public health HIV outcomes.

Randomised trials are unlikely to be conducted to determine whether accrual of viremia VCY prior to cART initiation increases mortality because of the difficulty and expertise in enrolling participants

soon after seroconversion, and because cART is now recommended in many asymptomatic populations. Additionally, there is substantial potential for lead-time bias in analyses using VCY due to variability in the extent of HIV replication an individual will have been exposed to prior to enrolment into care. One way to limit this bias is to restrict analyses to participants with serial viral load measurements since a known seroconversion date; such data are available from the CASCADE Collaboration, an international multi-centre collaboration of data from persons with well-estimated dates of HIV seroconversion. Previous analyses of CASCADE data have shown a protective effect of initiating cART on AIDS/death at CD4 <500 cells/mm³ (HR 0.59 (95% CI 0.43-0.81) and HR 0.75 (0.49-1.14) in CD4 cell strata 200-349 and 350-499 respectively), but no evidence for a reduction in risk at CD4 ≥ 500 cells/mm³ (HR 1.10 (0.67-1.79)) [14]. Here we examine the effect of initiating or deferring cART at different levels of VCY on HIV disease progression. We investigate whether or not individuals with CD4 ≥ 500 cells/mm³ but high VCY would benefit from starting cART.

Methods

Study population

Data from CASCADE (Concerted Action on Seroconversion to AIDS and Death in Europe) in EuroCoord (www.EuroCoord.net) 2013 data update were used for this analysis [15]. Briefly, CASCADE is a cohort collaboration of 29 cohorts of individuals with well estimated dates of HIV seroconversion from Europe (94%), Australia (2%), Canada (0.5%), and Sub-Saharan Africa (3%). Date of seroconversion is estimated as the midpoint between the last negative and first positive HIV antibody test results with a maximum of three years between the test dates (85%), laboratory evidence of acute seroconversion (real-time PCR positivity of incomplete Western blot) (13%), the date of seroconversion illness with a negative and positive test no more than three years apart (2%), or by a probability distribution to determine the most likely date of transmission for men with haemophilia infected with HIV following transfusion with clotting factor concentrates (<1% of the sample).

All cohorts contributing to CASCADE received ethical approval from their individual ethics review boards.

Adults (≥ 16 years old) seroconverting in the cART era (post 1995) were included provided they had at least one HIV-RNA measurement between 4 and 12 months following seroconversion. Two sub-Saharan African cohorts were excluded from this analysis as their CD4 cell count and cART initiation patterns are different from those in industrialised country cohorts [16].

Study Design

We created a series of sequential nested ‘trials’ corresponding to consecutive months of follow-up beginning four months post seroconversion, where each month represents the baseline month for a new ‘trial’ (Figure 1). As described previously, this approach allows appropriate adjustment for time-dependent confounding [17, 18]. We created new ‘trials’ with all eligible individuals for each month

between January 1996 and May 2013. Individuals were eligible for a ‘trial’ if they were cART-naïve prior to the baseline month, had a CD4 or HIV-RNA measurement 12 months prior to the baseline month, and were AIDS-free until the end of the baseline month. Time to AIDS/death was compared in those who initiated cART in each baseline month versus those who deferred, pooling across all ‘trials’.

AIDS events in the first year of seroconversion were not considered as disease progression outcomes, but rather as severe seroconversion illness. In addition, invasive candidiasis was not considered an outcome in this analysis as it is typically less severe and associated with longer survival compared to other AIDS-defining conditions [19-22].

Viremia Measurements

If HIV-RNA could be continuously measured within an individual from seroconversion (with the viral load distribution at any time t referred to as $V(t)$), then VCY would be calculated as the area under the HIV-RNA curve, or the integral of HIV-RNA from seroconversion to time $t=T$.

$$VCY = \int_{SC}^T V(t)dt,$$

However, in practice, we do not have continuously measured viral loads, but rather snapshots of HIV-RNA measurements for each individual at irregularly spaced intervals (usually approximately 3-monthly). The best approximation to the integral with the data available can be obtained through use of the trapezoidal rule, which is how we approximated VCY for the remainder of this analysis. At any given time point, J , say, $VCY(J)$ is given by:

$$VCY(J) = \sum_{j=1}^J \frac{\langle t(j) - t(j-1) \rangle * \langle V(j) + V(j-1) \rangle}{2}$$

We examined HIV-RNA data for implausible values and identified three individuals whose HIV-RNA dropped by factors of 4, 26, and 87 between consecutive measurements and without apparently

starting cART. These are far greater drops than would be expected based on the known biological variation of HIV-RNA [23, 24]. As all three individuals were recorded as having started cART in the following month, we assumed that the date of cART initiation had been incorrectly recorded, and reset the cART start dates for these individuals to one month prior to that recorded.

To estimate HIV exposure equally for all individuals, we removed HIV-RNA measurements taken in the first three months of seroconversion, as we were unlikely to capture the well documented peak in viremia shortly after seroconversion [25] for all individuals. Additionally, we assumed that HIV-RNA measurements remained relatively stable over the period 4-12 months (consistent with findings of the viral load stabilising after the initial peak in viremia), allowing us to make the assumption that an individual's first available HIV-RNA over the period 4-12 months was equal to their HIV-RNA at month four.

