

Navajo Area Indian Health Service HIV/AIDS Program Clinical Standards

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Background:

Clinical care of the patient with HIV/AIDS is a rapidly changing field. This document represents an attempt to set down standards of care for patients with HIV/ AIDS at Navajo Area Indian Health Service facilities. These standards are updated periodically.

NAIHS HIV Primary Care

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Patients followed in NAIHS facilities for HIV/AIDS will have the following tests performed at baseline and during follow up visits as noted.

Test	Frequency	Comments
CD4 Count	At diagnosis & q 3-6 months at first then every 6-12 months when viral load is undetectable and CD4 >200	Use one laboratory and methodology
HIV Viral Load	At diagnosis & q 3-6 months at first then every 6 months after 2-3 years of virologic control	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
RPR	At diagnosis and yearly	LP if positive
GC/Chlamydia	At diagnosis and yearly	Order Rectal & Pharyngeal test if MSM, in addition to urine
Quantiferon assay or PPD	At diagnosis and yearly	INH for 9 months if (+)
HBsAg, HBsAb, HCV Ab, Hep A total Ab	Once for all patients. Test MSM and IDUs annually for Hepatitis B and C	Vaccinate for Hep A and B if serology is negative
Toxoplasma Ab	Once	Prophylaxis if CD4<100
CMV Ab	Once	Test only if low risk (non MSM, non IDU)

Varicella Ab	Once if no h/o Chickenpox or Shingles	Consider vaccination if negative and CD4 > 200
CXR	Once	Only if symptoms or PPD +
CMP/CBC	Q 3-4 months or when CD4 and viral load are done	
Cervical PAP smear	Q 6 months x 2 then yearly	
Anal pap smear	Annually in MSM or if there is a history of anal sex, abnormal cervical PAP or history of genital warts	Recommended test. Refer positives for high resolution anoscopy
Lipids	Baseline and annually	Avoid simva/lovastatin
Urinalysis	Baseline and annually if on Tenofovir	
Hgb A1c	Baseline and annually	
G-6-PD level	once	If sulfa allergic

NAIHS Antiretroviral Therapy

Individuals at Navajo Area Indian Health Care facilities are eligible for free antiretroviral therapy if indicated. The standard indication for antiretroviral therapy is now quite simple:

Treat all HIV positive patients regardless of CD4 Count.

The preferred single pill regimen on Navajo is Tenofovir/Emtricitabine/Elvitegravir/Cobicistat (Stribild™) 1 po daily if there are no resistance mutations to the three components. A second excellent regimen requiring 2 pills is Tenofovir/Emtricitabine (Truvada™) 1 po daily and Dolutegravir 50 mg po daily. The second regimen is less convenient because it requires two pills but is the most potent regimen available and has few drug interactions. It is anticipated that this combination will soon be available in a single pill form. The preferred regimen for pregnant women or women of childbearing age planning for pregnancy is Emtricitabine/Tenofovir (Truvada™) 1 po daily plus Atazanavir 300 mg po daily plus ritonavir 100 mg po daily. Please consult an infectious disease physician prior to starting antiretroviral therapy and in two other situations: 1) The viral load fails to fall below 20 copies at 4-6 months 2) The viral load initially falls below 20 copies but later rebounds into the detectable range. More information about antiretroviral therapy can be accessed at <http://www.hivatis.org/> under the DHHS antiretroviral guidelines,

I am available for phone consultation at 505-409-3306. The UCSF HIV Warm-Line number for consultation on complex antiretroviral therapy questions is 1-800-933-3413. An alternate consultation resource is the Indian Health Service HIV ECHO teleconference held the second Wednesday of every month at noon Mountain Time. Please contact Brigg.Reilley@ihs.gov to connect with this resource.

NAIHS Prevention of Opportunistic Infections

Prophylactic therapy for HIV associated opportunistic infections has made a significant impact on HIV morbidity and mortality. Preventive is indicated for the following infections as per the USPHS/IDSA 2014 guidelines:

<u>Organism</u>	<u>CDC count cutoff</u>	<u>Drug regimens</u>
Pneumocystis	≤ 200	TMP/SMZ DS 1 po qd, TMP/SMZ DS 1 po 3x/wk Dapsone 100 mg po qd Atovaquone 1500 mg po qd Aerosolized pentamidine 300 mg per month.
Toxoplasmosis	≤ 100 & (+) serology	TMP /SMZ DS 1 po qd, Dapsone 50 mg po qd <i>plus</i> Pyrimethamine 75 mg po q week <i>plus</i> leukovorin 25 mg po q week.
<u>Mycobacterium avium complex</u>	≤ 50	Azithromycin 1200 mg po q week or Clarithromycin 500mg po bid

Institution of prophylactic therapy should be based on the nadir CD4 count. Preventive therapy can be stopped for the following organisms in patients who were receiving once there is immune reconstitution:

Criteria for stopping primary prophylaxis

<u>Pathogen</u>	<u>Criteria</u>	<u>Comment</u>
Pneumocystis	CD4 count >200 for 3 months	Restart when CD4 < 200
M. avium	CD4 count > 100 for 3 months	Restart when CD4 $< 50-100$
Toxoplasmosis	CD4 is >200 for 3 months	Restart when CD4 $< 100-200$

Health Maintenance

Partner notification/Case Management:

Referrals are routinely made to Navajo Nation Social Hygiene for contact investigation. New patients will be enrolled with the clinic HIV medical Nurse Case Manager. Patients should also be referred to a community social HIV case management programs if available.

