Primary Care of People Living with HIV

Echo session

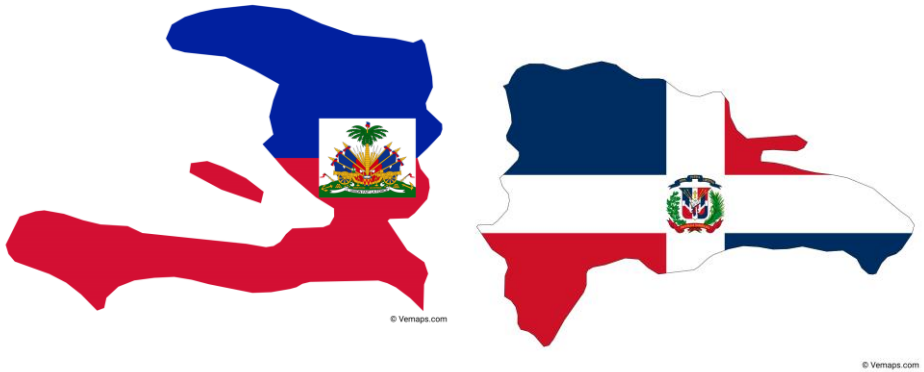
March 2025

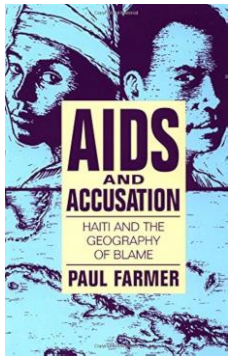
Alex Dworak and Spencer Kinzie

Agenda

- Present various cases of PLWHIV (all anonymized except for one which is shared publicly at express request of next of kin)
- Illustrate the advancement of HIV care over time
- Highlight health disparities and inequities in HIV incidence and morbidity/mortality
- Present guidelines for primary care of people living with HIV (spoiler alert: it’s just excellent primary care like for anyone else)

Disclosures





- Alex Dworak's disclosures: Alex has had an interest in infectious diseases since college, when as a Creighton undergraduate he spent the second half of his freshman year in the Dominican Republic (spring 1999). This included a trip to Haiti and time spent at a Home For the Dying where HIV was the most common terminal diagnosis and treatment was palliative. Upon his return to Nebraska, he read AIDS and Accusation: Haiti and the Geography of Blame by one of his heroes, the late Dr. Paul Farmer. He has since carried a careerlong vendetta against both infectious diseases and the social inequities that they exploit and illuminate by who gets sick and who dies from them. He was fortunate to have mentorship from UNMC Scientist Laureate Dr. Sue Swindells, among many others, and has completed an HIV Clinician Scholar mini-fellowship post-residency. He is an immediate past Board member of the Nebraska AIDS project, works part time at the SCC, and serves as ECHO faculty for the NMA Chronic Pain and Opioid Use Disorder series since 2024. He doesn't have any financial disclosures because there's a reason he chose Arts and Sciences, not Business for undergrad.

Disclosures

- Spencer Kinzie's disclosures: Spencer became interested in care for PLWHIV in medical school when a person close to him in his life contracted HIV and he soon thereafter cared for a patient dying of advanced HIV and multiple OI's and AIDS related illnesses. I have focused of other areas of medicine including primary care, hospital medicine, gender affirming care among others but recently had the opportunity to provide primary care for PLWHIV here at the SCC and jumped at the opportunity last year. In that time I have had the mentorship of the infectious disease specialists at the SCC as well as Dr. Dworak and am honored to have already learned a lot from them as I build on my medical knowledge in this area.
  - No Financial Disclosures

Case one (source: https://ryanwhite.hrsa.gov/about/ryan-white)

- The patient is a 13 year old White cisgender boy who is diagnosed with HIV in 1984. (Alex did not see him as a patient in no small part because Alex was five years old at the time). He has hemophilia and had required regular blood transfusions since birth. He had a series of chronic infectious symptoms and eventually received the diagnosis at a time when treatment options were limited and misinformation was rampant.
- His name is Ryan White.

Case one (source: https://ryanwhite.hrsa.gov/about/ryan-white)

- “Ryan really became famous because of his fight to go to school. When Ryan was diagnosed, they only gave him three to six months to live. So at that time, I thought every cough, every fever, I worried that it was going to be his last. And I really never thought he'd be healthy enough to go to school.
- But as he started getting healthy, as he started gaining weight, he started to ask, "Mom," he said, "I want to go to school. I want to go visit my friends. I want to see my friends." So I really kind of put him off for a while and finally he just said, "Mom, I want to go to school. I want to go visit."
- So it was a long process. We had to go through almost a year and a half, he didn't go to school for about a year and a half. He was worried about taking the seventh grade over again, and he didn't want people to think he was dumb, because he was a very smart and intelligent kid. So it was a long process. Through court hearings, we thought it would take one court hearing, and we'd have all these medical experts in so to speak, and then everybody would be educated, but it didn't happen that way.
- It was really bad. People were really cruel, people said that he had to be gay, that he had to have done something bad or wrong, or he wouldn't have had it. It was God's punishment, we heard the "God's punishment" a lot. That somehow, someway he had done something he shouldn't have done or he wouldn't have gotten AIDS.” Ryan’s mother, Jeanne White Ginder