Data Analysis

We describe baseline characteristics between those that initiated or deferred cART during the study period. We estimated the hazard ratios (HR) for initiating versus deferring cART by levels of viremia copy-years (<10,000 copy-years/mL, ≥10,000-19,999 copy-years/mL, ≥20,000-49,999 copy-years/mL, ≥50,000-99,999 copy-years/mL, ≥100,000 copy-years/mL) pooled across and stratified by CD4 cell count strata (initiate at CD4 <350 cells/mm³ compared to initiate at higher values, ≥350 cells/mm³, and initiate at <500 cells/mm³ compared to initiate at higher values, ≥500 cells/mm³) using Cox proportional hazards models. We adjusted for 'trial'-independent factors including country of care, sex, HIV transmission risk group, seroconversion year, and 'trial'-dependent factors of current age, time since last HIV-RNA measurement, CD4, viremia copy-years, HIV-RNA and mean number of previous CD4/HIV-RNA measurements per year. 'Trial'-dependent factors were ascertained prior to the baseline month to ensure they were measured before the decision to initiate or defer cART in the current month. Continuous variables were modelled using restricted cubic splines, all with three

knots with the exception of current CD4 which was modelled with five knots [26]. Most individuals contributed to more than one 'trial', so we used a robust variance estimator to account for within-person correlation. To investigate whether a threshold existed where cART initiation showed the most benefit, we fitted interactions between initiating cART and viremia copy-years as a continuous variable with a three knot spline.

Furthermore, we investigated if there was a benefit of incorporating other measures of viremia into the decision about when to initiate cART, namely, current HIV-RNA (most recent measurement), average HIV-RNA (mean of all previous measurements), and maximum HIV-RNA (maximum of all previous measurements). In order to compare results between all HIV-RNA measurements with viremia copy-years, we used the same inclusion criteria for all analysis. We used the Akaike information criteria (AIC), a measure of the relative quality of statistical models which evaluates trade-off between model complexity and goodness of fit, to determine which measure of viremia best fit the data [27].

Results

Baseline characteristics

The CASCADE 2013 update contains information on 30,006 individuals, of whom 21,082 seroconverted in the cART era, during or after 1996. Of those, we excluded 916 individuals from African cohorts and 10,813 individuals without at least one cART-naïve HIV-RNA measurement within 4-12 months of seroconversion, leaving 9,353 individuals in the analysis.

Among those seroconverting in the cART era (n=21,082), men who have sex between men (MSM) were slightly overrepresented in this analysis compared to those excluded (80% vs. 62%) and those who likely acquired HIV through sex between men and women (MSW) were slightly underrepresented (9% vs 29%). Date of seroconversion was later in those included in this analysis (Nov 2005 (July 2002- Aug 2008)) than in those excluded (July 2004 (July 2000, March 2008)) explained by availability of routine HIV-RNA measurements within the cohorts. All other baseline characteristics were similar among those included and excluded from this analysis, (data not shown).

Of 9,353 individuals, 5,312 (57%) initiated cART, 326 (3%) acquired AIDS and 160 (2%) died. Median (interquartile range (25th - 75th percentile - (IQR)) follow-up was 4.1 (1.8, 7.2) years. Most individuals were male (85%) and modes of HIV transmission included sex between men (71%), sex between men and women (21%), injection drug use (4%), and unknown (4%). Median (IQR) CD4 at cART initiation was 342 (265, 450) cells/mm³ and did not vary by viremia copy-year category. Median (IQR) seroconversion age was 33 (27, 40) years between 1996 and 2013. Individuals contributed to a median (IQR) of 21 (13, 36) 'trials'.

Individuals who initiated cART typically had much lower CD4 cell counts and higher HIV-RNA values than those deferring cART. Males were also more likely to defer in the lower viral copy-years strata (**Table 1**).

Viremia copy-years

Pooling across CD4 cell count strata, hazard ratios for the effect of initiating cART compared to deferring on time to AIDS/death significantly decreased as VCY increased (p-trend < 0.001). For example, at times when the VCY was in the range 10,000-20,000 copy-years/mL, there was only a modest 9% reduction in the hazard of AIDS/death associated with immediate initiation of cART compared to deferral (HR = 0.91 (95% CI 0.57, 1.46)), whereas at times when the VCY was >100,000 copy-years/mL, the estimated reduction in risk of AIDS/death associated with immediate versus deferred initiation was 56% (HR = 0.44 (95% CI 0.35, 0.55)), **Table 2**. Among individuals initiating with CD4 \geq 350 cells/mm³, there was a modest trend (p=0.11) towards a greater benefit of immediate of cART (vs. deferral), although the results continued to suggest some benefit of earlier initiation among the group with VCY > 100,000 copy-years/mL (HR = 0.68 (95%CI 0.49, 0.94)), **Table 2**. As expected among individuals initiating with CD4 < 350 cells/mm³, immediate initiation was beneficial in all VCY categories (all HR < 1), **Supplementary Table 1**.

