2012 WEBINAR SERIES PART II:
TACKLING THE TOUGH TOPICS IN ETHNOGERIATRICS

Sponsored by Stanford Geriatric Education Center and San Jose AIDS Education and Training Center in conjunction with American Geriatrics Society, California Area Health Education Centers, & Natividad Medical Center

HIV AND THE AGING PATIENT:
CULTURAL ASPECTS

Retired Physician
Former HIV Specialist, PACE Clinic, Former Clinical Professor of Medicine, Stanford

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“HIV and Aging: Cultural Implications”

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As part of our commercial guidelines, we are required to disclose if faculty have any affiliations or financial arrangements with any corporate organization relating to this presentation. Dr. Arnold Leff has indicated he has no conflicts of interest to disclose to the learners, relative to this topic. Dr. Leff will inform you if he discusses anything off-label or currently under scientific research.

Q & A
- If you have any questions, please use the “Chat” feature located on the right side of your screen. Please send your chat to everyone if possible.
- After the Q and A, we would like to ask each of the participants to answer the short evaluation questionnaire.

About the Presenter
Dr. Leff, a partially retired physician, was Clinical Professor of Medicine at Stanford University until 2010. He is a Family Practitioner with previous certification in geriatrics, family medicine, hospice and palliative medicine and is currently certified in HIV medicine.

Dr. Leff was in private practice, specializing in geriatrics and HIV from 1985 till 2005. He was also and HIV specialist at the PACE Clinic at Santa Clara Valley Medical Center from 2005-2009.

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HIV and the Aging Patient: cultural aspects

Arnold S. Leff, M.D.
Retired Physician
Former HIV Specialist, PACE Clinic; Former Clinical Professor of Medicine, Stanford

Objectives

• Review basic HIV virology and immunology

• Review epidemiology of HIV with attention to aging, racial/ethnicity and toxic issues

• Explore consequences of disease as patients age

• Define opportunities for healthcare professionals and community to intervene in endemic areas

HIV: the infection

• A "retro"virus:
  – hooks onto host DNA
  – can stay in "sanctuaries" for years
  – infectious through significant body fluid transfer

• Almost 100% fatal if untreated; may appear to be dormant for years
A brief biology review

- Virus destroys T lymphocytes: one of the "orchestrators" of a redundant human immune system

- Blood
  - White Blood Cells
  - Lymphocytes
    - T lymphocytes
      - T4
      - Memory and naïve
    - T8
    - Killer cells

HIV Infects and Destroys the T Cell (also other cells)

- Deficiency of T cells leads to deficiency in the immune system which in turn causes (among others):
  - Opportunistic infections
    - Pneumocystis pneumonia, TB, other serious infections
  - AIDS related cancers
    - Kaposi's Sarcoma, lymphomas, others
  - Neurocognitive disorder
  - Psychiatric Disorders
  - Pain (both infection and treatment related)
  - Premature Aging

HIV Infection

- Few (1%) show innate ability to fight off virus (long term non-progressives; elite non-progressives) May still be consequences

- Current treatment daily for life: a cure feasible (bone marrow transplant for other reasons)

- Mortality: used to be mainly opportunistic infections and selected cancers -now 50-50 AIDS related diseases:diseases of aging (cardiovascular/hepatic/oncologic)
HIV Diagnosis and Treatment issues

• Nationally, 25% of HIV infected do not know they are
  – Higher in some groups
  – Early treatment saves lives
  – Everyone between ages 13-64 and all high risk should be screened
• 30% HIV infected also infected with Hepatitis B/C
  – Hep B/C curable; sexually transmissible
  – Both potentially deadly
  – Those born between 1945-65 and all high risk should be screened

Treatment of HIV

• Adherence to medication essential: one pill, once daily, possible

• Viral resistance if poor adherence-increases number of pills and type of regimen

