IHS HIV Screening and Primary Care 2024

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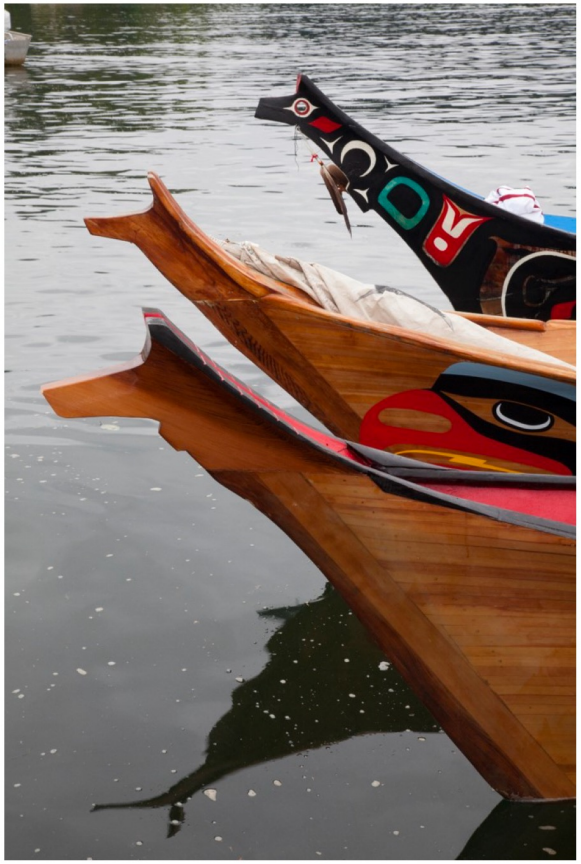
Disclosures



INDIAN HEALTH SERVICE

HIV Primary Care Treatment Guidelines for Adults and Adolescents

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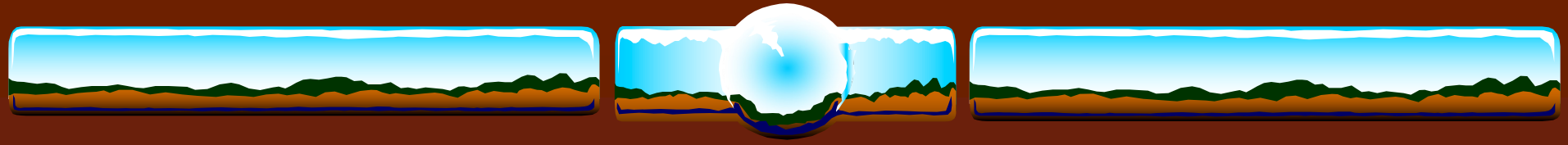
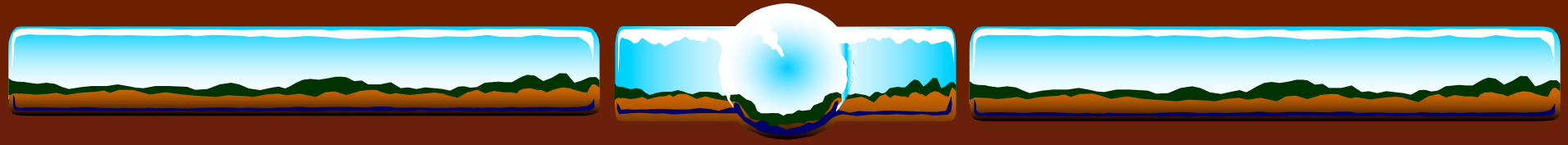


