

Geriatrics in Action

Chair:

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Case Presenters:

Case 1: Dr Ravipal Singh

Case 2: Julie Ringsell & Martin Hutcheson

MDT:

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Nurse - Justine Mellor

Pharmacist - Jacob Smiles

Physio – Dr Natalie St Clair-Sullivan

ASK A QUESTION HERE



GERIATRICS IN ACTION • AGEING & HIV • 2026

When HIV Is Not the Only Narrative

Frailty, cognitive deterioration and thrombotic crisis in an older person with HIV

Dr Ravipal Singh

HIV JCF · King's College Hospital NHS Foundation Trust

Patient Snapshot

62-year-old MSM, admitted with acute confusion and behavioural change

Off ART since

mid-2024

CD4 count

294 cells (31%)

HIV RNA

51,330 copies/mL

Key
risk

APS

● Antiphospholipid syndrome

Recurrent venous thromboembolism; non-compliant with anticoagulant therapy.

● Type 2 diabetes mellitus

Insulin-reliant; inadequate glucose regulation

● Heart failure (HFrEF)

Reduced ejection fraction

● Hepatitis C

Previously treated and cleared

ART history: Trizivir (2003) → Truvada + darunavir/ritonavir (Sept 2015–Feb 2026, following transfer to KCH) → Biktarvy (Feb 2026, as inpatient)

Additional context: historically very poorly controlled HIV; significant substance misuse with multiple partners / chemsex

A Long History of Vulnerability

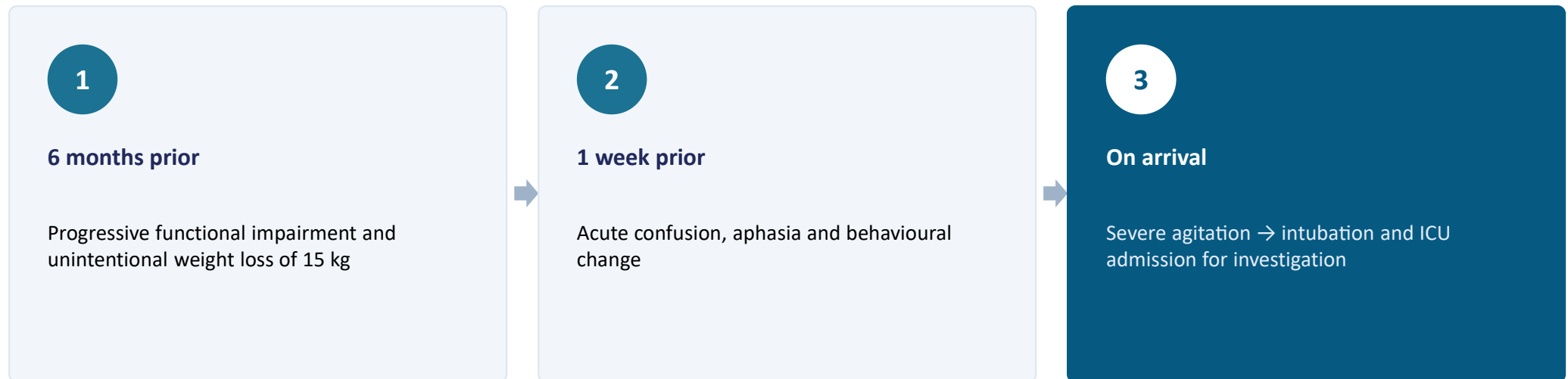
The pattern in this admission is not new — it predates it by more than twenty years



Recurring psychosocial vulnerability

Erectile dysfunction, depression, chronic back pain, hepatitis C (treated and cleared) and syphilis (treated on multiple occasions) were long documented, alongside a tumultuous relationship history and sparse support. Older, MSM, with multiple partners/chemsex and significant substance misuse — the drivers of non-adherence seen in this admission are not new to his HIV experience.

