Care of The Older Adult with HIV Infection

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Continuing Medical Education Disclosure

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- **Disclosure**: Financial Relationships: IAS-USA Lecture on HIV infection (honorarium), UpToDate (Royalty). Presentation does not include discussion of off-label products.

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Learning Objectives

1. Identify epidemiologic and clinical characteristics of the older HIV-infected patient
2. Describe HIV comorbidities with a focus on coronary artery disease predisposing conditions and premature bone loss
3. List immunizations and screening tests for coinfections and cancers relevant to care of the older HIV-infected patient
4. Explain changing mortality patterns in the modern era of antiretroviral therapy
Impact of HIV Infection on Aging

- HIV infection, even when controlled, is associated with chronic immune activation superimposed upon immunologic senescence in the older adult
- Because of IL-2 and thymic dysfunction, these patients may have delayed immune reconstitution
- Recent studies have shown that chronic immune activation results in accelerated aging of T cells
- It is not clear that these changes are reversed by antiretroviral therapy
Polling Question
Which of the following statements about HIV-infected patients over 50 years of age is false?

a) They present at an earlier stage of disease.
b) They constitute 30% of HIV-infected patients.
c) They are at increased risk of cognitive impairment compared to general population.
d) They are at increased risk of some common malignancies compared to general population.
e) They are more adherent to medical therapy.
HIV Epidemiology in Older Adult

- Since the 1980s, an increasing percentage of HIV-infected patients are over the age of 50.
- Approximately 30% of HIV-infected persons are ≥50 years of age.
- In 2012, 17.1% of newly diagnosed cases of HIV infection and 25.6% of newly diagnosed AIDS cases were in adults 50 years of age or older.
- MSM is the most common mode of transmission in older men, and heterosexual contact is the most common mode in older women.

Clinical Characteristics (1)

- Older persons may be diagnosed later and have more advanced HIV infection at presentation
- Increased risk of opportunistic infections and transmission to others
- Less robust immunologic response to antiretroviral therapy in this population
- Medication adherence is generally good, but there may be increased risk of drug toxicity because of changing pharmacokinetics
Immunologic Response to ART

- Among 12,196 treatment-naive patients in NA-ACCORD who initiated ART (observational cohort), immunologic response after 24 months of therapy decreased with increasing age starting at 40, but there was no effect on viral suppression.

- A prospective study that evaluated treatment outcomes in 3,015 patients (401 of whom were over age 50) found that, despite better virologic control, clinical progression to an AIDS-defining diagnosis was higher (HR 1.52; 95% CI 1.2-2.0).

Medication Adherence

- Literature has reported up to 95% adherence in older HIV-infected patients
- In a recent meta-analysis, older age reduced the risk for non-adherence by 27% (RR 0.72; CI 0.64-0.82)
- Those studies assessing short-term and long-term adherence showed a significant reduction in both groups (RR 0.75; CI 0.64-0.87 and RR 0.65; CI 0.50-0.85, respectively)

Drug Toxicity

- A higher rate of adverse events (64% vs. 35%) on protease inhibitors was reported in patients older than 60 compared to those under 40.
- Another study of 508 treatment-naive patients found that regimen changes due to toxicity were associated with increasing age.
- May be from age-related decrease in renal and hepatic function, decrease in serum albumin level, and changes in cytochrome p450 enzyme system.

Clinical Characteristics (2)

- HIV-infected patients accumulate “age-related” diseases at a younger chronological age
- Neurocognitive dysfunction, some non-AIDS-defining cancers, and a wide range of pulmonary diseases are also more prevalent
- Hypothesis that increased immune activation and long-term chronic inflammation contribute to premature aging in this population
Chronic Complications by Age and HIV Status

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Cases</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 40 yrs</td>
<td>3%</td>
<td>9%</td>
</tr>
<tr>
<td>41 to 50 yrs</td>
<td>15%</td>
<td>2%</td>
</tr>
<tr>
<td>51 to 60 yrs</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>&gt; 60 yrs</td>
<td>4%</td>
<td>0.25%</td>
</tr>
</tbody>
</table>

Pp Prevalence:
- Cases: 3.9% (N = 542), 9.0% (N = 1724), 20.0% (N = 452), 46.9% (N = 136)
- Controls: 0.5% (N = 1626), 1.9% (N = 5172), 6.6% (N = 1356), 18.7% (N = 408)