Modelling initiation of cART by viremia copy-years as a continuous variable showed the same trends as the categorical analysis, **Figure 2**. No obvious threshold of copy-years was found; however, pooling CD4 cell count categories, the upper bound of the 95% confidence interval first fell below one when VCY passed 17,343 copies-years/mL, suggesting that among, individuals with VCY values above this threshold, immediate initiation of cART may result in a reduction in the risk of AIDS/death. Stratifying by CD4 cell count, in those with CD4 \geq 350 cells/mm³, the upper bound of the 95% confidence interval fell below one when VCY surpassed 52,826 copy-years/mL, again suggesting that among individuals with high CD4 cell counts and VCY values above this threshold, immediate initiation of cART may result in a reduction in the risk of AIDS/death.

Utilising a CD4 count threshold of 500 cells/mm³ showed similar results. For those with CD4 \geq 500 cells/mm³, the greatest benefit of initiation was seen when VCY >100,000 copy-years/mL (HR = 0.41 (0.19, 0.87), p-trend = 0.09), **Table 2**. Modelling VCY continuously, the upper bound of the 95% confidence interval in those with CD4 \geq 500 cells/mm³ fell below one when VCY surpassed 38,152

copy-years/mL. In those with a CD4 count < 500 cells/mm³ there was an overall benefit of treatment initiation in VCY categories > 10,000 copy-years/mL, Supplementary Table 1.

Other measures of viremia

Pooling CD4 strata the hazard ratios for the effect of initiating cART on time to AIDS/death decreased as most recent HIV-RNA increased (p-trend < 0.001) with the largest benefit of initiation seen when current HIV-RNA exceeded 100,000 copies/mL (HR = 0.45 (0.36, 0.57)). Among individuals with a CD4 count ≥ 350 cells/mm³, there was a modest trend (p-trend = 0.08) for an increased benefit of immediate initiation (vs. deferral) as the current HIV-RNA increased, with the largest benefit of immediate initiation seen if the current HIV-RNA was > 100,000 copies/mL (HR = 0.65 (0.47, 0.89)), **Table 2**. Stratifying by CD4, there was a benefit of initiating versus deferring for all individuals with CD4 < 350 cells/mm³ regardless of current HIV-RNA level, as expected from the VCY analysis. The same trends were seen when modelling VCY and current HIV-RNA continuously, **Figure 2**, and when considering average and maximum viremia (data not shown).

Utilising a CD4 threshold of 500 cells/mm³, similar results were obtained for the average and maximum viremia (data not shown).

Pooling CD4 strata, model fit was best for viremia copy-years (minimum AIC, 230115) compared to current (increase in AIC = 238), average (increase in AIC = 124) and maximum HIV-RNA (increase in AIC = 163). Maximum HIV-RNA fit the model best in the CD4 <500 cells/mm³ strata (minimum AIC, 1024345; increase in AIC = 32, 128, 15 for VCY, current and average HIV-RNA respectively, for copyyears, current, average and maximum HIV-RNA, respectively). In the CD4 ≥ 500 cells/mm³ strata, viremia copy-years gave the best model fit (minimum AIC = 113258.00, increase in AIC = 196, 84, for current, average and maximum HIV-RNA, respectively).

Discussion

Pooling CD4 cell count strata, there is a benefit of initiating cART as the cumulative and absolute HIV-RNA increases, with benefits observed as the total VCY exceeds about 17,500 copy-years/mL. What is of clinical interest, however, is whether there is benefit of immediate cART initiation in individuals with healthy immune systems ($CD4 \geq 500$ cells/mm³) and high levels of viraemia. Among individuals with $CD4 \geq 500$ cells/mm³, we found a modest benefit of earlier cART initiation for those with high cumulative and absolute HIV-RNA > 100,000 copy-years/mL and copies/mL, associated with reducing risk of AIDS/death by 59% (13%, 81%) and 62% (23%, 81%). Our results support the recent evidence from the START trial[28] which found serious illness or death was reduced by 53% among those treated immediately vs waiting to initiate until CD4 cell count dropped below 350 cells/mm³[13].

All measures of viremia showed consistent and similar results with an increased benefit of cART initiation with increasing VCY. Among the pooled and separate CD4 cell count strata, there was not a single viremia measure that consistently showed best model fit using AIC. Viremia copy-years fit best when pooling CD4 and in the $CD4 \geq 350$ cells/mm³ strata, whereas average viremia fit best in the $CD4 < 350$ cells/mm³ strata. Although viremia copy-years incorporates cumulative HIV burden, it requires frequent HIV-RNA measurements from the start of infection, which are not available in most HIV positive individuals. Even if such measurements are available, cumulative viremia is difficult and time consuming to calculate. Average and maximum HIV-RNA also require frequent measurements from seroconversion, so too are not relevant for most HIV positive individuals. Current HIV-RNA, however, is a measure that is easily obtained from all HIV positive individuals and is therefore of greatest clinical relevance.

Although observational studies are not designed to inform the 'when to start' question, we provide evidence that cART initiation is beneficial when CD4 cell counts fall below 350 cells/mm³, supporting other observational studies [14, 29-31]. The START trial has recently reported a modest absolute risk

reduction of AIDS, other serious illnesses and death for cART initiation at CD4 cell counts above 500 cells/mm³ [11] compared with deferring initiation to CD4 below 350 cells/mm³ [13]. Our analysis, using data prior to guidelines recommending immediate cART initiation, suggests that benefit is likely to be greatest in those with highest viremia burden and adds to the body of evidence which informs clinical guidelines [32].

