Introduction

- With the advent of highly active antiretroviral therapy, the disease trajectory of HIV disease has changed from a terminal illness to a chronic disease.
- This change has been accompanied by several challenges and controversies in certain aspects of patient care, particularly palliative care.

Impact of Protease Inhibitor Use on Mortality


Life expectancy of individuals on combination antiretroviral therapy

Health indicators for overall (20 years or older) population by period of follow-up


Two Models of HIV Care

HIV and Chronic Pain

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Introduction

• Pain in patients with HIV is common
• Patients with HIV have high rates of substance abuse and psychiatric disorders
• As a result, risk for harmful opioid-related behaviors is higher (18.5% in one study)

Merlin, Hansen.

Case

40 y/o male HIV/Hep C, CD4 550 cells/mm3, VL < 48 copies/mL, on ART
Has bilateral hip pain 2/2 osteonecrosis
Also has cirrhosis and thrombocytopenia; since pt is a Jehovah’s witness and does no accept blood products, surgeon has recommended against intervention
History of heroin and cocaine use > 20 years ago; active in recovery program
Depression on escitalopram

Question 1

What therapeutic strategy would you use next?
A. Begin oxycodone 5mg po q6h standing plus 5mg po q2h prn, with a plan to switch to long-acting oxycodone within the first few weeks
B. Begin a fentanyl patch 12.5mcg, with no breakthrough
C. Continue acetominophen 2g/day, NSAIDS PRN, and prescribe lidoderm patches and massage therapy
1. Discussion

- Use of opioids common among patients with substance abuse disorders
- Patients with a history of substance abuse are at higher risk for development of opioid misuse behaviors
- In the absence of data to guide, recommendation is to weigh risk vs. benefit

Edlund, Fishbain, Chou.

Case (cont’d)

- You decide to begin round the clock oxycodone, with a plan to switch to long-acting soon

2. Discussion

- Data regarding impact on outcomes poor
- However, improves provider comfort with opioid prescribing
- Thought to be particularly important in high risk patients
- Opportunity to have an informed consent discussion

Starrels, Chou.

Question 2

Prior to initiating opioids, which of the following would you do:

A. Urine drug screen
B. Opioid treatment agreement
C. Screen for potential of developing opioid misuse/addiction such as SOAPP, ORT, or DIRE
D. All of the above
E. None of the above

Question 3

You pick up the phone to call the patient. What do you say?

A. “You will have to wait until your appointment next week before I give you more pills.”
B. “Thank you for letting me know you ran out. I will give you a new prescription for enough pills to last until you see me next week.”
C. “You violated your contract, I can no longer see you in this clinic.”
D. “You violated your contract. I can continue to manage your pain, but I will no longer prescribe opioids.”
E. Something entirely different

Case (cont’d)

- You give the patient oxycodone 5mg tabs, 100 tabs, enough to use round the clock plus 3 prns/day for two weeks until he sees you again
- The following week, the patient calls the clinic saying he is nearly out of his oxycodone
- The nurse tells him to wait until he sees you for more, and he becomes upset and loud
- He calls two more times that day and goes to the ED before you have a chance to call him back
3. Discussion

- Patient is exhibiting opioid misuse/aberrant opioid behaviors; no evidence for addiction
- In differential diagnosis must be undertreated pain, and pseudoaddiction

References


References


HIV Palliative Care at the Transition from Adolescence to Adulthood

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Young Adults Born with HIV

- Born with HIV prior to effective PMTCT
  - 1980 – 1992
  - Long-term survival with lifelong infection
  - Always at the leading edge
- Complex medical and psychosocial needs
  - Disease progression
  - Drug resistance
- Cognitive and emotional state evolving
  - Normal adolescent development
  - Disease effects
  - Environmental effects
- Complex array of decision-makers
  - Orphans, abandoned infants, child neglect
  - Foster care system
  - Kinship care
- Adherence
- Prognosis
- Hospice
- Vulnerable adult
- Impact on health professionals
Case

