People With HIV May Fare Better With Inflammatory Bowel Disease

People with HIV and ulcerative colitis or Crohn's disease may need less IBD medication and have fewer hospitalizations.

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People living with HIV took fewer medications to control inflammatory bowel diseases (IBD) and were hospitalized less often for IBD-related illness than their HIV-negative peers, according to what may be the largest study to date of people with HIV and IBD in the era of biologic drugs, the current standard of care for IBD.

In the paper, published in the journal Clinical Gastroenterology and Hepatology, lead author Laurent Peyrin-Biroulet and colleagues called the study "the first significant evidence of the effect of HIV" in IBD.

Nevertheless, the study was relatively small, did not identify how many people with HIV were on antiretroviral (ARV) treatments or look at IBD outcomes by specific ARV regimen. It also did not differentiate outcomes based on progression to AIDS. The authors suggested that to understand the real impact of HIV progression on IBD, "a prospective study design is probably necessary."

People with HIV are no strangers to bloating, diarrhea and abdominal pain. But clinical IBD is different. It includes ulcerative colitis (UC), which causes sores in the intestines that cause pain and diarrhea, as well as Crohn's disease (CD), an inflammation of the gut and intestines that also causes pain and diarrhea as well as malnutrition and weight loss. Add in HIV, which also causes changes in the gut, and scientists have long wondered about the interaction between the two.

Or, as the study authors put it, "Both [IBD and HIV] can be considered as ends of a spectrum, with IBD being associated with immune excess and HIV to immune paucity," or deficiency.

In this study, the researchers looked back at data from 22 IBD referral centers in France and Belgium and culled data on 65 people living with HIV and IBD (either UC or CD) and 130 matched controls—people without HIV but with UC or CD. Then they compared medicine use, hospitalization and outcomes between the two groups.

For people with HIV, the median CD4 count at the start of the study was 705, with a median nadir, or lowest-ever, CD4 count of 268. While the authors don't say how many participants were on

ARVs, the proportion appears to be high. The median time between HIV diagnosis and the start of ARVs was about two months.

What they found was that only one in three people with HIV (33.8%) required immunosuppressant medications, and nearly half (47.7%) required biologic therapy for their IBD. Both of these were significantly lower than rates for those with only IBD—this was especially true for people taking biologic medicines for CD. Despite lower medication use, CD and UC in people with HIV progressed at the same rate as they did in those without HIV who were taking more medication.

And while people with HIV were more likely to be hospitalized overall, many of those hospitalizations were for AIDS-defining illnesses, such as Kaposi sarcoma and pneumocystis pneumonia rather than an IBD-related cause. A 2016 report in the Journal of AIDS & Clinical Research pointed to case reports of IBD relapsing when CD4 counts decline.

“The difference between the groups could be explained in two different ways,” the study authors wrote. “Either the fear of serious infection could have led physicians to avoid biologics and immunosuppressants in HIV-1 patients, or HIV actually favorably influences the course of IBD, leading to a decreased need of immunomodulators.”

Click here to read the full study.

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