IHS HIV Primary Care 2023

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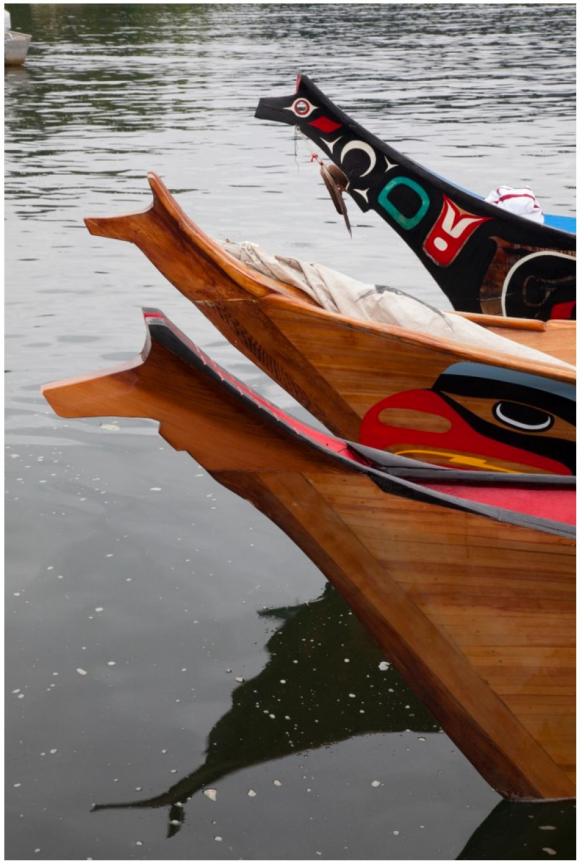
Disclosures



INDIAN HEALTH SERVICE

HIV Primary Care Treatment Guidelines for Adults and Adolescents

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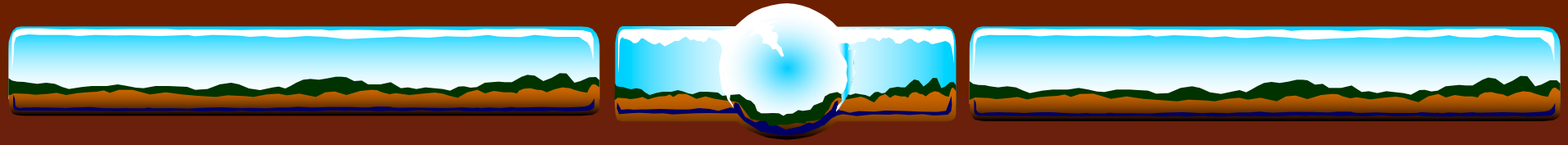
Presentation

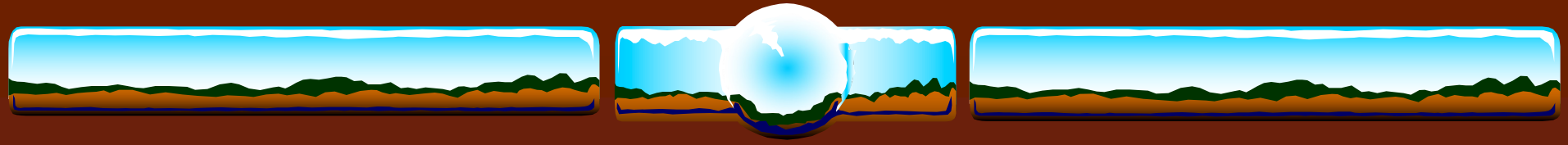
- A 42-year-old male teacher presents to the clinic for a blood pressure check after a recent emergency room visit for an ankle sprain. He feels well today and would like to establish primary care. You order a lipid panel, HgbA1c, Hepatitis C serology and fourth generation HIV test. The HIV test comes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