We reflected the dynamic process of initiating cART by allowing individuals to contribute information to multiple 'trials' rather than just considering a single point in time. This provided estimates of the average benefit of initiating cART compared to deferring cART at particular levels of CD4 cell counts and cumulative exposure to HIV-RNA. Our estimates can therefore be used to inform trade-offs between initiating treatment at varying points in disease progression compared with the lifelong challenges of initiating therapy, such as adherence and adverse effects.

The availability of HIV-RNA data from HIV seroconversion allowed us to investigate when to start treatment based on a variety of measures of viremia captured during the life course of HIV infection. Of particular importance, there is potential for lead-time bias [33] when measuring cumulative exposure to viremia in sero-*prevalent* cohorts which is essentially eliminated in this sero-*converter* study as we have serial HIV-RNA measurements taken from the date of seroconversion. This is, therefore, the first study, to our knowledge, that has compared the benefit of cART initiation by these levels of viremia in combination with CD4 cell count. Nevertheless, despite nearly 10,000 seroconverters being included, we were not able to assess the impact of initiating versus deferring within the CD4 strata where decisions on whether cART should be initiated have previously been most controversial (CD4>350 cells/mm³).

In addition to AIDS and death, there are several other non-AIDS defining conditions that can affect morbidity and mortality. Increased exposure to viremia has been shown to be associated with cardiovascular disease [34], multimorbidity [35], and AIDS and non AIDS malignancies [5, 36, 37], so

had these data been available, our estimates could have shown a stronger benefit of cART initiation. CASCADE does not currently collect data on non AIDS-conditions.

Like all observational studies, our estimates rely on the assumption of no unmeasured confounding. We adjusted for some of the most important factors in deciding when to initiate therapy, but it is possible that other unmeasured factors, such as comorbidities or likelihood of adherence, played a role in the initiation of cART in our population. The hazard ratios above one for cART initiation versus deferred treatment, albeit with wide confidence intervals, in the group with low current HIV-RNA suggest we may lack information on some confounders; this could be a particular concern among those with a CD4 count ≥ 350 cells/mm³, a group for which not all treatment guidelines recommended initiation of cART during the study period.

It is unlikely that randomised evidence will ever be available on when to initiate cART by these measures of viremia, so applying robust statistical methods to large observational data sets presented here will likely provide the best evidence that will ever be available. Our data suggest that deferring cART in an individual unwilling or unable to start treatment immediately may not impact the risk of AIDS/death provided a healthy CD4 cell count (≥ 350 , 500 cells/mm³) and low viremia copy years ($< 50,000$ copy-years/mL) are maintained. However, we found consistently that AIDS and death were delayed among those that initiated treatment with CD4 cell counts ≥ 350 cells/mm³ and VCY $> 100,000$ copy-years/mL.

Table 1: Baseline characteristic for individuals who initiated or deferred cART by levels of viremia copy-years

Characteristic	Initiated cART	Deferred cART
<i>VCY < 10,000 copy-years/mL</i>		
'Trial' observations N	651	50,349
Follow-up, median (IQR) person years	3.3 (1.4, 6.8)	4.2 (2.1, 7.0)
Male N (%)	398 (61%)	38,869 (77%)
Seroconversion year	2005 (2000, 2009)	2004 (2001, 2007)
Seroconversion age	30 (26, 37)	33 (27, 39)
CD4 cell count median (IQR) mm ³	397 (291, 567)	637 (486, 826)
HIV-RNA copies/mL median (IQR) ‡	3.7 (3.2, 4.1)	3.4 (3.0, 3.8)
Viremia copy-years median (IQR) ‡	3.6 (3.2, 3.8)	3.5 (3.0, 3.8)
<i>VCY ≥ 10,000 -19,999 copy-years/mL</i>		
'Trial' observations N	488	22825
Follow-up, median (IQR) person years	3.0 (1.4, 6.0)	4.0 (2.0, 6.6)
Male N (%)	382 (78%)	19,348 (85%)
Seroconversion year	2006 (2002, 2009)	2005 (2002, 2007)
Seroconversion age	33 (26, 40)	32 (27, 39)
CD4 cell count median (IQR) mm ³	360 (282, 475)	553 (437, 707)
HIV-RNA copies/mL median (IQR) ‡	4.3 (3.9, 4.6)	4.1 (3.7, 4.4)
Viremia copy-years median (IQR) ‡	4.2 (4.1, 4.2)	4.2 (4.1, 4.2)
<i>VCY ≥ 20,000 -49,999 copy-years/mL</i>		
'Trial' observations N	1026	39675
Follow-up, median (IQR) person years	3.3 (1.4, 6.6)	3.9 (1.9, 6.5)
Male N (%)	853 (83%)	34804 (88%)
Seroconversion year	2006 (2001, 2008)	2004 (2002, 2007)
Seroconversion age	34 (28, 41)	33 (27, 39)
CD4 cell count median (IQR) mm ³	355 (277, 466)	523 (417, 662)
HIV-RNA copies/mL median (IQR) ‡	4.6 (4.3, 4.9)	4.3 (3.9, 4.6)
Viremia copy-years median (IQR) ‡	4.5 (4.4, 4.6)	4.5 (4.4, 4.6)
<i>VCY ≥ 50,000 -99,999 copy-years/mL</i>		
'Trial' observations N	950	30925
Follow-up, median (IQR) person years	3.1 (1.4, 5.7)	3.8 (1.8, 6.2)
Male N (%)	837 (88%)	27,657 (89%)
Seroconversion year	2005 (2002, 2008)	2004 (2002, 2006)
Seroconversion age	33 (27, 41)	33 (27, 39)
CD4 cell count median (IQR) mm ³	340 (272, 440)	492 (393, 628)
HIV-RNA copies/mL median (IQR) ‡	4.8 (4.4, 5.1)	4.5 (4.2, 4.8)
Viremia copy-years median (IQR) ‡	4.9 (4.8, 4.9)	4.8 (4.8, 4.9)
<i>VCY ≥ 100,000 copy-years/mL</i>		
'Trial' observations N	2,102	44,581
Follow-up, median (IQR) person years	3.5 (1.6, 5.6)	3.9 (1.8, 6.2)
Male N (%)	1,928 (92%)	41,702 (94%)
Seroconversion year	2005 (2002, 2007)	2004 (2001, 2006)
Seroconversion age	35 (29, 42)	33 (28, 40)
CD4 cell count median (IQR) mm ³	320 (246, 411)	467 (370, 591)
HIV-RNA copies/mL median (IQR) ‡	5.2 (4.8, 5.5)	4.9 (4.5, 5.2)
Viremia copy-years median (IQR) ‡	5.3 (5.2, 5.6)	5.3 (5.1, 5.5)