- 20 year old male with congenital HIV, CD4 10 cells/mm³, VL 365,000 copies/mL; admitted with wasting, malnutrition, hypoalbuminemia and edema, anemia
- Medical history
  - Chronic, recurrent Candida esophagitis
  - Disseminated MAC
- Treatment history
  - Sequential mono, dual, triple ART
  - Triple class resistance

Case (continued)

- Nutritional support provided
- Salvage ART regimen started
- MAC treatment started
- OI prophylaxis continued
- Transfusions provided
- Transferred to rehab facility to continue to gain weight, strength, endurance for self-care

Question #1

- Would you offer ART as part of his treatment plan?
  A. Yes, if an effective regimen is available
  B. Yes, but only if given as Directly Observed Therapy (DOT)
  C. Yes, but the choice is his
  D. No, he is dying

1. Discussion

- Suboptimal medication adherence leads to resistance and loss of effectiveness
- Children depend on adults to give them their medicine
- Adults often delegate responsibility to children by age 12 years
- Threshold when poor adherence becomes reportable medical neglect
- Balance benefit of treatment with risk of losing family

Case (continued)

- Family/social history
  - Birth mother HIV positive IDU
  - Kinship care with great-aunt since infancy; considers her his “mother”
  - Aunt works full-time; patient receives SSI check
  - HS diploma; 1 year college
  - Fathered a son at age 18 years
- Adherence history
  - Self administration of ART began at age 9 years
  - Misses >50% of clinic appointments

Question #2

- You are concerned that as soon as he returns home, he will deteriorate. What to do?
  A. Plan a family meeting with him and his aunt to discuss adherence to home care plan
  B. Schedule frequent clinic visits to monitor his progress
  C. Transfer him to a nursing home because he cannot care for himself
  D. Refer to hospice to provide home-based interdisciplinary care, including daily HHA who reminds him to take his medicine
2. Discussion

- Inpatient care has been successful, so appropriate to continue
- All care can be given in the home, so discharge is appropriate
- Past experience tells you that patient won’t follow through on his own, but aunt believes he needs to be responsible for himself because she has to work.
- Hospice eligible; if improves can be discharged from hospice

Case (continued)

- Patient asking HHA to buy him his favorite foods; minimal food in house
- Patient routinely reports he has already taken his meds by the time HHA arrives
- Poor adherence to clinic visits, nutritional plan, prescribed medicines
- Rapid clinical deterioration
- Aunt "drops" him at emergency department

Question #3

- What do you do?
  A. Ask if he has an Advance Directive
  B. Ask if he wants you to “do everything”
  C. Remind him that this is his own fault
  D. Blame his aunt for not providing better care

3. Discussion

- He has an advance directive with limitations if he is terminally ill; he names his aunt as his health care agent
- He wants to survive to throw a 2nd Birthday Party for his son in 2 weeks

Case (continued)

- ICU admission, responds to aggressive support and stabilizes
- Wants to remain in inpatient setting
- Aunt becomes angry when residential nursing home with hospice support is recommended because she will lose his SSI income
- Patient returns home
- Hospice team visits and he is alone and unable to care for himself

Question #4

- What would you do?
  A. Call his aunt at work and tell her to come home
  B. Call adult protective services
  C. Ask patient if he is willing to be admitted to inpatient hospice unit
4. Discussion

- Patient is legally competent and has decisional capacity
- Primary duty is to the patient
- Maintaining hospice involvement offers emotional and spiritual support for aunt when she is able to accept it

Suggested reading


HIV and Non-adherence: When HAART is not enough

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Introduction

Non-compliance ≠
Psychosocial non-adherence

Psychosocial Non-adherence

May be due to:
- Isolation and stigma
- Lack of social support
- Financing and other resources
- Mental Health

Introduction

- Non-adherence with ART in patients with HIV infection is associated with treatment failure and ART resistance
- Unpredictable course with more prognostic uncertainty, particularly with patients non-adherent with ART
- Under what circumstances should ART be initiated/discontinued in non-adherent patients?
Case
CC: End Stage AIDS and dehydration
HPI: 28 year old female, HIV/AIDS x 5 years
Awoke in the middle of the night with a shaking chill followed by feeling hot all over. Took two aspirin tablets and began sweating profusely after a few hours. Noticed left flank pain for the first time which gradually worsened through the night. Diabetic since age 10. Uses insulin AM and PM.

