IHS HIV Primary Care 2022

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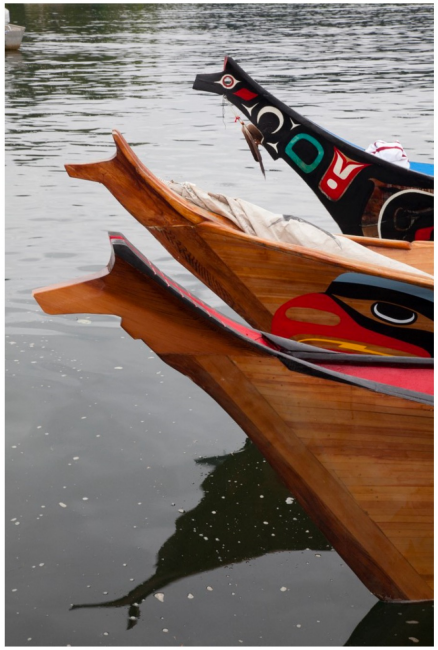
Disclosures



INDIAN HEALTH SERVICE

HIV Primary Care Treatment Guidelines for Adults and Adolescents

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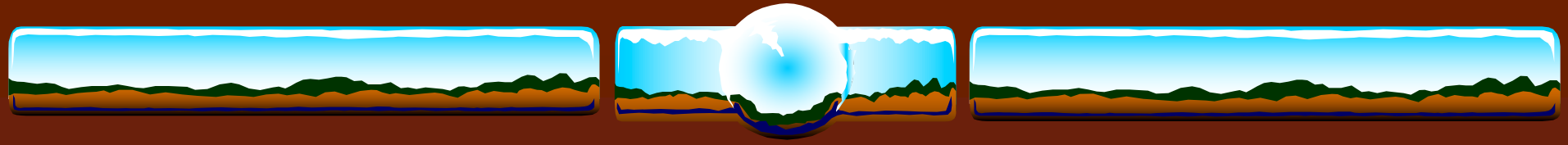
https://www.ihs.gov/sites/hivaids/themes/responsive2017/display_objects/documents/ihshivguidelinesadultadolescent.pdf

Presentation

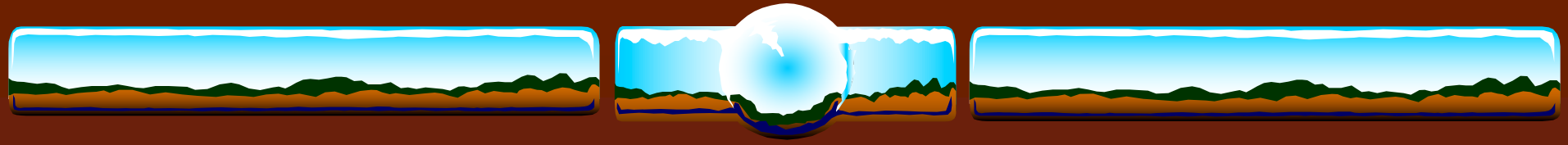
- A 42-year-old male teacher presents to the clinic for a blood pressure check after a recent emergency room visit for an ankle sprain. He feels well today and would like to establish primary care. You order a lipid panel, HgbA1c, Hepatitis C serology and fourth generation HIV test. The HIV test comes back positive.

What do you do now??



First visit goals

- Get to know the patient at the first visit
  - Spend most of that visit explaining the basics
  - Focus on the ease and effectiveness of modern treatment
  - Show that you care!
- Work to destigmatize HIV and normalize HIV care
- Connect the patient to your treatment team the same day



COMPASSION is the essential

"the secret of the care of the patient is in caring for the patient"

