AGEING&HIV

CHAIN UKI

CARE OF HIV AND AGEING IMPLEMENTATION NETWORK

Case Presentations

Mind the gap: detecting cognitive changes in a nurse-led HIV service.

Speaker:

Claire Petersen

HIV Care at the End of Life

Speaker:

Dr Matt Spencer

ASK A QUESTION HERE

Mind the gap: detecting cognitive changes in a nurse-led HIV service.

RB

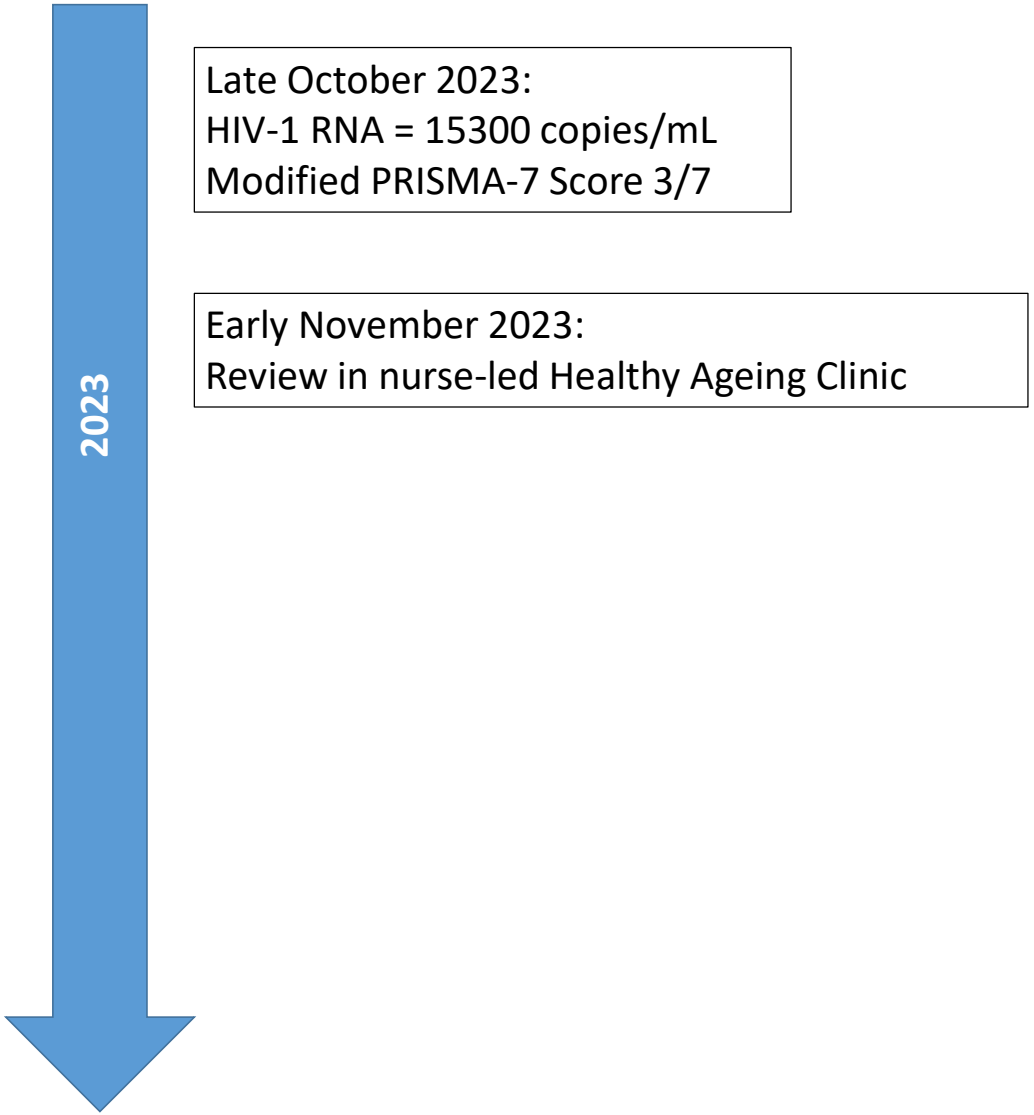
- 78 year old male
- Diagnosed with HIV in 1985
- Well controlled on NVP based ART from 2002
- Nadir CD4 10 (October 2001)
- Switched from TDF/3TC to FTC/TAF in October 2023 due to declining renal function

Other medical history:

