AETC AIDS Education & Training Center Pacific

Clinical Essentials: HIV New Diagnosis and Health Care Maintenance

Updated November 2018

New HIV Diagnosis
Chronic HIV: Treatment | Labs | Screenings

New HIV Diagnosis

At diagnosis, screen for:

- CD4 and HIV viral load
- HIV Resistance Testing (HIV Genotype)
- G6PD
- HAV IgG, HBV cAb, sAg, sAb, HCV Ab - for evidence of coinfection and immunity.
- IGRA or PPD to r/o latent TB
- HLA–B*5701 for abacavir hypersensitivity.
- CBC w/ diff, complete metabolic panel, LFTs, lipids, fasting glucose or HgA1c.
- STI screen: RPR, GC/CT (incl. extra-genital), trichomonas.
- Toxo IgG for evidence of prior exposure (counsel to avoid exposure if negative).
- Consider CMV IgG for lower -risk patients (i.e. non-MSM and non-PWID): if negative, avoid CMV+ blood products.
- Consider VZV antibody and vaccinate if non-immune and CD4>200 cells/mm^3.
- Perform full physical and mental health assessment at diagnosis and at each follow-up visit as clinically indicated.

Recommended follow-up visits:

- 1 week after ART initiation
- every month until viral load suppression, then every 3-6 months

Chronic HIV

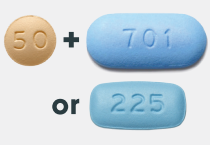
Treatment: ART should be started as soon as possible.

- **DHHS Recommended initial regimens** for most people living with HIV (2 NRTIs + 1 INSTI):

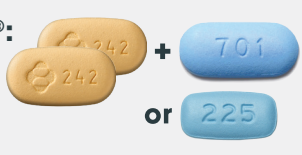
Biktarvy®: Bictegravir/emtricitabine/TAF

Triumeq®: Dolutegravir*/abacavir/lamivudine (only if HLA-B5701 negative)

Tivicay® + Truvada® or Descovy®: Dolutegravir* + tenofovir/emtricitabine (TDF or TAF ok)

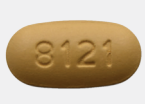


Isentress® + Truvada® or Descovy®: Raltegravir + tenofovir/emtricitabine (TDF or TAF ok)



- Also consider for an initial regimen:

Symtuza™: Darunavir/emtricitabine/cobicistat/TAF



Check the following labs:

- **CD4:** Q3-6 months in first 2 years after initiation of ART. After 2 years of ART with consistently suppressed viral load: CD4>300-500 cells/mm^3 monitor annually. CD4>500 cells/mm3: monitoring is optional.
- **Viral load:** 2-8 weeks after ART initiation, then every 4-8 weeks until suppressed. First 2 years of ART: Every 3-4 months. After 2 years of ART with consistently suppressed viral load: Q6 months.
- **Cr, LFTs, CBC w/ diff:** Q3-6 mos. UA for proteinuria Q6-12 months if on TDF or TAF.
- **Fasting lipid panel:** Annually, if abnormal, Q6 months.
- **Fasting glucose or HgA1c:** Annually, if abnormal, Q3-6 months.
- **TB screen:** Annual IGRA (e.g., Quantiferon) or PPD.
- **Repeat resistance testing:** In setting of treatment failure on ARVs—ensure that INSTI resistance testing is included if patient has been exposed to integrase inhibitors.

**Avoid or discuss potential risks of initiating dolutegravir-containing regimens in patients who are pregnant <8 weeks from sure LMP, or in patients with childbearing potential.*

STI screening

- Screen for STIs annually at minimum, more frequently (Q3-6 months) as clinically indicated if presence of behaviors that elevate risk for STIs
- GC/CT vaginal/cervical/urine for sexually active patients
- GC/CT oropharyngeal swab for patients reporting receptive oral sex
- GC/CT rectal swab for patients reporting receptive anal sex
- Syphilis (RPR)
- Hepatitis C and hepatitis B serologies

Opportunistic Infection Prophylaxis:

- P. Jiroveci (PCP) if CD4 <200 cells/mm3
- Toxoplasmosis if CD4 <100 cells/mm3
- Mycobacterium avium complex (MAC) if CD4 <50 cells/mm3
- CMV retinitis screen if CD4 <50 cells/mm3

Immunizations:

- HBV: Give series at double dose (40mcg). Check titers (HBsAb) if received standard series prior and if not immune, repeat series at double dose.
- HAV for at-risk patients
- Flu shot annually (inactivated; not live)
- Pneumococcal vaccine (PCV 13 and PPNV23)
- Tdap
- HPV vaccine (all men and women up to 45 years old)

Age-Appropriate cancer screening:

- Cervical cytology at baseline and repeat 6-12 months later, then annual thereafter if neg (refer for colposcopy if abnormal). If 3 consecutive pap smears are negative, may spread out pap smears to Q3 years. Avoid HPV co-testing for patients <30 years old. See OI guidelines for screening frequency if HPV co-testing available.
- Consider annual anal cytology for patients reporting receptive anal sex, patients with anal warts, patients with cervical dysplasia present (no clear consensus in DHHS guidelines currently; discuss risk:benefit of screening).
- All other cancer screenings follow routine primary care healthcare maintenance guidelines for general population (i.e. mammography, colorectal screening).

Screen for co-morbidities and address psychosocial well-being, including:

- Ask about current priorities: *"What is most important to you right now?"*
- Screen and offer support for mental health and psychiatric conditions including depression, anxiety, PTSD
- Screen and offer support/treatment for substance, tobacco, and alcohol use disorder
- Screen and offer support for unstable housing and food insecurity
- Screen and offer support for history of (and/or current) trauma
- Identify and troubleshoot strengths and barriers to medication adherence
- Assess family planning desires and sexual health and well-being for all patients
- Conduct comprehensive transmission risk reduction counseling (i.e. Treatment as Prevention, "Undetectable=Untransmittable"). Offer PEP or PrEP if indicated/appropriate for HIV-negative partners.
- Offer support for disclosure of diagnosis to partners, family and friends

Sources:

Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV*. Department of Health and Human Services. **aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/0**.

Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America. Clinical Infectious Diseases 58; 2013; 58 : 1 -34

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Pill photos: US DHHS National Institutes of Health (NIH) and Test Positive Aware Network (TPAN)

Feedback/questions: **paetc@ucsf.edu**.

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