Workup of the Newly Diagnosed Patient

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Goals of the Initial Medical Evaluation (1)

- Determine level of immunosuppression
- Identify HIV-related infections/malignancies
- Identify other medical conditions including those associated with HIV risk behaviors

Goals of the Initial Medical Evaluation (2)

- Assess patient's understanding of HIV disease
- Assess patient's need for counseling and psychosocial support
- Develop provider-patient partnership

Goals of the Initial Medical Evaluation (3)

- Develop strategies to:
  - Prevent or delay the progression of HIV
  - Prevent or delay the development of HIV-associated infections
  - Prevent the development of resistance to antiretroviral medications
  - Prevent HIV transmission

Comprehensive HIV/AIDS Care

- General health maintenance
- HIV-specific health maintenance
- Strategies to maximize the benefits of ART over time

Initial Evaluation-History (1)

- HIV Testing
- Current symptoms
- HIV-related illnesses
- Review previous records of care and Rx

Initial Evaluation-History (2)

- Past Medical History
  - STDs
  - TB infection/exposure
  - OB/GYN history
  - Vaccination history
  - Psychiatric history
  - Prior or ongoing medical conditions (cardiovascular, pulmonary, GI, renal, neurologic, CA, endocrine, skin)

Initial Evaluation-History (3)

- Review of systems
- Social history:
  - Habits
  - Sources of support
  - Sexual history
  - Education and knowledge of HIV

Initial Evaluation-History (4)

- Medications
  - Current medications including OTC meds
  - Review all prior use of ART and reasons for switching medications
- Allergies (include type of reactions)
- Family History
- Travel history
- Pets

Initial Evaluation-Physical Exam

- General-Vital signs, Wt
- Skin-KS, seborrheic dermatitis, VZV/HSV, folliculitis, molluscum
- Mouth-Thrush, OHL, aphthous ulcers, peridontal disease, dental hygiene
- Eyes-CMV retinitis, cotton wool spots
- Lymphatic system- LAD, splenomegaly

Initial Evaluation-Physical Exam

- Chest/lungs-Wheezes, consolidation, murmurs
- GI-HSM, masses, tenderness
- GU/Pelvic exam-Vaginal candidiasis, genital ulcer disease, cervical dysplasia, PID, HPV, anal dysplasia
- Extremities/Neuro-Mood (suicide risk), psychomotor slowing, peripheral neuropathy

Laboratory Examination-1

- CBC and diff, platelets
- SMA 6, 12, (ALT)
- G6PD, Hepatitis A, B, and C serology
- RPR, Toxo IgG, CMV IgG
- Urinalysis
- Consider amylase, lipase, fasting cholesterol/lipids, anti-varicella IgG (if no history of chickenpox or shingles)

Laboratory Examination-2

- HIV evaluation
  - Confirm HIV serology (if necessary)
  - Lymphocyte markers
  - HIV-1 RNA Viral load

Laboratory Examination-3

- Baseline CXR (as clinically indicated)
- Pap smear (all women at baseline and then q 6m- yearly)
- Assessment for GC and chlamydia
- Ophtho. referral (if CD4 <100)
- PPD (yearly)
- If febrile, obtain crypto Ag and Isolator Blood Cx

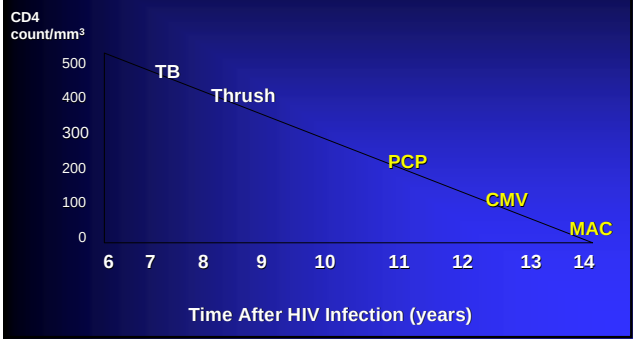
Immunizations

- Pneumovax-if no history of prior vaccination. Consider repeat q 5-6 yrs
- Hepatitis A if Hep A IgG negative
- Hepatitis B (at risk and non-immune)
- dT-repeat every 10 years
- Influenza-every fall