Presentation: A Converging Decline



Teaching point

The simultaneous occurrence of weight loss, functional decline, delirium, and behavioural changes should prompt consideration of concurrent frailty and neurocognitive impairment, rather than being interpreted as separate symptoms in an elderly individual with HIV.

Broad Initial Differential

Confusion and agitation on a background of ARV non-adherence and substance misuse

1

Opportunistic infection

Major initial concern given prolonged ARV non-adherence and a low CD4 count.

2

Meningoencephalitis

Infective encephalitis considered in view of the acute confusional presentation.

3

HIV encephalitis

Direct CNS effect of HIV considered, given historically uncontrolled viraemia.

4

Drug-induced psychosis

Agitation and confusion in the context of daily crystal methamphetamine use.

Syphilis was also considered: RPR was negative, but concern for vasculitic neurosyphilis prompted empirical treatment alongside the rest of the work-up. Opportunistic infection remained the leading concern until MRI confirmed an ischaemic stroke.

Step 1 — CT Brain

Initial imaging: reported as suggestive of a MASS LESION



Non-contrast CT head, axial · day of admission

What you can see

A wedge-shaped region of reduced density in the LEFT parietal lobe (encircled), exhibiting modest gyriform hyperdensity along the cortical ribbon.

Why it was called a mass

Diminished grey-white matter distinction accompanied by localised oedema may resemble a neoplasm on CT, especially in elderly patients with unmanaged HIV.

The problem

Neoplasm, ischaemia, haemorrhage, and opportunistic central nervous system infection are all included in this differential diagnosis. CT by itself was insufficient to distinguish them.

● *Amber circle marks the abnormality on every image in this deck*

Step 2 — MRI Brain

Three sequences, one answer: this is vascular, not neoplastic

DWI



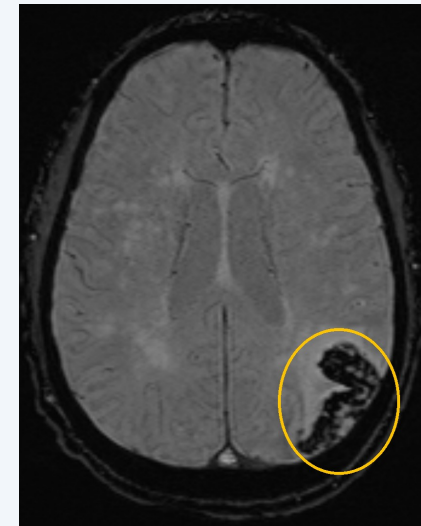
Patchy diffusion restriction in cortex and white matter — the signature of acute/subacute infarction.

T2



Wedge-shaped signal change in cortex and white matter, with gyriform low T2 signal.