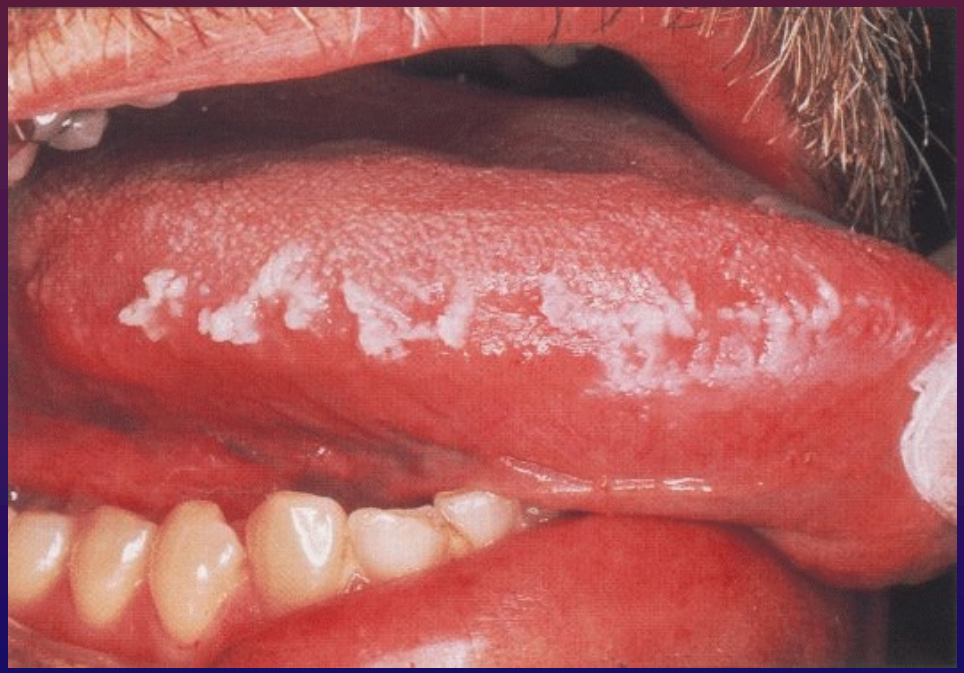
History

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

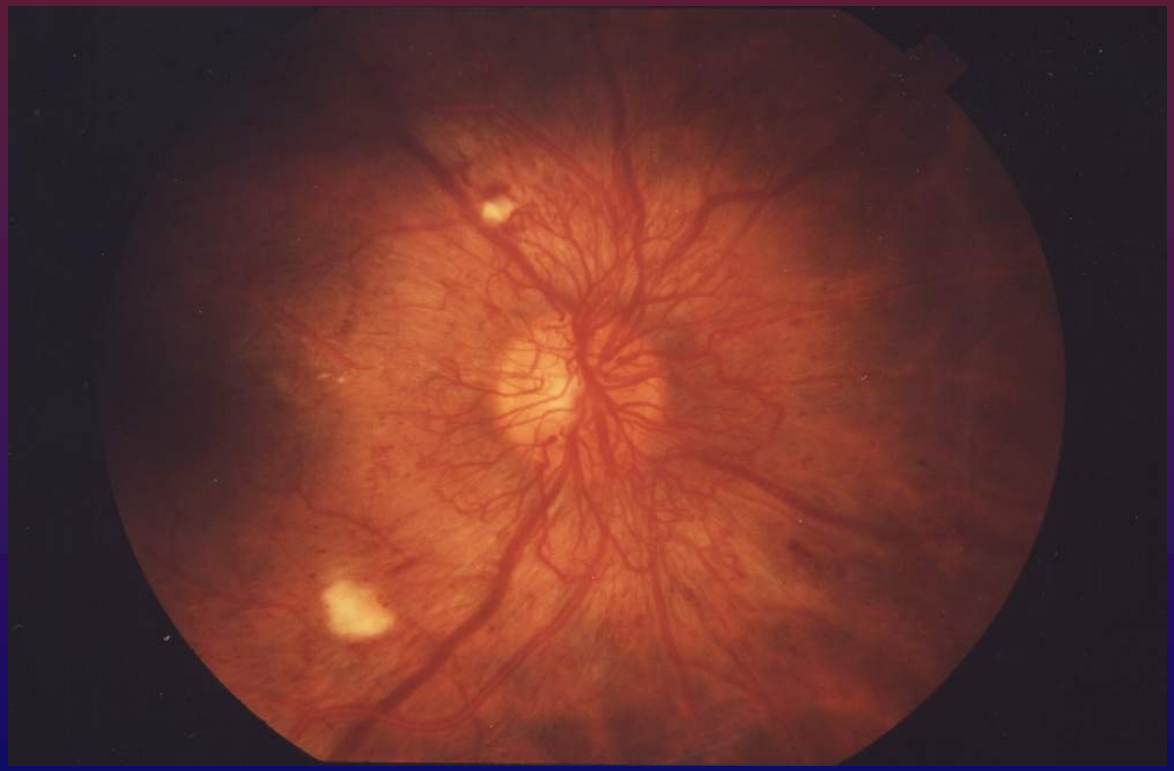
Physical Exam

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

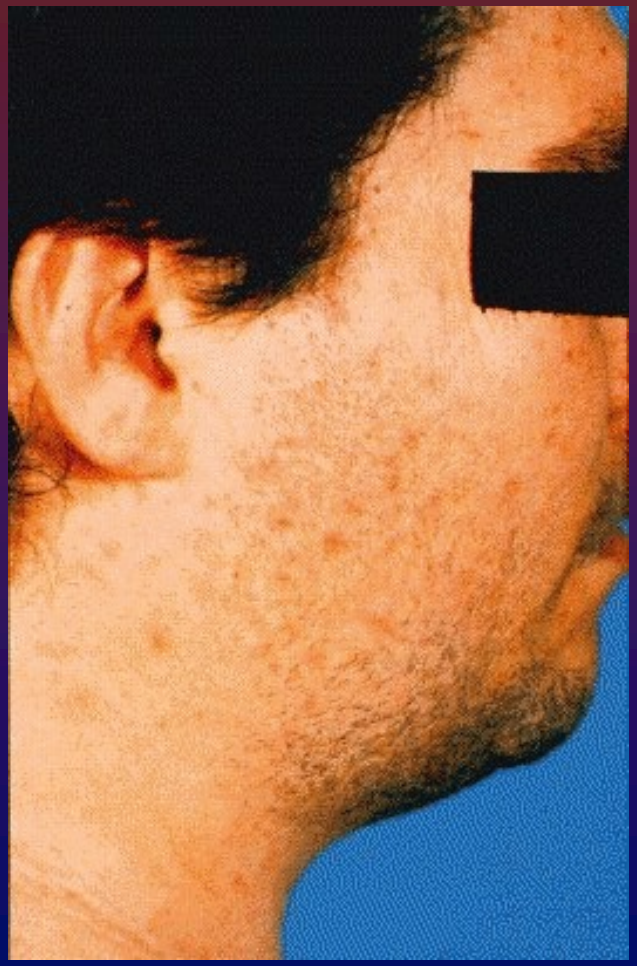
Oral Hairy Leukoplakia



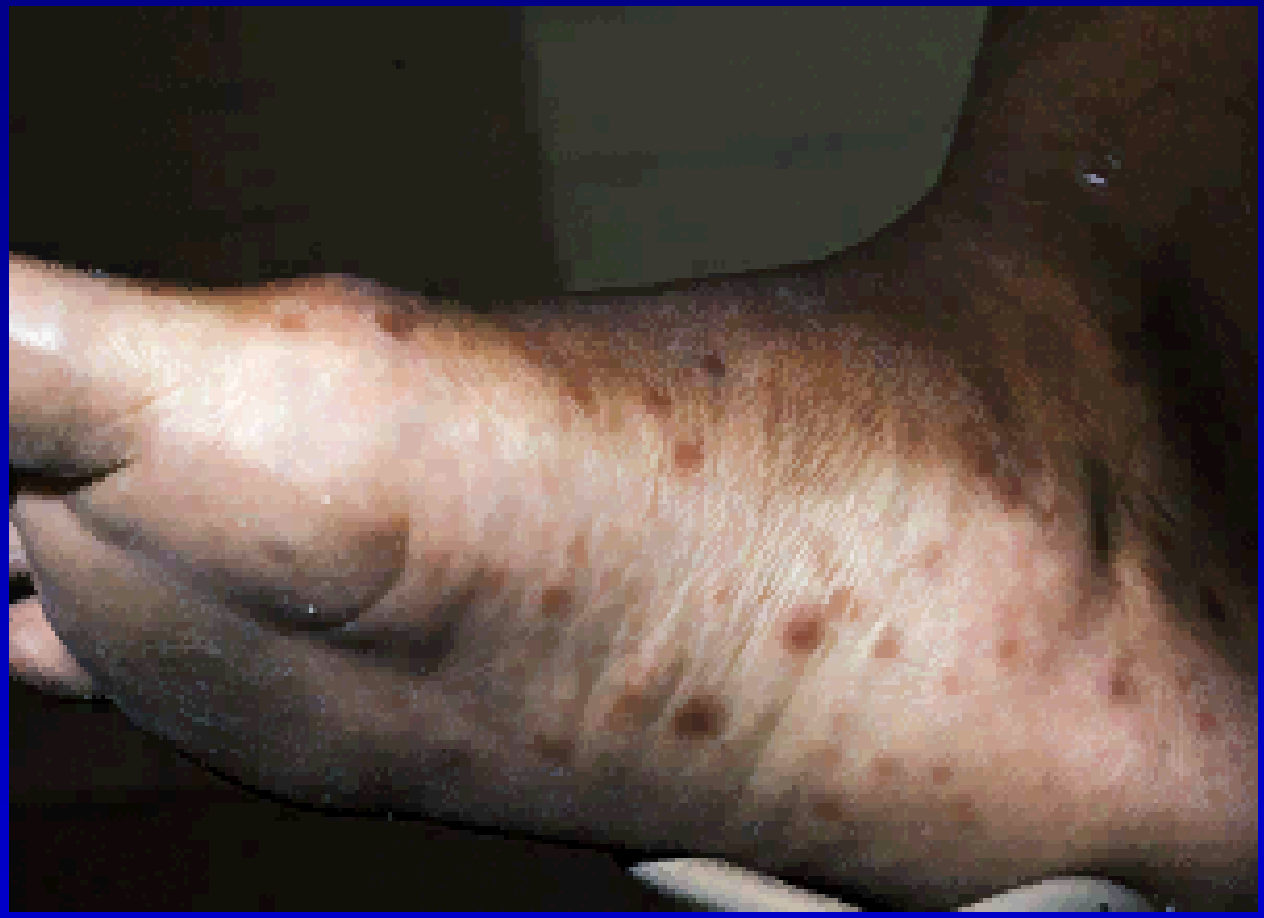
Cotton Wool Spots



Acute HIV Rash



Rash of Secondary Syphilis Papular Form



Mosby *STD Atlas, 1997*

CALIFORNIA STD/HIV PREVENTION TRAINING CENTER

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 when
	  • If CD4 < 300, monitor VL every 3-6 months
	  • If CD4 300-500, every year.
	  • If CD4 > 500, monitoring is optional.
		Use one laboratory and methodology
		
		CD4 monitoring is indicated at any time there is loss of virological control.

HIV Viral Load	At diagnosis & q 3-6 months. Measure every 6 months after suppressed and CD4 stable	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 PWID 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/transgender/PWID)