Abbreviations: HR – hazard ratio; IQR – 25th and 75th percentiles

‡ log₁₀ copies/mL

Table 2: The effect of initiation compared to deferring cART on time to AIDS/death by viremia copy-years alone by CD4 cell count strata (≥ 350 , ≥ 500 cells/mm³)

	All patients			CD4 ≥ 350 cells/mm ³			CD4 ≥ 500 cells/mm ³		
	Events (N)	HR (95% CI)	p, AIC	Events (N)	HR (95%CI)	p, AIC	Events (N)	HR (95%CI)	p
VCY (copy-years/mL)									
< 10,000	198	1.10 (0.74, 1.63)	*0.001	181	1.04 (0.63, 1.73)	*0.51	138	0.81 (0.36, 1.80)	*0.56
10,000-20,000	202	0.91 (0.57, 1.46)	†<0.001	175	0.79 (0.40, 1.58)	†0.11	116	0.96 (0.37, 2.52)	†0.09
20,000-50,000	260	0.69 (0.50, 0.94)	‡230115.30	227	0.88 (0.61, 1.29)	‡186803.80	166	0.70 (0.37, 1.31)	‡113258.00
50,000-100,000	242	0.56 (0.40, 0.80)		206	0.60 (0.36, 1.01)		146	0.45 (0.18, 1.09)	
>100,000	225	0.44 (0.35, 0.55)		182	0.68 (0.49, 0.94)		117	0.41 (0.19, 0.87)	
Curent HIV-RNA (copies/mL)									
< 10,000	180	1.14 (0.81, 1.61)	*0.001	167	1.37 (0.89, 2.09)	*0.03	161	‡ 0.86 (0.46, 1.61)	*0.40
10,000-20,000 ‡	140	0.63 (0.36, 1.08)	†<0.001	121	0.54 (0.22, 1.33)	†0.08	-	-	†0.08
20,000-50,000	211	0.53 (0.37, 0.76)	‡230353.40	182	0.55 (0.34, 0.89)	‡187014.80	132	0.58 (0.28, 1.23)	‡113454.30
50,000-100,000	202	0.62 (0.45, 0.86)		163	0.80 (0.57, 1.25)		107	0.61 (0.28, 1.31)	
>100,000	202	0.45 (0.36, 0.57)		195	0.65 (0.47, 0.89)		120	0.38 (0.19, 0.77)	

Abbreviations: HR – hazard ratio; cART – combination antiretroviral therapy

*p-heterogeneity (df = 4)

†p-trend (df = 1)

‡ AIC - Akaike information criterion

‡ by chance, there were no failures among initiators in the CD4 ≥ 500 cells/mm³, VCY 10,000-20,000 category so this category is <20,000 copies/mL

Supplementary Table 1: The effect of initiation compared to deferring cART on time to AIDS/death by viremia copy-years by CD4 cell count strata (<350, <500 cells/mm³)