Our Current HIV Screening Goal in the IHS

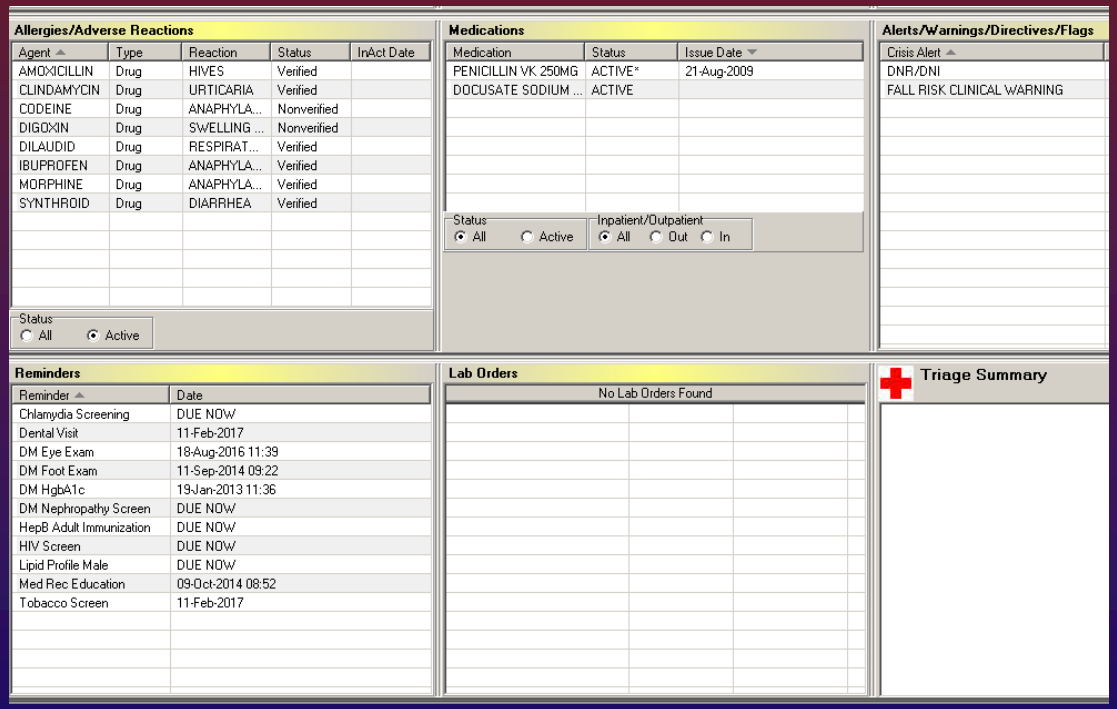
Offer HIV screening to every American Indian and Alaskan Native patient at least once in their life… and more often based on risk.



