A Biopsychosocial Approach to HIV-Associated Neurocognitive Disorders

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Special Thanks To

- Dr. Jordi Blanch for your invitation and inspiration

Introduction

- HIV/AIDS: severe, stigmatized, and complex multimorbid medical and psychiatric illnesses with a profound impact on patients, families, and caregivers
- HIV-Associated Neurocognitive Disorders (HANDs) magnify HIV stigma
- Understanding the psychiatric aspects of HIV-associated neurocognitive impairment in persons with HIV and AIDS can provide clinicians with the skills to decrease risk behaviors and HIV transmission, recognize and treat multimorbid psychiatric disorders, decrease morbidity and mortality, and reduce suffering in persons infected with and affected by HIV and AIDS

Outline of Presentation

- A Biopsychosocial Approach to Recognition, Diagnosis, and Differential Diagnosis of HIV-Associated Neurocognitive Disorder (HAND)
- Differential Diagnosis of Multimorbid Psychiatric Disorders
- Impact of HAND on Adherence to Risk Reduction, Medical Care, and ART
- Clinical Pearls for Treatment of HAND

What is Your Diagnosis of Ms. A's Visual Hallucinations?

- Ms. A is a 62 year old former librarian admitted with fever, abnormal chest x-ray, and late-stage AIDS (diagnosed only 1 month earlier) referred during her second admission when she reported new onset visual hallucinations.
- One month earlier, Ms. A had been admitted with vomiting, odynophagia, weakness, wasting, and weight loss. She was diagnosed with esophageal candida and late-stage AIDS with a CD4 of 2 and VL >750,000. She was treated for candida and discharged to the HIV clinic where she was started on ART.
- On her second admission she reported seeing frightening faces. Her fever and abnormal chest x-ray were due to *mycobacterium avium* pneumonia.
- What is the most likely cause of her visual hallucinations?

What is the Differential Diagnosis of Ms. A's Visual Hallucinations?

What is the Differential Diagnosis of Ms. A's Visual Hallucinations?

- Delirium
- Mood disorder with psychotic features
- Substance use disorder
- Psychotic disorders (schizophrenia)
- Psychosis due to medical condition (infectious, CNS lymphoma, toxoplasmosis, seizures and ictal states, neoplastic, paraneoplastic, endocrine)
- Immune reconstitution inflammatory syndrome (IRIS)

What is the Diagnosis of Ms. A's Visual Hallucinations?

- Cytomegalovirus (CMV) retinopathy

This vignette illustrates how an HIV-associated medical condition can cause a significant psychiatric symptom in persons with HIV/AIDS

Clinical Pearls for Differential Diagnosis of Psychiatric Symptoms in HIV and AIDS

- There is a need for a comprehensive biopsychosocial approach to psychiatric symptom evaluation in persons with HIV/AIDS
- This comprehensive approach to differential diagnosis includes exploring clues for infectious, neurologic, and psychiatric causes and requires complete medical, psychiatric, and psychosocial assessments as well as ancillary evaluations

Cohen, 1987, 1992; Cohen et al., 2010; Cohen and Alfonso, 2004; Cohen and Chao, 2008, Cohen and Gorman, 2008; Cohen and Weisman, 1986, 1988

Clinical Pearls for Prevention and Recognition of Cognitive Disorders

- Each person with HIV and AIDS needs a complete cognitive assessment at baseline and on a semi-annual or annual basis
- HIV-associated dementia can be prevented by early diagnosis of HIV infection and initiation of antiretroviral therapy immediately upon diagnosis HIV
- Cognitive impairment can cause nonadherence at any stage of HIV infection

Clinical Pearls for Prevention and Recognition of Cognitive Disorders

- Antiretroviral therapy may prevent progression or reverse cognitive impairment
- HAND is still prevalent and is the most common treatable cause of dementia in persons under 50 years of age (Ances and Ellis, 2007)
- Hypoactive delirium is prevalent in persons with HIV and AIDS, can masquerade as depression, and is easily resolved when the underlying cause is identified and treated

HIV/AIDS: A Paradigm of a Severe and Complex Medical Illness

AIDS is different from other severe and complex medical illnesses

- Nonadherence may have serious public health consequences as well as a devastating impact on patients and families
- Discrimination and AIDSism may worsen health care disparities and access to care
- AIDS is a preventable complex and severe illness
- Adherence to risk reduction and care can mean the difference between life and death to self as well as others
- Neurocognitive impairment can occur at any age throughout the course of illness and is highly prevalent

Prevalence of HAND in the ART Era

- 30 to 60 %

Cysique L, Murray JM, Dunbar M, Jeyakumar V, Brew BJ. A screening algorithm for HIV-associated neurocognitive disorders. HIV Medicine 2010;11:642-649.

