EACS Young Investigators Conference

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SUMMARY OF THE BREAKOUT SESSIONS

Address the health checks in medical care

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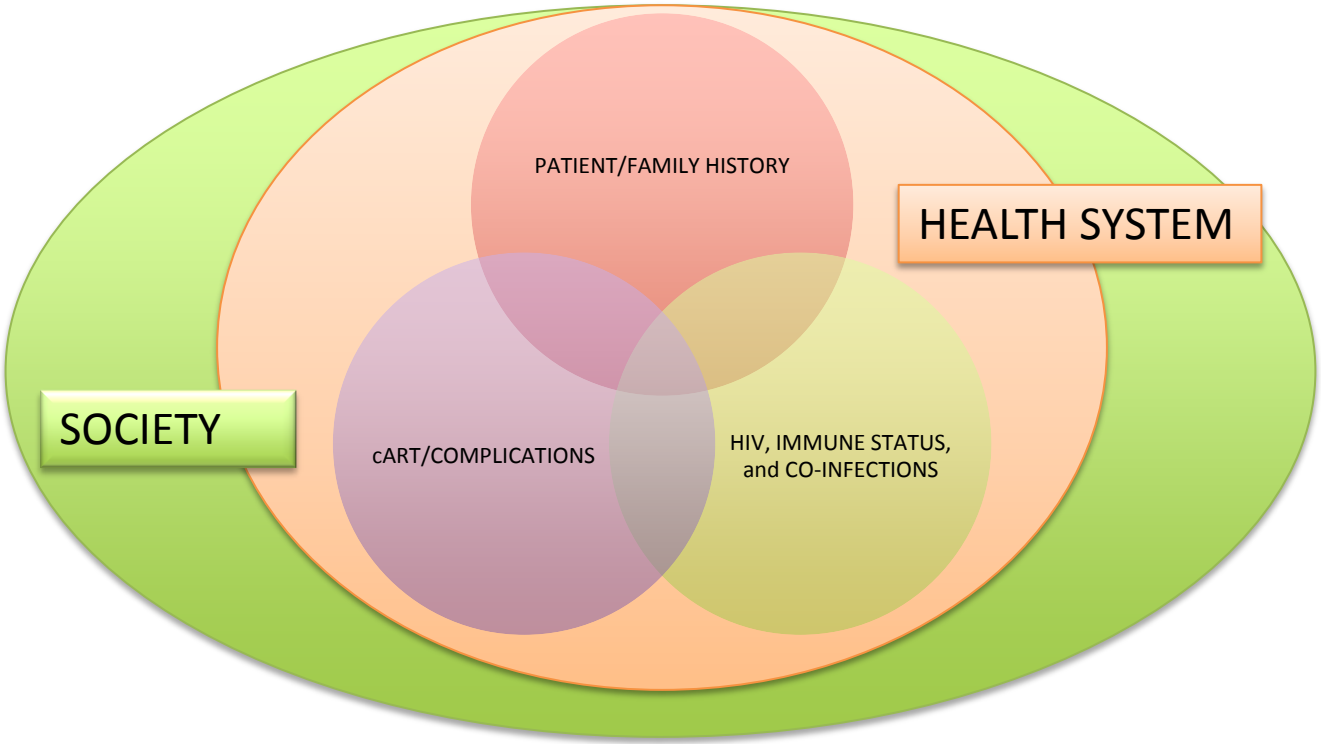

