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Striking differences in weight gain after cART initiation depending on early or advanced presentation: Results from the ANRS CO4 FHDH cohort

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80

81 **Running title:** Weight gain according to clinical presentation

82 **SYNOPSIS**

83

84 **Introduction:** Many studies have reported weight gain in ART-naïve people living with HIV (PWH)
85 initiating an integrase strand-transfer inhibitor-based regimen. We studied the impact of early or
86 advanced presentation and that of individual drugs in PWH initiating combined ART (cART) between
87 2012 and 2018.

88 **Methods:** From the French Hospital Database on HIV cohort, we assessed factors associated with a
89 weight gain \geq 10%, weight change after cART initiation or BMI increase \geq 5kg/m² up to 30 months. The
90 analyses were conducted overall, among PWH with early (primary infection or CD4 $>$ 350/mm³ and
91 viral load $<$ 100000 copies/mL, without AIDS), and advanced presentation (AIDS or CD4 $<$ 200/mm³, not
92 during primary infection).

93 **Results:** At 30 months, 34.5% (95%CI 33.5-35.6) of the 12,773 PWH had a weight gain \geq 10%, 20.9%
94 (95%CI 19.6-22.2) among the 5,794 with early presentation and 63.1% (95%CI 60.9-65.3) among the
95 3,106 with advanced presentation. Weight gain was 2.8 kg (95% confidence-interval (CI) 2.0-3.7) for
96 those with early presentation and 9.7 kg (95%CI 8.4-11.1) for those with advanced presentation.
97 Most weight gain occurred in the first 12 months. Underweight and obese PWH were at significantly
98 higher risk of BMI increase \geq 5kg/m² than normal-weight PWH. Results differed within classes and by
99 outcome. Raltegravir and dolutegravir were consistently associated with greater weight gain than the
100 other third agents. Tenofovir-alafenamide was also associated with higher weight gain than
101 **tenofovir-disoproxil** or abacavir.

102 **Discussion:** After initiating cART, PWH with early presentation exhibited a small weight gain, whereas
103 it was large among those with advanced presentation. The choice of ART should account for the risk
104 of weight gain, especially for PWH who present with advanced disease and/or are obese.

105

106 INTRODUCTION

107 In recent recommendations for people living with HIV (PWH),^{1, 2} the antiretroviral combination
108 prescribed at initiation should include an integrase strand-transfer inhibitor (INSTI). However, two
109 clinical trials conducted in sub-Saharan Africa (SSA) reported greater weight gain with dolutegravir
110 than efavirenz, especially with dolutegravir combined with tenofovir, alafenamide, and emtricitabine
111 (TAF/FTC).³⁻⁵ Among studies conducted in high-income countries, many observational studies and
112 pooled analyses of clinical trials have assessed the impact of treatment initiation on weight gain by
113 the class of the third agent and found greater weight gain with INSTIs than non-nucleoside reverse-
114 transcriptase inhibitors (NNRTIs) and divergent results with protease inhibitors (PIs).⁶⁻⁹ Only a small
115 number of studies have assessed specific drugs.¹⁰ Differences in weight gain between INSTIs were
116 found but also similar weight gain.⁶⁻¹¹ Greater weight gain was observed with TAF/FTC than with
117 tenofovir disoproxil and emtricitabine (TDF/FTC)^{7, 8, 10, 11}. In parallel, recent studies have shown the
118 capacity of dolutegravir and raltegravir to induce adipocyte hypertrophy, adipose tissue fibrosis, and
119 insulin resistance.¹²⁻¹⁴ Weight gain in PWH raises concerns about the potential associated increased
120 risk of cardiovascular and metabolic diseases and mortality^{15, 16}. A large meta-analysis in the general
121 population showed that an increase in body-mass index (BMI) of 5 kg/m² is associated with a 30%
122 increase in the risk of death.¹⁷

123 In most studies, factors such as sex, race, BMI at the initiation of treatment, CD4 T-cell levels, HIV-1
124 viral load (VL), and prior acquired immunodeficiency syndrome (AIDS), were shown to be associated
125 with weight gain in treatment-naïve PWH, in addition to the type of drugs. However, the association
126 between weight gain and clinical presentation (early or advanced) was not specifically explored,
127 although the initial signal came from two trials that included many people with advanced HIV
128 disease.^{3,4} The return-to-health phenomenon could confuse the effect of treatment on weight gain.

129 In this context, we aimed to study the factors associated with weight gain in ART-naïve PWH initiating
130 combined antiretroviral treatment (cART) in France between 2012 and 2018 according to clinical

131 presentation (early or advanced) and each component of the treatment combination using a large
132 cohort of PWH, the ANRS CO4-French Hospital Database on HIV (FHDH) cohort.

133

134 **MATERIALS AND METHODS**

135 **Participants**

136 The ANRS CO4 FHDH (French Hospital Database on HIV) is an ongoing open hospital cohort that
137 collects clinical, biological, and therapeutic data of adult PWH since 1989.¹⁸ Currently, more than 180
138 hospitals contribute to the data collection, 206,651 PWH have been included, and 102,030 were
139 being followed in 2018. All participants provided written informed consent for the use of their data
140 for research purposes. The cohort was initially approved by the French data protection authority, the
141 CNIL (Commission Nationale de l'Informatique et des Libertés) on 27 November 1991 (Official
142 Journal, 17 January 1992). The research authorisation was updated to comply with the new
143 regulations, including the General Data Protection Regulation. The ANRS CO4-FHDH cohort was
144 approved by the CEREES (Comité d'Expertise pour les Recherches, les Études et les Évaluations dans
145 le domaine de la Santé) on 20 July 2018 and as a hospital data warehouse by the CNIL on 19 February
146 2021. The cohort received the authorisation to conduct research projects on the data warehouse by
147 the CNIL on 30 March 2021.¹⁹

148

149 For the present analysis, we selected ART-naïve PWH infected with HIV-1 who initiated cART
150 between 2012 and 2018. Participants had to have had at least one BMI measurement within six
151 months prior to cART initiation (baseline) and one during the follow-up and to have initiated cART at
152 least one year before the last recorded FHDH visit in the centre. We excluded transgender
153 participants because of the interaction of hormone therapy with weight and pregnant women were
154 censored at the time of pregnancy. Only participants with cART combinations taken by at least 140
155 PWH were considered.

156

157 **Statistical analysis**

158 In addition to the whole population, we choose to study two contrasting groups, PWH with early or
159 with advanced presentation, to better assess the differential impact of treatment initiation according
160 of HIV disease stages and with the hypothesis that the issue of return to health would be less
161 pronounced in PWH presenting early.

162 PWH presenting early were defined as participants initiating cART at primary infection or with CD4 T
163 cells $>350/\text{mm}^3$ and a VL <100000 copies/mL and without AIDS at cART initiation and PWH
164 presenting with advanced HIV disease as participants with AIDS or CD4 T cells $<200/\text{mm}^3$ not at
165 primary infection at cART initiation.