Heaton R, Franklin D, Clifford D et al. Persistence and progression of HIV-associated neurocognitive impairment (NCI) in the era of combination antiretroviral therapy (CART) and the role of comorbidities: the CHARTER study. 5th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention. Cape Town, South Africa. July, 2009. (Abst)

Goodkin K, Cahn P, Concha M et al. Prevalence of HIV-1-associated Neurocognitive Disorders in Argentina. 5th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention. Cape Town, South Africa. July, 2009. (Abst)

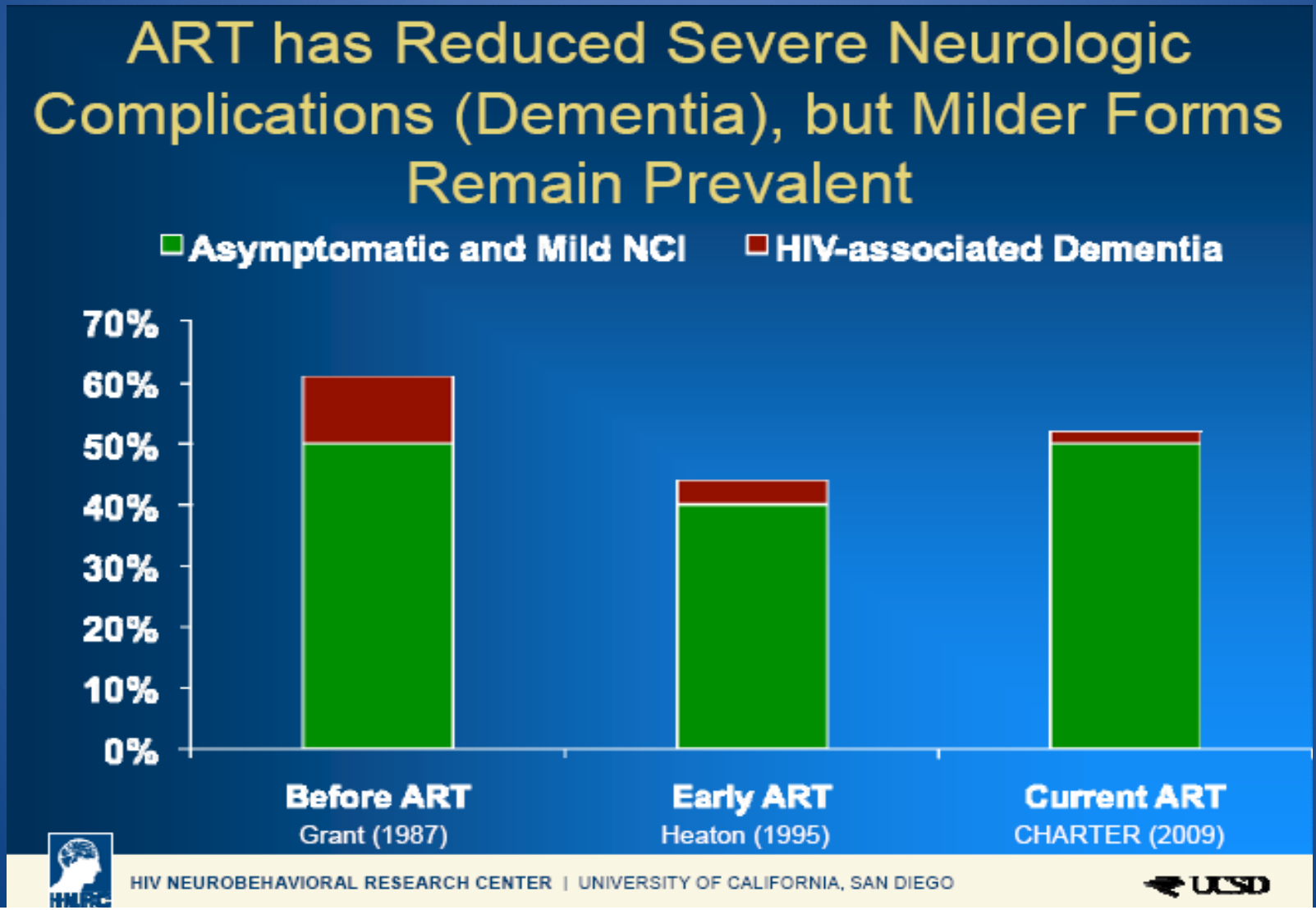
Garvey L, Yerrakalva D, Winston A. High rates of asymptomatic neurocognitive impairment (aNCI) in HIV-1 infected subjects receiving stable combination anti-retroviral therapy (CART) with undetectable plasma HIV RNA. 5th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention. Cape Town, South Africa. July, 2009. (Abst)

Vassallo M, Harvey-Langton A, Malandain G et al. The Neuradapt Study: Clinical, Radiological and Immunovirologic Findings in Patients with HIV-associated Neurocognitive Disorders. 17th Conference on Retroviruses and Opportunistic Infections. San Francisco, United States of America. February, 2010. (Abst)

