A Case Series of Acquired Drug Resistance-Associated Mutations in Human Immunodeficiency Virus-Infected Children: An Emerging Public Health Concern in Rural Africa

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The acquisition of drug-resistance mutations among African children living with human immunodeficiency virus on antiretroviral treatment has been scarcely reported. This threatens the overall success of antiretroviral programs and the clinical outcomes of children in care. We present a well characterized series of children from rural Tanzania with acquired drug-resistance mutations to contribute to the better understanding of this emerging public health concern.

Keywords. Africa; antiretroviral treatment; children; HIV; resistance mutations.

There are few data on the acquisition of drug-resistance mutations among African children living with human immunodeficiency virus (HIV) on antiretroviral treatment (ART). Overall, in resource-limited settings, HIV-1 treatment failure in children is estimated to be 40% [1]. Virologic suppression and long-term treatment success are harder to achieve in children than in adults [2]. This is mostly due to high pre-ART viral loads (VLs), poorer virologic response, and risk of subtherapeutic drug concentrations caused by limited pediatric drug formulations, variable pharmacokinetics, and rapid changes in body weight [1, 3–7]. These factors, often associated with suboptimal adherence, may promote the emergence of drug-resistance mutations. Only 1 study from Kenya has described the pattern of acquired drug-resistance mutations in African children presenting ART failure [5, 8]. In Tanzania, a small study found a virologic failure (VF) rate of 58%, 100% with drug-resistance mutations [9].

The emergence of acquired drug-resistance mutations in children threatens ART programs in sub-Saharan Africa and needs to be studied further. We present a well characterized series of children from a rural Tanzanian setting with treatment failure due to the acquisition of drug-resistance mutations.

MATERIAL AND METHODS

Study Setting and Population

The children in this study attended the Chronic Diseases Clinic of Ifakara (CDCI), in the Saint Francis Referral Hospital. The CDCI works in cooperation with the Ifakara Health Institute, the Swiss Tropical and Public Health Institute, and the University Hospitals of Basel and Bern. Patients attending the CDCI are offered informed consent to be enrolled in the Kilombero and Ulanga Antiretroviral Cohort (KIULARCO) [10]. The KIULARCO study received ethical clearance from the corresponding ethical review boards in Tanzania and Switzerland. This is the largest peripheral HIV cohort in Tanzania with almost 8000 patients. In January 2013, a pediatric and prevention of mother-to-child transmission (PMTCT) unit, named “The One Stop Clinic of Ifakara”, was established within the CDCI. By March 2015, 340 children and adolescents were under active follow-up. Care and treatment for patients were provided according to the National AIDS Control Program. CD4 counts were used to routinely monitor the ART response. Viral load was requested by clinicians after treatment failure was suspected due to poor immunological or clinical evolution. In case VL was suspected, HIV drug-resistance genotyping was performed.

Clinical Data

At each visit, clinical, laboratory, and pharmacy data were collected electronically. Adherence was estimated using self-reported adherence and pill counting and considered “suboptimal” if <95% of the prescribed pills had been taken. The individual prescriptions were reviewed to assess their adequacy. For children transferred from other facilities, ART dosage was checked by direct observation of their drugs at the enrollment visit.

Viral Load and Genotypic Resistance Testing

Blood samples were collected in 8 mL BD Vacutainer EDTA collection tubes. Plasma HIV RNA VL and HIV drug-resistance genotypes were determined at the Ifakara Health Institute laboratory. Cell-free plasma was collected by centrifugation at 956...
relative centrifugal force for 5 minutes and frozen at −80°C until testing for VL or drug-resistance genotyping. Human immunodeficiency virus RNA from plasma was extracted using the QIAamp Viral RNA Mini Kit (QIAGEN, Hilden, Germany), following the manufacturer’s protocol. Viral RNA quantification was performed with the TaqMan RNA-to-CT 1-Step Kit (Life Technologies) using the StepOne Real-Time PCR system (Life Technologies), with a detection limit of 200 viral RNA copies/mL. Human immunodeficiency virus drug-resistance genotyping was performed by Sanger sequencing on an ABI Genetic Analyzer (4-capillary model 3130) using a validated in-house polymerase chain reaction protocol [11]. Human immunodeficiency virus-1 drug resistance was predicted according to the Stanford University’s HIV Drug Resistance Database Program version 6.2.0 (http://hivdb.stanford.edu).