- Osteoarthritis in lower back/hands
- Osteopaenia
- Hypertension
- High cholesterol
- Cataract

Medications:

- Neviripine
- Descovy
- Atorvastatin
- Losartan


2023
Late October 2023:
HIV-1 RNA = 15300 copies/mL
Modified PRISMA-7 Score 3/7
Early November 2023:
Review in nurse-led Healthy Ageing Clinic

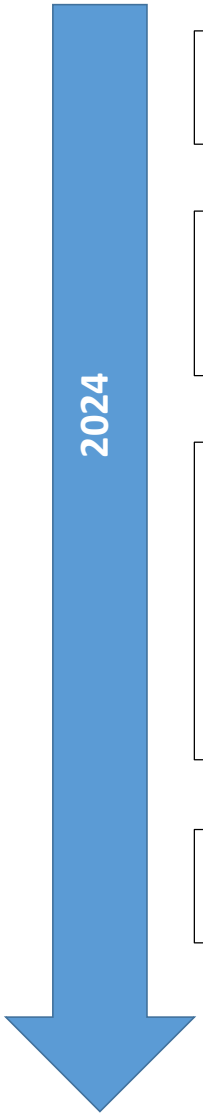
Comprehensive Geriatric Assessment

- Living independently at home
- Geriatric Depression Scale = 6/15
- Loneliness score = 8/9
- Poor sleep
- Postural drop of BP (147/82 sitting to 113/70 standing)
- Confusion about medications
- MoCA = 21/30
- Rockwood CFS score 4
- HIV Genotype requested

4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

Actions/recommendations:

- MRI brain
- Memory clinic referral
- GP review of anti-hypertensives
- Dietician review
- Psych liaison nurse review
- Switch to BIC/FTC/TAF

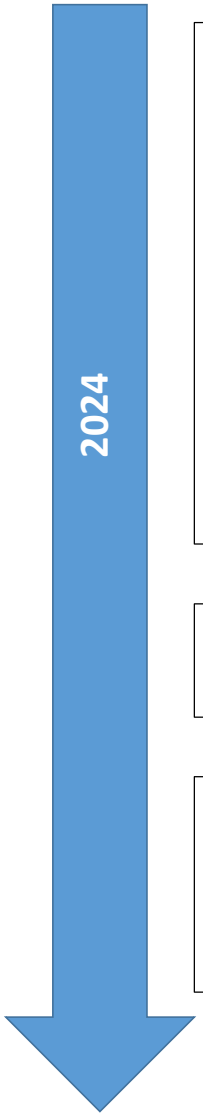


Late Jan 2024:
Several drop-ins as confused about appointments

Feb 2024:
LP to check for CSF viral escape
Reported recent cycling accident

March 2024:
Shares with nurse about anxiety around having dementia
Further support with medication management
Psych liaison review
Increasing vulnerability and concern regarding finances
Brain MRI

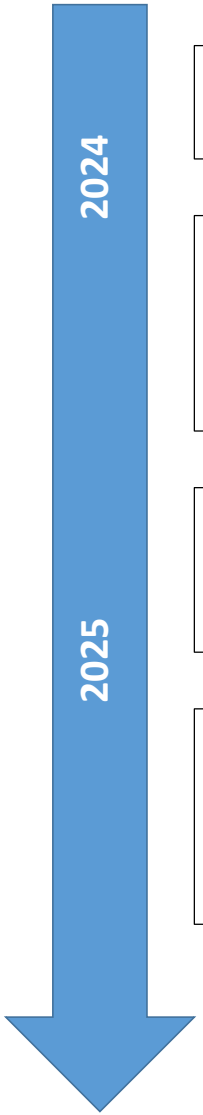
April 2024:
Increasing paranoia, confusion, memory loss and anxiety



Late April 2024:
Admitted with collapse/confusion/hypotension/AKI
X2 recent cycling accidents
MRI - Deep and periventricular white matter changes in both hemispheres, indicative of chronic small vessel disease
Lumbar puncture - low CSF Beta Amyloid 1-42/40 Ratio (0.046)
PD: early Alzheimer's disease
MoCA – 21/30
Switched to DRV/c + FTC/TAF
Discharged home, no care package

Summer 2024:
Multiple visits to HIV outpatient clinic for ongoing support with medication adherence

July 2024:
Review by memory clinic
PD: Cerberbral Amyloid Angiopathy and vascular dementia
Started rivastgmine.

