Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/clinicians-roundtable/the-aging-hiv-population-combatting-challenges-addressing-stigma/14634/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

The Aging HIV Population: Combatting Challenges & Addressing Stigma

Dr. Turck:
Treatment for HIV has come a long way, and we now know more about it than ever before. Despite this, there is still a gap between what we know and what we do to prevent and treat HIV. Treatment advances are allowing HIV patients to live longer, but the aging population comes with its own challenges, particularly for physicians who continue to treat patients with comorbidities as they age.

Welcome to *Clinician's Roundtable* on ReachMD. I'm your host, Dr. Charles Turck. And here with us to share his insights on HIV in the aging population is Dr. Andrew Clark, who is the global medical lead at ViiV Healthcare.

Andrew, welcome to the program.

Dr. Clark:
Thank you very much, Charles.

Dr. Turck:
Let's start by laying some groundwork on the challenges those with HIV who are aging face. Would you tell us about the obstacles they encounter with HIV and HIV treatment resistance?

Dr. Clark:
Many of the people who are getting older with HIV have actually lived with HIV for many years, sometimes decades, and that means that they have lived through some of the more complex regimens that we used to use in the old days, basically 30 years ago and right up until fairly recently before we had all these single-tablet regimens which are much more easily tolerated and easy to take. So that meant that for years individuals had to take medicines that were more frequent to take, more difficult to take, less tolerable, more toxic, had lots and lots of other issues with drug interactions. They also had lots of other complications that were related to their HIV infection because we diagnosed them late, so they had a lot of treatment for opportunistic infections and sometimes opportunistic cancers. And that meant that it was extremely difficult to take the regimens that we expected people to take, and so they couldn't always take them regularly or else they might have had poor drug levels, and as a result, that meant that for many people who survived through that era, they ended up with drugs that no longer worked because the virus had become resistant to them. But they still have those resistant biases, and that means that today those individuals might not be able to benefit from some of the newer tablets or regimens of treatments that are available because they have run out of those options, and so that means that, you know, they have quite complex regimens to try and treat as well as possible the resistance that they have. So resistance is a really unpleasant consequence of the way that we used to treat and also because of the challenges some individuals have in just taking regimens daily.

Dr. Turck:
And if we focus on our healthcare facilities and clinics, what obstacles do they need to overcome to effectively treat older patients who commonly have comorbidities?

Dr. Clark:
I think one of the main problems with comorbidities is really reflected on how the individual is actually managed. So, if all of the resources that they need are in a single venue or a single clinic destination, like we often have in some of the clinics around Europe. Then that's a little bit less challenging because those individual specialists that manage those comorbidities typically sit in the same clinic, and they can just basically pop down the passage, and it's not quite as difficult. But if they are attended to by individuals who don't have those other comorbidity specialists to hand, then that means that the individual whose got multiple comorbidities spends an awful

lot of time and expense and effort trying to navigate their way around the different appointments that they might have, and they might have to go to opposite sides of the town or the city. So it becomes really, really difficult for individuals who have got multiple comorbidities to have those comorbidities managed if they are not all in one place.

And I think the biggest risk of something like that is that then you land up with multiple healthcare providers treating an individual who don't always communicate as effectively or on time for when they might need to see the next person that's looking after them, and that means they don't always know what treatments they're on, and that's an incredible risk for really serious drug-drug interactions.

Dr. Turck:
Now, if we take a look at how treatment has advanced, Andrew, are there any other concerns or challenges clinicians face when prescribing more recent medications to HIV patients with comorbidities?

Dr. Clark:
So, unfortunately, as I had mentioned earlier, a lot of people who have gotten older living with HIV just don't benefit from the newer treatments because they have exhausted those options because of the way we used to treat, so they may not be able to be on some of the newer treatments, and that means they are often on boosted protease inhibitors, which have a significant impact on the ability to treat comorbidities because they interfere with the treatments that we can offer them mainly because of drug interactions. So, unfortunately, the protease inhibitor as a class, although they are very effective antivirals, are very, very problematic for treating comorbidities, and sometimes they in themselves can cause some of the comorbidities or exacerbate the comorbidities. So cardiovascular problems or cardiometabolic problems can be very significantly exacerbated by protease inhibitors as a class, and so can other systems and organ systems. Like, your cardiovascular system and the renal system doesn't particularly like boosted protease inhibitors, so we know of a lot of assessments of cohorts that those are two systems, cardiovascular disease and renal disease, are exacerbated by individuals who have been on protease inhibitors for a long time. So that's one issue I think is the kinds of treatments we have to use in people who have been exposed to HIV for a long time.

But we also have to think about some of the effects of the comorbidities on the drugs that we need to use nowadays, so if they still can use some of the newer regimens, for instance, the integrases, or even some of the other drugs that we use to treat complex drug resistance, they still have other problems.

