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HIV and Cardiometabolic Health: What's the Connection?

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Segal-Maurer:
This is CME on ReachMD, and I'm Dr. Sorana Segal-Maurer. Here with me today is Dr. David Wohl.

So, Dr. Wohl, let's dive right in. Are people living with HIV at increased cardiometabolic risk?

Dr. Wohl:
The short answer is yes, but it's not a full stop because we do know that people living with HIV are at a higher risk – if you had a bunch of people living with HIV and a bunch of people not living with HIV, chances are if you followed them, more cardiovascular disease in the folks living with HIV. The more complicated issue is why? And what is driving that? And as you know, there's a lot of factors that play into cardiovascular risk, including a lot of the traditional risk factors, but also things we're worried about that have to do with HIV.

Dr. Segal-Maurer:
So very interesting points. Do you think that people living with HIV, living longer now than decades ago, does that impact our cardiometabolic risk in our people living with HIV?

Dr. Wohl:
Of course, for sure. If you're not dying from toxoplasma encephalitis or PJP [pneumocystis jiroveci pneumonia], you're living a longer life. And I tell my patients all the time, you know, my goal is to have you live long enough to get old enough to have a heart attack, a stroke, or cancer. Because that's what kills the rest of us, most of the rest of us. So I think, really, it's a complicated issue in that it's very hard, as you know, to compare people living with HIV to some comparator group. It's been very challenging to do that. And even in cohorts where people are – like the MACS cohort or the WIHS cohort – where people living with HIV are enrolled and so are people at risk for HIV, even then, we don't see exact parity. So my big thing – and I think a lot of us who have observed this – is there are so many traditional risk factors that are enriched for in people living with HIV, whether it be smoking. So again, if we take a group of people with HIV, people without HIV, and look at rates of heart attacks, higher in the HIV group – but so is smoking, or a history of smoking. And not only that, but there's other risk factors that we have to really worry about that may be less obvious like substance use. And we don't know the contribution of vaping or smoking marijuana or even crack cocaine or other types of cocaine. And there's a lot of data showing that some of the MIs [myocardial infarctions] that people are experiencing with HIV are disproportionately related to issues with demand and delivery and supply of blood. So it's not so much atherosclerosis, but maybe some of this more type 2 MI that may be facilitated by vasoconstrictors like cocaine or methamphetamines. So it's complicated.

My feeling, to be honest, is that the vast majority of cardiovascular disease in people living with HIV is due to traditional risk factors and some of the traditional risk factors that we don't appreciate, like stress, poverty, food insecurity. We do know that adverse childhood experiences – we do know that these things also contribute to poor outcomes in people, including cardiovascular disease. So it's very hard to compare apples with apples, but that doesn't mean that there isn't something going on vis-à-vis inflammation with HIV or

medications as well.

Dr. Segal-Maurer:
That's right. So we will dive into that with another episode in terms of antiretroviral agents. You bring up a couple of very important points, which I think we will explore further in future episodes: the traditional risk factors, in addition to some HIV-specific risk factors. One thing that I think bears repeating is our patients are living longer, number one. As they age, they're going to have more comorbid conditions, and there are actually estimates in some of the very large cohorts, the NA ACCORD [The North American AIDS Cohort Collaboration on Research and Design] cohort, that tell us over the next several decades, we're going to be dealing with many more comorbid conditions in our people living with HIV. The other thing that you brought up, which is very stimulating to me, is that our HIV epidemic really intersects a number of other epidemics, certainly in the US, such as obesity and other cardiometabolic events. We will delve more into all of this with future episodes.

For today, this has been a great bite-sized discussion, Dr. Wohl. More to be said. That's all our time, everyone. Thanks so much for listening.

Announcer:
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