— Dr. Francis Peabody

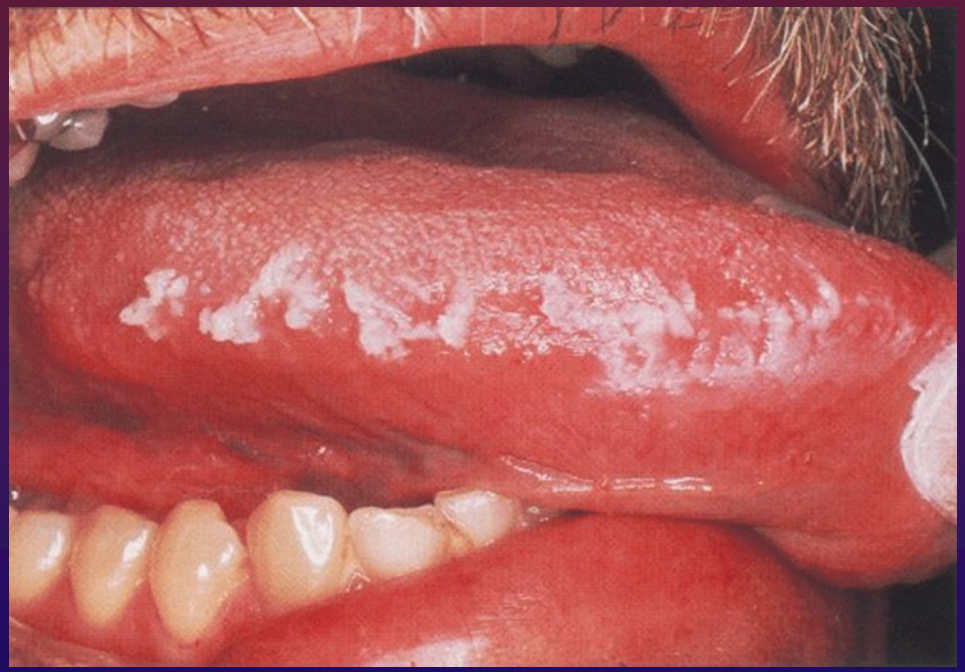
History

- Current symptoms
- Risk factor screening
- Sexual history
- Psychiatric history
- Substance Use
- Social: supports, employment, housing, incarceration history
- Domestic violence

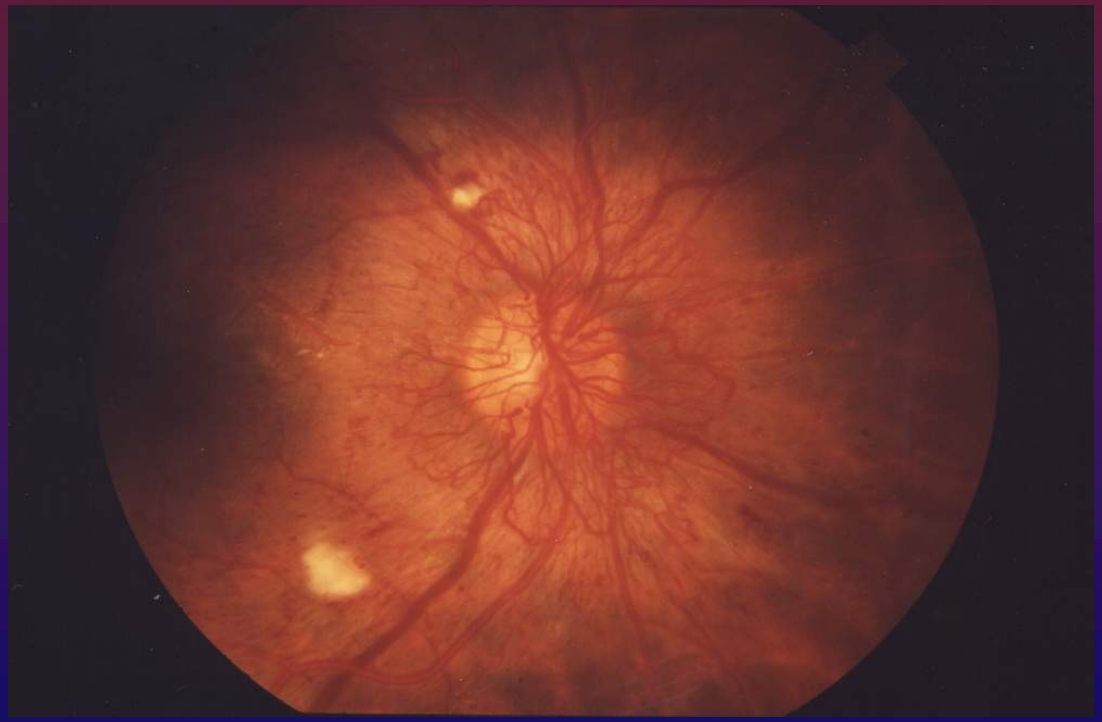
Physical Exam

- Lymphadenopathy
  - Cervical
  - Epitrochlear
- Oral Hairy Leukoplakia
- Oral Thrush
- Cotton Wool Spots
- Splenomegaly
- Rashes
  - Acute HIV rash
  - Syphilis

