clinical cases DDIs

Date of report 08 May 2019

Reported case interaction between **Cobicistat** and **Bosentan**

Drugs suspected to be involved in the DDI

Victim
Cobicistat

Daily Dose
150 (mg)

Dose adjustment performed
No

Administration Route
Oral

Start date
April 1, 2018

End date
Sept. 1, 2018

Perpetrator
Bosentan

Daily Dose
250 (mg)

Dose adjustment performed
No

Administration Route
Oral

Start date
April 1, 2018

End date
Sept. 1, 2018

Complete list of drugs taken by the patient

Antiretroviral treatment

Darunavir/Cobicistat
Raltegravir

Complete list of all comedications taken by the patient, included that involved in the DDI

Bosentan (125 mg twice daily), Tadalafil (20 mg once daily)

Clinical case description

Gender

Female

Age

55

eGFR (mL/min)

Hemodialysis

Liver function impairment

No

Description

HIV/HCV co-infected patient with pulmonary arterial hypertension (PAH) and end-stage renal disease (ESRD) on chronic hemodialysis (3 times per week). In April 2018, after completing 8 weeks of HCV treatment with glecaprevir/ pibrentasvir, cART was switched from raltegravir (400 mg twice daily) plus rilpivirine (25 mg once daily) to raltegravir plus darunavir/cobicistat (800/150 mg once daily). In addition, the patient re-started taking bosentan (125 mg twice daily) plus tadalafil (20 mg once daily) for PAH (this had been temporarily stopped during HCV treatment). In September 2018 the patient presented with severe respiratory failure and clinical signs compatible with decompensated heart failure. Despite increasing the negative fluid balance in each dialysis session, the response to hemodialysis was poorer than expected, suggesting additional determinants of her clinical

situation. In addition, virologic failure was evidenced (HIV-1 RNA load in plasma of 5,424 copies/mL), with new drug resistance mutations in the integrase gene (N155H) not present in previous genotypes. After ruling out other conditions, bosentan toxicity (probably because excessive exposure to bosentan due to drug interactions between bosentan and darunavir/cobicistat) was considered. Bosentan was replaced by ambrisentan, with progressive improvement in the clinical condition of the patient. Additionally, cART was optimized to darunavir/ritonavir (800/100 mg once daily) plus etravirine (200 mg twice daily) and dolutegravir (50 mg twice daily), and HIV RNA in plasma was re-suppressed (<40 copies/ml).

Clinical Outcome

Loss of efficacy

Drug Interaction Probability Scale (DIPS)

Score

5 - Probable

Editorial Comment

Bosentan induces CYP3A4 activity, which is the main metabolic pathway for both darunavir and cobicistat. Consequently, combining bosentan with darunavir/cobicistat plus raltegravir could have resulted in functional monotherapy with raltegravir, leading to the virological failure

and the development of new resistance mutations observed in this patient. (Bosentan (Tracleer) prescribing information. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/209279s000lbl.pdf)

University of Liverpool Recommendation

■ Potential interaction - may require close monitoring, alteration of drug dosage or timing of administration

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