SWI

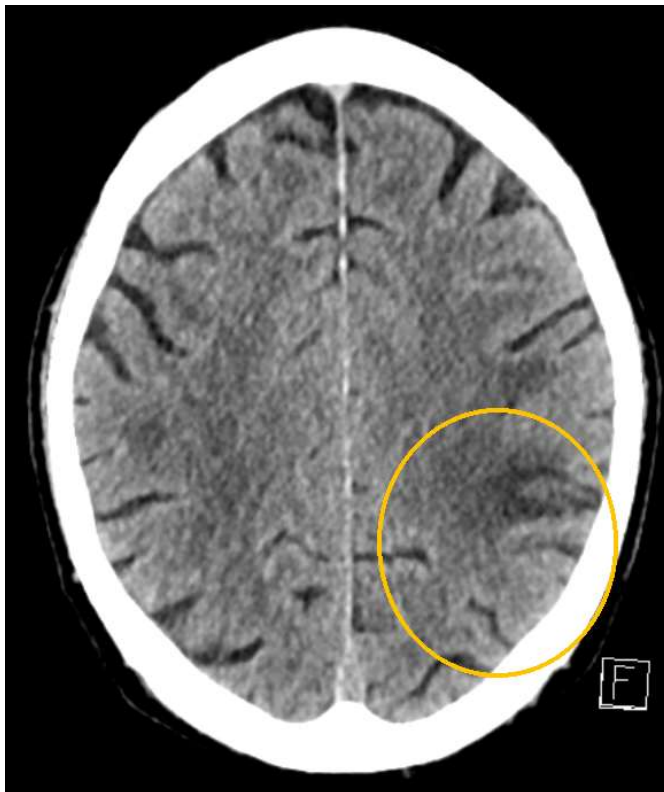


Signal drop-out in the same gyri — blood products, i.e. haemorrhagic transformation.

Diagnosis: subacute LEFT PARIETAL INFARCTION with cortical haemorrhagic transformation - not a tumour.

Step 3 — Follow-up CT at 2 Months

The evolution confirms the diagnosis



Non-contrast CT head, axial · 2 months later

What changed

Satisfactory development of the infarct, accompanied by volume reduction and gliosis in the left parietal lobe. A neoplasm would have developed; an infarction evolves and diminishes. The path itself serves as the validation.

Why this mattered clinically

- A mass-like lesion observed on CT in an elderly individual with HIV could represent an infarction, haemorrhage, neoplasm, or opportunistic infection.
- An MRI along with a comprehensive evaluation to rule out CNS infection was crucial prior to any diagnosis or therapy initiation.
- The identification of a "stroke" recontextualised the entire admission: it transformed into a thrombotic issue in an individual with APS who had ceased his anticoagulant therapy.

A Thrombotic Crisis Unfolds

Shortly after arrival: **PULSELESS ELECTRICAL ACTIVITY (PEA) CARDIAC ARREST**

1

Severe bilateral pulmonary emboli

Massive clot burden in both lungs

2

Right heart strain

Acute cor pulmonale on imaging

3

Bilateral proximal DVT

Deep vein thrombosis in both legs

Likely mechanism

Antiphospholipid syndrome exacerbated by non-compliance with anticoagulant treatment – the identical factors that probably caused the recently identified parietal infarct.

ART Strategy and Anticoagulation Challenges

Managing resistance risk created a second, harder problem

Why a boosted PI-based regimen

- Very poor treatment compliance historically
- Placed on boosted darunavir to avert accumulating ARV resistance
- Significant drug–drug interactions, particularly with warfarin
- DOACs are contraindicated with a boosted PI
- **INR monitoring became very difficult to manage.**

Anticoagulation: a moving target

- Greatly disliked INR testing; pragmatically started on dabigatran (a DOAC) despite this not being optimal for APS.
- Switched back to warfarin with a plan for careful, supported monitoring.
- Compliance with warfarin remained very problematic throughout.
- **Multiple DNAs to the anticoagulation service, who eventually discharged him from their care.**

ICU Course and the Revolving Door

Two admissions, the same cycle

ICU course

- Uncontrolled HIV viraemia
- Extended confusion and affective volatility
- Sarcopenia and severe deconditioning
- Suboptimal glycaemic regulation
- **Opportunistic CNS infection ruled out → antiretroviral treatment resumed.**

After discharge

- Acute pneumonia necessitating intensive treatment, elevated oxygen supply, and vasopressor administration.
- Recurrent thoracic discomfort and shortness of breath; CTPA was negative for pulmonary embolism upon readmission.
- Recent T3 vertebral fragility fracture identified on CT — osteoporosis monitoring scheduled
- **Persistent weight reduction, neglected insulin administration, and voluntary discharge contrary to medical counsel.**

Post-Discharge: A Cycle of Disengagement

Four intersecting threads that undid the gains made in hospital

1

HIV treatment disengagement

Continued non-adherence to ART after discharge, mirroring the pattern seen since 2003.

2

APS treatment disengagement

Missed anticoagulation monitoring, with multiple DNAs to the anticoagulation service.