Legend:
- No age-related diseases
- 1 comorbidity
- 2 comorbidities
- 3 comorbidities
- 4 comorbidities

Chronic Complications by Age and HIV Status

- Retrospective analysis of HIV-infected outpatients compared to seronegative persons (case-control study) from 2002 through 2009
- Examined cardiovascular disease, hypertension, diabetes mellitus, bone fractures, and renal failure
- Independent predictors of polypathology ($p < 0.001$) included older age (OR 1.11), male gender (OR 1.77), CD4 nadir below 200 (OR 4.46), and duration of antiretroviral therapy (OR 1.01)

Cognitive Dysfunction

- Epidemiologic findings suggest that increasing age is a risk factor for HIV-associated dementia, although the studies are small.
- Longitudinal study comparing 106 HIV-infected patients over 50 years of age to 96 patients between 20-39 years of age showed a three-fold higher risk of dementia on multivariate analysis.
- Study adjusted for race, education, depression, substance abuse, ART, CD4 count, and viral load.

Malignancies

- Observational studies suggest that lung, hepatic, and anal cancers occur at younger age in HIV-infected adults compared to seronegative persons.

- Using 15 HIV and cancer registry databases in the US, including 212,055 persons with AIDS, the age of diagnosis of non-AIDS-defining cancers was examined.

- Only lung and anal cancers were seen in AIDS patients at younger age (median 50 years old vs. 54; p < 0.001) than expected.

Shiels MS, Pfeiffer RM, Engels EA. Ann Intern Med 2010;153:452
Pulmonary Diseases

- Veterans Aging Cohort Study consisting of 33,420 HIV-infected patients and 66,840 seronegative controls
- Subjects were matched by age, sex, race, and ethnicity
- Incidence of chronic obstructive pulmonary disease, lung cancer, pulmonary hypertension, and pulmonary fibrosis was significantly higher in the HIV-infected group

Crothers K, Huang L, Goulet JL et al. Am J Respir Crit Care Med 2011;183:388
Major Comorbidities

- Coronary artery disease (CAD)
- CAD predisposing conditions
- Premature bone loss including osteoporosis and pathologic fractures
LDS Clinical Manifestations

- **Lipid metabolism**
  - Increased triglycerides
  - Increased cholesterol, LDL, cholesterol/HDL ratio
  - Decreased HDL

- **Glucose metabolism**
  - Insulin resistance
  - Glucose intolerance
  - Diabetes mellitus

- **Fat accumulation**
  - Increased visceral fat
  - Buffalo hump
  - Lipomatosis
  - Gynecomastia

- **Fat atrophy**
  - Face, extremities, buttocks
Management of Lipodystrophy Syndrome

Hyperlipidemia, insulin resistance
- Diet and exercise
- Switch therapy
- Older PI → atazanavir or NNRTI
- Statins/fibrates
- Insulin-sensitizing drugs

Visceral fat accumulation
- Diet and exercise
- Switch therapy
- Older PI → NNRTI
- Growth hormone or growth hormone releasing factor
- Cosmetic surgery

Subcutaneous fat wasting
- Switch therapy
- Older PI → NNRTI
- Insulin-sensitizing drugs
- Statins/fibrates
- Growth hormone or growth hormone releasing factor
- Cosmetic surgery
- Local injection (polylactic acid, calcium hydroxyapatite)
Traditional Risk Factors for Coronary Artery Disease

- Age (men ≥ 45 years, women ≥ 55 years)
- High LDL cholesterol (> 160 mg/dL)*
- Low HDL cholesterol (< 40 mg/dL)
- Hypertension
- Family history of premature coronary artery disease (CAD)
- Diabetes mellitus (DM)
- Cigarette smoking

* With CAD, DM, or multiple risk factors, the desirable level for LDL cholesterol decreases; <100 mg/dL is ideal.
HIV Infection and Coronary Artery Disease (1)

- Incidence of CAD is higher than that in HIV-negative patients matched for age and gender
- Studies have demonstrated an increase in subclinical atherosclerosis (eg, carotid intima media thickness) and clinical endpoints (eg, acute myocardial infarction)
- HIV infection is associated with increased soluble and cellular markers of inflammation, endothelial dysfunction, and altered coagulation, all of which have been shown to contribute to cardiovascular disease
HIV Infection and Coronary Artery Disease (2)