RESULTS

We present a series of children with acquired drug-resistance mutations: 10 of 12 enrolled in the CDCI at HIV diagnosis and 2 of 12 (#11, #12) transferred to our clinic after ART initiation. Six patients (#1–#6) were identified through a previous cross-sectional analysis within KIULARCO. The remaining 6 children were identified prospectively after presenting unsatisfactory evolution: patients #7, #8, and #9 presented poor CD4 increase, although they did not meet the World Health Organization (WHO) criteria of immunological failure; patient #10 presented clinical failure; patient #11 had been exposed to low doses of antiretrovirals; and patient #12 presented with both immunological and clinical failure.

Clinical Characteristics

The clinical characteristics of the patients are summarized in Table 1. Median age at ART initiation was 6.4 years (interquartile range [IQR], 5.3–9.4). Ten children were orphans. None was diagnosed through a PMTCT program or had documented exposure to PMTCT. Remarkably, 10 of 12 children were born before 2006, the year in which the first PMTCT intervention was scaled-up to our district. All children were initiated on a non-nucleoside reverse-transcriptase inhibitor (NNRTI)-based regimen. During follow-up, 7 of 12 had been exposed to more than 1 first-line regimen, mostly due to unavailability of drugs. In 3 of 7 cases, children were switched back and forth more than once. Only 1 child (#12) was treated for tuberculosis before presenting treatment failure. Median time on ART at the time when VF was detected was 3.7 years (IQR, 3.2–5.3). Most of the patients (11 of 12) presented VL > 1000 copies/mL. Suboptimal adherence was common (7 of 12). Information about the correctness of the antiretroviral dosages prescribed was available for 10 of 12, and 7 of 10 had been exposed to subtherapeutic doses for periods ranging from 2 months to 3 years. All prescription errors were due to failure to adjust the doses to the current weight, affecting in most cases all the regimen drugs. Only 4 of 12 children met the WHO criteria for clinical and/or immunological failure: patients #6 and #12 presented both immunological and clinical failure with persistent CD4 levels below 100 cell/mm³ and severe malnutrition; patient #4 had persistent CD4 levels below 100 cell/mm³; and patient #10 presented clinical failure due to severe malnutrition, and although the CD4 evolution was unsatisfactory he did not meet the WHO criteria for immunological failure.

Genotypic Resistance Profile

Ten children carried virus with double resistance to NNRTIs and nucleoside/nucleotide reverse-transcriptase inhibitors (NRTIs). None harbored major resistance to protease inhibitors (PIs) (Table 1).

Pre-ART plasma samples were available for 7 of 10 patients enrolled at HIV diagnosis. None of them presented pre-ART drug-resistance mutations, suggesting that they developed these mutations after treatment initiation. For another patient (#9), diagnosed together with her mother after cessation of breastfeeding, a pre-ART sample from the mother did not show resistance-associated mutations. The remaining 4 children presented history of poor adherence and/or underdosage of drugs, rendering the acquisition of resistance mutations likely.

Outcome

All patients were switched to a PI boosted with ritonavir (PI/r) + 2 NRTIs regimen. Based on the resistance testing, the regimens prescribed contained no predicted active NRTI in 5 of 12 cases, and 1 predicted active NRTI in 6 of 12 cases. Only 1 patient obtained a regimen with 2 active NRTIs.

By the time of the analysis, 6 of 12 children were under active follow-up and had completed 6 months of second-line ART with good self-reported adherence and compatible pill counting, 2 of 12 had not completed 6 months on the PI/r-based regimen, 1 of 12 had interrupted ART repeatedly, 2 of 12 had been transferred, and 1 had stopped ART (Table 1).

Viral load was performed in 4 of 6 children who had completed 6 months on second-line ART, and 3 of 4 presented satisfactory VL reduction. The remaining patient, aged 17, presented a VL 5-fold higher than the one when VF was detected, but HIV genotyping showed no drug-resistance mutations, suggesting low compliance with ART.