3

Psychiatric illness & substance abuse

Borderline schizophrenia and ongoing substance misuse undermined engagement with care.

4

Family strain & personal fragility

A difficult relationship with his own frail, elderly mother, against his own increasing fragility.

These threads reinforced one another: without stable psychiatric and social support, engagement with both HIV and anticoagulation care repeatedly broke down — recreating the conditions for the next admission.

The Geriatric Lens

Not four separate problems — one interacting syndrome

1

Frailty & sarcopenia

Unintentional weight reduction of 15 kg, fatigue, lethargy, and diminished activity – subsequently validated by a fragility fracture.

2

Neurocognitive decline

Delirium amidst cognitive alterations; frailty and neurocognitive deficits are mutually influential in ageing individuals living with HIV.

3

Psychosocial burden

Substance abuse, depressive disorders, and carer burden – all acknowledged impediments to ART compliance and participation.

4

Adherence breakdown

Neglected ART, overlooked warfarin, disregarded insulin, and repeatedly discharged oneself contrary to medical counsel.

Co-located HIV and geriatric care, shown by the HIV Age Well Clinic at our Caldecot center at King's, facilitates the integration of frailty and cognitive assessments into regular follow-up visits, rather than identifying them during emergencies.

For MDT Discussion

Questions to open the floor

Q1

What is the optimal timing and sequencing for the re-initiation of ART in relation to acute critical illness and delirium?

Q2

What is the most effective anticoagulant approach — together with adherence assistance — for patients with APS who have a background of non-compliance?

Q3

In what manner might frailty and cognitive assessments be included into standard HIV outpatient care?

Q4

How ought the team to tackle recurring self-discharge — capability, protection, and involvement?

References

- Zamudio-Rodríguez A, Belaunzarán-Zamudio PF, Sierra-Madero JG, et al. Association between frailty and HIV-associated neurodegenerative disorders among older adults living with HIV. *AIDS Res Hum Retroviruses*. 2018.
- Fried LP, Tangen CM, Walston J, et al. Frailty in older adults: evidence for a phenotype. *J Gerontol A Biol Sci Med Sci*. 2001;56(3):M146–M157.
- Rockwood K, Song X, MacKnight C, et al. A global clinical measure of fitness and frailty in elderly people. *CMAJ*. 2005;173(5):489–495.
- Heaton RK, Clifford DB, Franklin DR, et al. HIV-associated neurocognitive disorders persist in the era of potent antiretroviral therapy: CHARTER study. *Neurology*. 2010;75(23):2087–2096.
- Greene M, Covinsky KE, Valcour V, et al. Geriatric syndromes in older HIV-infected adults. *J Acquir Immune Defic Syndr*. 2015;69(2):161–167.
- Introducing the WHO ICOPE approach into HIV care: a perspective on healthy ageing in people living with HIV. 2025.
- Interventions and opportunities to enhance aging among people with HIV: a focus on frailty, sarcopenia and intrinsic capacity. 2026.
- Ambrosioni, J. *et al.* (2026) “Major revision version 13.0 of the European AIDS Clinical Society guidelines 2025,” *HIV medicine*, 27(1), pp. 18–32.
- Bennett, T., Walmsley, S. and Bendayan, R. (2025) “Aging with HIV and HIV-associated neurocognitive impairment,” *AIDS*, 39(3), pp. 215–228.
- Crane, H.M. *et al.* (2024) “Venous thromboembolism among people with HIV: design, implementation, and findings of a centralized adjudication system in clinical care sites across the United States,” *Journal of acquired immune deficiency syndromes (1999)*, 95(2), p. 207.
- Jones, H.T. and Barber, T.J. (2025) “A qualitative study of perspectives, experiences and priority outcomes for people living with HIV and frailty: Editorial comment on: “We are fragile, but we are strong”: Navigating Frailty and HIV in Aging Populations: Perspectives on Language, Stigma, and Holistic Care,” *HIV medicine*, 26(3), p. 336.
- Rokx, C. *et al.* (2020) “Risk of recurrent venous thromboembolism in patients with HIV infection: A nationwide cohort study,” *PLoS medicine*, 17(5), p. e1003101.
- Henderson, M. and Winston, A. (2024) “Risk factors for cognitive decline in persons with HIV,” *Current Opinion in Infectious Diseases*, 38(1), p. 37.