166 As primary endpoint, we considered the rates of weight gain of at least 10%, which is often
167 considered to be clinically significant,²⁰ and as secondary endpoints weight change after cART
168 initiation and BMI increase $\geq 5\text{kg}/\text{m}^2$. Rates of weight gain of at least 10% and BMI increase $\geq 5\text{kg}/\text{m}^2$
169 were estimated at 30 months using Kaplan Meier estimates. Follow-up was censored at treatment
170 modification, at the last available weight measurement, or at 30 months, whichever occurred first.
171 We assessed the factors associated with these endpoints using Cox regression models adjusted for
172 gender-age class (women >50 years, women ≤ 50 years, men >50 years, men ≤ 50 years), transmission
173 group (men who have sex with men (MSM) versus others), geographic origin (Sub-Saharan Africa
174 (SSA) versus other), baseline CD4 T cells (<200 , 200-350, 350-500, $\geq 500/\text{mm}^3$), baseline VL (50-
175 30,000, 30,000-100,000, 100,000-500,000, ≥ 500000 copies/mL), AIDS status (tuberculosis, AIDS-
176 defining cancer, other AIDS diagnosis or no AIDS), and BMI category (underweight ($<18.5\text{ kg}/\text{m}^2$),
177 normal weight (18.5-24.9), overweight (25-29.9), obesity (≥ 30)). The gender-age class categories
178 were chosen because previous data showed that weight/fat gain was higher among women >50
179 years of age, probably due to their menopausal status.²¹

180 In the models, we separately considered the nucleoside analogue backbones (TDF/FTC, TAF/FTC,
181 abacavir and lamivudine (ABC/3TC)) and the third antiretroviral agent (raltegravir, dolutegravir, or
182 elvitegravir for INSTIs; darunavir or atazanavir for PIs; and efavirenz or rilpivirine for NNRTIs). A

183 sensitivity analysis excluding participants presenting with AIDS was conducted for the primary
184 endpoint.

185 The association between weight change and time since cART initiation was assessed using a mixed
186 linear model with a spatial power law covariance structure to account for irregular duration between
187 clinical visits²² and adjusted for the same variables as previously described.

188 All analyses were conducted overall and separately in two subgroups according to early presentation
189 or advanced presentation, except for the factors associated with an increase in BMI of at least 5
190 kg/m². The change in BMI pattern was assessed in the two subgroups in the first 30 months (± 1.5
191 months). All statistical analyses were conducted using SAS 9.4. A p-value $\leq 5\%$ denoted statistical
192 significance.

193

194 RESULTS

195 Overall, 12,773 ART-naïve PWH initiating cART between 2012 and 2018 were included, accounting for
196 28,737 person-years (median 1.76 years (interquartile range (IQR), 0.71-3.32)). Among them, 5,794
197 presented with an early HIV disease and 3,106 with an advanced HIV disease, with a median follow-
198 up of 2.05 (IQR, 0.84-3.74) and 1.44 (IQR, 0.56-2.90) years, respectively. The median number of
199 weight measurements was 5 (IQR 3-7), with no difference according to the clinical presentation nor
200 the baseline category of BMI. Participants' characteristics are presented in Table 1. Overall, 75.6% of
201 the population was men and MSM accounted for approximately half of the participants. A quarter of
202 the population originated from SSA. At cART initiation, the median CD4 T-cell level was 377/mm³,
203 median VL 4.7 log copies/mL, and median BMI 23.0 kg/m² (IQR, 20.7-25.8). At cART initiation, 8.2% of
204 the participants were obese and 22.2% overweight: 20.6% and 30.7% for women originating from
205 SSA, 8.8% and 29.6% for men originating from SSA, 15.3% and 23.2% for other women, and 4.2% and
206 18.8% for other men, respectively.

207 Among the total population (Table 1), 41.7% initiated cART with a PI-based regimen, mostly with
208 darunavir, 33.3% with an INSTI-based regimen, mostly with dolutegravir or elvitegravir, and 25.0%
209 with a NNRTI-based regimen, mostly rilpivirine. TDF/FTC was the most frequently used backbone
210 (78.2%), whereas only 1,989 (15.6%) PWH received ABC/3TC and 800 (6.3%) TAF/FTC. The number of
211 participants receiving each specific cART combination is presented in Table S1.

212 The characteristics differed highly according to advanced or early presentation. PWH with advanced
213 presentation were older (median 42 versus 36 years), less likely to be MSM (29.0% versus 57.1%),
214 more likely to have originated from SAA (36.3% versus 20.3%), more likely to be underweight (12.6%
215 versus 5.0%), and more likely to have received a PI-based regimen (56.2% versus 30.5%) and less
216 likely an INSTI-based regimen (11.6% versus 35.7%).

217 ***Weight gain of at least 10%***

218 At 30 months, 34.5% (95%CI 33.5-35.6) of the PWH had a weight gain of at least 10%, 20.9% (95%CI
219 19.6-22.2) among PWH with early presentation and 63.1% (95%CI 60.9-65.3) among those with
220 advanced presentation (Table 2-4). Higher risks were observed for women, non-MSM, underweight
221 PWH, and those with more profound immunodeficiency, higher VL, and prior AIDS, with no
222 difference between AIDS-defining events. In the overall population, the percentage of PWH with a
223 weight gain of at least 10% at 30 months ranged from 20.9% among those receiving rilpivirine to
224 44.3% among those receiving raltegravir. In adjusted analyses, PWH initiating cART with dolutegravir
225 or raltegravir had a higher risk of a weight gain of at least 10% than those initiating with other drugs,
226 except PIs, with no significant differences between them. Those initiating with efavirenz had a lower
227 risk of a weight gain of at least 10% than with the other drugs, except rilpivirine (Table S2a). TAF/FTC
228 was associated with a significantly higher risk of weight gain of at least 10% than TDF/FTC (HR=1.52,
229 95%CI 1.29-1.79) or ABC/3TC (HR=1.61, 95%CI 1.31-1.96), whereas there was no statistical difference
230 between ABC/3TC and TDF/FTC (HR=0.95, 95%CI 0.84-1.06) (Table 2).

231 Among early-presenters, the percentage of weight gain of at least 10% ranged from 11% with
232 efavirenz to 27% with ATV/RTV. In adjusted analyses, there was no statistical difference among the

233 various INSTIs or between PIs, or between INSTIs and PIs. Detailed results are reported in Table 3 and
234 Table S5a. Among PWH with advanced HIV disease, the percentage of weight gain of at least 10%
235 ranged from 37% with rilpivirine to 74% with raltegravir. Detailed results are reported in Tables 4 and
236 Table S5b.

237 In the sensitivity analysis excluding participants presenting with AIDS (Table S7), the proportion of
238 participants with a weight gain of at least 10% was 30.9% instead of 34.5% in the whole population.
239 The results of the Cox model evaluating the factors associated with this weight gain were similar to
240 those of the analysis of the whole sample.