Case one (source: https://ryanwhite.hrsa.gov/about/ryan-white)

- Then we moved to Cicero, Indiana, and there the community welcomed us. And it was all because of a young girl, named Jill Stuart, who was president of the student body, who decided to **bring in the medical experts and talk to the kids, and the kids went home then and educated their parents**. (*emphasis added—atd)*
- So Ryan was welcome. He got to go to school. He got to go to proms and dances. He even got a job. It was kind of funny, he came home once after he turned 16 and told me he had a job for the summer. I thought, "Oh my gosh. Who is going to hire you, knowing who you are?" I said, "What are you going to be doing," and he said, "I'm working at Maui's Skateboard shop." I said, "Really? What are you going to be doing?" and he said, "I'm going to put together skateboards." And I said, "How much are you getting paid?" and he said "$3.50 an hour." I said, "Ryan, that won't even buy your gas to Indianapolis and back." He said, "Mom, you don't get it. I got a job just like everybody else does." So it was really important for Ryan, to just be one of the other kids, and to try and fit in. He never bragged or anything about who he was, or what he got to do, he just wanted to be around his friends.

Case one (source: https://ryanwhite.hrsa.gov/about/ryan-white)

- “At the time when Ryan was diagnosed with AIDS, I mean, we heard of so many drugs coming out, and none of them was worth nothing. By the time you heard of one, there would be another one out, and you would never get the research for one. And none of them worked. And so even in the early 90s, when I was hearing there was hope, I kind of thought, "You know, we had that hope, too, but they didn't pan out."
- But they did pan out! The biggest contribution I think that Ryan made is—and I didn't know it at that time—that his legacy would be that people are getting their drugs and their treatment and that people are living with AIDS.”

https://www.chick.com/products/tract?stk=1070&srsltid=AfmBOorKvQ2SdkD5HqYzRJCsgBSvnAuR0mmyTo-7gLkh4QqDoX6UlEnd Copyright: **2011**

https://education.cfr.org/media/1041/show?destination=/global-health/changing-response-aids

- June 5, 1981: The Centers for Disease Control (CDC) received a report that five otherwise healthy gay men in Los Angeles had suddenly come down with pneumocystis pneumonia. This infection is one that any healthy person's immune system should be able to easily fight off. Within days, the CDC was flooded with similar cases from all over the country. Because the first cases of the illness were documented in gay men in the United States, people called it GRID (gay-related immune deficiency), gay cancer, or the gay plague. This stigma assigned to AIDS and the gay community would make the spread of the illness even harder to stop for decades to come.
- Sept. 24, 1982: Cases had been detected in homosexual people, people with hemophilia (a bleeding disorder), Haitians, and heroin users. Infections across these demographics led the public to ridicule these communities as the 4-H Club. Health officials also recorded symptoms now believed to be associated with AIDS in patients in Uganda; at the time, no one on either side of the ocean made the connection. It would take until 1986 for even the cause of AIDS, the retrovirus HIV, to be confirmed and named.