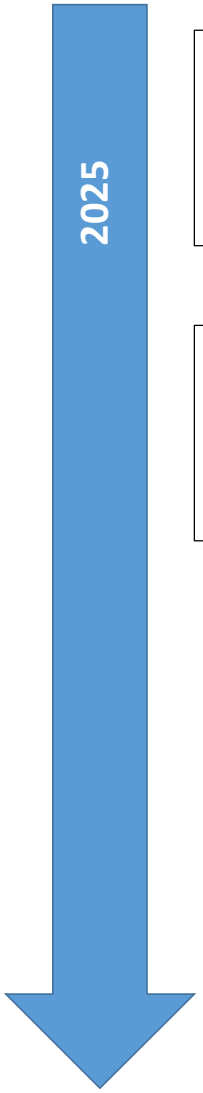


October 2024:
A&E attendance with falls at home

Winter 2024:
Regular visits to HIV outpatient clinic
Nurse liaising with GP, social worker and other community services to arrange package of care
Referred to local Falls Clinic

January 2025:
A&E attendance, knocked by a lorry
Further evidence of deterioration, niece seeking care at home

February 2025:
Admission with increasing confusion/wandering/AKI
HIV-1 RNA 389, 000 copies/mL
Deemed to have no capacity, POA invoked



March 2025:
Discharged to care home
Support with daily ARVs
HIV-1 RNA to 210 copies/mL

Now:
HIV-1 RNA <20 copies/mL
Rivastigmine stopped (postural hypotension)
Attends outpatient clinic with a staff escort

Key contributions from nurse-led Healthy Ageing Clinic

- Recognition of deteriorating cognition
- Appropriate referrals for imaging/memory clinic/psych review and ARV review
- Continuity of care and support
- Linked with NOK and Power of Attorney arrangements made in time
- Adherence support
- ANP able to expedite clinical reviews
- Liaise with GP and social care