	CD4 < 350 cells/mm ³			CD4 < 500 cells/mm ³		
	Events (N)	HR (95%CI)	p, AIC	Events (N)	HR (95%CI)	p
VCY (copy-years/mL)						
< 10,000	36	0.90 (0.47, 1.71)	*0.11	99	1.09 (0.69, 1.72)	*0.03
10,000-20,000	42	0.80 (0.42, 1.54)	†0.01	109	0.76 (0.44, 1.30)	†0.001
20,000-50,000	58	0.45 (0.25, 0.81)	‡33593.28	147	0.75 (0.52, 1.08)	‡102466.00
50,000-100,000	75	0.50 (0.31, 0.81)		146	0.62 (0.42, 0.91)	
>100,000	113	0.39 (0.29, 0.53)		186	0.46 (0.37, 0.59)	
Current HIV-RNA (copies/mL)						
< 10,000	45	0.72 (0.40, 1.31)	*0.56	101	0.99 (0.66, 1.50)	*0.05
10,000-20,000	40	0.57 (0.28, 1.13)	†0.09	89	0.73 (0.42, 1.26)	†0.01
20,000-50,000	67	0.50 (0.30, 0.84)	‡33524.76	140	0.55 (0.37, 0.83)	‡102562.60
50,000-100,000	72	0.48 (0.30, 0.77)		133	0.65 (0.46, 0.93)	
>100,000	106	0.41 (0.30, 0.57)		184	0.49 (0.38, 0.62)	

Abbreviations: HR – hazard ratio; cART – combination antiretroviral therapy

*p-heterogeneity

†p-trend

‡ AIC- Akaike information criterion

Figure 1: A diagram of the ‘trials’ construction. Individuals are assessed for eligibility at the beginning of each month (respective trial baseline). Each eligible individual is classified as having initiated or deferred cART in the baseline month. Time is measured from the beginning of the following month until AIDS, death or censoring for each eligible individual (excluding any with an outcome during the baseline month). Cox proportional hazards models are used to assess the effect of initiating compared to deferring cART on time to AIDS/death, pooled across all ‘trials’.

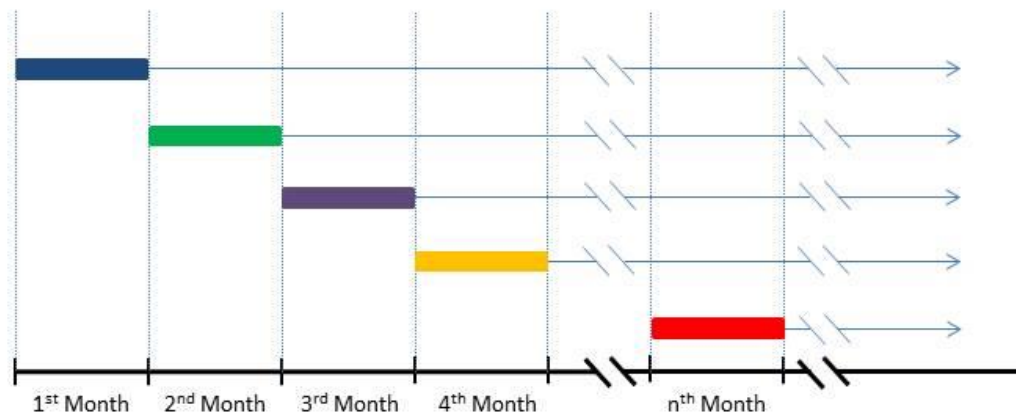
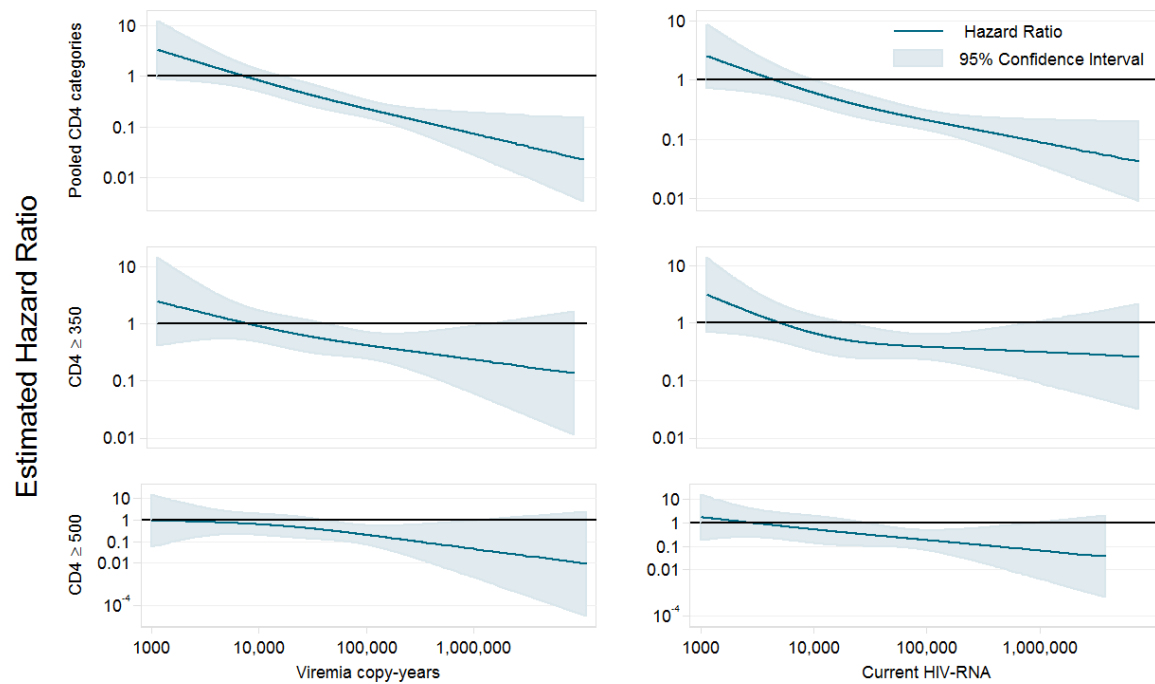