THE SUN, Thursday, February 7, 1985 5

AIDS IS THE WRATH OF GOD, SAYS VICAR

Ex-ballet boss is victim 53

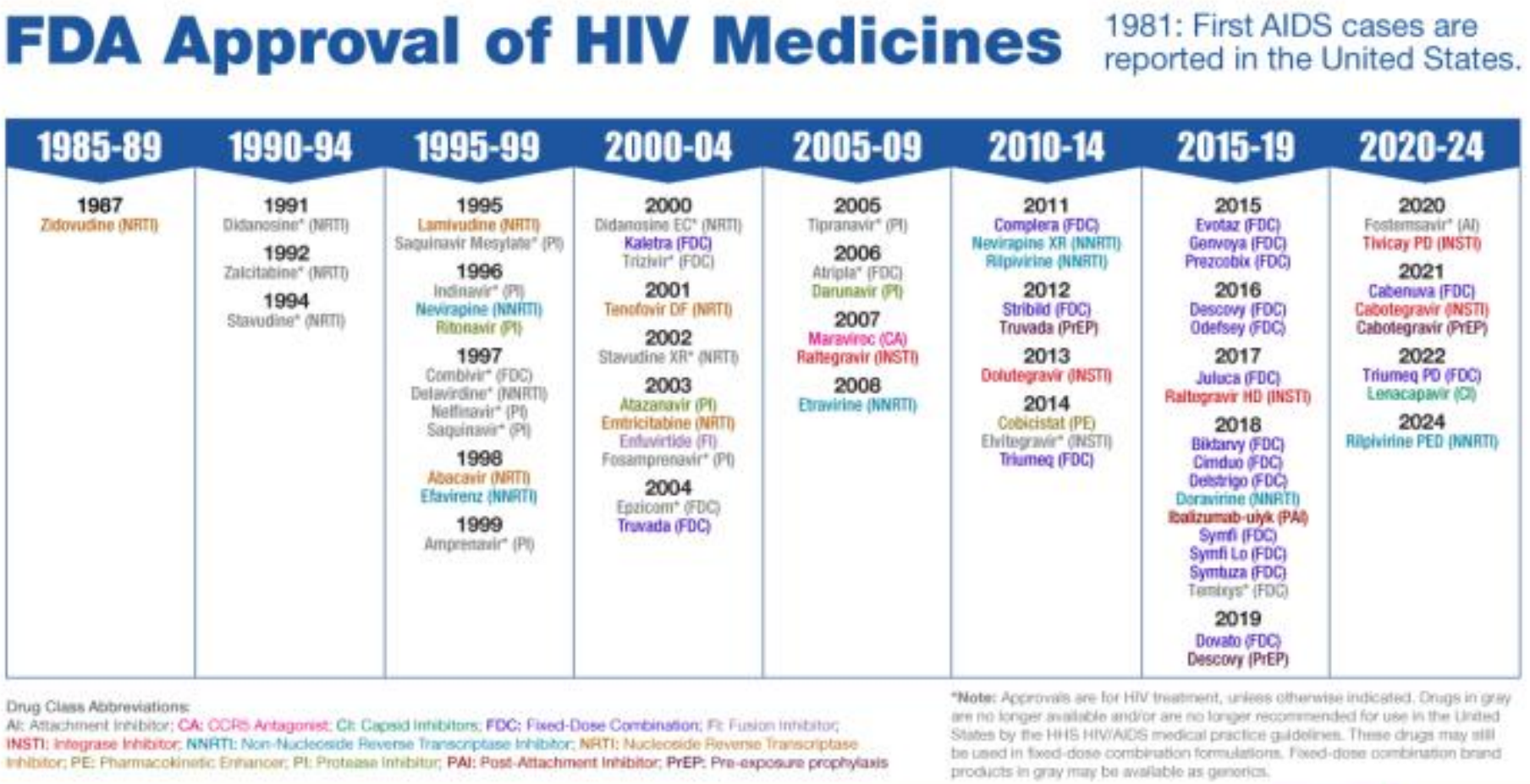
By HUGH WHITTOW

A VICAR yesterday branded the gay plague AIDS as the wrath of God.

The Rev Owen Leigh-Williams claimed homosexuals offended the Lord.

A FORMER boss of a world famous ballet company was named

https://hivinfo.nih.gov/understanding-hiv/infographics/fda-approval-hiv-medicines



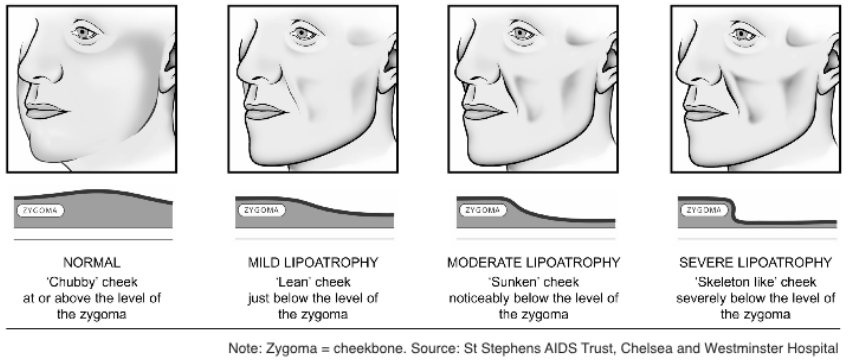
- Highlights:
- 1987: AZT
- 1996: meds approved began to be called HAART/ “highly active” and life expectancy improved
- 2006: first one pill, once a day medication
- 2014: INSTIs first line
- 2019: PrEP
- 2021: LAI ART
- 2022: Lenacapavir

Case two

- The patient is a 52 year old Black gay theater stage manager and costume designer. He is seen in 2003 at Nebraska Medicine for followup of Kaposi's sarcoma of the foot.
- His ART regimen includes Kaletra (lopinavir/ritonavir) which causes him significant diarrhea and insulin resistance, as well as abacavir and lamivudine.
- He has fat redistribution which gives his face a characteristic hollow appearance and is a visible stigmata of HIV infection. Despite all this, he is taking his medication and maintaining a low viral load.