• Medication side effects limited but still problematic for some; polypharmacy

Stigma and Discrimination

• Major reason for delay in diagnosis/treatment especially in minority groups; Tuskegee experiment causes distrust among blacks

• Denial of disease common in emergency situations

• Discrimination by insurers, pharmaceutical companies, care facilities, add to the usual racial/economic discrimination

• Stigma: how to keep one’s condition secret. (e.g. How to keep medications secret from family (refrigeration a potential issue); clinic visits a conundrum.)
### Diagnoses of HIV Infection among Adult and Adolescent Females, by Race/Ethnicity: 2010—46 States

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<th>Race/Ethnicity</th>
<th>No.</th>
<th>Rate</th>
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<td>6.4</td>
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<tr>
<td>Asian</td>
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<td>Hispanic/Latino</td>
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<tr>
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<td>133</td>
<td>9.7</td>
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<tr>
<td>Total</td>
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</tbody>
</table>

### Percentages of AIDS Diagnoses among Adults and Adolescents, by Race/Ethnicity, 1985–2010—United States and 6 U.S. Dependent Areas

![Graph showing trends in AIDS diagnoses by race/ethnicity]

### Survival after an AIDS Diagnosis during 1998–2006, by Months Survived and Race/Ethnicity—United States and 6 U.S. Dependent Areas

![Graph showing survival rates by race/ethnicity]

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More Numbers**

- Black women twice as likely to die of AIDS than white women (in U.S.) They are also less adherence to medication regimens.*

- Some black populations have higher incidence of HIV than parts of Africa (Washington DC=3%)**

- Blacks were 44% of all HIV cases newly diagnosed in 2009** Also have high risk for other STD's

- Young African-American men who have sex with men are at especially high risk for contracting infection


Latinos and HIV*

- Latino men who have sex with men (MSM) represent 81% of new infections among Latino men, and 19% among all MSM

- Latinos are 16% of the US population, but make up 17% of living HIV/AIDS cases and 20% of new HIV infections each year

- Youth (ages 13-29) accounted for 45% of new HIV infections among Latino MSM

*Fact Sheet: 2012 March 28; UCSF Center on AIDS

A recent study* of Latino MSM living in New York and Los Angeles reported that:

- Over 40% of the participants reported experiences of both racism and homophobia in the past year

- Low self-esteem and decreased levels of social support among Latino gay men are associated with increased rates of sexual risk behaviors, including unprotected anal sex

- Men who had both homophobic and racist experiences were more likely than men who reported no form of discrimination to engage in unprotected anal sex and binge drinking

*UCSF Fact Sheet
• 38% of Latinos test late in their illness.
• In a study of 21 major US cities, 46% of Latino MSM who tested positive for HIV were unaware of their infection.
• HIV+ Latinos are more likely than Whites to postpone care due to issues such as lack of transportation, and more likely to delay initiation of care after their diagnosis.
• 24% of Latinos living with HIV/AIDS are uninsured, compared to 17% of Whites; and only 23% of HIV+ Latinos have private health insurance, compared to 44% of Whites

Recent Immigrants
• Issues are area dependent
  – High prevalence TB
• Unidentified late stage
• Clinic visits an anathema due to severe stigmata in some cultures
• Illiteracy
• Improvements in developing world happening
  – Vaccine/prevention/woman’s issues important

By 2015
50% of HIV infected patients in the US will be over 50 years old
with the infection likely causing premature aging

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**Aging and HIV**

- Questionable criteria for frailty in HIV infected patients

- Immuno-senesence:
  - T cells naturally decrease in aging
  - Slower to respond to Rx
  - Anti viral treatment should be started upon diagnosis

- Multi-morbidity: cancer, pain and metabolic issues (hypertension, diabetes, heart disease) complicate diagnosis/treatment

*HIV and Aging Consensus Project: AGS, AAHIVM, AIDS Community Research Initiative

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**CARE Issues**

- Earlier cognitive decline due to HIV sometimes complicates placement.