241 ***Weight change overtime***

242 The mean weight changes estimated by multivariable mixed regression models at 12, 24 and 30
243 months are presented in Table 5 for the total population. At 30 months, the adjusted mean weight
244 gain was +7.9 kg (95% confidence interval [CI] 7.1-8.6). Most of the weight gain occurred in the first
245 12 months. ~~The weight plateaued after 24 months.~~ Weight gains were significantly larger among
246 women, PWH originating from SSA, non-MSM, underweight PWH, and those with more profound
247 immunodeficiency, higher VL, and prior AIDS, with no difference between AIDS-defining events. The
248 results and comparisons according to the various drugs are presented in Table S2b and Figure 1a for
249 third agents and Figure 1b for nucleoside backbones. Over 30 months, the adjusted weight gain was
250 the highest for PWH receiving dolutegravir (+8.7 kg) and raltegravir (+8.5 kg) and the lowest for those
251 receiving efavirenz (+6.5 kg). Weight gain with raltegravir was significantly greater than that with
252 efavirenz, whereas there was no statistical difference with any other third agent. Weight gain with
253 dolutegravir was significantly greater than that with darunavir, atazanavir, rilpivirine, or efavirenz.
254 Weight gain with TAF/TDF was greater than that with TDF/FTC ($p<0.0001$) and ABC/3TC ($p=0.05$), and
255 weight gain with ABC/3TC was greater than that with TDF/FTC ($p=0.04$) (Figure 1b and Table S2b).

256 Weight gain varied highly according to whether PWH initiated cART early or at advanced HIV disease.
257 Among early-presenters, the adjusted mean weight gain at 30 months was +2.8 kg ranging from 1.8

258 kg for efavirenz to 3.5 kg for dolutegravir. Detailed results are reported in Figure 1c and 1d and Table
259 S3.

260 Among PWH with advanced HIV disease, the adjusted mean weight gain was +9.7 kg at 30 months,
261 the detailed results are reported in Figure 1e and 1f and Table S4. Over 30 months, the adjusted
262 weight gain was the highest for PWH receiving dolutegravir (+10.9 kg), raltegravir (+10.6 kg), or
263 atazanavir (+10.2 kg) and the lowest for those receiving elvitegravir (+8.4 kg) (Figure 1e and Table
264 S4).

265

266

267 ***BMI increase and BMI categories over time***

268 Overall, 9.1% of participants (95%CI 8.5-9.8) had a BMI increase of at least 5 kg/m², 3.4% (95%CI 2.8-
269 4.0) among those presenting early and 23.9% (95%CI 21.9-26.1) among those with advanced HIV
270 disease. In adjusted analyses, a higher risk of a BMI increase of at least 5 kg/m² was observed with
271 raltegravir than with any other drugs, except dolutegravir, and with TAF/FTC than with TDF/FTC
272 (HR=1.68, 95%CI 1.19-2.38) or ABC/3TC than with TDF/FTC (HR=1.28, 95%CI 1.02-1.61) (Table S6a
273 and S6b). For the other factors, the association with a BMI increase of at least 5 kg/m² was in the
274 same direction as in the other analyses, except for BMI. The risk of a BMI increase of at least 5 kg/m²
275 was higher for both underweight (HR=1.33, 95%CI 1.07-1.67) and obese participants (HR=1.26, 95%CI
276 0.98-1.61).

277 The pattern of BMI categories over time was stable among PWH presenting early but changed for
278 PWH with advanced HIV disease, with more obese PWH, especially for those receiving raltegravir,
279 dolutegravir, or atazanavir (Figures S1 and S2).

280

281

282 DISCUSSION

283 In this observational study, a small weight gain over 30 months was observed among ART-naïve PWH
284 presenting early in the course of HIV disease, whereas it was large among those presenting with
285 advanced HIV disease, with a mean increase of 2.8 kg and 9.7 kg, respectively. At 30 months, 34.5%
286 of the PWH had a weight gain of at least 10% and 9.1% a BMI increase of at least 5k g/m². Among
287 those presenting early, 20.9% had a weight gain of at least 10% and 3.4% a BMI increase of at least 5
288 kg/m², whereas among those presenting with advanced HIV disease, the corresponding values were
289 63.1% and 23.9%, respectively. The weight gain trajectories were similar for the early and advanced
290 presenters, with most of the weight gain occurring during the first year. Concerning the drugs
291 received, the results differed within each class and varied by outcome (a weight gain of at least 10%
292 or weight change), making it difficult to draw any general conclusions. However, raltegravir and
293 dolutegravir were consistently associated with higher risk of weight gain than the other third agents
294 and TAF was also associated with higher risk of weight gain than TDF or abacavir.

295 Many studies have shown that lower CD4 T-cell levels, higher viral load, and a prior AIDS event are
296 associated with weight gain among ART-naïve PWH initiating treatment.^{6-8, 23} We show here that the
297 weight gain following treatment initiation is mainly observed in PWH with presenting with advanced
298 HIV disease, whereas the weight gain among PWH presenting early is limited. At treatment initiation,
299 PWH presenting with advanced HIV disease had a lower BMI than those presenting early with
300 median values of 22.3 kg/m² (IQR, 19.9-25.1) and 23.2 kg/m² (IQR, 21.2-25.7) respectively, and the
301 proportion of participants with a weight gain of at least 10% were significantly larger among
302 underweight PWH (58.4%) than among obese PWH (28.4%) at 30 months. The previously reported
303 deleterious effect of HIV infection on adipose tissue morphology, function, and metabolism may be
304 more pronounced in PWH presenting with advanced HIV disease and could explain the large weight
305 gain observed among these individuals.²⁴⁻²⁶ In PWH with advanced presentation, part of the weight
306 gain may simply be a return to health, and the clinical consequences, if any, could be limited to those
307 who become obese. However, it would be preferable not to be diagnosed late because of the

308 unknown consequences of rapid weight gain associated with treatment initiation and the already
309 known long-term consequences of advanced presentation²⁷, which underlines the need of continued
310 efforts to diagnose PWH early. Overall, 9.1% of PWH initiating cART had a BMI increase of at least 5
311 kg/m², known to be associated with deleterious health outcomes.¹⁷ Interestingly, the percentage of
312 those showing such an increase was significantly higher in both underweight (17.0%) and obese
313 (12.4%) PWH, (hazard ratio (HR) 1.33, 95%CI 1.07-1.67 and 1.26, 95%CI 0.98-1.61, respectively
314 relative to PWH with a BMI in the normal range) which may lead to different health consequences in
315 these two groups.²⁸ Additional studies are therefore needed on obese PWH with such weight gain to
316 assess its consequences in terms of metabolic and cardiovascular outcomes.²⁹

317 As in the two initial clinical trials reporting weight gain, we show that, among ART-naïve PWH
318 initiating treatment, weight gain with dolutegravir is greater than that with efavirenz.^{3, 4} Since the
319 publication of these trials, this result has been completed with studies of weight gain after initiating
320 treatment with other third drugs, such as raltegravir, bictegravir, elvitegravir, darunavir, atazanavir,
321 and rilpivirine. In accordance with our results, one large cohort study from northern America showed
322 that raltegravir and dolutegravir were associated with more weight gain than elvitegravir-, NNRTI- or
323 PI-based regimens.⁶ In pooled analyses that included eight clinical trials comparing weight gain in
324 ART-naïve PWH initiating dolutegravir, bictegravir, elvitegravir, atazanavir, and NNRTIs, the authors
325 found that dolutegravir and bictegravir were associated with more weight gain than elvitegravir,
326 atazanavir, or NNRTIs.⁸ In another recent American cohort study, elvitegravir was associated with
327 lower weight gain than bictegravir and dolutegravir after six months.¹¹ Thus, more weight gain was
328 observed with INSTIs other than elvitegravir. Recent studies showed that dolutegravir, bictegravir,
329 and raltegravir can directly affect adipocytes and adipose tissue.^{13, 14} Although raltegravir has been
330 consistently shown to be associated with the worst weight gain, the current practical consequences
331 are probably limited, because it is no longer frequently used to initiate treatment. In the entire
332 group, efavirenz was associated with less weight gain than all the other drugs, supporting the
333 hypothesis that it could inhibit weight gain. Concerning backbone drugs, we observed a higher risk of

334 weight gain with TAF/FTC than TDF/FTC, regardless of the criteria used to define weight gain, similar
335 to many published studies.^{4, 7, 8, 10, 11} Of note in our study TAF/FTC, was only available in France in
336 multidrug pills, either with rilpivirine or boosted elvitegravir. Overall, the observed effects of the
337 various drugs were not class effects per se. In the INSTI class, elvitegravir was associated with a lower
338 weight gain than the other INSTIs and TAF with a higher weight gain than the other NRTIs.