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	**If < 30, PAP yearly x 3 then if (-) q 3 years**	**If age ≥ 30 PAP/HPV co-test every three years**
Anal PAP Smear	Anal cytology annually or if positive cervical PAP	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 and with med changes or STI diagnoses	
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 co-infection 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?

DHHS guidance

Tenofovir/Emtricitabine/Bictegravir 1 po daily

Or

Tenofovir + (Emtricitabine or Lamivudine) +Dolutegravir 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)

What Drugs should you start?

IAS guidance

Tenofovir/Emtricitabine/Bictegravir 1 po daily

Or

Tenofovir (TAF or TDF) plus [Emtricitabine (FTC) or Lamivudine (3TC)] plus Dolutegravir daily

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 or Darunavir/ritonavir now preferred
  - Abacavir/Lamivudine or Tenofovir (TAF or TDF) plus FTC or 3TC
  - Bictegravir safety is unknown
  - Don’t use cobicistat or injectable ART

How soon should you treat?

(IAS 12/1/2022)

- Treat within 7 days of diagnosis ideally
- Treat the same day as rapid test diagnosis if possible
- Treat at the first clinic visit when establishing care

What if there is an opportunistic infection?
(IAS 12/1/2022)

- Start ART within 2 weeks for most opportunistic infections
- Tuberculosis
  - Start within 2 weeks for active TB without meningitis especially if CD4 count is < 50/µl
  - Start steroids with TB Rx for TB meningitis then start ART within two weeks
- Cryptococcal meningitis
  - Start ART within 2-4 weeks of diagnosis
  - If antigenemic with negative LP, Start ART immediately
- Cancer
  - Start ART immediately

Antiretroviral Therapy Basics

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

- Consult an 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 (Dolutegravir or boosted Darunavir)