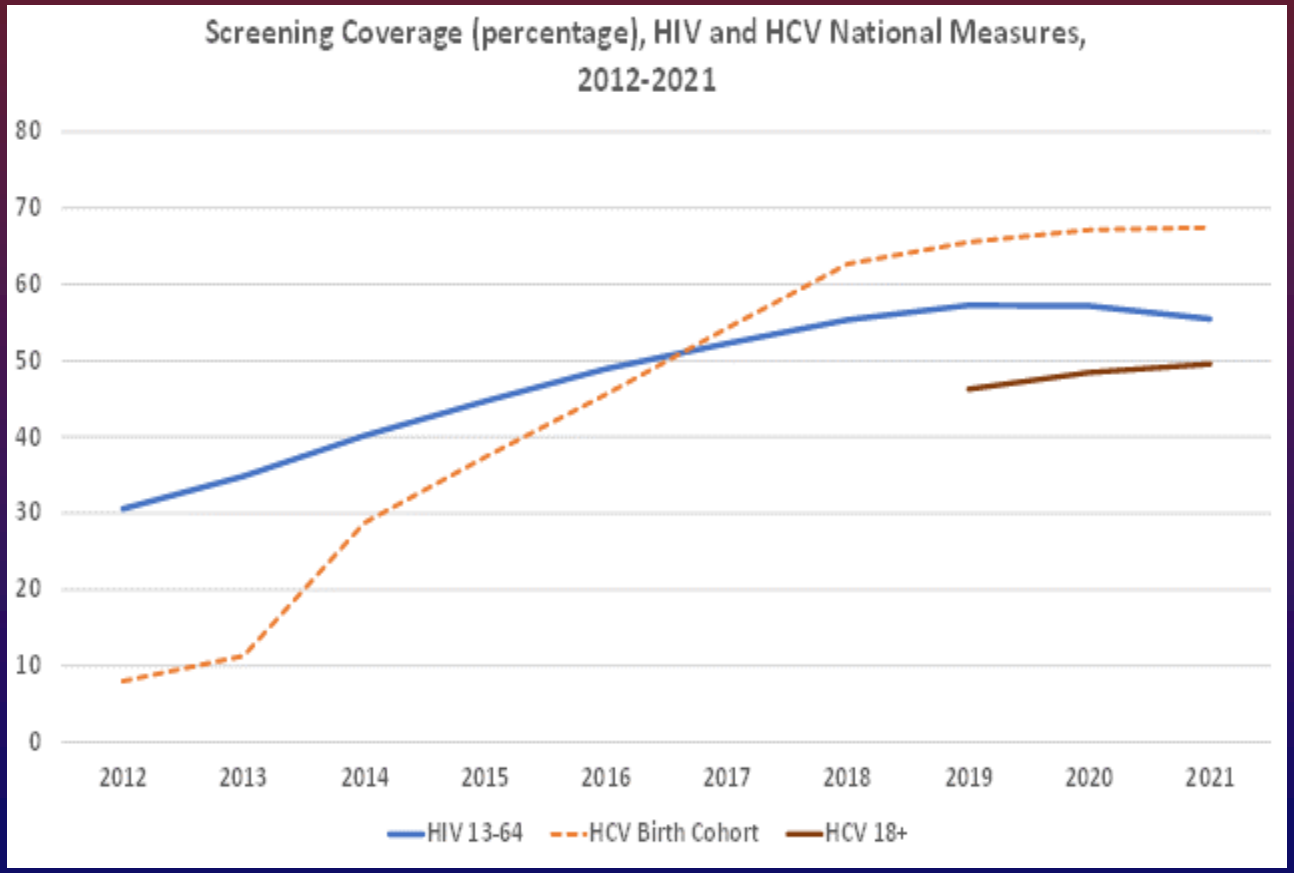
General IHS testing strategies

- Destigmatize HIV screening and offer it to everyone age 13-64
- Use an Opt-Out approach to offering an HIV test
- Utilize STI bundle testing for all Syndemic diseases at once:
  - HIV serology
  - Syphilis serology: EIA with reflex RPR/TPPA
  - Gonorrhea/Chlamydia (genital and extra-genital)
  - Viral hepatitis panel
  - Pregnancy test

EHR reminders are not the be all and end all



HIV Screening Coverage 2012-2021



Screen outside the office:

- Screen every admission to the hospital, especially the obstetrics ward

- ED/Urgent Care based testing has the highest yield
  - Universal screening is best
  - Risk-based screening is mandatory
  - Include the STI bundle into the order templates for
    - Substance use disorder
    - Pregnancy
    - Gastrointestinal bleeding
    - Trauma
    - Mental health crisis
    - STD

Express STI/HIV Testing:
On demand, no provider visit required

- Lab-based, never see a clinician or nurse
  - Patients walk directly into lab and request testing
  - Public Health team follows up on results and treatment

- Urgent Care testing with no provider visit
  - Patient signs in to Urgent Care for lab visit only
  - Telemedicine appointment made to discuss results in 7 days
  - Patient called in sooner for positive tests to arrange treatment

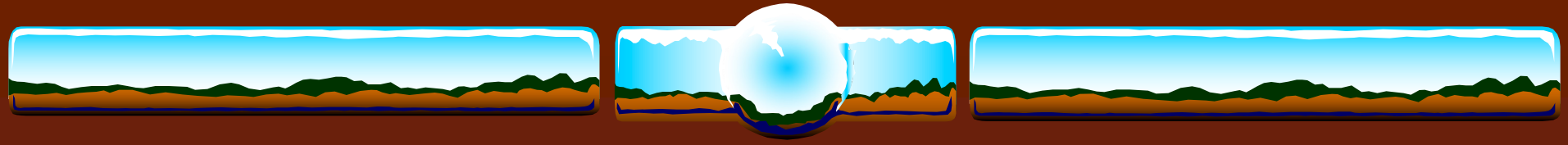
Testing the community for HIV

- Rapid testing by finger stick is optimal off campus
  - Tribal fair, soup kitchens, community pantry, shelters, jails, detox
  - Outreach vans
  - Partner testing during visits for Field Penicillin treatments for Syphilis
- I Want the Kit (IWTK)
  - Does not test for HIV and syphilis
- Getting the word out is the big challenge
  - Advertise on geospatial dating apps
  - Tribal radio and newspapers
  - Social Media