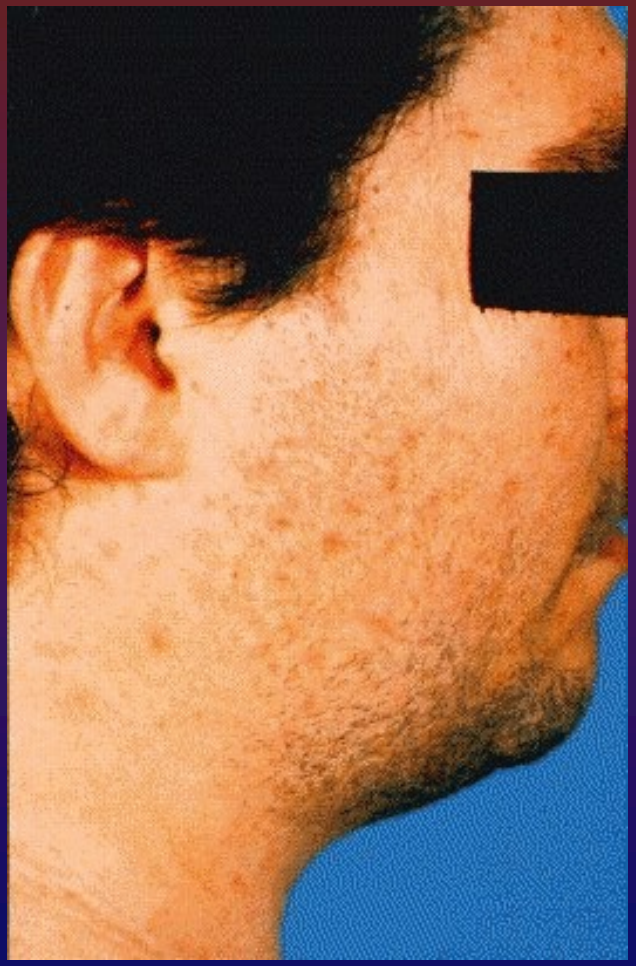
Oral Hairy Leukoplakia



Cotton Wool Spots



Acute HIV Rash



What Labs and Studies to Order…

- The Big Three for staging purposes
- The co-infection labs and x-rays
- The special cancer tests
- The pre-drug treatment tests
- Basic Primary Care tests

The Big Three

CD4 Count	At diagnosis, then 3 months after starting ART then ever 3-6 months for two years. After 2 years of virological suppression, monitor CD4 count every 3-6 months when CD4 < 300. If 300< CD4 <500, then monitor every year. If CD4 > 500, then monitoring is optional. CD4 monitoring is indicated at any time there is loss of virological control.	Use one laboratory and methodology
HIV Viral Load	At diagnosis & q 3-6 months at first then every 6 months after 2-3 years of virologic control	Use one laboratory and methodology
Genotypic antiretroviral resistance test	At diagnosis on all patients and with failure of virologic control	Test prior to starting antiretroviral therapy on all patients: NRTI, NNRTI, PI

The Co-infection labs

RPR or T. pallidum EIA	At diagnosis and yearly	LP if evidence for neuro/ocular syphilis
GC/Chlamydia NAAT	At diagnosis and yearly Consider q 3-6-month test if ongoing STI risk	Order rectal & pharyngeal test if at risk, in addition to urine
IGRA assay or PPD	At diagnosis and yearly	CXR if positive
Hep A tot Ab HBsAg, HBsAb HCV Ab	Once for all patients. Test MSM, transgender women and IDUs annually for Hepatitis B and C	Vaccinate for Hep A if serology is negative. Vaccinate for Hep B if no prior infection or vaccination
Toxoplasma Ab	Once	Prophylaxis if CD4<100
CMV Ab	Once	Test only if low risk (non MSM, non IDU)
Varicella Ab	Once if no h/o Chickenpox or Shingles	Consider vaccination if negative and CD4>200
Trichomonas vaginalis	Screen women at entry to care and annually	

The Special Cancer tests

Cervical PAP Smear	**Baseline then yearly**	**See below for age > 30**
Anal PAP Smear	Anal cytology annually	Refer positives for high resolution anoscopy/surgery clinic

Pre-treatment labs

G-6-PD Level	Once	If sulfa allergic
HLA B*5701 assay	Once if considering ART that includes Abacavir	Used to detect risk for Abacavir hypersensitivity

Baseline Laboratory Testing

CXR	Once	Only if symptoms or PPD+
Pregnancy test	Once	
Lipids	Baseline and annually	Avoid simva/lovastatin
Urinalysis	Baseline and annually if at risk for renal disease	
HGB A1c/fasting glucose	Baseline and annually	Fasting glucose is more accurate for diagnosing DM in HIV (+) persons
G-6-PD Level	Once	If sulfa allergic

The story continues…

- The returns and feels well. He confided in a close friend and feels more confident and at peace today.

