



HIV/AIDS Infection... The Next Step

Ricardo Correia de Abreu^{1*}, Alexandra R. Malheiro² and Frederico Duarte¹

¹Department of Infectious Diseases, Matosinhos Local Health Unit, Matosinhos, Portugal

²Internal Medicine Specialist and Geriatric postgraduate, Matosinhos Local Health Unit, Matosinhos, Portugal

***Corresponding author:** Ricardo Correia de Abreu, Department of Infectious Diseases, Matosinhos Local Health Unit, Matosinhos, Portugal.

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Introduction

With the onset of high-potency therapy in 1996, HIV infection, hitherto fatal, has become a chronic disease.

In this context, the aging of this population as well as new diagnosis in people over 65 years old summing multiple comorbidities and sometimes with significant polypharmacy leads us to challenges, concerns and needs that we will have to forcibly consider for the sake of those living with this chronic disease [1].

In the current situation, it is therefore not enough to have comfortable antiretroviral therapeutics that can adapt to complicated situations of polypharmacy, with few drug-drug interactions [2], nor to address/treat acute comorbidities when they are present, but we must think about the early management of all this, fundamentally, its prevention [3]. It is necessary to think and approach early on a preventive basis: cardiovascular risk, metabolic alterations, the development of diabetes/insulin resistance, arterial hypertension, and prothrombotic effect and also the repercussion that these situations may have if not addressed as soon as possible [4].

The definition of ageing in these patients also varies. As presented and discussed by different authors, this population, even though controlled, with HIV-negative RNA, continues to have, due to the chronic inflammatory state induced by residual virus populations in the "reservoirs", a more accelerated and early aging process [5] which, invariably, leads to the development of comorbidities, usually observed in general population only after 65 years, but in these cases about 10 years earlier [4]. This particular problem, increasingly complex, due to the success of antiretroviral therapy leading to a life expectancy close to the general uninfected

population, will be responsible for longer lasting effects of ageing and its associated pathologies. As example a 55-year-old patient with HIV infection, will have the equivalent, in terms of risk and comorbidities, to a 65-year-old having the same survival expectancy of up to 75-80 years, and the related costs [3].

Thus, as mentioned above, it is not only the treatment of the problems inherent to ageing, as it is currently done when they are detected, but rather its prevention through a specialized approach [6], so the next step for these patients will be the creation of Geriatric HIV clinics [7].

It will be necessary to create a multidisciplinary and specialized approach to be able to make preventive geriatrics and not only curative/palliative care [8]. This function should not be rooted in infectious disease's specialists only, but dependent on permanent and direct interaction with other specialties such as internal medicine and/or geriatrics [9], a specialty that has been much developed in recent years, in Anglo-Saxon countries. Infectious diseases specialists should be involved in group decisions and not be single decision-makers.

This concept of multi-discipline clinics, already implemented with great success in northern European countries, England, the United States and Canada for decades, should be a reality for all these patients, with the incorporation of a geriatrics strand [9] in HIV because only this way can the patient with HIV infection be treated as a whole, allowing that person to have a "healthy" and lasting life [8].

Now we have reached the stage of overcoming compartmentalization and no longer facing HIV patients as

exclusive by an infectious diseases problem, rather looking at them holistically, allowing for better care, opening the doors to other specialties that already deal with the elder population and their problems/pathologies. This is, therefore, the next step for HIV patients care [10].

Acknowledgment

None.

Conflict of Interest

None.

References

1. J Rockstroh, G Guaraldi, G Deray (2010) HIV and the body: a review of multidisciplinary management. *HIV Medicine* 11 (Suppl. 2): 1-8.
2. G Guaraldi, S Zona, M Menozzi, F Carli, P Bagni, et al. (2013) Cost of noninfectious comorbidities in patients with HIV. *Clinico Economics and Outcomes Research* 5: 481-488.
3. Sangarlangkarn A, Avihingsanon A, Appelbaum JS (2017) Application of Geriatric Principles and Care Models in HIV and Aging. *Interdiscip Top Gerontol Geriatr* 42: 119-133.
4. Erlandson KM, Karris MY (2019) HIV and Aging: Reconsidering the Approach to Management of Comorbidities. *Infect Dis Clin North Am* 33(3): 769-786.
5. Guaraldi G, Milic J, Mussini C (2019) Aging with HIV. *Curr HIV/AIDS Rep* 16(6): 475-481.
6. Althoff KN, Smit M, Reiss P, Justice AC (2016) HIV and ageing: improving quantity and quality of life. *Curr Opin HIV AIDS* 11(5): 527-536.
7. Sauce D, Pourcher V, Ferry T, Boddaert J, Slama L, et al. (2021) Immune activation and chronic inflammation: Is there an additional effect of HIV in a geriatric population? *Medicine (Baltimore)* 100(17): e25678.
8. Brañas F, Ryan P, Troya J, Sánchez-Conde M (2019) Geriatric-HIV Medicine: the geriatrician's role. *Eur Geriatr Med* 10(2): 259-265.
9. Allavena C, Hanf M, Rey D, Duvivier C, BaniSadr F, et al. (2018) DatAIDS study group. Antiretroviral exposure and comorbidities in an aging HIV-infected population: The challenge of geriatric patients. *PLoS One* 13(9): e0203895.
10. Guaraldi G, Cossarizza A (2017) Geriatric-HIV medicine: A science in its infancy. *Virulence* 8(5): 504-507.