So I think it's becoming really, really challenging as we start figuring out what these comorbidities are doing, how they are contributed to by HIV itself, the treatments we use for HIV, and then the individual comorbidities and how they cluster, because it appears that they might be even different between men and women, for instance, and whether you were infected for a long time or already had comorbidities existing before your HIV infection.

Dr. Turck:
For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Andrew Clark about the aging population of patients living with HIV.

Now, Andrew, in this post-pandemic era, have you seen people living with HIV seeing their specialists less? And if so, what impact has that had on their care?

Dr. Clark:
Well, unfortunately, COVID has had a massive impact on the way that we care for everybody. So, some of the clinics have actually not just been impacted by COVID during COVID but have fundamentally changed how they are able to or even willing to treat patients. So, you see many clinics now adopting these hybrid systems where they will only see some patients in person when they really need to or for their sort of biannual, annual checkups, and that means there's a really huge reduction in the face-to-face time that many patients will now have with their treating clinicians. And so, I think in some ways this makes sense if you don't need to see someone but you can still videoconference them and you can still have a teleconference with someone and just make sure that they're okay, particularly if they are stable. And many people living with HIV have been stable for years, so they don't necessarily need to be seen for their HIV issues, but they may need to be seen for comorbidities, so I think the hybrid system might work for many individuals. But for those individuals with mental health problems or other challenges particularly multiple comorbidities, it isn't an ideal situation, and they do need to see people face-to-face, and clinics just might not have those resources. But for other individuals, this is ideal because if you no longer have to travel vast distances to go to your clinic, that's perfect, so for many individuals this actually worked out quite well, so it's not all bad.

Dr. Turck:
And how have stigma and social challenges impacted patients who have lived for some time with HIV?

Dr. Clark:

I think stigma, unfortunately, and discrimination for people who are living with HIV is almost. Well, it is inescapable. There's just no way that anyone with HIV is going to be completely free of some form of stigma somewhere. And as this is a discussion about people who are aging, aging or agism itself, it carries its own form of stigma, so you land up with someone who has lived with HIV for a long time and then may belong to a socially discredited group of individuals, and that in itself carries its own stigma, and then you have people that are now aging, so you have these intersectional layers of stigma. And often, in fact, stigma originates from healthcare systems and clinics themselves.

And, unfortunately, stigma has many adverse effects. It impacts the way that people see themselves or their level of self-esteem, their mental health. It also might impact on their willingness to engage in care because of the clinic itself is hostile or they feel internalized stigma and are ashamed to go to an HIV clinic which then discloses them. You know, all of these things can really affect someone's ability to adhere to care or even decide on being adherent with their medication and seek care. And then this sort of internal stigma and the shame that is associated with that, the mental health complications that that brings, the social isolation that that stigma might enforce, there really are very profound effects of stigma. I think what's not been appreciated until fairly recently is that stigma and stress have profound health consequences for individuals and actually increase their morbidity and mortality. And older people are even more vulnerable. So, once again, because this is a topic about older people, we do have to really do something about stigma and think of it as a health crisis and not just as a social construct.

Dr. Turck:
Before we close, I'd like to give you the final word. Any key points you'd like to leave with our audience today?

Dr. Clark:
Well, getting old with HIV is something that, you know, fortunately, we're able to talk about because when we first started, or when I first started treating individuals with HIV in the early '80s, getting old just wasn't an option. Now we've got most of the people we treat living pretty much the same sort of lifespans as people without HIV, but they come with a set of challenges. So, while we've got people living longer, we don't have them living as well, so this accumulation of comorbidities unfortunately is something that we don't fully understand, so we are only just now starting to understand that the comorbidities are occurring more frequently. They are clustering differently. There may even be differences between men and women. But it is now I think the single most important challenge that we have in how we are going to manage all these comorbidities in people as they age.

But, ultimately, I think the clearer message is that we need to start much, much sooner. We know from the general population that if you are healthy when you are young, you are much more likely to be healthy and age healthily as you get older, and so lifestyle choices do matter, but you can't just suddenly consider them when you are already older even though when you do make lifestyle changes in your older age categories, then you're still going to get the benefit of some of those. But, you know, going into your late 40s and early 50s living with HIV and still smoking, still drinking excessively, still taking a lot of recreational drugs just isn't going to guarantee you a healthy outcome.

So I do think the lifestyle factors do need to be addressed, and we should be a little bit more aggressive about that in the setting of HIV because the costs are greater; but, ultimately, stigma also remains one of those things that has to be addressed, and we can't tolerate stigma anymore. It is just too damaging. And the long-term outcomes of stigma are even more dangerous for older people.

Dr. Turck:
Well, with those final thoughts in mind, I want to thank my guest, Dr. Andrew Clark, for joining me to share his insights on the challenges that aging patients who are living with HIV face.

Andrew, it was a pleasure speaking with you today.

Dr. Clark:
Thank you.

Dr. Turck:
For ReachMD, I'm Dr. Charles Turck. To access this and other episodes in our series, visit ReachMD.com/CliniciansRoundtable where you can be Part of the Knowledge. Thanks for listening.