- He is found to have a CD4 count of 187 and HIV viral load of 4,311. The screening tests for coinfection are all negative. You are planning the cancer screens for a later visit.

The Three questions for today…

- When should you start therapy?
- What drug should you start?
- Why should you start therapy?

When should you treat?

Treat all HIV positive patients

regardless of CD4 count

As Soon As Possible

What Drugs should you start?

Tenofovir/Emtricitabine/Bictegravir 1 po daily

Or

Abacavir/Lamivudine/Dolutegravir 1 po daily

(if HLA B*5701 (-) and HBV negative)

Or

Dolutegravir/Lamivudine 1 po daily

(if HIV VL< 500K, HBV negative, sensitive on GART)

Pregnancy

- Pregnancy during first trimester and non-pregnant women considering becoming pregnant
  - Dolutegravir is now preferred
  - Raltegravir is no longer recommended as first line
    - Updated Tsepamo data show less Neural tube defects with dolutegravir than previously seen
  - Avoid Tenofovir alafenamide, Cobicistat, and Bictegravir

Antiretroviral Therapy Basics

- The goal: Undetectable viral load at 4-6 months

- Consult and HIV Specialist if
  - Viral load fails to drop to undetectable at 4-6 month
  - Viral load rebounds to detectable level after previously undetectable
  - Pregnancy
  - Hepatitis B or C co-infection present

Virologic failure

- Three active drugs are no longer required for addressing virologic failure

- "A new regimen can include two fully active drugs if at least one with a high resistance barrier is included (DTG or boosted Darunavir"

Cabotegravir/Rilpivirine replacement

- Once monthly cabotegravir and rilpivirine IM injection can replace Rx for people on oral ART with suppression for at least three months who:
  - have no baseline resistance to either medication,
  - have no prior virologic failures,
  - do not have active hepatitis B virus (HBV) infection (unless also receiving an oral HBV active regimen),
  - are not pregnant and are not planning on becoming pregnant, and
  - are not receiving medications with significant drug interactions with cabotegravir and rilpivirine.
- The IM regimen can be started immediately without 28-day oral lead in period previously required

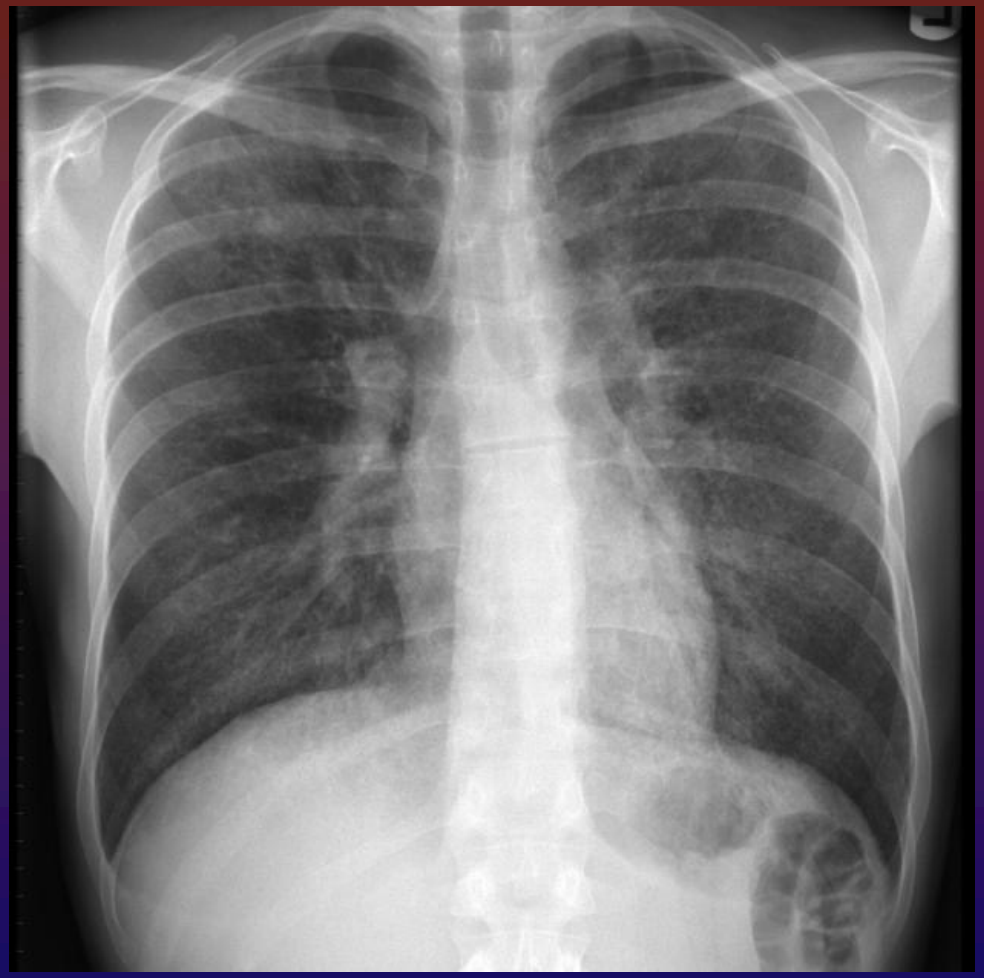
What's Next?