Key Points To Take Away

1 Keep the CNS differential broad

A mass-like lesion observed on a CT scan in an elderly individual with HIV could represent myocardial infarction, haemorrhage, neoplasm, or opportunistic infection. MRI incorporating DWI, T2, and SWI has resolved the matter here.

2 Frailty is a red flag

Prefrility, in addition to clear frailty, ought to initiate rigorous assessments of cognitive function and bone health- as evidenced by a subsequent fragility fracture.

3 APS + non-adherence = high thrombotic risk

Proactive anticoagulation assistance is a crucial concern for patient safety, rather than only a matter of adherence. A subtherapeutic INR reemerged during the subsequent admission.

4 This is a pattern, not an episode

Recurrences of non-compliance, metabolic instability, and weight reduction were seen. Longitudinal, community-integrated MDT monitoring is what disrupts the loop.



Person-Centred Care for a Woman Ageing with HIV

A Multidisciplinary Approach to Complex Needs

02 October 2026



Introductions

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National HIV Service Manager
Terrence Higgins Trust

Julie Ringsell

Ageing with HIV Lead
Terrence Higgins Trust



Background

The Changing Face of HIV Care for those ageing with HIV

- People with HIV are living longer
- Frailty
- Multimorbidity
- Cognitive impairment
- Social isolation are increasingly common.



Service user: Case study

51-year-old woman

- Living with HIV for over 30 years
- HIV well controlled
- Recovered from substance use
- Significant decline in QoL over past few years
- Early menopause
- Cognitive impairment



Clinical Complexity

- Frailty
- Osteoporosis
- Peripheral neuropathy
- Chronic pain
- Polypharmacy
- Moderate cognitive impairment
- Mental health concerns



Psychosocial Challenges

- History of substance use
- Prison
- Domestic abuse
- Financial hardship
- Inadequate housing conditions
- Digital exclusion



MDT Approach

- HIV Consultants
- Specialist Nurses
- Psychology /counselling (THT and other)
- Social Work
- Physiotherapy
- Recovery organisation
- GP Practice
- THT Living Well Team