339 For clinical practice, our results suggest that it would be important to monitor weight gain in the first
340 year after cART initiation and to carefully select the prescribed regimen, balancing its virological and
341 immunological advantages with its consequences in terms of weight gain, in particular for PWH
342 presenting with advanced HIV disease or who are obese.²⁹ Given the persisting high proportion of
343 people diagnosed with advanced presentation, 29% in France in 2021³⁰, this could concern a large
344 proportion of newly diagnosed PWH.

345 The main strength of our study was its large size, allowing us to study the risk of weight gain
346 according to whether PWH presented early or with advanced HIV disease and to the type of drug.
347 Distinguishing two subgroups of participants allowed us to reduce the confusion between the effect
348 of the HIV infection itself and the impact of the drugs on weight gain. Studying the association of
349 weight gain by drug rather than by the class of drug allowed us to highlight the differential effects of
350 drugs from the same class on weight gain. Among the limits of our study, bictegravir could not be
351 analyzed due to the study period, which preceded its availability in France. Data on physical activity
352 and diet are not collected in the FHDH and therefore could not be accounted for. The study also
353 lacked pre-HIV measures of weight, which could have helped to assess the return to health
354 phenomenon, and the composition of the body changes following cART initiation.

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356 In conclusion, weight gain was mainly observed among participants presenting with advanced HIV
357 disease. The limited weight gain observed among PWH presenting early emphasizes, once again, the
358 need to be diagnosed early for early immediate treatment. Multiple factors are associated with
359 weight gain and the choice of initial treatment should depend on the characteristics of each PWH. In

360 further studies, it would be important to assess the population of PWH for whom clinical
361 consequences of the observed weight gain could occur.

362

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366 Members of ANRS CO4-FHDH are listed at <https://anrs-co4.fhdh.fr/>

367

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370

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374

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380

381 **AUTHORS AND CONTRIBUTION**

382 DC, SG, JC, and VP designed the study. SA, LB, CA, FC, PT, CD, PE, CK, MAK, OL, SM, GM, HM, JLM, JP,
383 LP, LS, SR, and PT included PWH. VP analyzed the data. SG, VP, and DC drafted the manuscript, had
384 full access to the data, verified the data, and had final responsibility for the decision to submit the
385 study for publication. All authors were involved in the interpretation of the data and critical revision
386 of the manuscript and approved the final version.

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388

389 **TRANSPARENCY DECLARATIONS**

390 CA received personal fees from Gilead, Janssen-Cilag, MSD, and ViiV Healthcare for travel grants and
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413 **REFERENCES**

414

- 415 1. European AIDS Clinical Society Guidelines. EACS Guidelines. 2021.
- 416 2. Department of Health and Human Services. Guidelines for the Use of Antiretroviral Agents in
417 Adults and Adolescents Living with HIV. 2021.
- 418 3. Namsal Anrs Study Group, Kouanfack C, Mpoudi-Etame M et al. Dolutegravir-Based or Low-
419 Dose Efavirenz-Based Regimen for the Treatment of HIV-1. *N Engl J Med* 2019; **381**: 816-26.
- 420 4. Venter WDF, Moorhouse M, Sokhela S et al. Dolutegravir plus Two Different Prodrugs of
421 Tenofovir to Treat HIV. *N Engl J Med* 2019; **381**: 803-15.
- 422 5. Calmy A, Tovar Sanchez T, Kouanfack C et al. Dolutegravir-based and low-dose efavirenz-
423 based regimen for the initial treatment of HIV-1 infection (NAMSAL): week 96 results from a two-
424 group, multicentre, randomised, open label, phase 3 non-inferiority trial in Cameroon. *Lancet HIV*
425 2020; **7**: e677-e87.
- 426 6. Bourgi K, Jenkins CA, Rebeiro PF et al. Weight gain among treatment-naive persons with HIV
427 starting integrase inhibitors compared to non-nucleoside reverse transcriptase inhibitors or protease
428 inhibitors in a large observational cohort in the United States and Canada. *J Int AIDS Soc* 2020; **23**:
429 e25484.
- 430 7. Martinez-Sanz J, Blanco JR, Muriel A et al. Weight changes after antiretroviral therapy
431 initiation in CoRIS (Spain): a prospective multicentre cohort study. *J Int AIDS Soc* 2021; **24**: e25732.
- 432 8. Sax PE, Erlandson KM, Lake JE et al. Weight Gain Following Initiation of Antiretroviral
433 Therapy: Risk Factors in Randomized Comparative Clinical Trials. *Clin Infect Dis* 2020; **71**: 1379-89.
- 434 9. Calza L, Colangeli V, Borderi M et al. Weight gain in antiretroviral therapy-naive HIV-1-
435 infected patients starting a regimen including an integrase strand transfer inhibitor or
436 darunavir/ritonavir. *Infection* 2020; **48**: 213-21.
- 437 10. Bansi-Matharu L, Phillips A, Oprea C et al. Contemporary antiretrovirals and body-mass index:
438 a prospective study of the RESPOND cohort consortium. *Lancet HIV* 2021; **8**: e711-e22.
- 439 11. Ruderman SA, Crane HM, Nance RM et al. Brief Report: Weight Gain Following ART Initiation
440 in ART-Naive People Living With HIV in the Current Treatment Era. *J Acquir Immune Defic Syndr* 2021;
441 **86**: 339-43.
- 442 12. Bastard JP, Pelloux V, Alili R et al. Altered subcutaneous adipose tissue parameters after
443 switching ART-controlled HIV+ patients to raltegravir/maraviroc. *AIDS* 2021; **35**: 1625-30.
- 444 13. Gorwood J, Bourgeois C, Pourcher V et al. The Integrase Inhibitors Dolutegravir and
445 Raltegravir Exert Proadipogenic and Profibrotic Effects and Induce Insulin Resistance in
446 Human/Simian Adipose Tissue and Human Adipocytes. *Clin Infect Dis* 2020; **71**: e549-e60.
- 447 14. Ngono Ayissi K, Gorwood J, Le Pelletier L et al. Inhibition of Adipose Tissue Beiging by HIV
448 Integrase Inhibitors, Dolutegravir and Bictegravir, Is Associated with Adipocyte Hypertrophy,
449 Hypoxia, Elevated Fibrosis, and Insulin Resistance in Simian Adipose Tissue and Human Adipocytes.
450 *Cells* 2022; **11**: 1841.
- 451 15. Milic J, Renzetti S, Ferrari D et al. Relationship between weight gain and insulin resistance in
452 people living with HIV switching to integrase strand transfer inhibitors-based regimens. *AIDS* 2022;
453 **36**: 1643-53.
- 454 16. Rebeiro PF, Jenkins CA, Bian A et al. Risk of Incident Diabetes Mellitus, Weight Gain, and
455 Their Relationships With Integrase Inhibitor-Based Initial Antiretroviral Therapy Among Persons With
456 Human Immunodeficiency Virus in the United States and Canada. *Clin Infect Dis* 2021; **73**: e2234-e42.

