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cases (2% vs. 7%, $p = 0.005$). The rates of vegetations (69% vs. 81%) and mitral involvement (26% vs. 39%) were significantly lower in HIV-positive patients. Cardiac surgery was less frequent in HIV-infected patients (26% vs. 48%, $p < 0.001$), but in-hospital and one-year mortality rates were similar in both groups. In the propensity analysis, complications (heart failure, stroke, systemic embolisms and persistent bacteraemia) were similar in patients and controls. However, cardiac surgery was significantly lower in HIV-infected patients (26% vs. 52%, $p = 0.004$) without significant differences in in-hospital mortality (20% vs. 14%, $p = 0.45$) and one-year mortality (36% vs. 26%, $p = 0.26$).
Conclusions: Compared to the general population with IE, HIV-infected IE patients are younger and predominantly male and have a different comorbidity pattern. Although HIV infection did not influence the prognosis, these patients had less access to cardiac surgery.

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Switching from tenofovir disoproxil fumarate to tenofovir alafenamide and hepatic safety: a new paradigm?

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Background: A switch from tenofovir disoproxil fumarate (TDF) to tenofovir alafenamide (TAF) was associated with a better renal and bone profile. Some studies reported liver toxicity due to TDF [1,2]. We aimed at investigating the effect of switching TDF to TAF on lipid, renal and hepatic safety profile.
Methods: Consecutive HIV patients (pts) enrolled in Surveillance Cohort Long-term Toxicity Antiretrovirals/Antivirals (SCOLTA) project switching from TDF/FTC/EVG/COBI to TAF/FTC/EVG/COBI for any reasons were included. Changes from baseline (T0) to six-month follow-up (T1) were evaluated using paired *t*-test if differences were normally distributed (blood lipids, estimated glomerular filtration rate [eGFR]), and using signed rank test if not (liver enzymes).
Results: One hundred and eighty-eight pts switched from TDF/FTC/EVG/COBI to TAF/FTC/EVG/COBI, and 100 had at least one six-month follow-up. They were 79% male, 76% at CDC stage A–B, 97% with undetectable HIV viral load, 36% on second ART regimen. Mean age was 45.1 ± 10.6 years, body mass index 24.5 ± 3.3 kg/m^2, total cholesterol (TC) 193 ± 37 mg/dL, HDL cholesterol (HDL) 54 ± 40 mg/dL, eGFR 88 ± 18 mL/min, median CD4 cell count 716 cells/μL (interquartile range [IQR] 513 to 914), ART duration 5.6 (IQR 2.0 to 12.2) years, AST 23 (IQR 19 to 30) IU/L and ALT 24 (IQR 18 to 33) IU/L. Sixteen pts were positive for HCV-Ab and 10 pts for HbsAg. TDF/FTC/EVG/COBI duration before switch was 827 days (range 41 to 1610). At T1, we observed increased TC (+13 ± 26 mg/dL, $p < 0.001$) and LDL cholesterol (LDL) (+8 ± 28 mg/dL, $p < 0.05$) while HDL, triglycerides (TG) and TC/HDL ratio remained stable. At T1, both ALT (median -2, IQR −7 to 2 IU/L, $p = 0.009$) and AST (median -1, IQR −2 to 5 IU/L, $p = 0.02$) were significantly reduced. AST and ALT reduction remained significant in HCV-/HbsAg- patients. Among 16 pts with ALT >40 IU/L, a significant proportion reduced this parameter (median change −23.5, −38.5 to −13.5, $p < 0.0001$). In details 11 pts normalised ALT, four pts had a reduction without normalisation and one no variation. At T1, eGFR showed a slight increase (+2.6 ± 13.0 mL/min, $p = 0.05$).
Conclusions: Switching from TDF/FTC/EVG/COBI to TAF/FTC/EVG/COBI in a real-life setting was associated with an improvement in eGFR, with increased TC and LDL, and stable HDL, TC/HDL ratio and TG. A significant reduction of ALT and AST, especially in pts without HBV and/or HCV infection, was observed. Further studies are needed to confirm a better liver safety of TAF versus TDF.

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E-vaccine registry: systematic vaccine registry improves immunisation coverage in HIV patients

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Background: Infections represent a significant threat for HIV patients, with higher attack rates and an increased risk for severe and complicated illness, especially when CD4 counts fall below 200 cells/mm^3. Despite existing recommendations, HIV patients may not be immune to vaccine-preventable diseases due to immunisation schedules not being systematically reviewed during routine consultations, as well as concerns over vaccinal side effects and efficacy in this immunocompromised population. The aim of this study is to evaluate the impact of an electronic vaccine record on the immunisation status of HIV patients in Geneva.
Materials and methods: In this controlled before-and-after cohort study, a total of 328 HIV patients were enrolled between 1 May 2016 and 10 April 2018 at the Infectious Diseases Division of the University Hospitals of Geneva. A vaccinology consultation was offered systematically to all adult patients. After oral consent, vaccine history was taken and immunisation status documented in a national electronic immunisation registry (www.myvaccines.ch), which was accessible by the collaborators of the HIV Division, the patients themselves and their general practitioners. Vaccine status was assessed by an expert clinical decision support system (CDSS) embedded in the registry and based on age, gender, risk factors, registered vaccines and serologies. Incomplete immunisation was defined by the CDSS according to national guidelines. The catch-up immunisation plan generated by the CDSS was then implemented during follow-up visits.
Results: Of the 328 patients, 152 (46%) were enrolled in 2018. [EN4] The cohort had a median age of 49 years (range 13 to 85) and a male-to-female gender ratio of 2.22. CD4 counts were >200 cells/mm^3 in 296/323 (90%). At enrolment, past HBV infection was documented in 106 (32%) patients, 101 (31%) had been immunised and