Image credit: https://www.pcds.org.uk/clinical-guidance/lipoatrophy-syn-lipodystrophy

Figure 3: Visual scale to grade HIV-related facial lipoatrophy



Note: Zygoma = cheekbone. Source: St Stephens AIDS Trust, Chelsea and Westminster Hospital

Case Three

- The patient is a 64 year old White gay man seen in 2010 for an abscess I&D.
- You continue his care until the present day.
- He has been on ART since his diagnosis in 1993:
  - AZT plus DDI, then 3TC plus AZT until 1997
  - Indinavir added in 1997.
  - Due to development of diabetes as well as history of kidney stones, lipodystrophy and bilateral AVN of hips requiring core decompression, indinavir changed to nevirapine in 2003.
  - Financial difficulties led to being off treatment from 2004 to 2008 (acceptable in those years if CD4 preserved) and then through 2010 (against medical advice but he could not afford treatment despite being employed).
  - Atripla started in 2010, morbilliform rash occurs due to Efavirenz.

Case Three

- After Atripla initiated in 2010, his kidney function worsened.
  - Changed to Darunavir/r + EFV + 3TC
  - In 2013, he was placed on EFV + 3TC + Raltegravir, the first integrase inhibitor
  - In 2017, his regimen was simplified to 2-drug DTG/RPV due to excellent control
  - In 2023, he changed to CAB/RPV, the first long acting injectable HIV treatment 2 drug regimen
  - He is now in his late 70s and has many health issues, but is appreciative for the many years he has received which friends and lovers did not.

Case four

- The patient is a 36 year old Black transgender woman (assigned male at birth) seen in 2009 for hypertension and smoking.
- Her HIV regimen is Atripla and her hormone therapy includes injectable estradiol. You treat her blood pressure with amlodipine and addition of spironolactone which acts as an androgen blocker.
- You try to change her HRT to topical patch estradiol to lower her chances of VTE, but she is on Medicaid and you are told Medicaid does not cover anything trans related.

Case four

- When Dr. Swindells tells you to go see her because of your primary care expertise and comfort with hypertension, you readily agree.
- She tells you to refill the patient's Atripla which is controlling her HIV well and you say "no problem."
- She also tells you to refill the patient's hormones. Keenly aware that you have received absolutely no training on transgender medicine, you ask her "Don't we have to send her to Endocrine for that?"
- Dr. Swindells gives you a look of profound British disappointment which you are well acquainted with and hands you the Harry Benjamin International Gender Dysphoria Society guidelines. She says to read fast, get on with it and go take care of our patient.

Case four

- Reading the guidelines, you realize it is… much more straightforward than hypertension control.
- You go and talk with the patient, who is initially rather mistrustful, but who agrees to work with you and you wind up getting along very well with her as you continue to see her.
- You had noticed a diagnosis of a personality disorder in her chart. Digging deeper after the visit, you realize one of your co-residents had previously gotten into a heated argument and he documented following her out of the exam room and into the clinic lobby yelling at her, misgendering and dead-naming her the whole time and assigning the personality disorder because she was upset at his behavior.

Case four

- You continue to work with her and her blood pressure and HIV are very well controlled.
- Several years later, Dr. Swindells comes up to you when you arrive for afternoon clinic and tells you the patient has been shot and killed.
- You look her up and she is misgendered and dead-named in the news reports, which are the last records of her existence on Earth. No mention is made of any of her interests, personality or character.
- Over time, you realize that none of this was an accident, and that it is not getting better.

Black Americans and HIV

- https://www.kff.org/hivaids/fact-sheet/the-impact-of-hiv-on-black-people-in-the-united-states/
- “Black people in the U.S. have been disproportionately affected by HIV since the epidemic’s beginning, and that disparity has deepened over time.
- Although they represent only 12% of the U.S. population, Black people account for a much larger share of HIV diagnoses (39%), people living with HIV (40%), and deaths among people with HIV (43%) than any other racial/ethnic group in the U.S.”
- https://oneill.law.georgetown.edu/the-forgotten-community-black-women-weathering-the-waves-of-hiv
- “Data conducted from 2019 to 2020 in seven major U.S. cities revealed that 62% of Black transgender women had HIV.”

