AETC AIDS Education & Training Center Pacific

Clinical Essentials: HIV New Diagnosis and Health Care Maintenance

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▶New HIV Diagnosis

■ At diagnosis, screen for:

- CD4 and HIV viral load
- HIV genotype including RT, PI, integrase resistance if prior CAB-LA or other concern
- HAV IgG, HBV cAb, sAg, sAb, HCV Ab - for evidence of coinfection and immunity
- IGRA or PPD/TST to rule out latent TB
- HLA–B*5701 for hypersensitivity if considering abacavir
- CBC w/ diff, complete metabolic panel, lipids, fasting glucose or HbA1c
- STI screens: RPR, GC/CT (incl. extra-genital), trichomonas.
- Toxo IgG for evidence of prior exposure (counsel to avoid exposure if negative).
- Consider checking G6PD levels. Assess need for PCP/PJP prophylaxis
- 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 antiretrovial therapy (ART) initiation
- Every 4-8 weeks until viral suppression, then Q3-6 months
- Consider more frequent screen if pregnant, chestfeeding, or sexually active with partner who is pregnant/chestfeeding.

▶Chronic HIV

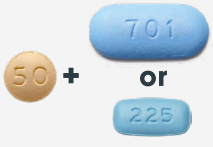
■ Treatment: antiretroviral therapy (ART) should be started as soon as possible.

- **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® + either Truvada® or Descovy®: Dolutegravir* 50 mg+ tenofovir/emtricitabine (TDF 300/200 mg or TAF 25/200 mg)



Dovato®: Dolutegravir/lamivudine (only if HLA-B570 negative. Do not use if HBV coinfection, or HIV RNA >500,000 copies/mL)

Cabenuva®: Cabotegravir/rilpivirine – long acting injectable ART (Patient should first achieve viral suppression on another regimen before switching to CAB-RPV)

■ 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. Consider more frequent screen if pregnant, chestfeeding, or sexually active with partner who is pregnant/chestfeeding.
- **Cr, LFTs:** At 4-8 weeks after ART initiation, then Q6 months.
- **CBC w/ diff:** Q3-6 months (w/ CD4), then annually
- **Fasting lipid panel:** Annually, if abnormal, Q6 months.
- **Fasting glucose or HgA1c:** Annually, if abnormal, Q3-6 months.
- **TB screen:** Annual IGRA.
- **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.

**For people who are pregnant or have childbearing potential, we recommend counseling patients through informed decision-making regarding the use of dolutegravir and other ARV drugs for people who are pregnant or have childbearing potential. Discuss future reproductive plans and timing with all patients as well as the risks and benefits of conceiving on specific ARV medications and contraceptive options.*

STI screening

- Screen for STIs annually at minimum (unless sexually abstinent), more frequently (Q3-6 months) as clinically indicated with ongoing exposures
- GC/CT vaginal/cervical/urine for sexually active patients
- GC/CT oropharyngeal swab for patients reporting receptive oral sex. Refer to CDC STD treatment guidelines.
- GC/CT rectal swab for patients reporting receptive anal sex
- Syphilis (RPR)
- Hepatitis C and hepatitis B serologies (if not previously infected or immune)
- Trichomonas at baseline and yearly in people with vaginas

Opportunistic Infection Prophylaxis:

- P. Jiroveci (PCP) if CD4 <200 cells/mm^3 or CD% <14%
- Toxoplasmosis if CD4 <100 cells/mm^3 and Toxo IgG positive
- Mycobacterium avium complex (MAC) if not on HIV ART, VL>200 copies/mL and CD4 <50 cells/mm^3
- CMV retinitis screen if CD4 <50 cells/mm^3 (quarterly)
- Consider discontinuing prophylaxis if CD4 100-200 and patient has an undetectable viral load on ART (see guidelines)

Immunizations:

- HBV if HBVsAg, sAb and cAb negative: Give series at regular dose. Check HBsAb 2-3 months after series and if not immune, repeat series at double dose (40 mcg). Consider immunization for isolated HBcAb + patients as well.
- HAV if HAV IgG negative
- Meningococcal vaccine (MenACWY) 2 initial dose series at least 8 weeks apart, then every 5 years
- Flu shot annually (inactivated; not live)
- Pneumococcal vaccine: Either PCV20 alone or PCV15 + PPSV23 (at least 8 weeks later) for adults aged 19-64 years with HIV and for 65 and older if vaccine history is absent or unknown
- Tdap (if not received as an adult; tetanus recommended every 10 years)
- HPV vaccine: all men and women up to 45 years old
- Zoster (RZV): Two-dose series of Shingrix recommended for all adults 19 y/o and older
- COVID-19: see CDC guidelines
- MMR: Two-dose series at least 1 month apart (Contraindicated if CD4 <200)
- Varicella: Two-dose series 3 months apart (Contraindicated if CD4 <200)

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 is available.
- Consider anal cytology for patients reporting receptive anal sex, patients with anal warts, patients with cervical dysplasia present (there is 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/treatment for:
- Mental health and psychiatric conditions including depression, anxiety, PTSD
- Substance, tobacco,and alcohol use disorder
- Unstable housing and food insecurity
- History of 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

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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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