DISCUSSION

This case series raises concern about a scarcely reported emerging public health concern in sub-Saharan Africa. To our knowledge, only 1 study from Kenya has described the pattern of
### Table 1. Clinical Characteristics and Antiretroviral Drug-Resistance Mutations of 12 Children Living With HIV in Rural Tanzania

<table>
<thead>
<tr>
<th>Child</th>
<th>Age at ART Initiation (Years)</th>
<th>Orphan Status</th>
<th>Baseline HIV Genotyping</th>
<th>CD4 Count in Cell/mm³ (and %) at ART Initiation</th>
<th>1st-Line ART Regimens Prescribed</th>
<th>Number of 1st-Line ART Switches</th>
<th>History of Suboptimal Adherence</th>
<th>Under Dosage of Drugs</th>
<th>Time on ART When DRM Detected (Years)</th>
<th>VL at the Time of Treatment Failure Detection (Copies/mL)</th>
<th>NNRTI Resistance Mutations</th>
<th>NRTI Resistance Mutations</th>
<th>2nd-Line Regimens</th>
<th>VL ≥ 6 Months After Switched to 2nd-Line Regimens (Copies/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4.5</td>
<td>Maternal</td>
<td>No DRM</td>
<td>238 (7%)</td>
<td>d4T/3TC/NVP</td>
<td>N/A</td>
<td>Yes</td>
<td>Yes</td>
<td>4.6</td>
<td>5396</td>
<td>A98G, K103N, V108I, K238T</td>
<td>M41L, V75M, M184V, L210W, T215Y</td>
<td>TDF/FTC/ LPV/r</td>
<td>Not done a</td>
</tr>
<tr>
<td>2</td>
<td>4.9</td>
<td>Double</td>
<td>No DRM</td>
<td>425 (13%)</td>
<td>d4T/3TC/NVP, AZT/3TC/NVP, TDF/3TC/EFV</td>
<td>3</td>
<td>No</td>
<td>Yes</td>
<td>3.4</td>
<td>330</td>
<td>Y181C</td>
<td>M184V</td>
<td>TDF/FTC/ LPV/r</td>
<td>Undetectable</td>
</tr>
<tr>
<td>3</td>
<td>13.2</td>
<td>Non-orphan</td>
<td>No DRM</td>
<td>317 (10%)</td>
<td>AZT/3TC/EFV, TDF/3TC/EFV</td>
<td>1</td>
<td>Yes</td>
<td>No</td>
<td>2.7</td>
<td>22 071</td>
<td>V90I, K103N, P225H</td>
<td>Y115F, M184V</td>
<td>TDF/ATV/r</td>
<td>N/A b</td>
</tr>
<tr>
<td>4</td>
<td>6.1</td>
<td>Paternal</td>
<td>No DRM</td>
<td>152 (12%)</td>
<td>d4T/3TC/NVP</td>
<td>N/A</td>
<td>No</td>
<td>Yes</td>
<td>1.2</td>
<td>174 546</td>
<td>A98G, K103N, V108I, K238T</td>
<td>M41L, V75M, L210W, T215Y</td>
<td>TDF/FTC/ LPV/r</td>
<td>345</td>
</tr>
<tr>
<td>5</td>
<td>11.7</td>
<td>Paternal</td>
<td>No DRM</td>
<td>124 (12%)</td>
<td>d4T/3TC/NVP, AZT/3TC/NVP</td>
<td>1</td>
<td>Yes</td>
<td>No</td>
<td>3.3</td>
<td>1340</td>
<td>K101E, Y181C, H221Y</td>
<td>–</td>
<td>TDF/ATV/r</td>
<td>N/A c</td>
</tr>
<tr>
<td>6</td>
<td>11.5</td>
<td>Paternal</td>
<td>No DRM</td>
<td>16 (1%)</td>
<td>AZT/3TC/EFV, AZT/3TC/NVP</td>
<td>2</td>
<td>Yes</td>
<td>Yes</td>
<td>4.0</td>
<td>22 623</td>
<td>K103KN</td>
<td>M184I, L210LW</td>
<td>TDF/FTC/ LPV/r</td>
<td>124 278</td>
</tr>
<tr>
<td>7</td>
<td>8.7</td>
<td>Double</td>
<td>Not done d</td>
<td>375 (12%)</td>
<td>AZT/3TC/EFV</td>
<td>N/A</td>
<td>No</td>
<td>Yes</td>
<td>5.8</td>
<td>1478</td>
<td>–</td>
<td>M184V</td>
<td>TDF/ATV/r</td>
<td>N/A d</td>
</tr>
<tr>
<td>8</td>
<td>6.6</td>
<td>Maternal</td>
<td>No DRM</td>
<td>331 (10%)</td>
<td>AZT/3TC/EFV</td>
<td>N/A</td>
<td>Yes</td>
<td>N/A</td>
<td>3.3</td>
<td>31 000</td>
<td>L100I, Y188L</td>
<td>M184V</td>
<td>TDF/ATV/r</td>
<td>N/A e</td>
</tr>
<tr>
<td>9</td>
<td>0.8</td>
<td>Non-orphan</td>
<td>Not done d</td>
<td>66 (2%)</td>
<td>d4T/3TC/NVP, AZT/3TC/NVP</td>
<td>2</td>
<td>No</td>
<td>No</td>
<td>5.1</td>
<td>5648</td>
<td>K101E, G190A, T68L, V75M, M184V, L210W, T215Y</td>
<td>M41L, D67N, V75M, M184V, L210W, T215Y</td>
<td>TDF/ATV/r</td>
<td>Undetectable</td>
</tr>
<tr>
<td>10</td>
<td>5.4</td>
<td>Maternal</td>
<td>Not done d</td>
<td>201 (3%)</td>
<td>d4T/3TC/NVP, AZT/3TC/EFV</td>
<td>1</td>
<td>Yes</td>
<td>N/A</td>
<td>7.0</td>
<td>3775</td>
<td>V90I, K103N, V108I, K238T</td>
<td>M41L, D67G, K70R, V75M, M184V, L210W, T215F, K219E</td>
<td>TDF/ATV/r</td>
<td>N/A f</td>
</tr>
<tr>
<td>11</td>
<td>5.8</td>
<td>Double</td>
<td>N/A f</td>
<td>158 (no % information)</td>
<td>AZT/3TC/EFV</td>
<td>N/A</td>
<td>Yes</td>
<td>Yes</td>
<td>1.8</td>
<td>Not done a</td>
<td>A98AG, K101P, K103N, E138AE</td>
<td>M184V, T215F</td>
<td>TDF/ATC/ LPV/r</td>
<td>Not done a</td>
</tr>
</tbody>
</table>
CONCLUSIONS