- 457 17. Global BMI Mortality Collaboration, Di Angelantonio E, Bhupathiraju Sh N et al. Body-mass
458 index and all-cause mortality: individual-participant-data meta-analysis of 239 prospective studies in
459 four continents. *Lancet* 2016; **388**: 776-86.
- 460 18. Mary-Krause M, Grabar S, Lievre L et al. Cohort Profile: French hospital database on HIV
461 (FHDH-ANRS CO4). *Int J Epidemiol* 2014; **43**: 1425-36.
- 462 19. The ANRS CO4 French Hospital Database on HIV. [https://anrs-co4.fhdh.fr/documents-de-](https://anrs-co4.fhdh.fr/documents-de-reference-2/)
463 [reference-2/](https://anrs-co4.fhdh.fr/documents-de-reference-2/) (2022/09/06 2022, date last accessed).
- 464 20. Ryan DH, Yockey SR. Weight Loss and Improvement in Comorbidity: Differences at 5%, 10%,
465 15%, and Over. *Curr Obes Rep* 2017; **6**: 187-94.
- 466 21. Assoumou L, Racine C, Fellahi S et al. Fat gain differs by sex and hormonal status in persons
467 living with suppressed HIV switched to raltegravir/etravirine. *AIDS* 2020; **34**: 1859-62.
- 468 22. Littell R, Milliken G, Stroup W et al. SAS for Mixed Models. Cary, NC: SAS Institute Inc, 2006.
- 469 23. Hasse B, Iff M, Ledergerber B et al. Obesity Trends and Body Mass Index Changes After
470 Starting Antiretroviral Treatment: The Swiss HIV Cohort Study. *Open Forum Infect Dis* 2014; **1**:
471 ofu040.
- 472 24. Vidal F, Domingo P, Villarroya F et al. Adipogenic/lipid, inflammatory, and mitochondrial
473 parameters in subcutaneous adipose tissue of untreated HIV-1-infected long-term nonprogressors:
474 significant alterations despite low viral burden. *J Acquir Immune Defic Syndr* 2012; **61**: 131-7.
- 475 25. Gorwood J, Bourgeois C, Mantecon M et al. Impact of HIV/simian immunodeficiency virus
476 infection and viral proteins on adipose tissue fibrosis and adipogenesis. *AIDS* 2019; **33**: 953-64.
- 477 26. Gorwood J, Ejlalmanesh T, Bourgeois C et al. SIV Infection and the HIV Proteins Tat and Nef
478 Induce Senescence in Adipose Tissue and Human Adipose Stem Cells, Resulting in Adipocyte
479 Dysfunction. *Cells* 2020; **9**: 854.
- 480 27. Montlahuc C, Guiguet M, Abgrall S et al. Impact of late presentation on the risk of death
481 among HIV-infected people in France (2003-2009). *J Acquir Immune Defic Syndr* 2013; **64**: 197-203.
- 482 28. Yuh B, Tate J, Butt AA et al. Weight change after antiretroviral therapy and mortality. *Clin*
483 *Infect Dis* 2015; **60**: 1852-9.
- 484 29. Kumar S, Samaras K. The Impact of Weight Gain During HIV Treatment on Risk of Pre-
485 diabetes, Diabetes Mellitus, Cardiovascular Disease, and Mortality. *Front Endocrinol (Lausanne)* 2018;
486 **9**: 705.
- 487 30. Santé Publique France. Surveillance du VIH et des IST bactériennes. *Bulletin de Santé*
488 *Publique*, 2022; 1-6.
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Table 1. Individual characteristics of all PWH and according to their clinical presentation at cART initiation

	All PWH (n = 12773)		PWH presenting early (n = 5794)		PWH presenting with advanced HIV disease (n = 3106)	
	n or median	% or [IQR]	n or median	% or [IQR]	n or median	% or [IQR]
Age	38	[30-48]	36	[29-46]	42	[34-51]
Gender						
Men	9653	75.6	4481	77.3	2166	69.7
Women	3120	24.4	1313	22.7	940	30.3
Age and gender						
Women ≤ 50 years	2440	19.1	1043	18.0	723	23.3
Women > 50 years	680	5.3	270	4.7	217	7.0
Men ≤ 50 years	7831	61.3	3831	66.1	1544	49.7
Men > 50 years	1822	14.3	650	11.2	622	20.0
Transmission group						
MSM	6147	48.1	3309	57.1	900	29.0
Injecting drug users	204	1.6	74	1.3	58	1.9
Heterosexual	5777	45.2	2171	37.5	1907	61.4
Other	645	5.0	240	4.1	241	7.8
Geographic origin						
Sub-Saharan Africa	3288	25.7	1175	20.3	1127	36.3
Other	9485	74.3	4619	79.7	1979	63.7
BMI (kg/m²)		[20.7-		[21.2-		[19.9-
	23.0	25.8]	23.2	25.7]	22.3	25.1]
Underweight (< 18.5)	917	7.2	287	5.0	391	12.6
Normal [18.5-25[	7974	62.4	3589	61.9	1925	62.0
Overweight [25-30[	2838	22.2	1368	23.6	591	19.0
Obese (≥ 30)	1044	8.2	550	9.5	199	6.4
Year of HIV-1 diagnosis		[2012-		[2012-		[2012-
	2014	2016]	2014	2016]	2014	2016]
3rd agent						
RAL	469	3.7	155	2.7	186	6.0
DTG	1922	15.0	877	15.1	460	14.8
EVG/COBI	1866	14.6	931	16.1	354	11.4
DRV/RTV	4448	34.8	1401	24.2	1522	49.0
ATV/RTV	879	6.9	364	6.3	223	7.2
EFV	854	6.7	363	6.3	188	6.1
RPV	2335	18.3	1703	29.4	173	5.6
Backbone						
TDF/FTC	9984	78.2	4417	76.2	2495	80.3
TAF/FTC	800	6.3	419	7.2	153	4.9
ABC/3TC	1989	15.6	958	16.5	458	14.7
CD4 (cells/mm³) at cART initiation						
	377	[220-539]	520	[422-672]	105	[44-167]
< 200	2861	22.4	43*	0.7	2814	90.6
200-350	2911	22.8	216*	3.7	157	5.1
350-500	3178	24.9	2390	41.2	77	2.5
≥ 500	3823	29.9	3145	54.3	58	1.9