Recent History
• Multiple hospitalizations over 2 years
• In past 12 months:
  – 10 hospital admissions
  – 8 observations admissions
  – 12 ER visits

Recent History
• Labs one year ago: CD4 10, VL 125,223
• Diagnosed with DMAC via blood culture 1 year ago
• Started on 3 drugs for DMAC
• ART initiated at that time

Case
SHx: Lives with mother (primary caregiver); receives monthly assistance which pays home mortgage
ROS: negative
PE: T-103 °F, P-115, BP-130/85, RR-20
Appears flushed and acutely ill. Exam is normal except for punch tenderness over the lower left back.

Case
• Labs: WBC-16,500 70% PMNL’s and 20% bands. HCT- 32, blood glucose – 185, SMA 7 otherwise normal. UA – many PMNs, few RBC’s, no organisms seen, positive for protein, glucose
• CD4 8 ( 10 -1 year prior)
• VL 117800 ( 125,223 - 1 year prior)
• Blood cultures growing AFB

That morning, the medical team rounds...
Medical student: "The patient is anemic. Let's transfuse 2 units of PRBC's.
Intern: "The patient's fever could be due to infection. Let's begin empiric antibiotics."
Resident: "The patient might be in septic shock because of her neutropenia, fever, and hypotension. Let's transfer her to the ICU."
Attending: "Hold on. The patient has been chronically non-adherent with her HIV medications for the past year. Given this fact, isn't transferring her to the ICU a waste of resources? If she can't take her HIV meds, I believe heroic resuscitation and intensive care is futile care."
Question 1
What do you do?
A. Transfuse the patient, begin antibiotics and transfer the patient to the ICU
B. Restart HAART and OI treatment
C. Realizing that continuing curative therapies is futile, keep the patient on the floor, write a DNR order, and initiate comfort care

1. Discussion
• No standard definition of ART treatment failure due to non-adherence
• Determination of prognosis is poorly defined in HIV infected patients who are non-adherent with therapy
• Difficult to define futile care due to non-adherence
• Under what circumstances should ART be discontinued in non-adherent patients?

The case continues…
• The patient is transferred to the ICU and stabilized
• She was transferred to the floor
• The PCT was consulted to discuss goals of care
• The primary service felt that continuing HAART would be futile care

Question 2
Prior to reinitiating HAART and OI treatment, which of the following would you do:
A. Re-educate the patient and family about the importance of adherence as well as the benefits and burdens of continued ART
B. Petition the court to order NH admission so that the patient can receive HAART and OI DOT
C. Discharge the patient home with hospice
E. None of the above

2. Discussion
• Controversy exists regarding when to discontinue HAART due to non-adherence
• Current guidelines do not address withdrawal of HAART
• Discontinuing treatment and prophylaxis of opportunistic infections seems acceptable in patients near death but what about others?
• Difficult to identify irreversibly/terminally ill phase in patient non-adherent with ART
Ethical Concerns Regarding Non-adherence with ART

- Threat of emerging drug resistance raising a possible public health threat
- Should therapy be offered at all to chronically non-adherent patients?
- Are there entire classes of patients (e.g., the homeless and IDU) whom ART should not be offered?

The case continues…

- The patient and family again decline hospice and nursing home placement
- She discharged with home health and her ART and OI medications are prescribed
- 1 month later, she is readmitted to the hospital with weakness
- Her CD4 is 10 and her viral load is 239,000

Question 3

What do you do?

http://bighornriver.org/images/40/pulling-out-hair.jpg

References


Fausto JA, Selwyn PA. Palliative care in the management of advanced HIV/AIDS. Primary Care Clinics in Office Practice. 2011,38:311-326.


Questions/Comments?