- Degree to which HIV infection itself, antiretroviral therapy, and other risks contribute to increased risk in this population is unknown
- High prevalence of traditional risk factors in this population
- Protease inhibitor class appears to be associated with higher risk of CAD; some data suggesting abacavir and efavirenz may also increase risk
- Discontinuation of ART is associated with higher risk of CAD
Polling Question

HIV infection has been associated with the following increased percentage risk of acute myocardial infarction beyond that explained by recognized risk factors:

a) 90 percent
b) 30 percent
c) 70 percent
d) 10 percent
e) 50 percent
The Risk of Coronary Artery Disease in HIV-infected Patients

Table 2. Rates of AMI by HIV Status and Age Group

<table>
<thead>
<tr>
<th>Status</th>
<th>&lt;30</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70-79</th>
<th>80-89</th>
<th>&gt;89</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uninfected</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of participants</td>
<td>1175</td>
<td>6783</td>
<td>21866</td>
<td>19805</td>
<td>4209</td>
<td>1120</td>
<td>148</td>
<td>3</td>
</tr>
<tr>
<td>No. of AMI events</td>
<td>0</td>
<td>10</td>
<td>164</td>
<td>218</td>
<td>66</td>
<td>36</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>AMI rates per 1000 person-years (95% CI)</td>
<td>...</td>
<td>0.3 (0.2-0.6)</td>
<td>1.5 (1.3-1.7)</td>
<td>2.2 (1.9-2.5)</td>
<td>3.3 (2.6-4.2)</td>
<td>6.7 (4.8-9.2)</td>
<td>21.5 (12.7-36.4)</td>
<td>...</td>
</tr>
<tr>
<td><strong>HIV Infected</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of participants</td>
<td>725</td>
<td>3848</td>
<td>10575</td>
<td>9342</td>
<td>2065</td>
<td>557</td>
<td>56</td>
<td>0</td>
</tr>
<tr>
<td>No. of AMI events</td>
<td>0</td>
<td>13</td>
<td>105</td>
<td>171</td>
<td>46</td>
<td>25</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>AMI rates per 1000 person-years (95% CI)</td>
<td>...</td>
<td>0.7 (0.4-1.2)</td>
<td>2.0 (1.6-2.4)</td>
<td>3.9 (3.3-4.5)</td>
<td>5.0 (3.8-6.7)</td>
<td>10.0 (6.7-14.7)</td>
<td>13.5 (4.3-42.0)</td>
<td>...</td>
</tr>
<tr>
<td>Incidence rate ratio (95% CI)</td>
<td>...</td>
<td>2.19 (0.89-5.58)</td>
<td>1.34 (1.04-1.72)</td>
<td>1.80 (1.47-2.11)</td>
<td>1.53 (1.03-2.26)</td>
<td>1.50 (0.86-2.57)</td>
<td>0.63 (0.12-2.25)</td>
<td>...</td>
</tr>
</tbody>
</table>

Abbreviations: AMI, acute myocardial infarction; HIV, human immunodeficiency virus.

An ellipsis indicates that a rate was not calculated because there were 0 events.

Freiberg MS, Chang CC, Kuller LH et al. JAMA Intern Med 2013;173:614
Hypertension

- Similar approach to that in patients without HIV infection
- Defined as ≥140/90 in three separate visits over a week or more
- In the absence of history or physical exam pointing to secondary hypertension, baseline evaluation should include renal function, potassium, urinalysis, and electrocardiogram
- Nonpharmacologic management consists of modest salt restriction, increased physical activity, and weight reduction
- Initial drug therapy should consist of thiazide diuretic, ACE inhibitor or receptor blocker, or calcium channel blocker in most patients
- For those who are more than 20/10 mmHg above goal, ACE inhibitor or receptor blocker plus calcium channel blocker is recommended
- No important ART interactions for commonly used drugs
**Diabetes Mellitus**