	All PWH (n = 12773)		PWH presenting early (n = 5794)		PWH presenting with advanced HIV disease (n = 3106)	
	n or median	% or [IQR]	n or median	% or [IQR]	n or median	% or [IQR]
Viral load (copies/mL) at cART initiation	4.7	[4.1-5.3]	4.3	[3.7-4.7]	5.2	[4.8-5.7]
]50-30 000]	5058	39.6	3658	63.1	484	15.6
]30 000-100 000]	3110	24.3	1708	29.5	655	21.1
]100 000-500 000]	3018	23.6	269*	4.6	1189	38.3
> 500 000	1587	12.4	159*	2.7	778	25.0
Prior AIDS defining event						
No	11665	91.3			2009	64.7
Tuberculosis	262	2.1			261	8.4
AIDS cancer	175	1.4			173	5.6
Other AIDS defining event	671	5.3			663	21.3

495 * Diagnosed at primary infection

496

497 **Abbreviations:** RAL, raltegravir; DTG, dolutegravir; EVG, elvitegravir; DRV, darunavir;
498 ATV, atazanavir; EFV, efavirenz; RPV, rilpivirine; COBI, cobicistat; RTV, ritonavir; TAF,
499 tenofovir alafenamide; TDF, tenofovir disoproxil; FTC, emtricitabine; 3TC, lamivudine;
500 ABC, abacavir; MSM, male who have sex with male; BMI, body-mass index

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Table 2. Factors associated with a weight gain of at least 10%: univariable and multivariable Cox regression models for all PWH (n=12773)

Characteristics	N	Δ weight ≥ 10% Kaplan-Meier estimates at 30 months [95% CI]	Univariable Cox		Multivariable Cox	
			HR [95% CI]	P	HR [95% CI]	P
Total	12773	34.5 [33.5-35.6]				
3rd agent						
RAL	469	44.3 [38.9-50.1]	2.75 [2.28-3.32]	<0.0001	1.44 [1.18-1.76]	<0.0001
DTG	1922	36.9 [34.2-39.7]	2.07 [1.81-2.36]		1.48 [1.26-1.74]	
EVG/COBI	1866	34.0 [31.3-36.9]	1.82 [1.59-2.08]		1.12 [0.96-1.30]	
DRV/RTV	4448	44.0 [42.0-46.1]	2.61 [2.33-2.92]		1.38 [1.22-1.56]	
ATV/RTV	879	38.1 [33.8-42.7]	2.01 [1.70-2.37]		1.26 [1.06-1.50]	
EFV	854	24.9 [21.6-28.6]	1.28 [1.06-1.53]		0.90 [0.74-1.08]	
RPV	2335	20.9 [19.1-22.8]	1		1	
Backbone						
TDF/FTC	9984	33.6 [32.4-34.8]	1	0.01	1	<0.0001
TAF/FTC	800	41.1 [36.9-45.6]	1.23 [1.08-1.40]		1.52 [1.29-1.79]	
ABC/3TC	1989	36.1 [33.6-38.7]	1.06 [0.97-1.17]		0.95 [0.84-1.06]	
Age and gender						
Women ≤ 50 years	2440	46.3 [43.8-48.8]	1.71 [1.57-1.86]	<0.0001	1.34 [1.21-1.48]	<0.0001
Women > 50 years	680	48.1 [43.5-52.9]	1.93 [1.68-2.21]		1.52 [1.31-1.76]	
Men ≤ 50 years	7831	29.0 [27.7-30.3]	1		1	
Men > 50 years	1822	36.1 [33.4-38.9]	1.39 [1.26-1.54]		1.10 [0.99-1.22]	
Transmission Group						
MSM	6147	25.5 [24.1-26.9]	1	<0.0001	1	<0.0001
Other	6626	42.7 [41.2-44.2]	1.95 [1.81-2.10]		1.42 [1.29-1.56]	
Geographic origin						
Sub-Saharan Africa	3288	43.5 [41.4-45.7]	1.46 [1.35-1.57]	<0.0001	1.07 [0.98-1.17]	0.13
Other	9485	31.2 [30.1-32.4]	1		1	
BMI (kg/m²)						
Underweight (< 18.5)	917	58.4 [54.4-62.5]	2.50 [2.25-2.79]	<0.0001	1.78 [1.60-1.99]	<0.0001
Normal [18.5-25[	7974	34.1 [32.8-35.4]	1		1	
Overweight [25-30[	2838	30.5 [28.3-32.7]	0.78 [0.71-0.86]		0.73 [0.67-0.80]	
Obese (≥ 30)	1044	28.4 [25.0-32.1]	0.71 [0.61-0.82]		0.62 [0.54-0.72]	
CD4 (cells/mm³)						
< 200	2861	64.1 [61.8-66.4]	5.19 [4.69-5.73]	<0.0001	2.46 [2.18-2.77]	<0.0001
200-350	2911	36.3 [34.1-38.7]	1.96 [1.76-2.19]		1.53 [1.36-1.72]	
350-500	3178	24.9 [23.1-26.9]	1.25 [1.11-1.41]		1.14 [1.01-1.28]	
≥ 500	3823	20.4 [18.9-22.1]	1		1	
Viral load (copies/ml)						
]50-30 000]	5058	23.7 [22.2-25.2]	1	<0.0001	1	<0.0001
]30 000-100 000]	3110	31.4 [29.4-33.5]	1.39 [1.26-1.54]		1.17 [1.05-1.30]	
]100 000-500 000]	3018	46.1 [43.7-48.5]	2.47 [2.25-2.71]		1.57 [1.41-1.74]	
> 500 000	1587	59.3 [55.9-62.7]	3.91 [3.52-4.33]		2.00 [1.78-2.25]	
Prior AIDS defining event						
No	11665	30.9 [29.8-31.9]	1	<0.0001	1	<0.0001
Tuberculosis	262	69.0 [61.8-75.9]	3.46 [2.91-4.13]		1.78 [1.47-2.15]	
AIDS cancer	175	62.6 [52.7-72.5]	2.83 [2.24-3.57]		1.65 [1.30-2.09]	
Other AIDS defining event	671	80.4 [76.4-84.2]	5.83 [5.25-6.47]		2.39 [2.12-2.68]	

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Abbreviations: 95% CI, 95% confidence interval; RAL, raltegravir; DTG, dolutegravir; EVG, elvitegravir; DRV, darunavir; ATV, atazanavir; EFV, efavirenz; RPV, rilpivirine; COBI, cobicistat; RTV, ritonavir; TAF, tenofovir alafenamide; TDF, tenofovir disoproxil; FTC, emtricitabine; 3TC, lamivudine; ABC, abacavir; MSM, male who have sex with male; BMI, body-mass index

513 **Table 3. Factors associated with a weight gain of at least 10%: univariable and multivariable**
514 **Cox regression models for PWH presenting early (at primary infection or with CD4 > 350/mm³**
515 **and VL < 100 000 copies/mL, without AIDS). (N=5794)**
516