Ciccarelli N, Fabbiani M, Di Giambenedetto S et al. Prevalence and Correlates of Minor Neurocognitive Disorders in Asymptomatic HIV-infected Outpatients. 17th Conference on Retroviruses and Opportunistic Infections. San Francisco, United States of America. February, 2010. (Abst)

Royal W, Akomolafe A, Habib A et al. Neurocognitive Impairment and HIV in Nigeria: Functional and Virologic Correlates. 17th Conference on Retroviruses and Opportunistic Infections. San Francisco, United States of America. February, 2010. (Abst)

Prevalence of Neurocognitive Impairment in Relation to ART Era



Risk Factors for HAD

- Older age
- History of CNS disease
- Shorter duration of antiretroviral treatment
- Low CD4 (current and nadir)
- Asymptomatic neurocognitive impairment (ANI)
- Mild neurocognitive impairment (MCI)
- Co-infection with hepatitis C (HCV)
- Insulin resistance
- Seroconversion disorder
- Anemia
- Vitamin deficiencies (B6, B12)
- High CSF viral load
- Depression
- Alcohol, amphetamines, cocaine

Valcour V, Sacktor N, Paul R et al. Insulin resistance is associated with cognition among HIV-1-infected patients: the Hawaii Aging with HIV cohort. J Acquir Immun Defic Syndr 2006;43:405-410.

Cysique L, Murray JM, Dunbar M, Jeyakumar V, Brew BJ. A screening algorithm for HIV-associated neurocognitive disorders. HIV Medicine 2010;11:642-649.

What is Your Diagnosis of Mr. B's Cognitive Impairment?

- Mr. B is a 64 year old with AIDS diagnosed in 1997 when he was found to have late-stage AIDS and a CD 4 of 17 who self-referred in 2012 because of memory impairment, difficulty retaining new information and multitasking
- Fluent in Greek, Russian, Italian, Portuguese, Spanish, French, and English, he resigned from his job at an international firm because he had begun to make mistakes at work
- He mourns both the loss of his job and the loss of his excellent memory that was once a source of great pride

What is the Differential Diagnosis of Mr. B's Memory Impairment?

What is the Differential Diagnosis of Mr. B's Memory Impairment?

- Delirium
- Mood disorder with depressive features
- Substance use disorder
- Mr. B had no evidence of delirium, depression, or substance use disorder but had difficulty with executive function (on clock drawing) and on copying a cube
- MMSE is 30 and his Bender drawings, formal tests of recall, registration, Mental Alternation Test (verbal Trailmaking), similarity testing, proverb interpretation, and serial 7s are all within normal limits.

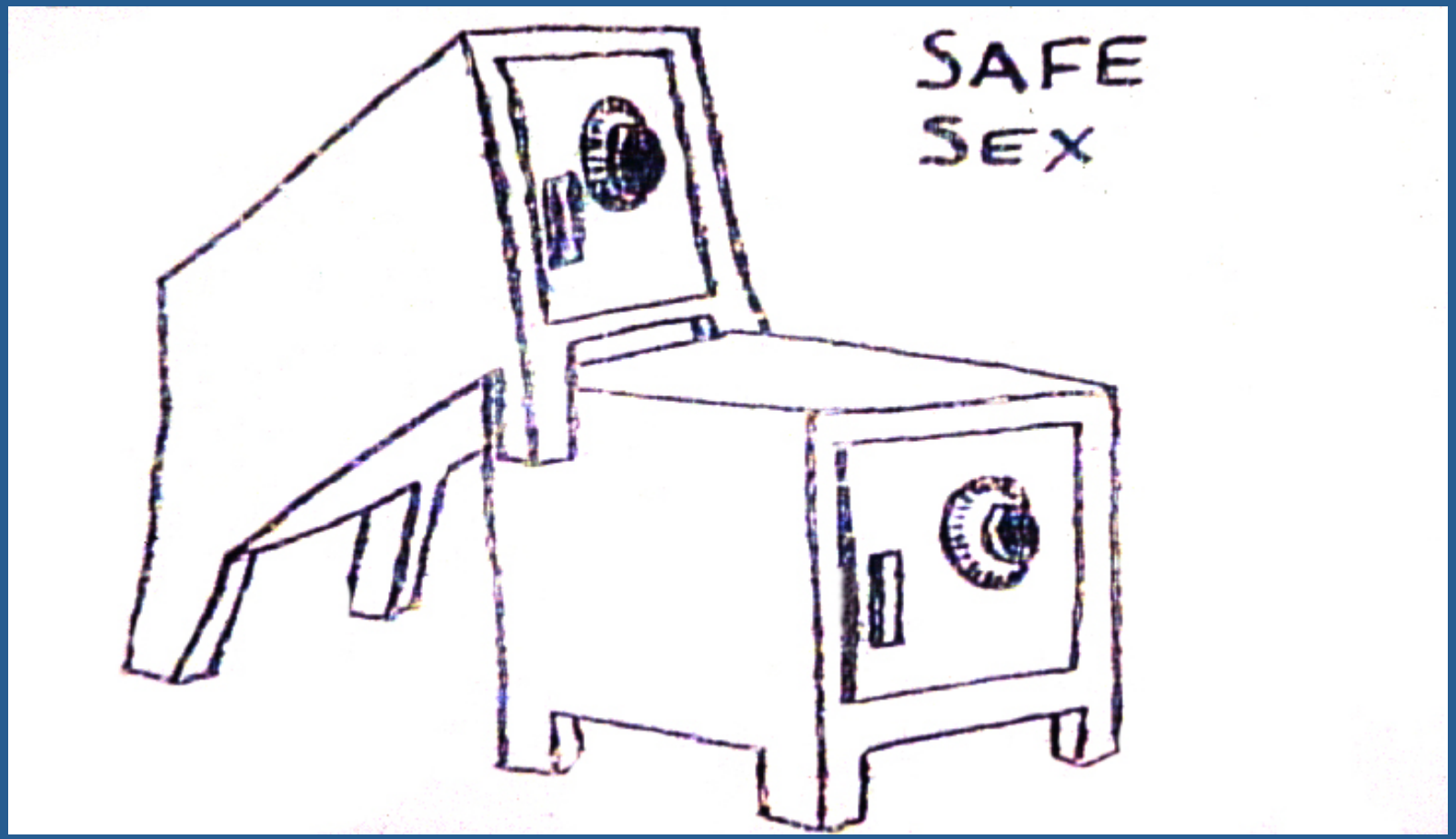
What is the Diagnosis of Mr. B's Memory Impairment?