- Similar approach to that in patients without HIV infection
- Diagnosis is often based upon HgbA1c ≥ 6.5%
- Treatment goals include prevention of symptomatic hyperglycemia and vascular complications; HgbA1c target < 7.0%
- Nonpharmacologic management consists of weight reduction through dietary modification and increased physical activity
- Initial drug therapy generally consists of metformin with sulfonylurea (eg, glipizide) added as the second agent
- Metformin may cause lactic acidemia as do older NRTI drugs
- No other important ART interactions for commonly used drugs
- DM and HIV have particularly detrimental effect on renal function (Medapalli RK et al. J Acquir Immune Defic Syndr 2012;60:393)
Cigarette Smoking

- HIV-infected patients are more likely to smoke and less likely to quit compared to general population (Ann Intern Med 2015;162:335-44)
- No evidence that specific smoking cessation approaches are more or less effective
- Management includes behavioral intervention and/or pharmacologic therapy; evidence suggests that combination approach works better than either alone
- Drug options include nicotine replacement (eg, patch, gum, lozenge), bupropion, and varenicline, which can be used alone or in combination
- No important ART interactions for commonly used drugs
Hyperlipidemia in General Population

- Desirable total cholesterol is less than 200 mg/dl and LDL cholesterol is less than 130 mg/dl in general population.
- Epidemiologic studies show a graded relationship between total cholesterol level and CAD risk.
- Patients with clinical atherosclerosis (e.g., CAD, CVD, PVD) or combination of factors that result in a 10-year risk of new event of > 20% benefit substantially from statin therapy.
- Patients without clinical atherosclerosis achieve a lesser absolute benefit from statin treatment.
- Relative risk reduction in all populations is 20%-30%.
Framingham Risk Calculator

Uses data from an urban northeastern United States population.

Many consider it the preferred risk calculator.
ACC/AHA CV Risk Calculator

Uses data primarily from non-Hispanic whites and African Americans in the United States.

Concerns about accuracy of results have been made (statin recommendations, DM yes vs. no categorization, FMH of premature CAD not included).
ACC/AHA Cholesterol Guidelines

- Categories of patients to be considered for treatment:
  - Group 1: known cardiovascular disease
  - Group 2: LDL cholesterol ≥ 190 mg/dL
  - Group 3: diabetes mellitus aged 40 to 75 years and LDL cholesterol ≥ 70 mg/dL
  - Group 4: age 40 to 75 years with LDL cholesterol ≥ 70 mg/dL and an estimated 10-year risk of a cardiovascular event of ≥ 7.5%

- Groups 1 and 2: high-intensity statin (rosuvastatin 20 to 40 mg or atorvastatin 40 to 80 mg), although patients with known cardiovascular disease > 75 years of age can receive moderate-intensity statin
- Group 3: high-intensity statin if 10-year risk is ≥ 7.5%; otherwise they can receive a moderate-intensity statin
- Group 4: moderate- to high-intensity statin

Polling Question
Which of the following statements regarding hyperlipidemia in HIV infection is true?

a) It is defined differently than in the general population.
b) It is usually related to antiretroviral drug therapy.
c) It should always be treated with medication.
d) Simvastatin cannot be administered with cobicistat.
e) High dose atorvastatin is recommended as initial treatment in patients with concurrent CAD.
Hyperlipidemia in HIV Infection

- Dyslipidemia is common in HIV-infected patients on ART; it may be isolated or seen in combination with other features of LDS
- HIV-infected patients should be evaluated and treated for dyslipidemia in a similar fashion to seronegative persons
- Cardiac risk factor assessment should be considered when designing an initial ART regimen; avoid protease inhibitors (except possibly atazanavir) and abacavir if there are other risks
- Protease inhibitors, particularly ritonavir, increase most statin levels
- Simvastatin and lovastatin are contraindicated with protease inhibitors and cobicistat; atorvastatin and rosuvastatin can be used as alternatives
- Prudent to start with low dose and to monitor LFTs and CPK on treatment
Premature Bone Loss (1)

- Osteopenia, osteoporosis, and pathological fractures have been described
- Osteopenia is asymptomatic condition
- Osteoporosis may present with fractures of vertebrae, forearms, or hips
- HIV infection itself, tenofovir, protease inhibitors, alterations in vitamin D metabolism, and lactic acidemia related to older NRTI drugs may be contributing factors to premature bone loss
Premature Bone Loss (2)