Characteristics	N	Δ weight ≥ 10%	Univariable Cox		Multivariable Cox	
			HR [95% CI]	P	HR [95% CI]	P
		Kaplan-Meier estimates at 30 months [95% CI]				
Total 3rd agent	5794	20.9 [19.6-22.2]				
RAL	155	19.6 [13.1-28.8]	1.11 [0.71-1.73]	<0.0001	1.07 [0.68-1.67]	0.0003
DTG	877	21.2 [18.0-24.9]	1.20 [0.97-1.49]		1.41 [1.04-1.90]	
EVG/COBI	931	25.3 [21.9-29.1]	1.48 [1.21-1.80]		1.19 [0.95-1.49]	
DRV/RTV	1401	24.8 [21.6-28.4]	1.49 [1.24-1.80]		1.34 [1.10-1.64]	
ATV/RTV	364	26.8 [21.1-33.7]	1.71 [1.29-2.26]		1.55 [1.16-2.07]	
EFV	363	11.4 [8.0-16.1]	0.62 [0.43-0.90]		0.62 [0.43-0.90]	
RPV	1703	17.7 [15.8-19.9]	1		1	
Backbone						
TDF/FTC	4417	19.8 [18.4-21.4]	1	<0.0001	1	0.0004
TAF/FTC	419	32.0 [26.5-38.3]	1.68 [1.35-2.10]		1.59 [1.23-2.06]	
ABC/3TC	958	20.7 [17.7-24.1]	1.00 [0.83-1.20]		0.79 [0.61-1.03]	
Age and gender						
Women ≤ 50 years	1043	30.0 [26.7-33.6]	1.74 [1.48-2.03]	<0.0001	1.49 [1.20-1.84]	0.0005
Women > 50 years	270	29.0 [22.7-36.5]	1.70 [1.28-2.26]		1.62 [1.18-2.23]	
Men ≤ 50 years	3831	18.2 [16.7-19.8]	1		1	
Men > 50 years	650	17.7 [14.4-21.7]	0.99 [0.78-1.25]		0.99 [0.78-1.26]	
Transmission Group						
MSM	3309	17.3 [15.7-19.0]	1	<0.0001	1	0.001
Other	2485	25.4 [23.4-27.6]	1.58 [1.38-1.81]		1.37 [1.13-1.66]	
Geographic origin						
Sub-Saharan Africa	1175	26.9 [23.9-30.2]	1.46 [1.26-1.70]	<0.0001	1.17 [0.98-1.41]	0.09
Other	4619	19.2 [17.8-20.7]	1		1	
BMI (kg/m²)						
Underweight (< 18.5)	287	34.2 [27.8-41.7]	1.99 [1.55-2.56]	<0.0001	1.82 [1.41-2.35]	<0.0001
Normal [18.5-25[	3589	20.4 [18.8-22.1]	1		1	
Overweight [25-30[	1368	20.2 [17.7-23.0]	0.95 [0.80-1.12]		0.81 [0.69-0.97]	
Obese (≥ 30)	550	18.9 [15.2-23.5]	0.90 [0.71-1.15]		0.66 [0.51-0.85]	
CD4 (cells/mm³)						
< 200*	43	43.6 [27.1-64.6]	2.62 [1.51-4.55]	<0.0001	1.38 [0.76-2.50]	0.12
200-350*	216	34.6 [26.4-44.5]	2.03 [1.50-2.76]		1.43 [1.01-2.02]	
350-500	2390	22.1 [20.1-24.3]	1.19 [1.04-1.37]		1.12 [0.97-1.29]	
≥ 500	3145	18.8 [17.2-20.6]	1		1	
Viral load (copies/ml)						
]50-30 000]	3658	19.0 [17.5-20.7]	1		1	<0.0001
]30 000-100 000]	1708	22.0 [19.6-24.6]	1.17 [1.01-1.36]		1.23 [1.06-1.43]	
]100 000-500 000]*	269	33.0 [25.5-42.1]	1.90 [1.42-2.52]	<0.0001	1.84 [1.33-2.54]	
> 500 000*	159	44.7 [32.4-59.3]	2.82 [1.98-4.01]		2.43 [1.63-3.64]	

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518 * Diagnosed at primary infection
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520 **Abbreviations:** 95% CI: 95% confidence interval; RAL, raltegravir; DTG, dolutegravir;
521 EVG, elvitegravir; DRV, darunavir; ATV, atazanavir; EFV, efavirenz; RPV, rilpivirine;
522 COBI, cobicistat; RTV, ritonavir; TAF, tenofovir alafenamide; TDF, tenofovir disoproxil;
523 FTC, emtricitabine; 3TC, lamivudine; ABC, abacavir; MSM, male who have sex with male;
524 BMI, body-mass index

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Table 4. Factors associated with a weight gain of at least 10%: univariable and multivariable Cox regression models for PWH presenting with advanced HIV disease (with AIDS or with CD4 < 200/mm³, not during primary infection). (N=3106)

Characteristics	N	Δ weight ≥ 10%	Univariable Cox		Multivariable Cox	
			Kaplan-Meier estimates at 30 months [95% CI]	HR [95% CI]	P	HR (95% CI)	P
Total	3106	63.1 [60.9-65.3]				
3rd agent						
RAL	186	74.1 [65.5-81.9]	3.30 [2.34-4.67]	<0.0001	2.19 [1.53-3.14]	<0.0001
DTG	460	68.8 [63.2-74.2]	2.99 [2.19-4.10]		2.24 [1.60-3.14]	
EVG/COBI	354	55.6 [49.1-62.3]	2.15 [1.56-2.98]		1.39 [0.98-1.97]	
DRV/RTV	1522	65.6 [62.4-68.8]	2.68 [2.00-3.58]		1.96 [1.44-2.66]	
ATV/RTV	223	63.5 [54.7-72.3]	2.26 [1.60-3.21]		1.72 [1.20-2.47]	
EFV	188	62.7 [54.1-71.3]	2.49 [1.74-3.55]		1.80 [1.25-2.61]	
RPV	173	36.6 [28.7-45.8]	1		1	
Backbone						
TDF/FTC	2495	62.5 [59.9-65.0]	1	0.28	1	0.02
TAF/FTC	153	65.1 [55.1-75.0]	1.08 [0.85-1.36]		1.52 [1.12-2.05]	
ABC/3TC	458	65.6 [60.4-70.7]	1.11 [0.97-1.28]		0.98 [0.83-1.15]	
Age and gender						
Women ≤ 50 years	723	68.6 [64.2-72.9]	1.17 [1.03-1.33]	0.0001	1.19 [1.03-1.37]	0.01
Women > 50 years	217	72.0 [64.1-79.4]	1.40 [1.15-1.71]		1.28 [1.04-1.58]	
Men ≤ 50 years	1544	57.1 [53.9-60.3]	1		1	
Men > 50 years	622	66.8 [61.7-71.7]	1.30 [1.13-1.49]		1.20 [1.05-1.39]	
Transmission Group						
MSM	900	54.9 [50.8-59.2]	1	<0.0001	1	0.0001
Other	2206	66.4 [63.8-69.0]	1.32 [1.17-1.48]		1.32 [1.15-1.53]	
Geographic origin						
Sub-Saharan Africa	1127	64.6 [61.0-68.3]	0.96 [0.86-1.06]	0.40	1.03 [0.91-1.17]	0.65
Other	1979	62.1 [59.3-64.9]	1		1	
BMI (kg/m²)						
Underweight (< 18.5)	391	81.1 [75.9-85.7]	2.10 [1.83-2.41]	<0.0001	1.79 [1.55-2.06]	<0.0001
Normal [18.5-25[	1925	63.3 [60.6-66.1]	1		1	
Overweight [25-30[	591	53.7 [48.2-59.4]	0.64 [0.55-0.74]		0.64 [0.55-0.75]	
Obese (≥ 30)	199	53.2 [44.1-62.9]	0.56 [0.44-0.72]		0.56 [0.43-0.72]	
Viral load (copies/ml)						
]50-30 000]	391	47.0 [41.5-52.9]	1	<0.0001	1	<0.0001
]30 000-100 000]	1925	52.4 [47.4-57.5]	1.19 [0.97-1.45]		1.22 [1.00-1.49]	
]100 000-500 000]	591	67.5 [64.0-71.0]	1.85 [1.55-2.21]		1.73 [1.45-2.08]	
> 500 000	199	76.0 [71.9-80.0]	2.44 [2.04-2.94]		2.03 [1.68-2.44]	
Prior AIDS defining event						
No	2009	56.5 [53.7-59.4]	1	<0.0001	1	<0.0001
Tuberculosis	261	68.7 [61.5-75.7]	1.44 [1.20-1.74]		1.31 [1.07-1.61]	
AIDS cancer	173	62.2 [52.2-72.2]	1.18 [0.93-1.50]		1.21 [0.95-1.55]	
Other AIDS pathology	663	81.2 [77.1-84.9]	2.42 [2.14-2.73]		2.05 [1.81-2.32]	