PATIENT/FAMILY HISTORY
HEALTH SYSTEM
SOCIETY
cART/COMPLICATIONS
HIV, IMMUNE STATUS, and CO-INFECTIONS

	Assessment	At HIV diagnosis	Prior to starting ART	Follow-up frequency	Comment
HISTORY					
Medical	Complete medical history including:	+	+	First visit	On transfer of care repeat assessment
	• Family history (e.g. premature CVD, diabetes, hypertension, CKD)	+		First visit	Premature CVD: cardiovascular events in a first degree relative (male < 55, female < 65 years)
	• Concomitant medicines[1]	+	+	Every visit	
	• Past and current co-morbidities	+	+	Every visit	
	• Vaccination history	+		Annual	Measure antibody titres and offer vaccinations where indicated, see Vaccination
Psychosocial	Current lifestyle (alcohol use, smoking, diet, exercise, drug use)	+	+	6-12 months	Adverse lifestyle habits should be addressed more frequently
	Employment	+	+	Every visit	Provide advice and support if needed Provide counselling if needed
	Social and welfare	+	+		
	Psychological morbidity	+	+		
	Partner and children	+			Test partner and children if at risk
Sexual and Reproductive Health	Sexual history	+		6-12 months	Address issues concerning sexual dysfunction Risk of sexual transmission should be addressed
	Safe sex	+			
	Partner status and disclosure	+			Recommend starting ART in serodifferent couples
	Conception issues	+	+		

HIV and immune status

- Resistance testing
- Viro-immunological monitoring
  - Viral load
  - CD4+ cell counts
  - CD4+/CD8+ ratio

	Assessment	At HIV diagnosis	Prior to starting ART	Follow-up frequency	Comment
CO-INFECTIONS					
STIs	Syphilis serology	+		Annual/ as indicated	Consider more frequent screening if at risk
	STI screen	+		Annual/ as indicated	Screen if at risk
Viral Hepatitis	HAV serology	+		Annual/ as indicated	Screen at risk; vaccinate if non-immune
	HCV screen	+			Annual screen if ongoing risk Measure HCV-RNA if HCV Ab pos or if acute infection suspected
	HBV screen	+	+		Annual screen in susceptible persons; vaccinate if non-immune
Tuberculosis	CXR	+		Re-screen if exposure	Consider routine CXR in persons from high TB prevalence populations. Use of PPD/IGRA depending on availability and local standard of care. IGRA should, however, be tested before PPD if both are to be used, given the potential for a false positive IGRA after PPD See Diagnosis and Treatment of TB in HIV-positive Persons
	PPD if CD4 count > 400 cells/µL	+			
	IGRA in selected high-risk populations (if available)	+			
Others	Varicella zoster virus serology	+			Offer vaccination where indicated
	Measles/Rubella serology	+			Offer vaccination where indicated
	Toxoplasmosis serology	+			
	CMV serology	+			
	Cryptococcus antigen	+/-			Consider screening for cryptococcus antigen in serum in persons with CD4 count < 100 cells/µL
	Leishmania serology	+/-			Screen according to travel history/origin
	Tropical screen (e.g. Schistosoma serology)	+/-			Screen according to travel history/origin
	Influenza virus	+		Annual	In all HIV-positive persons, see Vaccination
	Streptococcus pneumonia	+			No recommendations available regarding the need for a booster dose, see Vaccination

Cancer screening

Problem	Persons	Procedure	Evidence of benefit	Screening interval	Additional comments
Anal cancer	MSM	Digital rectal exam ± anal cytology	Unknown; advocated by some experts	1-3 years	If anal cytology abnormal, anoscopy
Breast cancer	Women 50-70 years	Mammography	↓ Breast cancer mortality	1-3 years	
Cervical cancer	Sexually active women	Liquid based cervical cytology test	↓ Cervical cancer mortality	1-3 years	Target age group should include the 25 to 64 years at least. HPV testing may aid screening
Colorectal cancer	Persons 50-75 years	Faecal occult blood test	↓ Colorectal cancer mortality	1-3 years	Flexible sigmoidscopy at 55-years is an alternative
Hepatocellular carcinoma	Persons with cirrhosis & persons with HBV co-infection at high risk of HCC(ii)	Ultrasound and alpha-foetoprotein	Earlier diagnosis allowing for improved ability for surgical eradication	Every 6 months	See pages 52 and 69
Prostate cancer	Men > 50 years	Digital rectal exam ± PSA	Use of PSA is controversial	1-3 years	Pros: ↑ early diagnosis. Cons: overtreatment; ambiguity about size of ↓ cancer-related mortality