- Prevent co-infections
- Prevent cancer
- Prevent complications of HIV and its therapy
- Caring for the whole person
- Preventing transmission to others
- Maintaining primary care

Preventing Opportunistic Infections

Organism	CD4 Count Cutoff	Drug Regimens
Pneumocystis	≤ 200	TMP/SMZ DS 1 po qd Dapsone 100 mg po qd Atovaquone 1500 mg po qd
Toxoplasmosis	≤100 & (+) serology	TMP /SMZ DS 1 po qd Pyrimethamine, Leukovorin Dapsone
Mycobacterium Avium complex	≤50 and not starting ART	Azithromycin 1200 mg po weekly Clarithromycin 500mg po BID

Pneumocystis jiroveci pneumonia



https://radiopaedia.org/articles/1901

Routine General Health Maintenance

- Eye Care:
  - Annual eye clinic check-up to rule out HIV related eye disease.
- Dental Care:
  - Annual dental clinic check-up to rule out HIV related oral disease.
- GYN Care:
  - Pap smear preferred for women < 30 years of age.
    - If negative, repeat in 1 year
    - If 3 consecutive annual Paps are negative, test every 3 years
  - Pap plus HPV co-testing can be done every 3 years for women ≥ 30
  - Biennial Mammography age 50-74

Health Maintenance

- Bone Health
  - DEXA scans are indicated for post-menopausal women and for men age 50 or greater with HIV, especially those on Tenofovir.
  - Vitamin D level testing is recommended once and periodically as indicated.
- TB screening:
  - An IGRA test (or PPD) should be done at diagnosis and annually.
  - Twelve weeks INH-Rifapentine or 9 months of INH are indicated for PPD tests greater than 5 mm induration (not 10 mm) or positive Quantiferon tests.
  - INH-Rifapentine can also be used with dolutegravir
  - A symptom review and CXR are mandatory to rule out TB disease first.

Health Maintenance

- Vaccines:
  - Hepatitis B, influenza, TdAP and pneumococcus vaccines.
    - Consider double dose Hep B vaccine or Heplisav for failure to convert to HBsAb +
  - (PCV-20 alone or PCV-15 followed by PPSV-23)
  - HPV vaccine for females and males 9-26 per ACIP (up through age 45 permitted by FDA and recommended by IHS)
  - Meningococcal vaccine (Menactra® or Menveo®)
  - Offer Varicella vaccine if CD4> 200 and nonimmune
  - Shingrix recommended for HIV positive people (aged 19 and up) regardless of CD4 count
  - COVID series: four doses if CD4 $\geq$ 200, five if <200

Health Maintenance

- Mental Health:
  - All patients should be screened for depression, anxiety, suicidal ideation and substance use at every visit.
  - Refer to a mental health or substance use disorder counselor with MAT services as appropriate.
  - Domestic violence screening is indicated at every visit with social work referral as appropriate

Health Maintenance

- Spiritual Health:
  - All patients should be screened for spiritual health concerns and referred to a traditional healer or other pastoral care provider if desired.