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Abbreviations: 95% CI: 95% confidence interval; RAL, raltegravir; DTG, dolutegravir; EVG, elvitegravir; DRV, darunavir; ATV, atazanavir; EFV, efavirenz; RPV, rilpivirine; COBI, cobicistat; RTV, ritonavir; TAF, tenofovir alafenamide; TDF, tenofovir disoproxil; FTC, emtricitabine; 3TC, lamivudine; ABC, abacavir; MSM, male who have sex with male; BMI, body-mass index

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Table 5. Mean weight change at 12, 24, and 30 months for all PWH (n = 12773)

Multivariable mixed model					
	N	Weight change at 12 months (kg)	Weight gain at 24 months (kg)	Weight gain at 30 months (kg)	P
Total	12773	5.45 (5.04-5.87)	7.84 (7.27-8.41)	7.85 (7.13-8.57)	
3rd agent					
RAL	469	6.04 (5.33-6.74)	8.69 (7.77-9.61)	8.51 (7.33-9.69)	<0.0001
DTG	1922	5.97 (5.43-6.50)	8.82 (8.10-9.55)	8.71 (7.81-9.61)	
EVG/COBI	1866	5.52 (5.04-6.01)	7.74 (7.07-8.40)	8.03 (7.20-8.86)	
DRV/RTV	4448	5.50 (5.04-5.95)	7.71 (7.08-8.33)	7.84 (7.05-8.63)	
ATV/RTV	879	5.23 (4.64-5.81)	7.33 (6.54-8.12)	7.44 (6.46-8.42)	
EFV	854	4.28 (3.69-4.86)	6.88 (6.10-7.66)	6.51 (5.56-7.47)	
RPV	2335	5.65 (5.17-6.14)	7.73 (7.08-8.37)	7.93 (7.11-8.74)	
Backbone					
TDF/FTC	9984	4.78 (4.39-5.17)	7.02 (6.47-7.57)	7.04 (6.36-7.71)	<0.0001
TAF/FTC	800	7.21 (6.53-7.88)	9.00 (8.20-9.81)	8.80 (7.79-9.82)	
ABC/3TC	1989	6.57 (5.96-7.18)	7.50 (6.80-8.20)	7.72 (6.84-8.60)	
Age and gender					
Women ≤ 50 years	2440	5.59 (5.11-6.06)	8.17 (7.53-8.80)	8.59 (7.78-9.40)	<0.0001
Women > 50 years	680	5.81 (5.21-6.42)	8.45 (7.63-9.26)	8.17 (7.17-8.55)	
Men ≤ 50 years	7831	5.00 (4.57-5.42)	7.21 (6.63-7.79)	7.12 (6.38-7.86)	
Men > 50 years	1822	5.41 (4.94-5.90)	7.55 (6.90-8.19)	7.54 (6.72-8.35)	
Transmission Group					
MSM	6147	5.11 (4.64-5.58)	7.55 (6.92-8.19)	7.63 (6.84-8.43)	<0.0001
Other	6626	5.80 (5.39-6.21)	8.13 (7.57-8.69)	8.07 (7.36-8.79)	
Geographic origin					
Sub-Saharan Africa	3288	5.63 (5.16-6.09)	8.22 (7.59-8.84)	8.21 (7.42-8.99)	<0.0001
Other	9485	5.28 (4.86-5.70)	7.47 (6.89-8.05)	7.50 (6.77-8.23)	
BMI (kg/m²)					
Underweight (< 18.5)	917	6.69 (6.12-7.25)	8.76 (8.00-9.52)	8.50 (7.54-9.45)	<0.0001
Normal [18.5-25[	7974	5.55 (5.13-5.98)	7.99 (7.41-8.57)	8.03 (7.30-8.75)	
Overweight [25-30[	2838	5.10 (4.64-5.56)	7.62 (7.01-8.24)	7.71 (6.94-8.48)	
Obese (≥ 30)	1044	4.47 (3.94-5.01)	7.00 (6.28-7.71)	7.18 (6.30-8.06)	
CD4 (cells/mm³)					
< 200	2861	7.37 (6.94-7.80)	9.72 (9.11-10.32)	9.84 (9.09-10.59)	<0.0001
200-350	2911	5.39 (4.92-5.87)	7.95 (7.31-8.59)	7.69 (6.89-8.50)	
350-500	3178	4.74 (4.27-5.22)	6.98 (6.34-7.62)	7.20 (6.41-8.00)	
≥ 500	3823	4.31 (3.84-4.78)	6.73 (6.09-7.37)	6.68 (5.87-7.49)	
Viral load (copies/ml)					
]50-30 000]	5058	4.39 (3.94-4.83)	6.69 (6.08-7.30)	6.39 (5.64-7.15)	<0.0001
]30 000-100 000]	3110	4.87 (4.41-5.33)	7.21 (6.59-7.83)	6.93 (6.16-7.70)	
]100 000-500 000]	3018	5.85 (5.39-6.32)	8.05 (7.42-8.69)	8.38 (7.58-9.19)	
> 500 000	1587	6.71 (6.19-7.23)	9.42 (8.70-10.14)	9.70 (8.79-10.62)	
Prior AIDS defining event					
No	11665	3.57 (3.29-3.85)	4.57 (4.21-4.93)	4.83 (4.38-5.28)	<0.0001
Tuberculosis	262	7.15 (6.30-8.00)	8.67 (7.53-9.81)	9.71 (7.99-11.43)	
AIDS cancer	175	3.90 (2.90-4.89)	8.51 (7.08-9.95)	7.90 (6.35-9.44)	
Other AIDS defining event	671	7.20 (6.63-7.78)	9.61 (8.80-10.42)	8.98 (7.95-10.01)	

Note: 95% confidence intervals are in parentheses

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Abbreviations: RAL, raltegravir; DTG, dolutegravir; EVG, elvitegravir; DRV, darunavir; ATV, atazanavir; EFV, efavirenz; RPV, rilpivirine; COBI, cobicistat; RTV, ritonavir; TAF, tenofovir alafenamide; TDF, tenofovir disoproxil; FTC, emtricitabine; 3TC, lamivudine; ABC, abacavir; MSM, male who have sex with male; BMI, body-mass index