Black Trans Women and Violence

- https://www.hrc.org/press-releases/hrcs-2024-epidemic-of-violence-report-fatal-violence-against-transgender-and-gender-non-conforming-people-continues-with-black-trans-women-comprising-nearly-half-of-the-deaths
- “Since 2013, fatal violence against transgender and gender non-conforming people has disproportionately impacted the Black, Indigenous, and People of Color community with at least 314 BIPOC trans and gender non-conforming people killed – translating to 84.4% of all victims identified to date. Three quarters (73.7%) of all victims have been Black trans women–a total of 274 lives lost. The majority of victims (74.7%) were under the age of 35, and almost 70% of incidents involved a firearm (a total of 258 lives lost), with many cases remaining unsolved.”
- “Over half of the victims reported [in 2024] were Black trans women, a disturbing reality that reflects the trend of violence that continues to plague our community which disproportionately faces racism, misogynoir, sexism, transphobia and a myriad of other societal issues. In spite of these tragedies, I choose to remember the beauty brought to the world by those victims who left this earth far too soon and will celebrate their memories by continuing to fight for them through the Trans Justice Initiative’s advocacy and our leadership development work.” Tori Cooper, Director of Community Engagement for the Transgender Justice Initiative for the Human Rights Campaign Foundation

Primary Care for People Living with HIV (PLWHIV)

Updates for 2024 and beyond

Primary Care is Primary Care

- Much of the care we provide in primary care is no different than it is in any other population!
- However, there are several unique aspects and a lot to remember…

Immunizations -
- Influenza - Yearly
- COVID-19 - Yearly
- Hep A – Screen and revaccinate
- Hep B –Screen and revaccinate
- Pneumococcal – See Guidelines*
- Tdap-See guidelines
- RZV (Shingles) – all >18
- Meningococcal conjugate- 2 dose series then q5 years
- MMR - Check serologies and consider revaccination
- HPV – all 9-26, consider 27-45
- Mpox – Advise in all with high-risk sexual practices, within 2 weeks of exposure, 2 dose 4 weeks apart
- RSV – all >75, Consider 65-75 w/ RF's

STI surveillance and prevention -
- GC/CT: Consider q3-12 mo depending on risk
- Syphilis: Consider q3-12 mo depending on risk
- Hep C: yearly for MSM/TGW and IVDU)
- DoxyPEP - not indicated (MSM or TGW with STI within last 6-12 months)

TB surveillance -- negative January 2025

DM screening –Consider yearly

Lipid screening –(Indications: mod-high intensity statin for age 40-75 with 10-year ASCVD 5-20%; discuss the option of a mod-intensity statin for age age 40-75 with ASCVD <5%; if known ASCVD, DM, or 10-year risk >20%, or age<40, refer to guidelines for those without HIV)

Kidney screening: Yearly

Last urine protein Cr ratio – Consider yearly

Bone density screening – Age 50 AMAB, post-menopause AFAB

Cancer Screening
- Cervical – Start age 21 – Check guidelines!
- Breast – Discuss at age 40
- Anal cancer – start age 35 for MSM, >45 for all
- Prostate – Discuss at age 50
- Colon cancer - Discuss at Age 45
- Lung cancer - (if age 50 to 80 with > 20 pack-year history and currently smoking or quit in past 15 years)

AAA screening - Not indicated (men 65-75 if any smoking history)

Oral health - (yearly)

Eye care - (yearly)

Depression Screening – PHQ2 or 9 yearly, consider GAD7 yearly

Cognitive – Consider MMSE or MoCA yearly

#Social determinants of health:

Housing: Yes

Insurance: Yes, BCBS

In case management: No

Case manager: NA

Primary Care in PLWHIV Perspective

- Most deaths in patients living with HIV receiving ART are related to NON-AIDS related illnesses
- HIV infections increases the risk of CVD, renal, liver, and malignant disease.
  - Also, these thing happen at YOUNGER ages than the general population

Primary Care Guidance for Providers Who Care for Persons With Human Immunodeficiency Virus: 2024 Update by HIVMA/IDSA

-a summary-

Patient Engagement

- Optimizing **engagement**, **adherence** and **viral suppression**
  - Decrease barriers to care
  - Linguistically and culturally appropriate care
  - Gender-affirming and Trauma informed care
  - Address structural and social determinants of health
  - Identify a PCP

Long Term HIV Monitoring

- HIV specific monitoring after initial assessment
  - Start ART→HIV RNA within 8 weeks and every 8 weeks until viral suppression
    - Then q 3 months to ensure maintenance of suppression
  - “Blips” – HIV RNA detectable but <200 – address adherence, tolerability and interactions
  - CD4 Count – q3-6 mo for 2 years or if not virally suppressed
    - Optional when CD4 rises >500
  - Repeat HIV genotyping for resistance, consider if:
    - Virologic failure
    - If ART initiation has been substantially delayed, repeat testing

Long Term HIV Monitoring

- CBC q year
- CMP q 6 months
  - Glucose, creatine, GFR, electrolytes, AST/ALT, total bilirubin 1-2 months after ART initiation or change
- UA – yearly consider in all
  - Before and during treatment with tenofovir (TDF or TAF)
- TB screening – yearly in those at continued risk
  - Repeat testing for negative TST or IGRA at dx with CD4 <200 that laters rises to >200
- HCV screening q year – antibody ok
  - With RNA if suspected infection in last 6 mo and previous infection that has cleared or been treated
  - With RNA if CD4 <200
- HBV – screen repeat when switching to ART that does not cover HBV
- Pregnancy Testing when indicated prior to ART start or change
- STI Screening (see later)

Mental Health and **Substance Use**

- Depression screening yearly – PHQ 2/9
- Anxiety screening yearly is reasonable – GAD 7
- Tobacco use screening at every visit
- Unhealthy Alcohol use at least once, consider more often
- IVDU – screen regularly
  - For those that do inject:
    - counsel on safer injection, safe use practices to prevent viral hepatitis and other infections
    - PreP and PEP for injection partners
    - Info on syringe services if available
    - Naloxone!