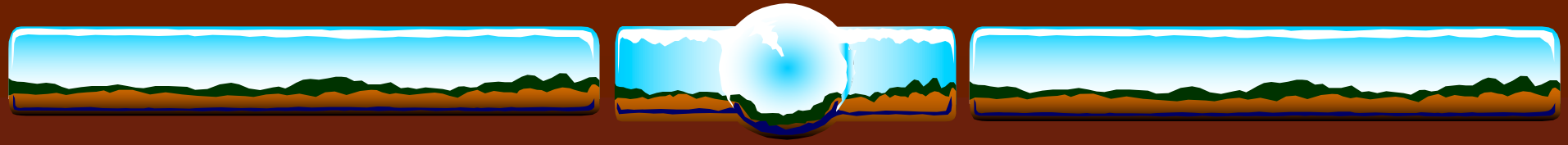
HIV Prevention in Primary Care

U = U: Undetectable equals un-transmittable

- If HIV viral load is < 200 copies/ml, there is "essentially no risk of transmission" to the HIV uninfected partner
- Condom usage should be promoted to decrease STI risk
- Prep is recommended for any person with an HIV positive partner where the partner is not on ART or not with consistently suppressed viral load
- Prep is also indicated when the HIV negative partner has additional partners or shares injection equipment

How do you keep the new patient in care?

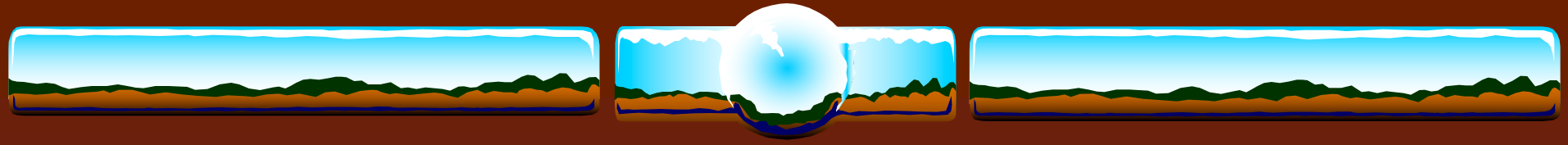
HIV Outreach Patient Empowerment
Navajo Area IHS HIV Home Treatment:
TEAM NIZHONI



Gallup Indian Medical Center
Team Nizhoni

- HIV Nurse Specialist
  - Home visits to monitor therapy
  - Jail/Detox outreach visits
  - Nurse Clinic visits: STI care, counseling, crisis intervention
- Two Health technicians
  - Navajo Speakers
  - "Home" visits to established high risk and newly diagnosed patients
- Four Pharmacists
  - Med refills
  - Adherence counseling in clinic at every visit
  - Interactions, prophylaxis, lipids, etc
  - Jail Detox visits
- 2 IM and 3 ID doctors
  - HIV ID referral and HIV Primary Care
  - Transgender care
  - Suboxone and Naltrexone
  - HCV-coinfection

HOPE Program essential tools: Flip Charts and Blister packs



How am I supposed to keep up with all of this?!!!


Speaker View
IHS HIV
Gallup
jorge-mera
Bruce Struminger, MD [UNM ...
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NAV Chinle 02 (592867402)-h323
Jaclyn Kotula PharmD IHS
Project ECHO
IT Support
Project ECHO IT Support
Cheryl
Join Audio
Start Video
Invite
Participants
10
Share Screen
Chat
Record
Leave Meeting

IHS HIV Project ECHO

- Monthly IHS telemedicine conference
  - Sponsored by University of New Mexico and IHS
  - Twenty-minute didactic talk re HIV care
  - Participants present 2-3 active cases

IHSECHO@unm.salud.edu

Second Wednesday each month, noon Mountain Time

References

- Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America, Thompson et al., https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/
- DHHS Adult and Adolescent Antiretroviral HIV Guidelines: https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/hhs-adults-and-adolescents-antiretroviral-guidelines-panel
- ACIP Recombinant Shingles Vaccine for immunocomopromised patients: https://www.cdc.gov/mmwr/volumes/71/wr/mm7103a2.htm
- ACIP Pneumococcal vaccine recomendations: https://www.cdc.gov/mmwr/volumes/71/wr/mm7104a1.htm?s_cid=mm7104a1_w