Injectable Antiretroviral Therapy

- Injectable cabotegravir and rilpivirine IM injection can replace Rx for people on oral ART with suppression for 3-6 months who:
  - have no baseline resistance to either medication,
  - have no prior virologic treatment 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 oral lead in
- Monthly or every two month regimens acceptable (7 day window)

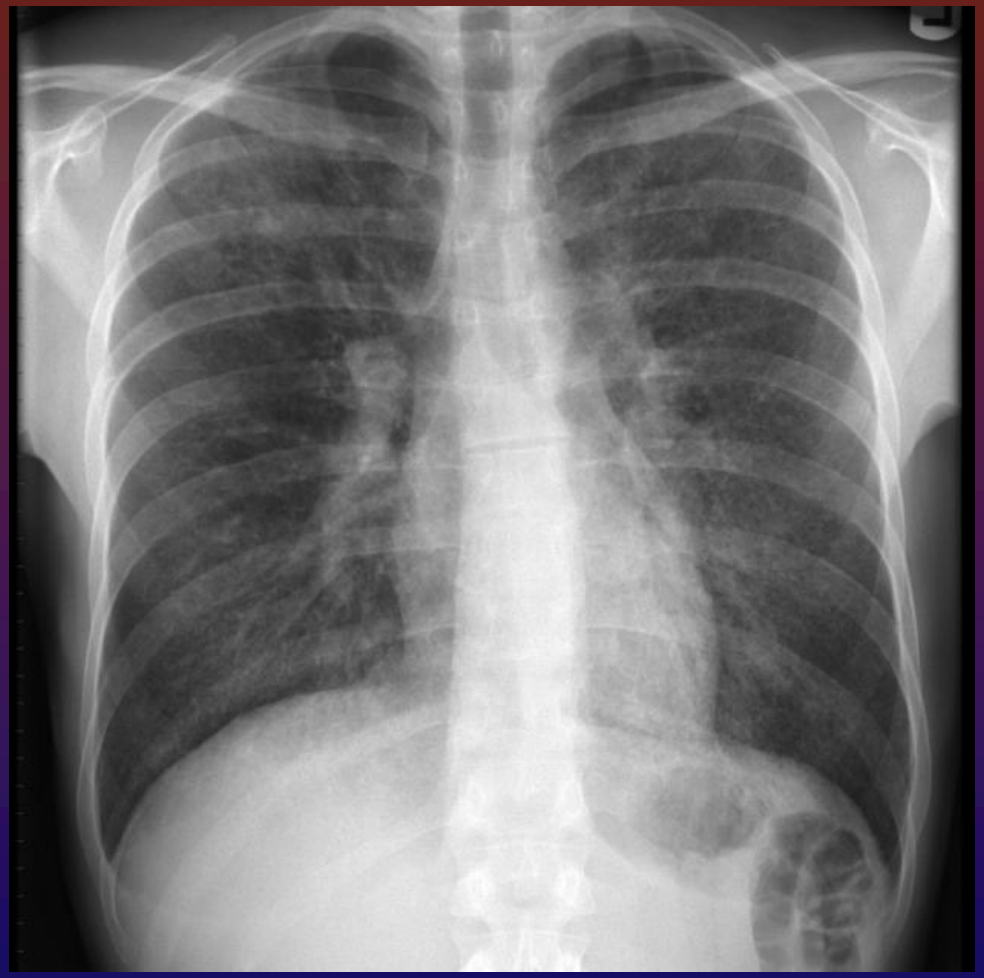
What's Next?

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

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 $\geq$ 30
  - Biennial Mammography age 50-74

Health Maintenance

- Bone Health
  - DEXA scans are indicated for post-menopausal women and for men aged 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 Heplisav for failure to convert to HBsAb +
  - PCV-20 alone or PCV-15 followed by PPSV-23
  - HPV vaccine for females and males aged 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: 2-3 doses initial series then bivalent vaccine
  - Mpox vaccine: two doses intradermal or subcutaneous

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 and offer.
    - Naltrexone IM and PO or Acamprosate for alcohol UD
    - Suboxone for opiate UD
    - Mirtazapine or Bupropion/Naltrexone for methamphetamine UD
  - 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.
- Gender Affirming Care:
  - All IHS patients deserve gender-affirming primary and referral care.

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

References

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- IAS Antiretroviral Drugs guidelines: https://doi.org/10.1001/jama.2022.22246

- 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