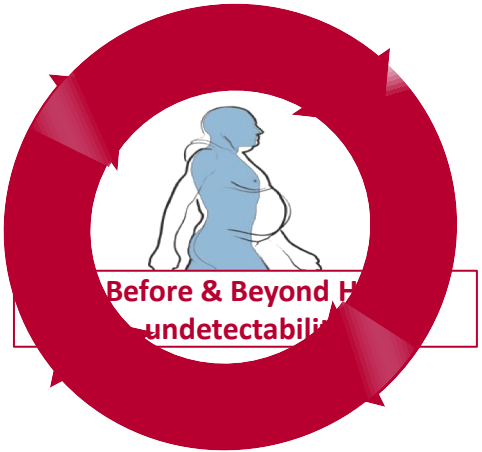
Vaccinations

Infection	Vaccination rationale in HIV-positive persons	Comment
Influenza Virus	Higher rate of pneumonia. Explicitly recommended in all HIV-positive persons	Yearly
Human Papilloma Virus (HPV)	Shared risk with HIV of contracting infection. Higher rate of cervical and anal cancer	If HPV infection is established, efficacy of vaccine is questionable
Hepatitis B Virus (HBV)	Shared risk with HIV of contracting infection. HIV accelerates liver disease progression	Vaccinate if seronegative. Consider double dose (40 µg) in non-responders, in particular with low CD4 count and high HIV-VL. Repeat doses until HBs antibodies ≥ 10 IU/L / ≥ 100 IU/L according to national guidelines. See page 69
Hepatitis A Virus (HAV)	According to risk profile (travel, MSM, IVDU, active hepatitis B or C infection)	Vaccinate if seronegative. Check antibody titres in individuals with risk profile See page 69
Neisseria meningitidis	As general population	Use conjugated[D] vaccine (2 doses 1-2 months apart) if available. Booster every five years if exposure continues. Polysaccharide vaccine not recommended anymore.
Streptococcus pneumoniae	Higher rate and severity of invasive disease. Vaccine explicitly recommended for all HIV-positive persons	Use conjugated[D] 13-valent vaccine instead of PPV-23 polysaccharide vaccine if available. No recommendations yet about the need for a booster dose.
Varicella Zoster Virus (VZV)	Higher rate and severity of both chickenpox and zoster	Perform serology if exposure history negative. Vaccinate if seronegative. For contra-indications, see*
Yellow Fever Virus	Mandatory for travel to selected countries (provide exemption letter if no true risk of exposure)	Contra-indicated if past or current haematological neoplasia or thymus affection (thymoma, resection/radiation) For other contra-indications, see*

Clinical management of comorbidities

How to screen for comorbidities

1. Collect modifiable and not modifiable **risk factors**
2. Estimate **risk probability** with algorithms
3. Evaluate **vulnerability** with markers of subclinical disease



How to treat comorbidities

1. Get HIV **un-detectability**
2. Reactive or pre-emptive **ARV switch**
3. **Treat risk factors** or existing comorbidities
4. **Empower the patients for life style changes**

PROMs

- Needs and perceptions of patients are not the needs of public health system
- Many scores of tools to measure outcomes that are important for the patient have been developed in the recent past
- **Measures of subjective well-being (like satisfaction or happiness) experienced by the patient**

Quality of life as a health check

*Adapted from: UNAIDS. 90-90-90: an ambitious treatment target to help end the AIDS epidemic. 2014. Available at http://unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf. Accessed on 25 April 2016

Fig. 1 The 'fourth 90': proposed revision to the UNAIDS 90-90-90 targets*

Lazarus JV *et al*. *BMC Med.* 2016. 14:94

Acknowledgements

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