Presentation

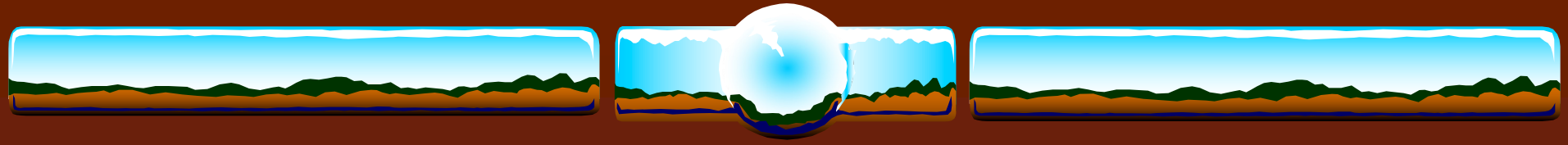
- A 42-year-old male teacher presents to the clinic for a blood pressure check after a recent emergency room visit for an ankle sprain. He feels well today and would like to establish primary care. You order a lipid panel, HgbA1c, Hepatitis C serology and fourth generation HIV test. The HIV test comes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

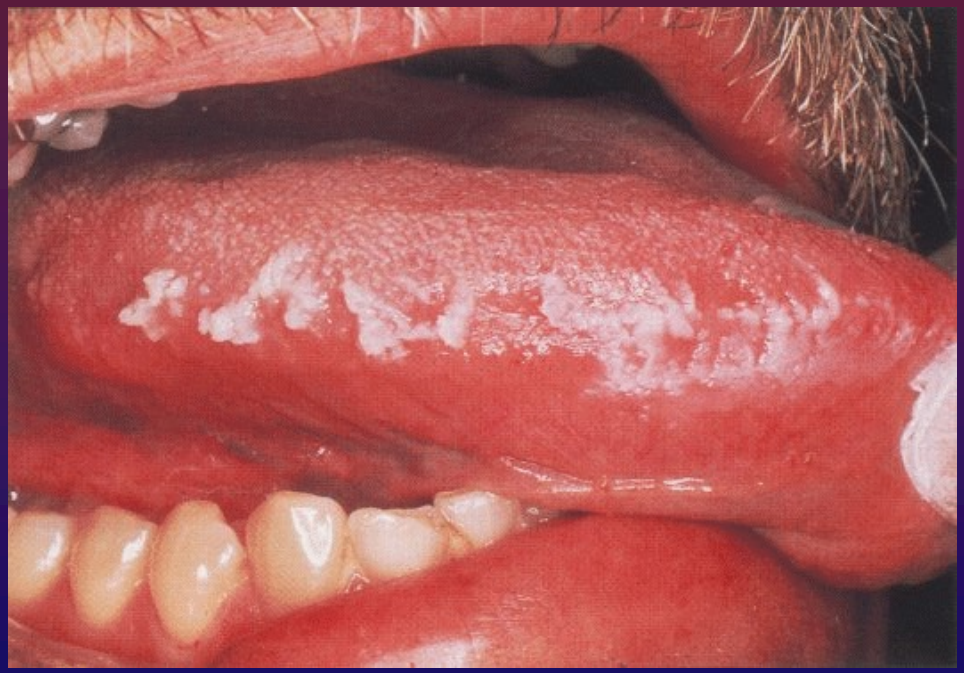
History

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

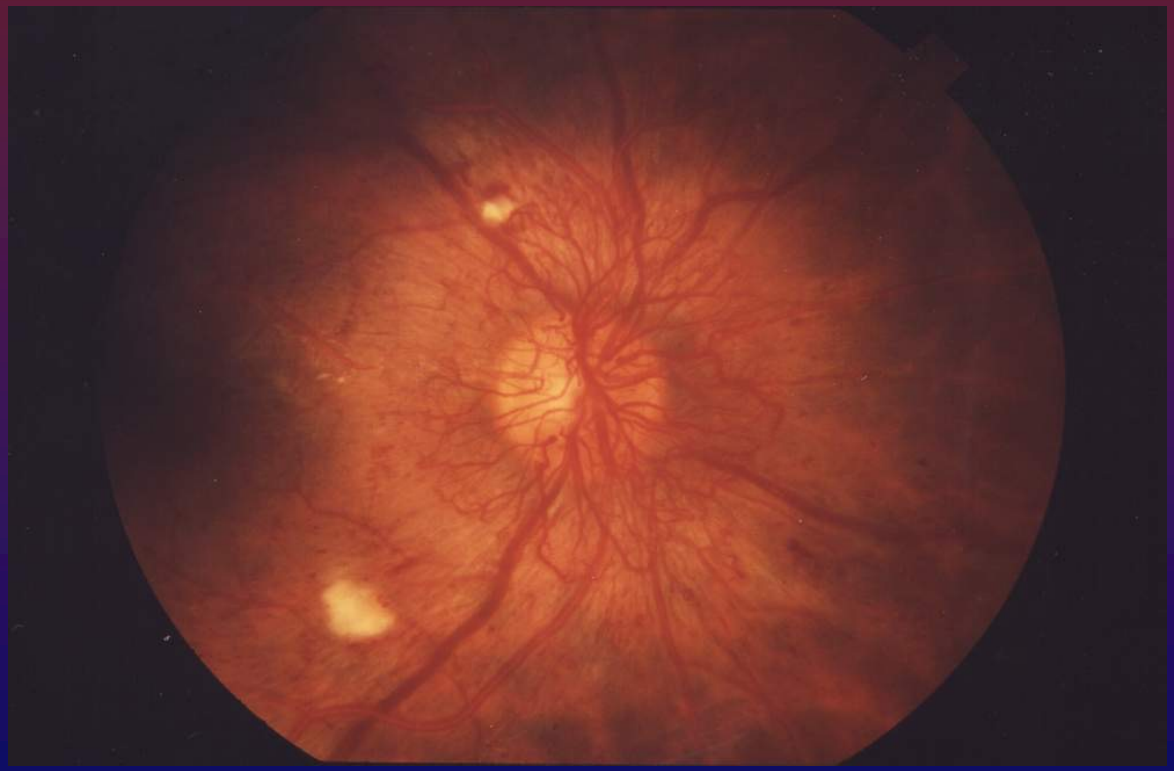