HIV Care at the End of life

Matt Spencer

Internal Medicine Trainee

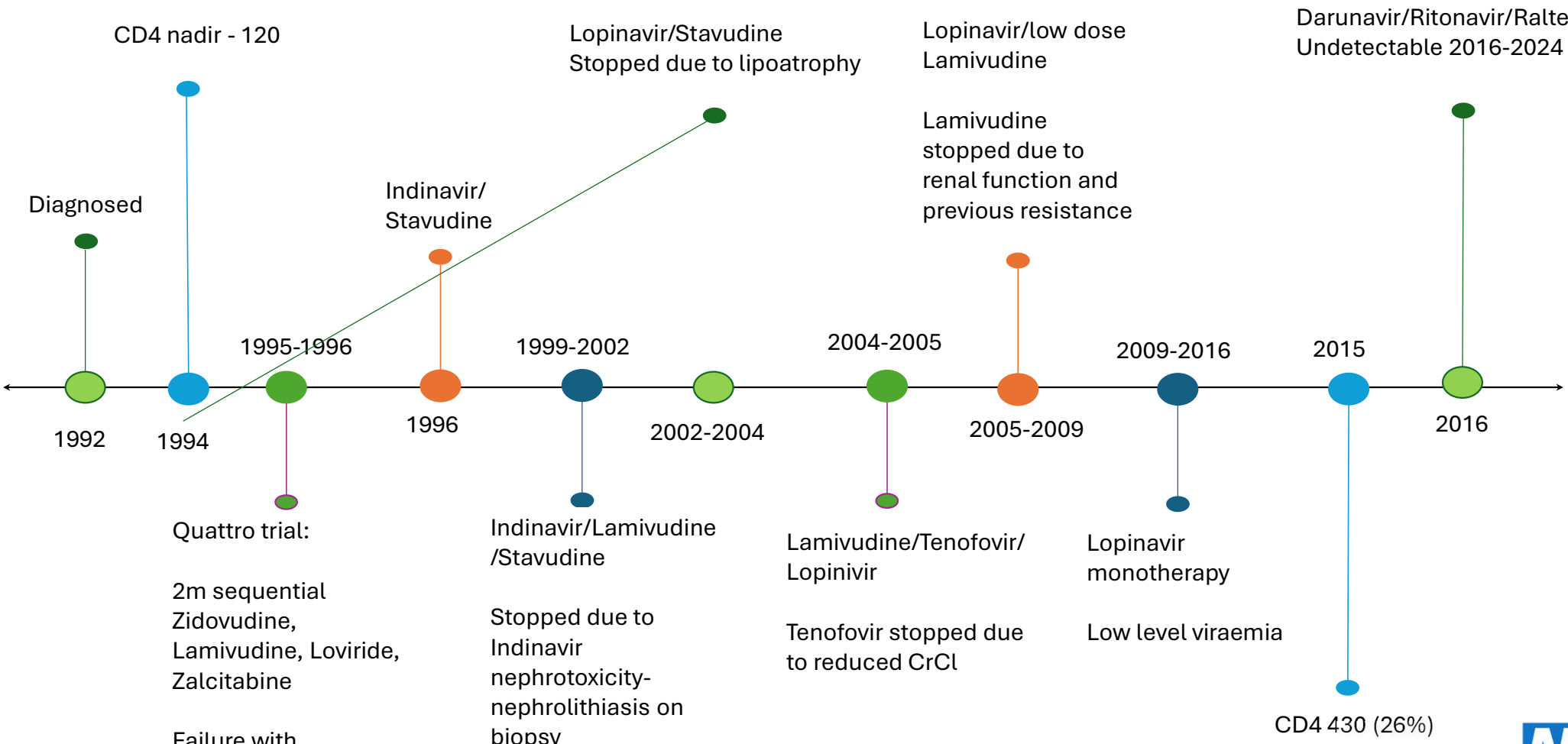
Royal Free London
NHS Foundation Trust

Presentation

- 82 year old male
- HIV care under Mortimer Market Centre
- Diagnosed 1992
- Nadir CD4 120 (1994), CD4 count 430 (2015)
- LLV 2009-2016, otherwise well controlled HIV
- Royal Free Records HBV coinfection (incorrect)

NRTI additional info:: 41L 70R 215Y 184V

NNRTI additional info: no known resistance however Loviride monotherapy



NHS
Royal Free London
NHS Foundation Trust

Medical History

- Lung adenocarcinoma July 2024
  - Picked up on CT whilst investigating GI symptoms
  - T1bN0M0 at diagnosis
  - VATS segmentectomy RBH Oct 24
  - Declined adjuvant chemotherapy
  - Extensive bony mets within weeks
  - Liver and brain mets

- Hypercholesterolaemia
- Hypertension
- LVH
- CKD 3 – under RFH Nephrology
  - Indinavir microlithiasis and tenofovir nephrotoxicity
- Barrett's oesophagus

- Medications:
  - Atorvastatin
  - Doxazosin
  - Lansoprazole

- Allergic to Perindopril and Losartan (angioedema)

- Social History
  - Lived alone
  - No formal POC
  - March 2024 – ran 5m alt days
  - Never smoker

NHS
Royal Free London
NHS Foundation Trust

December 2024 Admission

Admitted Under Oncology

1. Hip, rib and sternal pain
- MRI shoulder revealed new metastatic deposits
- Single fraction palliative radiotherapy to R shoulder and hip
- Reviewed regularly by palliative care & started on alfentanil CSCI, stepped down to fentanyl patch on discharge

2. Pleural effusion ?empyema
- Not drained as clinically well during admission

3. Delirium
- Likely secondary to both of the below

4. Covid +ve
- Paxlovid given

5. Urinary retention - Catheterised

6. Progressive dysphagia

- HIV team informed of admission 08/01 & gave advice about ARVs in context of Covid 19 infection
  - HIV Team liaised with MMC team
- Decision made to discharge to NH & referred to community palliative care
- HIV team not aware of dysphagia on discharge, continues on oral ART

NHS
Royal Free London
NHS Foundation Trust

January 2025 Admission

Presented with increasing confusion & 'cloudy' urine in catheter
- Overall significant deterioration from discharge to NH

1. Catheter associated UTI
2. LRTI - ?empyema, however felt to be too unwell for chest drain insertion to be appropriate
3. Delirium secondary to above
4. AKI stage 2 (pre-renal) with hypernatraemia and hypercalcaemia
5. No oral intake due to dysphagia, NG tube not possible due to agitation

- HIV team informed of admission
- Discussed in ARV MDT 28/01 decision made to convert to cabotegravir and rilpivirine injectable & administered same day

- Palliative care team and HIV geriatrician reviewed
- Recognition of dying, discussions with NOK re preferred place of care, discharged back to NH for end of life care
  - All oral medications stopped
  - UCP updated at discharge and GP informed on day of discharge for urgent home visit

NHS
Royal Free London
NHS Foundation Trust

Discussion

- HIV Team and palliative care team input is crucial for people living with HIV and co-morbidities at the end of life
- Modification of ART treatment for PLWH at end of life
- Advanced care planning for PLWH and personalisation of care