In conclusion, after a decade of successful rollout of ART in Africa, children and adolescents still represent an underprivileged group in terms of access to appropriate treatment, with barriers such as suboptimal adherence being frequently overlooked. Importantly, 8 of 12 children did not meet the WHO criteria of clinical or immunological failure, despite presenting with high VL. Awareness needs to be raised among health workers, and tools to facilitate the prescription of pediatric formulations need to be widely disseminated and routinely used [14].

It is possible that the mutations in the pre-ART plasma genotype did not show DRMs. The patient interrupted ART 3 times since switched to second-line ART. Pre-ART sample was not available.

Importantly, 8 of 12 children did not meet the WHO criteria of clinical or immunological failure, despite presenting with high VL. Awareness needs to be raised among health workers, and tools to facilitate the prescription of pediatric formulations need to be widely disseminated and routinely used [14].

Several studies have shown that the rates of virologic suppression after switching to a PIs + 2NRTIs regimen remain high despite the implementation of integrase inhibitors such as dolutegravir in pediatric ART programs in resource-limited settings [11]. The inclusion of new drugs, such as dolutegravir, in clinical trial PENTA 20 (www.clinicaltrials.gov) may provide key information to support its rollout in Africa. Furthermore, we have identified a frequently overlooked factor: the prescription of inadequate doses of antiretroviral drugs. Awareness needs to be raised among health workers, and tools to facilitate the prescription of pediatric formulations need to be widely disseminated and routinely used [14].

Finally, it is possible that the mutations in the pre-ART plasma genotype did not show DRMs. The patient interrupted ART 3 times since switched to second-line ART. Pre-ART sample was not available.

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population. Antiretroviral treatment coverage is lower and failure rates are higher than in adults. Children living with HIV have peculiarities and needs that must be acknowledged by the often overwhelmed health workers, and specific policies targeting the pediatric population should be implemented. Moreover, VL is not available in most African treatment centers, leading invariably to a late recognition of failure and development of multiclass drug-resistance mutations. New classes of antiretrovirals and their adequate pediatric formulation are urgently needed to ensure the long-term survival of millions of children living with HIV in sub-Saharan Africa.

Acknowledgments

We acknowledge the collaboration of Joelle Bader, who performed the viral load and human immunodeficiency virus genotyping of some of the samples. Moreover, we are grateful to the children and caregivers who are part of this case series and all the staff of the Chronic Diseases Clinic of Ifakara.


Financial support. This work was supported by the funders of the Chronic Diseases Clinic of Ifakara and its Paediatric and PMTCT unit, the One Stop Clinic: the Ministry of Health and Social Welfare of Tanzania; the Swiss Tropical and Public Health Institute; the Ifakara Health Institute; the Government of the Canton of Basel; the United States Agency for International Development; and the Merck for Mothers Global Giving Program.

Potential conflicts of interest. All authors: No reported conflicts. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest.

References