Physical Exam

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

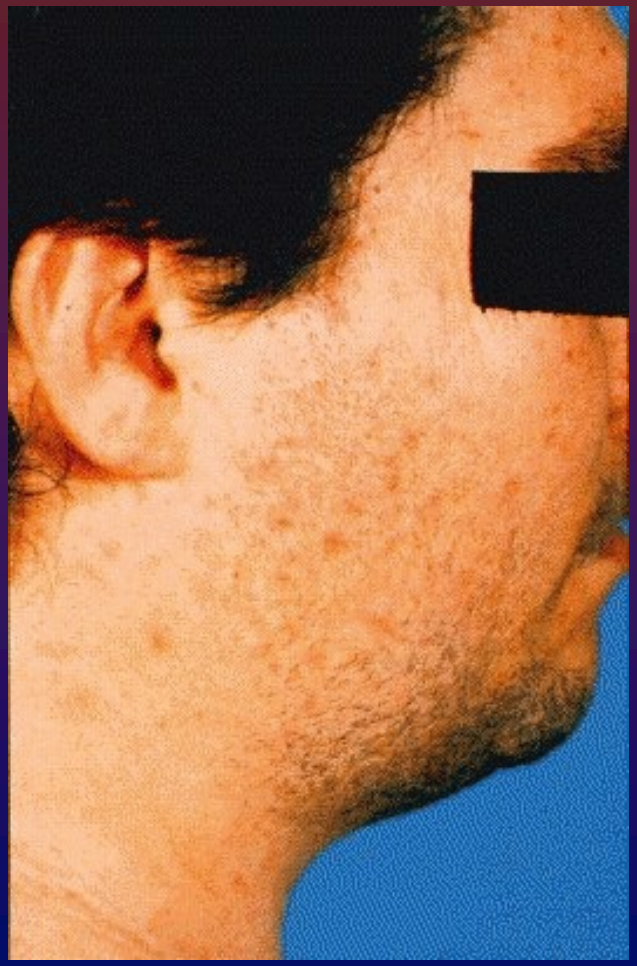
Oral Hairy Leukoplakia



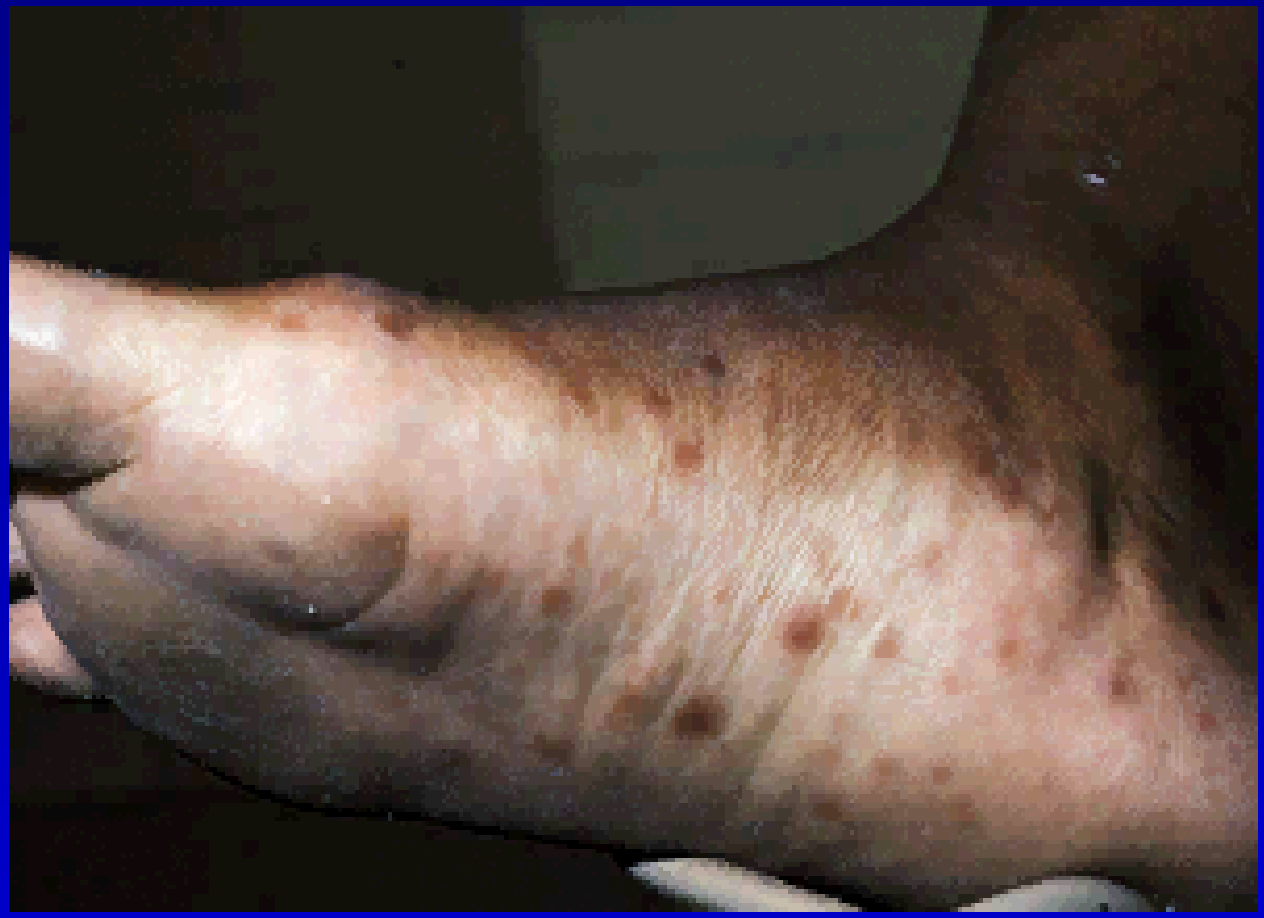
Cotton Wool Spots



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	Annual age-based screening (see below)	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

Dolutegravir/Lamivudine 1 po daily

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

What Drugs should you start?
DHHS guidance

- Recent changes from September 14, 2024
  - Abacavir/3TC/DTG is no longer preferred
    - Can be used if renal and bone effects are of concern
  - If prior injectable Cabotegravir PrEP was given
    - Check a genotypic resistance test
    - Use boosted Darunavir plus TAF or TDF plus FTC or 3TC while awaiting results
  - Don's use Rilpivirine if CD4 <200 or VL > 100K

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?

- Treat as soon as possible
- Treat the day of confirmed diagnosis if possible
- Treat at the first clinic visit when establishing care

What if there is an opportunistic infection?