Eye Care:

HIV positive patients need an annual eye clinic check-up to rule out HIV related eye disease.

Dental Care:

HIV positive patients need an annual dental clinic check-up to rule out HIV related oral disease.

GYN Care:

HIV positive women need 2 PAP smears six months apart after HIV diagnosis then annual screening if negative. Routine mammography is indicated as per the standard guidelines for the general population starting at age 40.

Colorectal/Anal Cancer Screening:

HIV positive patients need an annual anal and rectal exam to rule out anal cancer and STD's. Anal PAP smears have not yet become mandatory but are encouraged on Navajo. Patients with an abnormal anal PAP smear should be referred to an experienced surgeon for management. Colorectal cancer screening should be done as indicated by guidelines for the general population starting at age 50.

STD Screening:

An annual RPR and urine gonorrhea/Chlamydia nucleic acid probe test is indicated on all patients. Men Who Have Sex with Men should also have an annual pharyngeal and anal GC/Chlamydia swab nucleic acid probe test.

Lipid Screening

HIV positive patients need annual lipid screening and screening after a change in antiretroviral therapy. Simvastatin and Lovastatin should not be used due to drug interactions with efavirenz and the protease inhibitors. Pravastatin is not affected by antiretroviral therapy but is a less active drug. We use Atorvastatin or Rosuvastatin, and Fenofibrate as indicated since these are not as susceptible to drug interactions.

Bone Health

DEXA scans are indicated for post-menopausal women and for men age 50 or greater with HIV, especially those on Tenofovir. Vitamin D level testing is recommended once and periodically as indicated.

TB screening:

A PPD skin test or Quantiferon test should be done at diagnosis and annually. Quantiferon testing offers the advantage of a single visit to complete the test and may save gas money for the patient and our clinic outreach staff. Nine months of INH are indicated for all positive PPD tests greater than 5 mm induration (not 10 mm) or positive Quantiferon tests. A symptom review and CXR are mandatory to prove there is no active tuberculosis. All HIV positive patients getting INH need pyridoxine 50 mg po daily to prevent neuropathy.

Nutritionist Consultation:

HIV positive patients should see a nutritionist yearly at a minimum. If malnourished or diabetic, more frequent monitoring is indicated.

Hepatitis Testing:

Baseline testing for hepatitis A, B and C is indicated. Annual testing for Hepatitis B and C of patients with high risk behavior (MSM or IDU) should be considered.

Vaccines:

All patients should be immunized with hepatitis B, influenza, TdAP and pneumococcus vaccines. Patients should receive both the conventional Pneumovax and the PCV-13 vaccines. PCV 13 is give 1 year or more after the last Pneumovax and Pneumovax is given 2 months after the last PCV if vaccination is required). All patients require a hepatitis B surface antibody test after immunization to document immunity. A second pneumovax is given after 5 years, and in the NAIHS this is usually repeated every five years for life. A double dose Hep B vaccine given at 0, 1, 2 and 6 months has been shown to be more effective in HIV positive patients who have not responded to an initial standard vaccine series of three injections. Hepatitis A immunity should also be documented and if non-immune the hepatitis A vaccine series should be given. HPV should be given to males and females age 9 through 26. Patients with no immunity to varicella can be offered Varicella vaccine if CD4 > 200. . Varicella primary vaccination may be considered for adults who are varicella seronegative and have a CD4 count greater than 200. Zoster vaccine is not routinely recommended for HIV positive adults

Mental Health:

All patients should be screened for depression, anxiety, suicidal ideation and substance abuse at every visit. Patients with a positive mental health/substance abuse screen should be referred to a mental health provider or substance abuse counselor. Domestic violence screening is indicated at every visit for both men and women with appropriate referrals if screening is positive.

Spiritual Health:

All patients should be screened for spiritual health issues and referred to a medicine man or other spiritual health provider if desired by patient.

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References:

1. Adult and Adolescent ARV Guidelines:
<http://aidsinfo.nih.gov/guidelines>
2. Adult and Adolescent OI prevention and treatment guidelines:
<http://aidsinfo.nih.gov/guidelines>
3. Primary Care Guidelines for the Management of Persons Infected with HIV:
<http://cid.oxfordjournals.org/content/58/1/e1.full.pdf+html>