- His own complaints and validation by collateral informants suggest that his diagnosis is consistent with mild neurocognitive impairment (MCI) and is causing him to resign from his job although his assessment on formal cognitive testing as well as the MAT reveals no abnormalities.

  There is a need for a complete comprehensive cognitive assessment of persons with HIV/AIDS including clock and cube drawing.

New Cases: Major Causes

- Unprotected sexual behavior
- Sharing needles and drug paraphernalia


SAFE
SEX

Stigma of HIV and AIDS: AIDSism

AIDSism is a form of discrimination with determinants that include

- Racism
- Homophobia
- Addictophobia
- Ageism
- Misogyny
- Discomfort with medical and mental illness, poverty, sexuality, infection, and death

Public Health Consequences of AIDSism

Obstacles to:

- Getting tested for HIV
- Obtaining test results
- Disclosing serostatus
- Taking medications in a timely manner
- Obtaining optimal medical care
- Taking antiretrovirals
- Engaging in safer sex practices

Cohen MA.

AIDSism

a new form of discrimination

Tragic Consequences of AIDSism

- Suffering in silence and alone
- Late diagnosis and treatment
- Nonadherence to care
- Increased morbidity
- Increased mortality
- Dying alone
- Racial, ethnic, and socioeconomic disparities
- Increasing numbers of AIDS orphans

How Can We Decrease Transmission of AIDSism and HIV?

- Teach sexual history-taking to trainees and faculty
- Teach drug history-taking to trainees and faculty
- Diagnose and treat neurocognitive disorders
- Diagnose and treat substance use disorders
- Diagnose and treat other multimorbid psychiatric disorders such as PTSD and depression
- Educate and encourage use of barrier contraception for sexually active patients
- Make free condoms openly available in ambulatory and inpatient medical and psychiatric settings, day treatment programs, MMTPs, and drug rehabilitation facilities

Cohen MA. AIDSism, a new form of discrimination.
AMA News, January 20, 1989; 32:43

HIV/AIDS:
A Paradigm for Comprehensive and Compassionate Care with a Biopsychosocial Approach

- Complex and severe medical and psychiatric illness
- Persons with HIV/AIDS are vulnerable
  - Medically
  - Psychiatrically
  - Socially

Cohen MA and Gorman JM. *Comprehensive Textbook of AIDS Psychiatry*. Oxford University Press, New York, 2008

Cohen MA, Goforth HW, Lux JZ, Batista SM, Khalife S, Cozza KL, and Soffer J. *Handbook of AIDS Psychiatry*. Oxford University Press, New York, 2010.

