Revised U.S. Treatment Guidelines Focus on HIV and Aging

March 31, 2012 By Tim Horn

If you're living with HIV, over 50 years of age and haven't yet started antiretroviral (ARV) therapy, revised guidelines from the U.S. Department of Health and Human Services now recommend HIV treatment, regardless of your CD4 cell count. This is just one key consideration in a new section, entitled "HIV and the Older Patient," added to the Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, published March 27, 2012.

"In the United States," the guidelines panelists write, "approximately 30 percent of people currently living with HIV/AIDS are age 50 years or older and trends suggest that the proportion of older persons living with HIV/AIDS will increase steadily. Care of HIV-infected patients increasingly will involve adults 60 to 80 years of age, a population for which data from clinical trials or pharmacokinetic studies are very limited."

Because there are several distinct associations between age and HIV infection, the need for age-specific guidelines becomes abundantly clear.

First, the panelists note, older HIV-infected patients may suffer from aging-related illnesses that can complicate the management of HIV infection. For example, many older people living with HIV take medications to ameliorate discomfort, such as prescription or over-the-counter pain medications or sedatives. With ARVs also being used, the complexity of taking multiple medications and the need for expert guidance is realized—medication errors, poor adherence, additive drug side effects and drug-drug interactions are all risks.

Second, HIV disease may affect the biology of aging. Though it is still unclear if the immune activation associated with HIV actually causes those living with the virus to age faster or to develop a select number of health complications typically seen in older people, there is a need for guidelines that focus on identifying and managing risks of conditions such as heart, liver and kidney disease; cancer; and bone mineral loss in people living with HIV infection.

Third, reduced mucosal tissue and other immunologic defenses—such as those that occurs after menopause—and changes in risk behaviors—such as decreased condom use because pregnancy may no longer be a concern, along with increased use of erectile dysfunction drugs—can potentially lead to an increased risk of acquiring or transmitting the infection.

Finally, because older adults generally are perceived to be at low risk of HIV infection, screening for HIV in this population remains low.

“For these reasons,” the panelists state, “HIV infection in many older adults may not be diagnosed until late in the disease process." The new “HIV and the Older Patient” section, they explained, “focuses on HIV diagnosis and treatment considerations in the older HIV-infected patient.”

The recommendation that treatment be started by all people living with HIV over 50 years of age, regardless of CD4 cell count, is “moderate,” as opposed to “strong,” given that it is based primarily on expert opinion and not on the results of clinical trials or long-term cohort studies looking specifically at the effects of ARV therapy on disease outcomes in older patients. Still, the guidelines panelists thought it important to make this specific treatment recommendation “because the risk of non-AIDS related complications may increase and the immunologic response to [ARV therapy]”—such as CD4 cell gains—“may be reduced in older HIV-infected patients.”

Another recommendation stresses the need for vigilant monitoring while on ARV therapy. “[ARV therapy]-associated adverse events may occur more frequently in older HIV-infected adults than in younger HIV-infected individuals. Therefore, the bone, kidney, metabolic, cardiovascular, and liver health of older HIV-infected adults should be monitored closely,” the guidelines note.

Watching for drug interactions is also vital. “The increased risk of drug-drug interactions between antiretroviral (ARV) drugs and other medications commonly used in older HIV-infected patients should be assessed regularly,” the panelists write, “especially when starting or switching ART and concomitant medications.”

Another recommendation specifies the need for close communication between patients’ various health care providers. The panelists state: “HIV experts and primary care providers should work together to optimize the medical care of older HIV-infected patients with complex comorbidities.”

HIV prevention is also essential for older people living with HIV. “Counseling to prevent secondary transmission of HIV remains an important aspect of the care of the older HIV-infected patient,” the panelists note.

In their concluding remarks, the guidelines panelists spell out some of the key issues that lay ahead for the aging HIV-positive population. “As HIV-infected adults age, their health problems become increasingly complex, placing additional demands on the health care system,” they write. “This adds to the concern that outpatient clinics providing HIV care in the United States share the same financial problems as other chronic disease and primary care clinics and that reimbursement for care is not sufficient to maintain care at a sustainable level. Continued involvement of HIV experts in the care of older HIV-infected patients is warranted. However, given that the current shortage of primary care providers and geriatricians is projected to continue, current HIV providers will need to adapt to the shifting need for expertise in geriatrics through continuing education and ongoing assessment of the evolving health needs of aging HIV-infected patients.”

To learn more about HIV and aging, click here to read our lesson on the subject.

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