- Start ART within 2 weeks for most opportunistic infections
- Tuberculosis
  - Start within 2 weeks for active TB without meningitis if CD4 count is < 50/µl and a t 2-8 weeks if CD4 is >50/ µl
- 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 viral suppression for 3 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
  - 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)

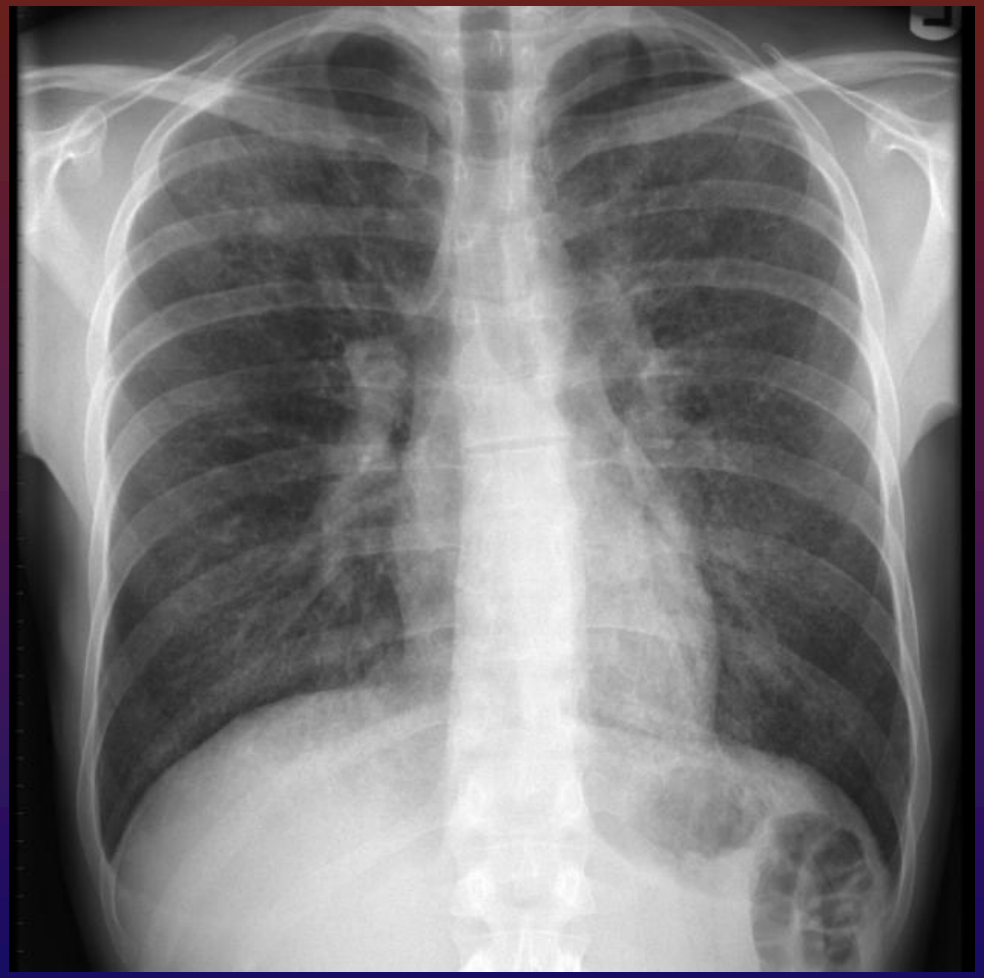
What's Next?

- 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

Anal PAP Cancer Screening

- All patients need an annual rectal exam
- Age based recommendations:
  - <35 years-old : Anoscopy alone for anal symptoms or abnormal rectal exam
  - 35-44 years-old: Anal cytology +/-HPV test if MSM, transgender women with high resolution anoscopy (HRA) ordered if positive
  - Age 45 and above: All patients need anal cytology with f/u HR if positive

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: MenACWY x2 then q5years
  - Offer Varicella vaccine if CD4> 200 and nonimmune
  - Shingrix recommended for HIV positive people (aged 19 and up) regardless of CD4 count
  - COVID vaccine
  - Mpox vaccine: two subcutaneous (MSM, bisexual, transgender)

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

Doxycycline Post Exposure Prophylaxis

New CDC guideline!

- Patients with STI risk can be offered 200 mg doxycycline within 24-72 hours of sex
  - MSM
  - Bisexual
  - Transgender women
- Indicated for
  - Bacterial STI within the last year
  - Participating in sexual activities that are known to increase the likelihood of exposure to STIs (see CDC fine print).

https://www.cdc.gov/mmwr/volumes/73/rr/pdfs/rr7302a1-H.pdf

Take Home Message for today…

- Screen for HIV at every opportunity in primary, prenatal, urgent and emergency care settings
- HIV is a primary care illness that is now simple to treat
- HIV treatment prevents HIV transmission
- You can do this!

References

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