MDT Coordination

Shared decision making



Medication optimization



Care planning



Patient-led priorities



Trauma-Informed Care

Trust-building



Flexible communication



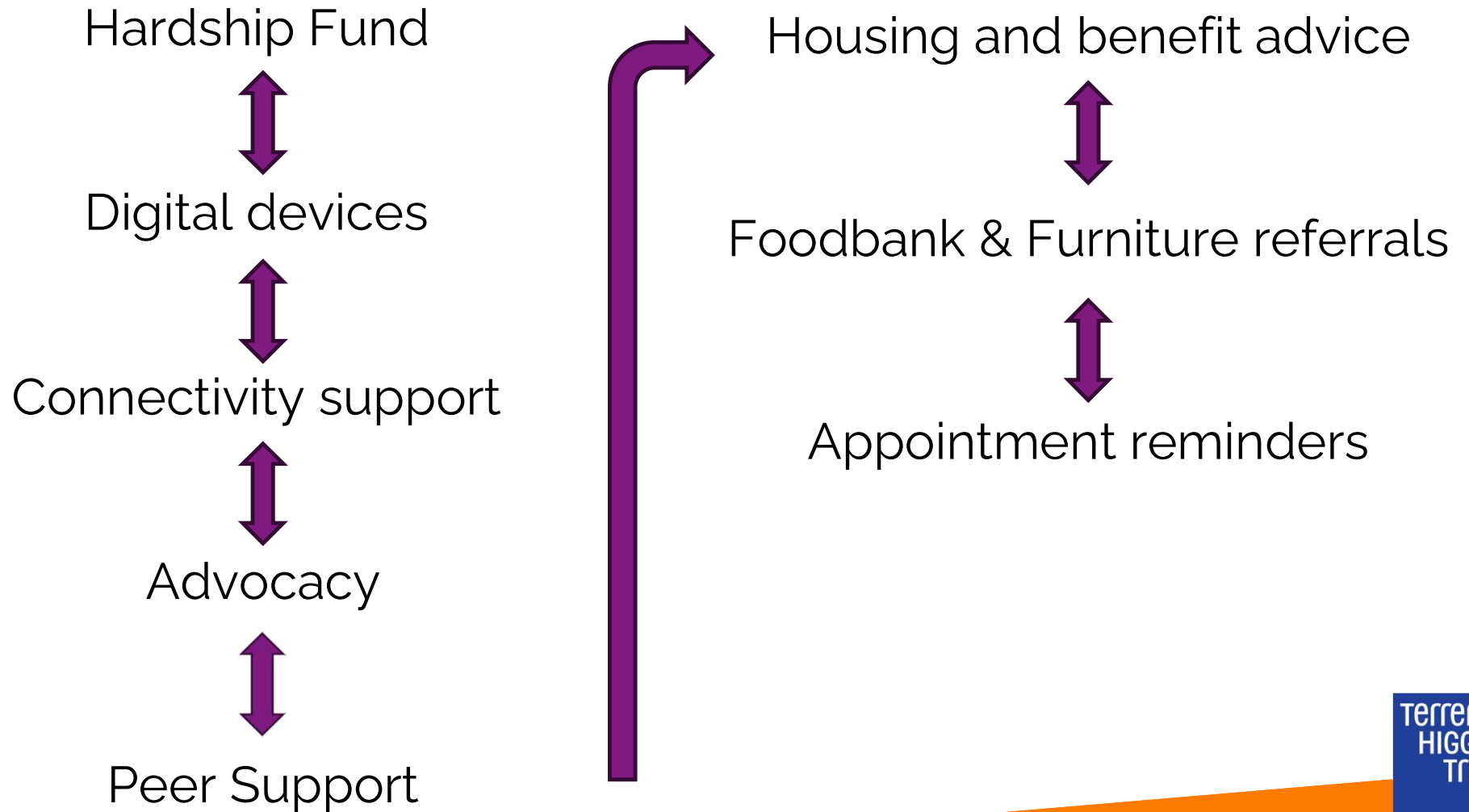
Psychological support



Strengths-based interventions



Practical Interventions (THT)



Peer Support

- One-to-one support
- Women's groups
- Community social activities
- My Community platform
- Work shops



Outcome for service user

- Improved engagement
- Better access to resources
- Reduced isolation
- Improved wellbeing
- Increased confidence
- Medication adherence



Key Learning

Viral suppression does not guarantee quality of life.

Reflection from the service user

“Not everyone can access care in the same way, all the time. People fall through the gaps. See the person”

KEY TAKEAWAYS



1 Person-centered care is essential

Putting the person at the centre ensures care is tailored to their needs, values and goals.



2 MDT collaboration improves outcomes

Working together across disciplines leads to better decision-making, coordinated care and improved quality of life.



3 Practical support matters

Help with everyday needs, resources and guidance reduces stress and enables people to live well.



4 Peer support reduces isolation

Connecting with others who understand builds belonging, strengthens resilience and improves wellbeing.



Together, we can make a real difference.

Thank you

Thank You for Listening

Supporting people living with HIV to live well and age well.

Thank you for your time, interest and commitment to improving outcomes for people ageing with HIV. Through person-centred care, multidisciplinary collaboration and meaningful support, together we can help people live healthier, more connected and more fulfilling lives.



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Questions



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