HIV/AIDS Psychiatry

Taboo Topics

- Sex
- Trauma
- Drugs
- Infection
- Death

Stigmatized Illness

Hepatitis C STDs TB
PTSD Dementia Delirium
Psychosis Injecting Drug Use

Severe Multisystem Illness

- Cardiac
- Dermatological
- Endocrinological
- GI
- Infectious
- Neurological
- Oncological
- Ophthalmologic
- Psychiatric
- Pulmonary
- Renal

Prevention

- Barrier contraception
- Drug treatment
- Safe sex
- Sterile works
- Trauma prevention

Lethality

Adherence to Prevention and Treatment

Vulnerable Populations

Women | African-American | Latino-American | Men who have sex with men | Addicted | Children | Elderly

HIV/AIDS Psychiatry

- Stigmatized illnesses
- Vulnerable populations
- Stigmatized populations
- High prevalence of psychiatric disorders
- Multidisciplinary team approach
- Comprehensive, and compassionate care
- Integrated model of care with psychiatrists co-located in the HIV clinic

Need for Recognition and Treatment of Psychiatric Disorders

- Vectors of HIV
- Barriers to adherence
- Psychiatric treatment:

  ↓ transmission, morbidity, mortality, suffering

  ↑ adherence

Psychiatric Vectors of HIV Lead to Nonadherence to Risk Reduction and Care

- PTSD
  - sense of foreshortened future, problems with caring for self and body, compulsive need to reenact trauma, unsafe sex
- Mania
  - disinhibition, hypersexuality, unsafe sex
- Psychosis
  - disinhibition, regression, unsafe sex
- Depression
  - low self-esteem and self-worth, nonadherence with care and risk reduction, unsafe sex
- Cognitive impairment
  - disinhibition, regression, unsafe sex
- Substance Use Disorders
  - exchange of sex for drugs, sharing works, disinibition while intoxicated, unsafe sex

Easy Ways to Differentiate Psychiatric Disorders

- PTSD – history of childhood or adulthood trauma, nightmares, intrusive thoughts, hypervigilance, easy startle
- Mania – irritability, rapid speech, difficult to follow, excitable
- Psychosis – delusions, difficult to understand, guarded
- Depression – sadness, crying, suicidal thoughts or attempts, guilt, low self-esteem, soft, slow speech, makes clinician feel sad or angry
  - are you depressed?
  - are you suicidal?
- Delirium – confusion, nodding out, disorientation, fluctuating behaviors, illusions
  - hypoactive delirium can masquerade as depression
- Dementia – memory impairment, slow speech and responses, slow movements, problems recalling dates and history
- Substance Use Disorders – how much can you hold/use in a day?
  - what happens if you do not use for a day?

What is Your Diagnosis of Ms. C's Nonadherence to Medical Care?

- Ms. C is a 33 year old unemployed single woman with AIDS who was referred for depression because of decreasing CD4 counts and elevated viral load despite treatment with antiretrovirals.
- Ms. C has has an excellent relationship with her HIV clinician for the six years since her diagnosis of AIDS and keeps most of her appointments.
- Her HIV clinician believed that untreated masked depression may have contributed to her immune system unresponsiveness since her virus was sensitive to the antiretrovirals he prescribed.

What is Your Diagnosis of Ms. C's Nonadherence to Medical Care?

What is Your Diagnosis of Ms. C's Nonadherence to Medical Care?

- Ms. C endorses worries about her forgetfulness and cannot give accurate dates of significant events in her life
- She states that she left her apartment to come to her doctor without turning off a burner on her stove and that only the vigilance of her neighbor who called the fire department resulted in saving her home and her pets
- Ms. C has constructional apraxia on clock and Bender drawings
- She registers 4/4 items but recalls 0/4 items in 5 minutes
- She is unable to perform on serial 7s or serial 3s

What is Your Diagnosis of Ms. C's Nonadherence to Medical Care?

- She has a great deal of difficulty remembering to take her medication and is not sure when to take them
- A diagnosis of HIV-associated dementia (HAD) explained her rising VL and diminishing CD4 count
- When use of cues, support from family, and DOT were instituted her lab values improved along with her memory

There is a need for a complete biopsychosocial assessessment and plan of care for persons with HAD.

Adherence

- Need 95% adherence to ARVs
- Need 100% adherence to safer sex
- Need 100% adherence to use of sterile works
- Only 28% of persons with HIV in the US have achieved viral suppression
- Only 69% are linked to care and 59% retained in care

Thompson MA *et al.* Guidelines for improving entry into and retention in care and antiretroviral adherence for persons with HIV: evidence-based recommendations from an international association of physicians in AIDS care panel. *Ann Intern Med* 2012; 156:817-833

Adherence and Disclosure

- Adherence means disclosing serostatus as well as using condoms
- People lie for sex *
- Fear of rejection
- Fear of abandonment
- AIDS stigma

* Cochran SD, Mays VM. Sex, lies, and HIV. NEJM 1990; 22:774-775

Tragic Results of Psychiatric Barriers to Adherence

- Lack of access to care
- Nonadherence to care
- Stopping and starting ARVs
- Emergence of viral mutations and viral multidrug resistance
- Dying of opportunistic infections

HIV Psychiatry – High Prevalence of Disorders and Unique Manifestations

- PTSD
- Mood disorders
- Anxiety disorders
- Cognitive disorders – delirium and HAND
- Substance use disorders
- Insomnia
- Fatigue
- Pain
- Suicide

Multimorbid and Diagnostic Complexities in Persons with HIV/AIDS

Freedman JB, O'Dowd MA, Wyszynski B, Torres JR, McKegney FP. Depression, HIV dementia, Delirium, Posttraumatic Stress Disorder (or all of the above). General Hospital Psychiatry 1994; 16:426-434

Many of our patients have multimorbid psychiatric and medical illnesses with complex histories, elements of trauma, as well as complicated courses and treatments.