- Immobility, cigarette smoking, excessive alcohol use, chronic renal disease, hypogonadism, hyperparathyroidism, hyperthyroidism, and steroid use accentuate bone loss.
- Optimal use of bone densitometry as screening test in this population is uncertain.
- Calcium and vitamin D should be given in high-risk patients; regular exercise and smoking cessation should be advised.
Antiretroviral Exposure and Risk of Osteoporotic Fractures

Bedino R, Maalouf NM, Zhang S et al. AIDS 2012;26:825
Polling Question
Which of the following statements reflects current IDSA/HIVMA recommendations about bone densitometry screening in HIV-infected persons?

a) It should be performed in post-menopausal women and in men who are 50 years of age.

b) It should be performed in women who are 65 years of age.

c) It should be performed in women and men who are 65 years of age.

d) It should not be routinely performed in this population.
Screening for Long-Term Complications

- **Glucose Intolerance/Diabetes Mellitus**
  - Fasting glucose and/or HgbA1c every 6-12 months

- **Lipid Abnormalities**
  - Fasting lipid profile every 6-12 months

- **Body Fat Maldistribution**
  - Patient self-report, weight at each visit, and anthropometric measurements (skin fold, waist, and hip) periodically

- **Lactic Acidemia/Acidosis**
  - Venous lactic acid level only in symptomatic patients

- **Premature Bone Loss**
  - Baseline bone densitometry in post-menopausal women and in men at age 50

- **Avascular Necrosis of Hips**
  - X-rays and MRI only in symptomatic patients
**Immunization Principles in HIV Infection**

- Avoid live vaccine preparations, especially in patients with a low CD4+ cell count, unless the benefits clearly outweigh risks.
- Vaccines are generally more immunogenic in patients with higher CD4+ cell counts and lower viral loads and should be delayed pending immune reconstitution when appropriate.
- Immunologic response to vaccine preparations should be assessed when possible in HIV-infected patients.
Polling Question

In an HIV-infected patient who has not been immunized against pneumococcal infection:

a) Give pneumococcal polysaccharide vaccine 23 (PPSV23) once.

b) Give pneumococcal conjugate vaccine (PCV13) first followed by PPSV23 at least 8 weeks later and second PPSV23 dose 5 years later.

c) Give PPSV23 first followed by PCV13 at least 8 weeks later and second PPSV23 dose 5 years later.

d) Give PPSV23 with second dose 5 years later.
Pneumococcal Vaccine (1)

- Rationale: HIV-infected patients are at increased risk for serious pneumococcal infections, including pneumonia and bacteremia
- May result from altered antibody production leading to decreased opsonization
- There are 2 types: 1) 23-valent polysaccharide vaccine; 2) 13-valent conjugate vaccine
- Recent revision of the recommendations for immunocompromised persons
Pneumococcal Vaccine (2)

- Pneumococcal vaccine-naive persons:
  - PCV13 first followed by PPSV23 at least 8 weeks later and second PPSV23 dose 5 years later
- Previous vaccination with PPSV23:
  - PCV13 at least one year after the last PPSV23 dose; for those who require additional doses of PPSV23, the first should be given no sooner than 8 weeks after PCV13 and at least 5 years after most recent PPSV23 dose

Centers for Disease Control and Prevention. *MMWR* 2012;61:816
Influenza Vaccine

- Rationale: HIV-infected patients appear to be at increased risk for complications of influenza
- However, there is limited literature on subject
- Recommendation: Administer inactivated seasonal flu vaccine to all patients; especially important for those at risk for influenza exposure or complications from other underlying conditions
- Do not use live (intranasal) vaccine preparation
Polling Question
Which of the following statements is consistent with CDC recommendations regarding zoster vaccine in HIV-infected persons?

a) It should never be given to such patients since it is a live attenuated vaccine preparation.
b) It should routinely be given in adults who are 60 years of age or older.
c) It may be considered in some adults who are 60 years of age or older.
d) It should be given to all HIV-infected patients who have never had shingles.
Zoster Vaccine in HIV-infected Adults

- 395 adults on stable ART with CD4 count > 200 were randomized 3:1 to receive two doses of zoster vaccine or placebo
- After 24 weeks, the only significant difference in safety was higher incidence of local reactions in those receiving active vaccine
- Antibody titers increased in vaccine recipients
- No significant difference in number of zoster cases in the two groups