Other Health Care maintenance

- All with childbearing potential:
  - Ask about pregnancy intentions
- **Adherence education**: maximize personal health and reduce transmission - U=U
- **Optimize Sexual Health**: PreP, PEP, barrier protection, other strategies to reduce STI transmission
- Oral health exam q6-12 mo

Immunization Considerations

- Inactive is safe
- Live ok with CD4 >200

- **Everyone** gets: Pneumococcus, influenza, meningococcus, Tdap per standard guidelines
- HAV and HBV
  - HAV for all nonimmune – repeat HAV IgG 1-2 months after 2nd vaccine to assess immunogenicity – REPEAT series if still non-immune
  - HBV for all susceptible – adjuvant recombinant vaccine preferred (Heplisav)
  - HBV for all nonimmune sexual partners of anyone with positive HBsAg
  - HBV vaccine for those with HBcAb but negative HBsAb and HBsAg

Immunizations Continued

- **MMR** vaccine (if CD4 >200)**
  - Born after 1957 w/o vaccination yet
  - Check for immunity
- HPV
  - 3 dose series 0, 2, 6 mo (9-valent vaccine)
  - All 9-26
  - Offer with shared decision making for 27-45
- VZV – Shingles
  - *Those exposed WIHTOUT vaccination/varicella zoster infection/seronegative need PEP with varicella zoster IgG ASAP/within 10 days of exposure
  - Primary vaccination**: >8 yo** with CD4 >200
  - RZV 2 dose series – **for all >18** (response may be better on ART and CD4 >200)

Immunizations Continued

- **Mpox**
  - Offer live nonreplicating modified vaccine Ankara-Bavarian Nordic (MVA-BN – 2 dose series 4 weeks apart
    - People w/o lesions with known or suspected exposure in last 2 weeks
    - MSM, gender diverse individuals with new STI in last 6 months or more than 1 sexual partner
    - Had sex in a place with high mpox transmission in last 6 mo
    - Had sex at a commercial sex venue in last 6 mo
    - People with a sex partner with any of the above risk factors or anticipate the above scenarios
- RSV – all >/= 75, 65-74 with RF's for severe RSV (see guidelines) -1 dose

Cancer Screening

- Same except for HPV related cancers
  - **Cervical Cancer** screening differences:
    - 21-30 yo q year until 3 consecutive normal → q 3 years
    - >30 yo q year until:
      - 3 normal w/o HPV → q 3 years
      - 1 normal with neg HPV and smear
    - NO age limit
  - **Anal Cancer** screening:
    - >35 if anal penetrative intercourse (transwomen and MSM)
    - >45 all
  - Consider oncogenic cancers such as:
    - EBV
      - general-Lymphoproliferative ds, Burkitt lymphoma, Hodgkin, nasopharyngeal CA, Gastric CA, T cell lymphoma
      - HIV-specific – NHL, child-smooth muscle tumors, oral hairy leukoplakia
    - HPV: Cervical, Head and Neck, Anal, Penile
    - HCV: HCC-see below
    - HBV: HCC-see below
  - Prostate, breast, lung, colon according to USPSTF
  - HCC screening q6 mo if:
    - Any cirrhosis
    - Chronic Hep B
    - Chronic Hep C w stage F3 or F4 fibrosis
- Screen for tobacco use, alcohol use, vaccinate against HPV and HBV

Cancer screening for Gender Diverse Patients

- Screening to be done for all tissues present that should be screened
  - Post Vaginoplasty (AMAB) – Prostate cancer screening still needs to be discussed
    - PSA is NOT reliable for patients on androgen blockade or s/p orchiectomy
    - A DRE or DRE and neovaginal prostate exam should be used
  - AMAB on feminizing HRT
    - consider mammogram after 5 years of HRT
    - Don’t forget about the prostate!
  - AFAB
    - Pap Smear! This is difficult for patients. Build rapport and consider referral to a gender competent gynecologist

STI Screening

- Gonorrhea, chlamydia and syphilis (trichomonas for receptive vaginal sex) q year for sexually active and all on entrance to care
  - Gon/Chlam testing by NAAT at site: oral, anal, urethral/urine, vaginal/neovaginal
  - Consider self swabs – inc acceptance, teach technique well
  - Pharyngeal Gon – Test of Cure with NAAT at 7-14 days
    - Positive ToC need susceptibilities
  - Pregnant: screen for Gon/Chlam, Syphilis @ 1st visit, 28wks, and syphilis again at delivery
- Mycoplasma genitalum: screen in recurrent urethritis or cervicitis, consider in PID
- TB screening – for all once diagnosed with IGRA or TST
  - Consider yearly screening for those at continued increased risk

STI Screening cont.