Figure 2: The effect of initiating compared to deferring cART on time to AIDS/death by viremia copy-years and CD4 cell count modelled continuously with three knot splines using the CASCADE dataset



References

1. Mellors JW, Margolick JB, Phair JP, Rinaldo CR, Detels R, Jacobson LP, *et al.* Prognostic value of HIV-1 RNA, CD4 cell count, and CD4 Cell count slope for progression to AIDS and death in untreated HIV-1 infection. *JAMA* 2007,**297**:2349-2350.
2. Mellors JW, Munoz A, Giorgi JV, Margolick JB, Tassoni CJ, Gupta P, *et al.* Plasma viral load and CD4+ lymphocytes as prognostic markers of HIV-1 infection. *Ann Intern Med* 1997,**126**:946-954.
3. Attia S, Egger M, Muller M, Zwahlen M, Low N. Sexual transmission of HIV according to viral load and antiretroviral therapy: systematic review and meta-analysis. *AIDS* 2009,**23**:1397-1404.
4. Murray JS, Elashoff MR, Iacono-Connors LC, Cvetkovich TA, Struble KA. The use of plasma HIV RNA as a study endpoint in efficacy trials of antiretroviral drugs. *AIDS* 1999,**13**:797-804.
5. Zoufaly A, Stellbrink HJ, Heiden MA, Kollan C, Hoffmann C, van Lunzen J, *et al.* Cumulative HIV viremia during highly active antiretroviral therapy is a strong predictor of AIDS-related lymphoma. *J Infect Dis* 2009,**200**:79-87.
6. Cole SR, Napravnik S, Mugavero MJ, Lau B, Eron JJ, Jr., Saag MS. Copy-years viremia as a measure of cumulative human immunodeficiency virus viral burden. *Am J Epidemiol* 2010,**171**:198-205.
7. Mugavero MJ, Napravnik S, Cole SR, Eron JJ, Lau B, Crane HM, *et al.* Viremia copy-years predicts mortality among treatment-naïve HIV-infected patients initiating antiretroviral therapy. *Clin Infect Dis* 2011,**53**:927-935.
8. Wright ST, Hoy J, Mulhall B, O'Connor C C, Petoumenos K, Read T, *et al.* Determinants of viremia copy-years in people with HIV/AIDS after initiation of antiretroviral therapy. *J Acquir Immune Defic Syndr* 2014,**66**:55-64.
9. Gunthard HF, Aberg JA, Eron JJ, Hoy JF, Telenti A, Benson CA, *et al.* Antiretroviral treatment of adult HIV infection: 2014 recommendations of the International Antiviral Society-USA Panel. *JAMA* 2014,**312**:410-425.
10. El-Sadr WM, Lundgren J, Neaton JD, Gordin F, Abrams D, Arduino RC, *et al.* CD4+ count-guided interruption of antiretroviral treatment. *N Engl J Med* 2006,**355**:2283-2296.
11. Lundgren JD, Babiker A, El-Sadr W, Emery S, Grund B, Neaton JD, *et al.* Inferior clinical outcome of the CD4+ cell count-guided antiretroviral treatment interruption strategy in the SMART study: role of CD4+ Cell counts and HIV RNA levels during follow-up. *J Infect Dis* 2008,**197**:1145-1155.
12. Reekie J, Gatell JM, Yust I, Bakowska E, Rakhmanova A, Losso M, *et al.* Fatal and nonfatal AIDS and non-AIDS events in HIV-1-positive individuals with high CD4 cell counts according to viral load strata. *AIDS* 2011,**25**:2259-2268.
13. National Institute of Allergy and Infectious Diseases (NIAID). Starting Antiretroviral Treatment Early Improves Outcomes for HIV-Infected Individuals. In; May 2015 (Accessed June 18, 2015).
14. Timing of HAART initiation and clinical outcomes in human immunodeficiency virus type 1 seroconverters. *Arch Intern Med* 2011,**171**:1560-1569.
15. de Wolf F, Sabin C, Kirk O, Thorne C, Chene G, Porter K. Developing a multidisciplinary network for clinical research on HIV infection: the EuroCoord experience. *Clinical Investigation* 2012,**2**:255-264.
16. Pantazis N, Morrison C, Amornkul PN, Lewden C, Salata RA, Minga A, *et al.* Differences in HIV natural history among African and non-African seroconverters in Europe and seroconverters in sub-Saharan Africa. *PLoS One* 2012,**7**:e32369.