Benson C. CROI 2012. Abstract 96
Infectious Diseases Screening

- Sexually Transmitted Diseases: Annual chlamydia, gonorrhea, and syphilis testing in adults at ongoing risk for STDs
- Tuberculosis: Annual PPD or interferon-gamma testing in adults at ongoing risk for tuberculosis infection

Cancer Screening

- Breast Cancer: Biannual mammography in women aged 50 to 74 years; individualize for younger ages
- Cervical Cancer: Annual Pap test in women after 2 normal Pap tests documented; role of HPV testing in HIV-infected patients is unclear
- Colon Cancer: Colonoscopy every 10 years starting at age 50; earlier and more often screening if history of polyps or inflammatory bowel disease
- Prostate Cancer: Consider annual digital exam in males aged 50 to 74 years; prostate-specific antigen (PSA) testing is no longer recommended in most patients

Adapted from US Preventive Services Task Force Guidelines, 2013
Heart and Vascular Disease Screening

- Hypertension: Regular blood pressure checks
- Abdominal Aortic Aneurysm: One-time ultrasound in men ages 65-75 who ever smoked
- Coronary Artery Disease: ASA for men ages 45-79 when risk of atherosclerosis outweighs risk of GI bleeding
- Cerebrovascular Disease: ASA for women ages 55-79 when risk of atherosclerosis outweighs risk of GI bleeding

Adapted from US Preventive Services Task Force Guidelines, 2013
Polling Question
Which of the following statements regarding mortality in the modern era of ART is false?

a) The overall mortality rate in HIV-infected adults has declined over the past three decades.

b) A higher percentage of causes of death are related to non–AIDS-defining conditions.

c) The age group with the highest percentage of HIV-infected adults who die is 55 or older.

d) Life expectancy of a 20-year-old person recently diagnosed with HIV infection is similar to that of the general population.
Trends in Annual Rates of Death due to HIV Infection by Age Group, United States, 1987−2010

Note: For comparison with data for 1999 and later years, data for 1987−1998 were modified to account for ICD-10 rules instead of ICD-9 rules.
Trends in the Percentage Distribution of Deaths due to HIV Infection by Age Group, United States, 1987–2010

Note: For comparison with data for 1999 and later years, data for 1987–1998 were modified to account for ICD-10 rules instead of ICD-9 rules.
Mortality Trends

- In the D:A:D study, 3,909 deaths occurred among 49,731 subjects followed from 1999 through 2011.
- Crude mortality rate of 12.7 per 1000 person-years.
- AIDS-related causes were responsible for 29% of deaths, non-AIDS-related cancers for 15%, liver disease for 13%, and cardiovascular disease for 11%.
- Deaths attributable to AIDS-related events decreased from 34% to 22%.
- Proportion attributable to non-AIDS-defining malignancies increased from 9% to 23%.

Mid-point Life Expectancy Estimates at Age 20 Years in Three Calendar Periods, Overall and by Sociodemographic Characteristics, 2000-2007


NATIONAL CENTER FOR INNOVATION IN HIV CARE
Summary (1)

- Aging is characterized by progressive physiologic changes associated with increased susceptibility to many diseases
- HIV infection, even when controlled, is associated with chronic immune activation that is superimposed upon immunologic senescence in the older adult
- Older persons may be diagnosed later and have more advanced HIV infection at presentation
- There is a less robust immunologic response to antiretroviral therapy in this population
- HIV-infected patients accumulate “age-related” diseases at a younger chronological age
- Hypothesis that increased immune activation and long-term chronic inflammation contribute to premature aging in this population
Summary

- Lung, hepatic, and anal cancers occur at younger age in HIV-infected adults compared to seronegative persons.
- Incidence of CAD is higher than that in HIV-negative patients matched for age and gender.
- CAD risk calculator results need to be interpreted in context of increased risk in the HIV-infected population.
- HIV infection and its treatment have been associated with premature bone loss.
- Age-related immunizations and screening tests for cancers and other conditions should be addressed.
- Mortality in HIV-infected persons has fallen substantially over past two decades with non-AIDS-related conditions accounting for the majority of deaths.