- Mpox
  - Exposure: monitor for sx for 21 d, consider vaccination if asymptomatic and w/in 14 d of exposure
  - Cutaneous, oropharyngeal or anorectal lesions → test for orthopoxvirus (Mpox) and isolate per CDC
  - Screen for all other STI's with suspected mpox cases
  - Do NOT delay ART if mpox dx'd at same time as HIV
  - Tx mpox with tecovirimat in HIV patients if
    - Not virally suppressed
    - CD4 <350
    - Pregnant
    - Other immunocompromising conditions
    - Severe disease/lesions
    - Bacterial super infections especially needing debridement
    - Other conditions that put them at risk of poor outcomes

STI Prevention

- DoxyPEP
  - Offer to Cisgender men, bisexual men, transwomen, and other MSM
  - Anyone with HIV that has had Gon/Chlam or Syphilis in last 12 months or engage in high-risk sexual activities
  - Dose: Doxycycline 200 mg single dose after and within 72 hours of sexual contact
  - Anyone using DoxyPEP needs STI screening q 3-6 months

Cardiovascular and Metabolic Disease

- Cardiovascular disease
  - HIV itself increases risk
  - PI's and abacavir
  - People living with HIV have higher rates of weight gain, HTN, hyperlipidemia, hyperglycemia/glucose intolerance: Be vigilant
    - HTN at every visit
    - Lipids – Reprieve Trial* - see later
    - Diabetes screening (fasting glucose!)
    - Tobacco cessation

Cardiovascular Health

- **Lipids** fasting or random prior to AND within 1-3 months of starting ART
  - Abnormal random → fasting
  - Abnormal → National Lipid Assoc. Part 2 and 2018 Multispecialty Blood Cholesterol Guidelines
  - Assess ASCVD risk
  - Statin for primary prevention for 40-75yo can be considered for ALL
    - **Strong recommendation for ASCVD risk >5%**
    - High intensity for ASCVD >20%
    - At least Moderate intensity for any lower risk

Cardiometabolic Health

- Random or fasting blood sugar AND A1c PRIOR to ART
- **After ART A1c is insensitive – may underestimate DM risk**
  - A1c >6.5% CAN dx DM
  - A1c <6.5% needs a fasting plasma glucose to screen and assess DM risk more accurately
  - Can still use A1c to assess DM treatment goals with goal <7%
- **Weight** - each visit
  - Counsel on diet, exercise, etoh use
  - No current data to switch ART solely based on weight gain

Metabolic Disease

- LFT increase
  - NAFLD w/u with US, MRI or CT.
    - Steatosis → Fibrosis w/u with FIB-4, Fibroscan or MRI elastography
    - Weight loss is corner stone of treatment (consider medications)
  - Remember screening for viral hepatitis

Premature Bone Loss

- **DEXA** start at age 50 for AMAB, postmenopausal for AFAB
    - Dx underlying secondary causes: hypogonadism, vitamin D deficiency, hyperparathyroidism, thyroid disease: hormone level, vit D 25OH, PTH, TSH
    - Tx: Increase physical activity (weight bearing), smoking cessation, Calcium and vitamin D supplementation, bisphosphonates for those that meet criteria for osteoporosis

Chronic Lung Disease

- Chronic Lung Diseases all appear more common in patients living with HIV
  - COPD
  - Lung Cancer
  - Pulmonary HTN
  - Pulmonary fibrosis

PC in PLWHIV

- Common Infections vs OI's
  - If they are virally suppressed and have a normal CD4 since or before being virally suppressed…
    - Treat normally! OI's are LOW on the DDx

Pregnancy in PLWHIV

- All pregnant and breast feeding/chest feeding persons with HIV need ART regardless of immunologic/virologic status as early as possible, ideally prior to contraception
- Infant Feeding:
  - Get evidence-based counseling – Shared decision making
  - Patients on ART that are virally suppressed and choose to breast/chest feed should be supported
    - CPS is NOT an appropriate response to those that choose to breast/chest feed

Transgender and GD people LWHIV

- Gender affirmation and respect is key to engagement
  - Affirming, non-stigmatizing, non-discriminatory and culturally sensitive
- Consider intake forms, medical records should include:
  - Gender identity options, sex assigned at birth, chosen name, pronouns, legal name
- Gender affirming medical care should be offered in accordance with national guidelines (Endocrine Society, WPATH, etc)
- Be comfortable with GAHT or know how to refer to a provider or endocrinological specialist that is competent in gender affirming medical care