HIV Specific Periodic Physical Exam Screening

- Each visit: skin, mouth, eyes, lymph nodes, liver, and spleen
- Pap smear: q 6-12 months in all women
- Mammogram for older women (yearly if >50, start screening at 30-40)
- Rectal exam and PSA screening in all men who have taken anabolic steroids
- Yearly rectal exams if >40-50 years

Risk of Opportunistic Infections According to CD4 counts



Indications for PCP Prophylaxis*

- CD4 <200 or a history of oral thrush
- Oral Candidiasis
- Prior history of PCP
- Constitutional symptoms >2 weeks
  - Unexplained fever, weight loss, diarrhea
- Consider if CD4 <14%, or if CD4 between 200 and 250 and q 3 months CD4 monitoring not obtainable

* USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with HIV. MMWR 1999;48 (No.R-10):4-9

Prophylaxis for PCP

- Trimethoprim/Sulfamethoxazole (T/S)
  - 1 DS tablet daily
  - Provides prophylaxis against toxoplasmosis
  - Decreases incidence of bacterial infections
- Adverse Reactions
  - Rash
  - Fever
  - Leukopenia/anemia
  - Stevens-Johnson Syndrome

Prophylaxis of PCP-Alternatives

- Dapsone 50-100 mg daily or Dapsone daily plus pyrimethamine 50 mg plus leucovorin 25 mg q wk [Combination effective against T gondii]
- Must check G6PD
- Adverse Reactions
  - Rash, Fever
  - Hemolytic anemia with G6PD deficiency
  - Methemoglobinemia

Prophylaxis of PCP-Alternatives

- Aerosolized pentamidine 300 mg
  - Via Respirgard II nebulizer q 4 weeks
  - Well tolerated, few allergies
- Disadvantages
  - Less efficacious than TMP/SMX
  - Risk of extrapulmonary PCP
  - Increased risk of pneumothorax
  - Dissemination of TB
  - Bronchospasm

Prophylaxis of PCP-Alternatives

- Alternative regimens
  - Dapsone*
  - Dapsone plus pyrimethamine plus leucovorin
  - Aerosolized pentamidine*
  - Atovaquone suspension 1500 mg q d
    - As effective as A. pentam or dapsone but more costly

*Not recommended for Toxo prophylaxis

Prophylaxis for Toxoplasmosis

- Indications for primary prophylaxis
  - CD4 <100 with positive toxo IgG titer
- Standard regimen
  - TMP-SMZ 1 DS tablet daily
- Alternate regimen
  - Dapsone 100 mg daily with pyrimethamine 50 mg and folinic acid 25 mg weekly
  - Atovaquone with or without pyrimethamine

Prophylaxis for *Mycobacterium Avium* Complex (MAC)

- Indications for MAC prophylaxis
  - CD4 <50 and MTB ruled out
- Standard regimen
  - Azithromycin 1200 mg weekly
  - Clarithromycin 500 mg BID
- Alternative regimen
  - Rifabutin 300 mg daily

Prophylaxis for M. tuberculosis

- Indications for TB prophylaxis in HIV
  - PPD >5 mm, a negative CXR and no evidence of active TB
- Standard regimen
  - INH 300 mg (with B6 50 mg) daily or
  - INH 900 mg twice weekly for 9 mos or
  - Rifampin 600 mg or rifabutin 300 mg and PZA 20 mg/kg daily for 2 mos

Prophylaxis for Cytomegalovirus (CMV)

- Prophylaxis not routinely recommended
- Prophylaxis with ganciclovir may be considered for pts who are CMV seropositive with CD4 <50
- Acyclovir and valacyclovir are not effective
- Best way to prevent severe CMV disease is to recognize early CMV via regular funduscopic exams q 3-6 mos if CD4 <100

Prophylaxis for Varicella-Zoster Virus (VZV)

- Patients at risk for VZV should avoid exposure to persons with chickenpox or shingles
- Susceptible adults should receive VZIG within 96 hours following exposure to someone with chickenpox or shingles