What is Your Diagnosis of Mr. D's Cognitive Impairment?

- Mr. D is a 68 year old married disabled attorney admitted with chest pain, who has diabetes mellitus, hypertension, coronary artery disease, HIV (CD4 1100, viral load undetectable), and hepatitis C and was referred for depression.
- Psychiatric consultation revealed no evidence of depression, low self-esteem, low self-worth, guilt, loss of interest in his usual activities, or anhedonia.
- What is the most likely diagnosis?

What is Your Differential Diagnosis of Mr. D's Cognitive Impairment?

What is Your Differential Diagnosis of Mr. D's Cognitive Impairment?

- Mr. D had psychomotor slowing, confusion, disorientation to time and place, fluctuating levels of consciousness, emotional incontinence, and when alert had no evidence of depression
- He fell asleep mid-sentence
- It was difficult to perform formal tests of cognitive function because of inability to concentrate and fluctuating levels of consciousness
- Unable to draw a clock or copy a cube

What is Your Diagnosis of Mr. D's Cognitive Impairment?

- Diagnosis was hypoactive delirium. A comprehensive medical evaluation, including urine and blood cultures, was recommended and revealed a urinary tract infection with *E. coli* sepsis.
- Hypoactive delirium often presents as depression in the general medical setting.
- Mr. D had multimorbid medical illness and was found to have hypoactive delirium due to urosepsis.

Delirium is the most prevalent diagnosis in general care and hypoactive delirium is frequently misdiagnosed as depression. Delirium can also be superimposed on dementia as well as depression or other psychiatric disorders.

Differentiating Delirium from Dementia

	Delirium	Dementia
Fluctuation of symptoms	+	–
Fluctuating levels of consciousness	+	–
Drowsiness	+	–
Illusions	+	–
Hallucinations	+	+
Confusion	+	+
Carphologia (picking)	+	+
EEG background slowing	+	+
Insomnia	+	+
Impaired attention	+	+
Impaired concentration	+	+
Slow speech	–	+
Slow motor responses	–	+
Delusions	–	+
Ataxia	–	+
Leg weakness	–	+

PTSD and its Comorbities: Vectors of HIV

PTSD

- Sense of a foreshortened future
- Problems with care for self and body
- Unsafe sex
- Substance use dependence to anesthetize pain
- Exchange of sex for drugs
- IV drug use
- Sharing works
- Depression and low self-esteem

Major Depressive Disorder

- Depression is very prevalent in persons with HIV*
- Neurocognitive disorders can resemble depression and are seldom diagnosed
- Depression can lead to HIV illness progression
- The mortality of depression is suicide
- Depression is seldom diagnosed
- Once diagnosed, it is seldom treated
- Once treated, adherence improves, preventing illness progression

*Bing EG, et al. Arch Gen Psychiatry 2001;58:721-728

AIDS and Injection Drug Use

- >1/3 of new cases in US from IV drug use
- 40% of US AIDS deaths related to drug use
- All drugs of abuse cause intoxication and increase risky sexual behaviors - increasing spread of HIV, HBV, and HCV
- Substance use disorders lead to nonadherence
- Treatment of substance use disorders improves outcomes and decreases mortality
- Directly observed antiretroviral therapy in MMTPs improves outcomes

What Psychiatric Disorder is a Factor in Mr. E's Refusal to Remain in a Nursing Home?

- Mr. E is a 37 year old disabled former investment banker with AIDS (CD4 112 and elevated viral load) who was admitted to a nursing home when he was no longer able to care for himself in the community or perform activities of daily living (ADLs) or instrumental ADLs (IADLs). He was referred for refusal to stay in the nursing home.
- Mr. E was no longer able to care for his partner or himself and did not believe that he was ill or that he had HIV.

Diagnosis and Treatment of Mr. E

- On initial psychiatric consultation Mr. E denied being ill or needing care. He wanted to return home to live with his partner.
- What is your diagnosis?

Diagnosis and Treatment of Mr. E

- On initial psychiatric consultation Mr. E denied being ill or needing care. He wanted to return home to live with his partner.
- He had impaired memory, abstract thinking, and executive function as well as anosognosia. He had constructional apraxia on clock and Bender drawings, psychomotor retardation, and profoundly diminished intellectual functioning relative to his educational (MBA) and occupational levels. He was incontinent of urine and feces.

Diagnosis and Treatment of Mr. E

- Mr. E's diagnosis was HIV-associated dementia.
- After two years of directly administered ART in the nursing home setting, evidence of dementia could not be detected on psychiatric examination. Mr. E was able to resume independent living and went from disabled young man with dementia to dapper investment banker.