Primary Care Guidance for Providers Who Care for Persons With Human Immunodeficiency Virus: 2024 Update by HIVMA/IDSA
Published by Clinical Infectious Diseases, 10/12/2024

- Michael Horberg, Melanie Thompson, Allison Agwu, Jonathan Colasanti, Marwan Haddad, Mamta Jain, Grace McComsey, Asa Radix, Natella Rakhmanina, William R Short, Tulika Singh, Hansel Tookes, on behalf of the HIV Medicine Association, Primary Care Guidance for Providers of Care for Persons With Human Immunodeficiency Virus: 2024 Update by the HIV Medicine Association of the Infectious Diseases Society of America, Clinical Infectious Diseases, 2024;, ciae479, https://doi.org/10.1093/cid/ciae479

https://pmc.ncbi.nlm.nih.gov/articles/PMC9025375

- **Primary Care of the Person Living with HIV**
- Mary J Kasten
- Editor: Nathan W Cummins
- “Many primary care providers become involved in the care of persons living with HIV once they are on stable ART and doing well from the HIV standpoint. Primary care of these patients is very similar to the general population; however, liver disease, coronary artery disease, HPV-related cancers, osteoporosis, and mental health concerns are more common among people living with HIV.”

https://www.nih.gov/news-events/news-releases/end-hiv-epidemic-we-must-address-health-disparities

- Scientific strides in HIV treatment and prevention have reduced transmissions and HIV-related deaths significantly in the United States in the past two decades. However, despite coordinated national efforts to implement HIV services, the epidemic persists, especially in the South. It also disproportionately impacts marginalized groups, such as Black/African-American and Latinx communities, women, people who use drugs, men who have sex with men, and other sexual and gender minorities.
- The authors explained that stark disparities in HIV outcomes also exist between certain age, racial, and ethnic groups, as well as between sexual and gender identities. While HIV diagnoses decreased overall and among white men who have sex with men between 2009 and 2018, new cases remained stable among Black/African-American men who have sex with men and increased among young people aged 25-34 and Latino men who have sex with men. While Blacks/African Americans make up only about 13% of the U.S. population, they accounted for 43% of HIV-related deaths in 2018. Researchers suggested that culturally appropriate, tailored interventions may help communities respond to the unique needs of people in—or at the intersections of—these groups.

https://www.ajmc.com/view/health-disparities-in-hiv-care-and-strategies-for-improving-equitable-access-to-care

- The US HIV/AIDS Strategy and Ending the HIV Epidemic (EHE) initiatives aim to reduce HIV transmission by 90% by 2030 through targeted care and prevention initiatives such as the Undetectable = Untransmittable strategy. Effective HIV management involves implementation of widely available testing to ensure early diagnosis, immediate or early initiation of antiretroviral therapy (ART), patient adherence to medication, and retention in care to achieve viral suppression and improve clinical outcomes. A disproportionate burden of HIV incidence is experienced by certain populations that include Black/African American and Hispanic/Latinx people, transgender individuals, those who inject drugs, older adults, and people living in the southeastern US. People with HIV (PWH) in vulnerable and underserved populations are more likely to be affected by the negative impacts of structural and social determinants of health—such as experiencing HIV-related stigma, poverty, and homelessness—resulting in barriers to accessing HIV care and achieving favorable treatment outcomes. Suboptimal HIV care negatively impacts outcomes for both individuals and society. Overall and comorbidity-free life expectancies are lower for individuals who start ART late than for the overall PWH population, and a lack of viral suppression increases community transmission rates. These poor outcomes increase costs for both patients and health care systems.

https://aidsunited.org/targeting-the-most-vulnerable-how-trumps-executive-orders-undermine-progress-in-hiv-care/

- The executive orders issued and rescinded by President Trump have numerous implications for the well-being and livelihood of those living with and impacted by HIV. Many of these executive orders are likely to undermine the years of progress we have made in securing the rights of our communities and ensuring an end to the HIV epidemic.
- The administration's efforts to block DEI efforts, and in turn limit federal funding for such programs, will have negative consequences on our ability to effectively respond to the HIV epidemic in the U.S. The National HIV/AIDS Strategy and Ending the HIV Epidemic Initiatives are both built on the understanding that any efforts to combat HIV in the U.S. are predicated on eliminating racial health inequities. This requires targeted and sustained investment in communities of color who are disproportionately impacted by the epidemic. Great progress and achievement have been made by programs that address health disparities of Black and Latine people living with HIV. HIV initiatives rely heavily on these grants and their potential recession will make efforts to address racial health disparities among people living with HIV more difficult.