- Multiple stigmas (e.g. psychiatric and HIV plus minority plus underinsured) complicates care

- Caregivers require adequate education in often very complicated care issues

- Stigma and discrimination often the norm

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**AIDS and Aging: Drugs Are HUGE Problem**

- Therapeutic pharmaceuticals for diseases of aging plus HIV drugs = multiple possible interactions/side effects/ adherence/confidentiality and economic issues

- Better than 12 different pills/day common in Aging and HIV
  - Examples:
    - High blood pressure 3 drugs
    - Asthma 3 drugs
    - Pain 3 drugs
    - Antihypertensive 3 drugs
    - Psychiatric medication (sleeping pills, antianxiety/depression medication) common 3+
    - Cardiovascular prevention 1+
    - Osteoporosis prevention 1+
    - Antioxidant medication to counter side effects 1
More Than 1 Pill A Day

• Interactions common:
  – decreases efficacy
  – leads to potential toxicities and increased side effects
• Side effects common: ?add another drug
• Set up mistakes common
  – Appropriate setup boxes and reminder systems essential
  – One and only one pharmacy
  – Even some of the smartest people make mistakes
  – Generic drug use complicates set up: all meds look the same
  – Prescription labels still to hard to read

AIDS and Aging

• Still lots of denial; non-testing
• Assumptions that older adults do not have sex, do not abuse drugs = underestimated risk by healthcare professionals
• Limited HIV knowledge in older adults
• Still lots of stigma/discrimination (HIV, Aged, Minority, Woman, Gay/Transsexual)
• Early treatment now shown to prevent progression, so lives at risk if denial, stigma

Diseases of Aging (all increased prevalence in HIV)

• Coronary Artery Disease = heart attacks
• Osteoporosis= increase fracture risk
• Cancers: Cervical, Uterus (hepatitis C related), Anal, lymphomas, lung, skin, head and neck
• Diabetes=4 higher in HIV
• Renal disease-HIV related especially in African Americans one of the few truly race related differences
• HIV associated neurocognitive disorders (50% test in abnormal range)
• Psychiatric disorders/substance abuse a hidden problem

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Prevention

- Immunize, immunize, immunize:
  - Most dead vaccines OK in immunocompromised; do not work as well in older adults, HIV infected
  - But they do work; careful with live vaccines (flu shot vs. intranasal flu) also important for neighbors
  - HIV vaccine in research: some optimism

- Good life habits:
  - D/c smoking tobacco
  - Diet/exercise
  - Control co-morbidities

- Preventive drugs available for selected individuals/circumstances including occupational exposure

Sex, Safety and Culture

- Those MWM who also are married and producing children raise the importance of diagnosis and adherence to treatment in order to prevent the tragedy of HIV spreading to the baby

- Those who do not use safe injection techniques (including healthcare professionals)........ditto

Things We Should Do

1. Maintain funding for those things not covered by insurance and for those without (Ryan-White Federal Funds)
2. Convince healthcare professionals to follow screening guidelines and assure basic funding
3. Convince African-American and Latino community institutions to make HIV the priority it deserves (Education will reduce stigma, Prevention works)
4. Continue to train healthcare professionals in geriatric and HIV issues
5. Immunize all when vaccine available
Challenges in Linkage to Care and Successful Treatment

Estimated that only 18% of HIV infected individuals in the US have undetectable HIV viral load.

Major References

• CDC.gov/HIV
• HIV and Aging Consensus Project
• UCSF Fact Sheets: Center on AIDS
• ClinicalCareOptions.com/AIDS

Thanks and Remembrance

• To the San Jose Community Health Partnership for sponsoring me doing this webinar
• To my teachers, many of whom were also my patients
• Remembering All who passed on before we knew what to do

......we now know what to do. Why are we not doing it?
Thank You for Participating!

Reminder: Please complete our short survey. We appreciate your feedback.

NOTE: Continuing Education Participants must complete a final survey in order to receive CEU/CME credit.