  Dementia can occur at any age in persons with HIV infection. Early treatment with ART and early recognition of HAND can lead to decrease or resolution of cognitive impairment and restoration of function in some persons with HIV/AIDS.

Diagnosis and Treatment of HAND

- This vignette illustrates that although ART has had a major impact on both morbidity and mortality in persons with AIDS, HAND is still prevalent and is the most common treatable cause of dementia in persons under 50 (Ances and Ellis, 2007).
- It is important to diagnose HIV infection early and begin ART, since there is evidence that HIV begins to damage the brain within months of infection.
- Every person with HIV infection needs a comprehensive evaluation for cognitive impairment at baseline and at least twice yearly to ensure early diagnosis and of HAND. Comprehensive psychiatric assessment for HAND and other psychiatric disorders in persons with HIV and AIDS is described in the *Handbook of AIDS Psychiatry*.
- HAND is a prevalent diagnosis young persons as well as in elderly persons with AIDS.

HIV-Associcated Neurocognitive Disorder (HAND)

- HAND is found in 69% of viral suppressed HIV+ *
- Neurocognitive disorders can resemble depression and are seldom diagnosed
- Diagnosis requires complete cognitive assessment but brief screening can help lead to diagnosis
- HAD leads to nonadherence with HIV care
- HAD may reverse with ART
- Once treated, adherence improves, preventing illness progression

Simioni et al. 2010

Neurocognitive Disorders: Screening

- Do you experience frequent memory loss (e.g. do you forget the occurrence of special events even the more recent ones, appointments, etc?)?
- Do you feel that you are slower when reasoning, planning activities, or solving problems?
- Do you find it more difficult to perform activities that used to be automatic for you (paying bills, writing checks, making plans)?
- Do you have difficulties paying attention (e.g. to a conversation, a book, or a movie)?

Simioni et al, AIDS 2010 (adapted with additions)

Treatment of Psychiatric Disorders in Persons with HAND

- Crisis Intervention
- Individual psychodynamic psychotherapy
- Supportive psychotherapy
- Cognitive behavioral therapy
- Group psychotherapy
- Couple therapy
- Family therapy
- Bereavement therapy
- Substance use treatment
- Palliative psychiatry
- Psychoeducational approaches to prevention
- Psychopharmacology

Treatment of Psychiatric Disorders in Persons with HAND

- Crisis Intervention
- Individual psychodynamic psychotherapy
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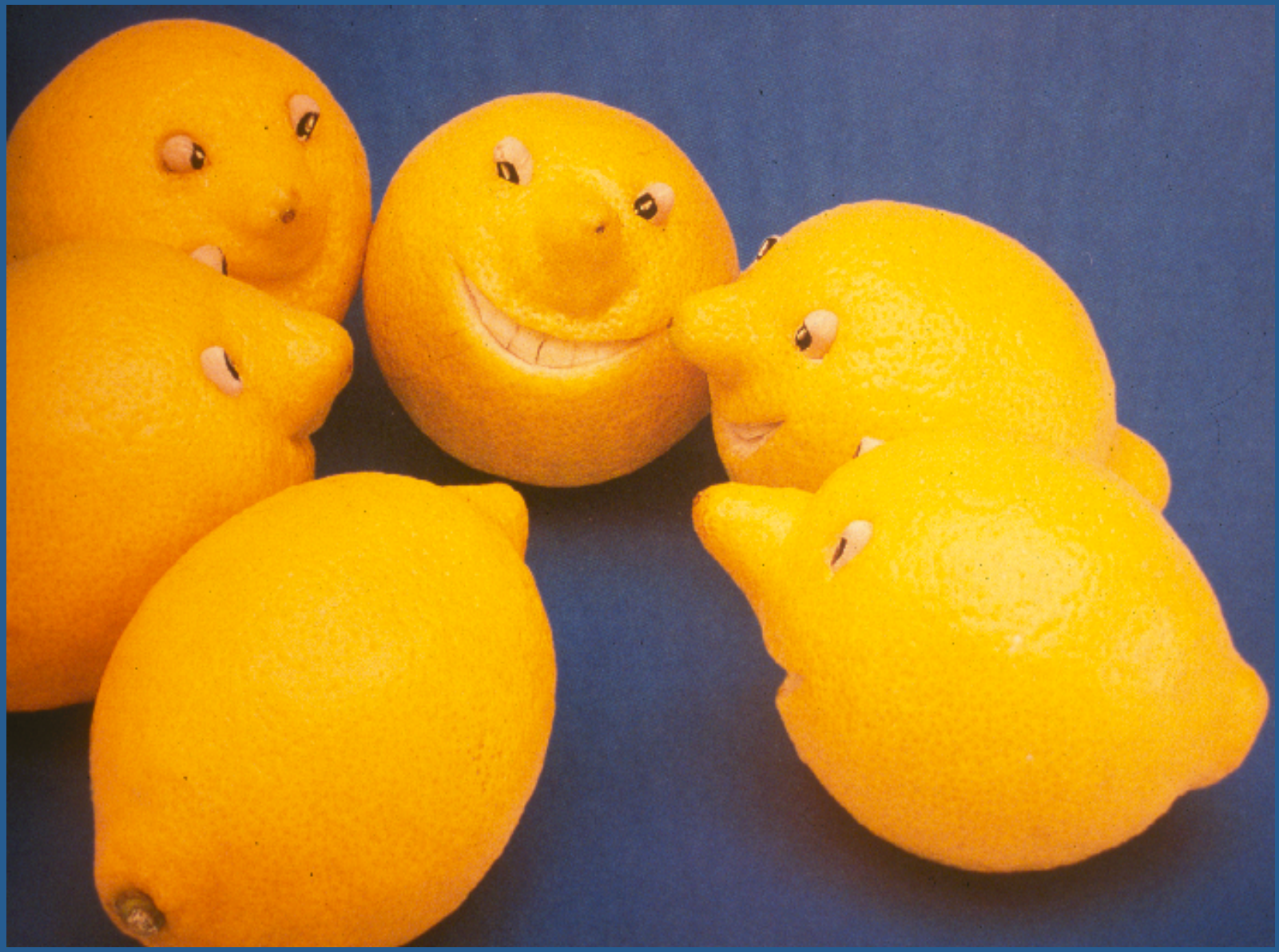
- Substance use treatment
- Palliative psychiatry
- Psychoeducational approaches to prevention
- Psychopharmacology