17. Hernan MA, Alonso A, Logan R, Grodstein F, Michels KB, Willett WC, *et al.* Observational studies analyzed like randomized experiments: an application to postmenopausal hormone therapy and coronary heart disease. *Epidemiology* 2008,**19**:766-779.
18. Writing Committee for the CASCADE Collaboration. Timing of HAART initiation and clinical outcomes in human immunodeficiency virus type 1 seroconverters. *Arch Intern Med* 2011,**171**:1560-1569.
19. Mocroft A, Oancea C, van Lunzen J, Vanhems P, Banhegyi D, Chiesi A, *et al.* Decline in esophageal candidiasis and use of antimycotics in European patients with HIV. *Am J Gastroenterol* 2005,**100**:1446-1454.
20. Lundgren JD, Pedersen C, Clumeck N, Gatell JM, Johnson AM, Ledergerber B, *et al.* Survival differences in European patients with AIDS, 1979-89. The AIDS in Europe Study Group. *BMJ* 1994,**308**:1068-1073.
21. Luo K, Law M, Kaldor JM, McDonald AM, Cooper DA. The role of initial AIDS-defining illness in survival following AIDS. *AIDS* 1995,**9**:57-63.
22. Mocroft AJ, Lundgren JD, d'Armino Monforte A, Ledergerber B, Barton SE, Vella S, *et al.* Survival of AIDS patients according to type of AIDS-defining event. The AIDS in Europe Study Group. *Int J Epidemiol* 1997,**26**:400-407.
23. Bartlett JA, DeMasi R, Dawson D, Hill A. Variability in repeated consecutive measurements of plasma human immunodeficiency virus RNA in persons receiving stable nucleoside reverse transcriptase inhibitor therapy or no treatment. *J Infect Dis* 1998,**178**:1803-1805.
24. Brambilla D, Reichelderfer PS, Bremer JW, Shapiro DE, Hershow RC, Katzenstein DA, *et al.* The contribution of assay variation and biological variation to the total variability of plasma HIV-1 RNA measurements. The Women Infant Transmission Study Clinics. Virology Quality Assurance Program. *AIDS* 1999,**13**:2269-2279.
25. Pantaleo G, Graziosi C, Fauci AS. New concepts in the immunopathogenesis of human immunodeficiency virus infection. *N Engl J Med* 1993,**328**:327-335.
26. Durrleman S, Simon R. Flexible regression models with cubic splines. *Stat Med* 1989,**8**:551-561.
27. Akaike H. A new look at the statistical model identification. *Automatic Control, IEEE Transactions on* 1974,**19**:716-723.
28. University of Minnesota - Clinical and Translational Science Institute Strategic Timing of Antiretroviral Treatment (START). Available from: <https://clinicaltrials.gov/ct2/show/results/NCT00867048>; NLM Identifier: NCT00867048. In.
29. Kitahata MM, Gange SJ, Abraham AG, Merriman B, Saag MS, Justice AC, *et al.* Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med* 2009,**360**:1815-1826.
30. Cain LE, Logan R, Robins JM, Sterne JA, Sabin C, Bansi L, *et al.* When to initiate combined antiretroviral therapy to reduce mortality and AIDS-defining illness in HIV-infected persons in developed countries: an observational study. *Ann Intern Med* 2011,**154**:509-515.
31. Sterne JA, May M, Costagliola D, de Wolf F, Phillips AN, Harris R, *et al.* Timing of initiation of antiretroviral therapy in AIDS-free HIV-1-infected patients: a collaborative analysis of 18 HIV cohort studies. *Lancet* 2009,**373**:1352-1363.
32. Sabin CA, Cooper DA, Collins S, Schechter M. Rating evidence in treatment guidelines: a case example of when to initiate combination antiretroviral therapy (cART) in HIV-positive asymptomatic persons. *AIDS* 2013,**27**:1839-1846.
33. Cole SR, Li R, Anastos K, Detels R, Young M, Chmiel JS, *et al.* Accounting for leadtime in cohort studies: evaluating when to initiate HIV therapies. *Stat Med* 2004,**23**:3351-3363.
34. Calmy A, Gayet-Ageron A, Montecucco F, Nguyen A, Mach F, Burger F, *et al.* HIV increases markers of cardiovascular risk: results from a randomized, treatment interruption trial. *AIDS* 2009,**23**:929-939.

35. Salter ML, Lau B, Go VF, Mehta SH, Kirk GD. HIV infection, immune suppression, and uncontrolled viremia are associated with increased multimorbidity among aging injection drug users. *Clin Infect Dis* 2011,**53**:1256-1264.
36. Bruyand M, Thiebaut R, Lawson-Ayayi S, Joly P, Sasso AJ, Mercie P, *et al.* Role of uncontrolled HIV RNA level and immunodeficiency in the occurrence of malignancy in HIV-infected patients during the combination antiretroviral therapy era: Agence Nationale de Recherche sur le Sida (ANRS) CO3 Aquitaine Cohort. *Clin Infect Dis* 2009,**49**:1109-1116.
37. Guiguet M, Boue F, Cadranet J, Lang JM, Rosenthal E, Costagliola D. Effect of immunodeficiency, HIV viral load, and antiretroviral therapy on the risk of individual malignancies (FHDH-ANRS CO4): a prospective cohort study. *Lancet Oncol* 2009,**10**:1152-1159.

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