Treatment of Psychiatric Disorders in Persons with HAND: Support Groups

- Provide a safe environment to discuss concerns about HIV, its stigma, and its treatments
- Provide support from both members and leaders
- Confidential
- Non-judgmental
- Compassionate
- Caring
- “All in the same boat”
- Acceptance and sense of family



Treatment of Psychiatric Disorders in Persons with HAND: Alleviation of Symptoms

- Exercise emphasizing walking, balance, core strength
- Relaxation response
- Yoga
- Music therapy, dance therapy
- Reading, crossword and jigsaw puzzles, Ken Ken, movies
- Brain games including computer use
- Education and involvement of family in care
- Spiritual assessment and support
- Development of support networks if family or friends are unavailable
- Directly observed ART and other medications where indicated

Psychopharmacologic Treatment of Psychiatric Disorders in Persons with HAND

- High prevalence of multimorbid psychiatric disorders
- Increased risk of suicide
- Vulnerability to all side effects of medications
- Increased vulnerability to the psychiatric side effects of antiretroviral medications
- Increased vulnerability to anticholinergic side effects of medications (includes antihistamines, antispasmodics, most psychotropic medications, some ARVs, and warfarin)
- Special affinity of HIV to basal ganglia makes for high risk for extrapyramidal side effects especially psychotropic medications and antiemetics (except ondansetron)

Use of Psychotropic Medications in Persons with HAND

START VERY LOW AND GO VERY SLOW

- The maxim for geriatric psychiatry is even more significant for AIDS psychiatry because of the increased vulnerability of this population
- In the US, 26% of persons with HIV and AIDS are over 50 years old
- Avoid use of psychotropic medications except where essential for safety or alleviation of distress
- Avoid combinations of psychotropic medications if possible to prevent multiplication of side effects

HIV/AIDS Psychopharmacology: Effects on Patients

- Slowing of Metabolism
- Drug-Drug Interactions
- Drug–Illness Interactions
  - vulnerability to dysglycemia
  - Vulnerability to anticholinergic side effects
  - vulnerability to extrapyramidal side effects
  - vulnerability to falls
  - vulnerability to confusion
  - vulnerability to lipodystrophy

HIV/AIDS Psychopharmacology: Recommendations

- Antidepressants
  - Citalopram, 5 mg to 40 mg
  - Escitalopram, 10 mg
  - Bupropion, 75 mg to 150 mg
- Antipsychotics
  - Quetiapine, 12.5 mg to 100 mg
  - Olanzapine, 1.25 mg to 10 mg

The Role of Collaborative Care in the HIV Pandemic

- Prevention

  Can promote adherence to:

  - safe sex
  - drug treatment
  - harm reduction
  - needle exchange

- Treatment

  Can improve adherence to:

  - medical care
  - antiretrovirals

  Can decrease:

  - suffering
  - morbidity
  - mortality

Academy of Psychosomatic Medicine AIDS Psychiatry SIG

- Founded 2003, meets annually
- To develop networks
- To present work and share findings
- To develop consensus on treatment
- To develop collaborative research
- To educate other clinicians and trainees
- Has 300 mental health clinician members
- Since 2012 it is a Section of the WPA
- macohen@nyc.rr.com to join – no dues
- www.apm.org/sigs/oap