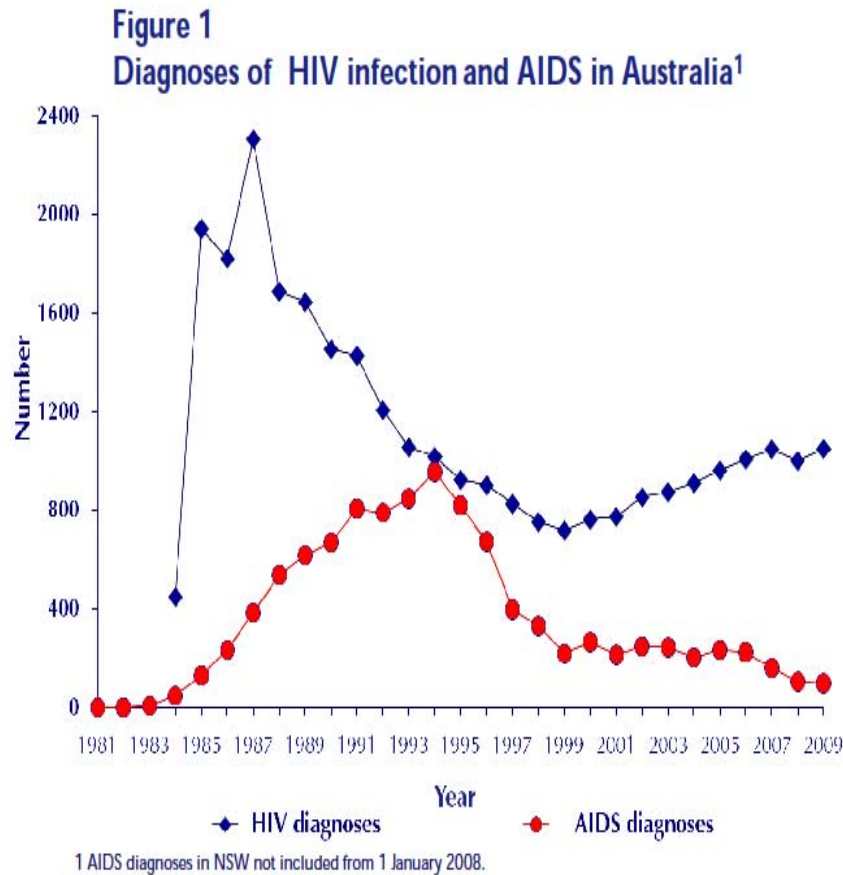


Controversies and Successes in Provision of Palliative Care to HIV Patients

Acquired Immune Deficiency Syndrome



- First recognised almost 30 yrs ago
- Since then, highly active antiretroviral therapy (HAART) made quality and length of survival much better
- In Australia, this year there were over 1000 new cases of HIV diagnosed
- The prevalence of AIDS cases remains at 10,429, with incidence at a plateau
- Current survival is close to 40 yrs for newly diagnosed case (Ard van Sighem et al, AIDS 2010)

Mr BT

- 58years old man
- Retired taxi driver
- Lives alone on a pension
- Brother in Adelaide although not very close
- Patient's partner died of HIV 8 years prior
- Diagnosed with HIV in October 2008
- Copy of genotype testing shows fully susceptible virus prior to HAART

4. 11. 0 (20.07)

Protease Resistance Interpretation	
PI Major Resistance Mutations:	None
PI Minor Resistance Mutations:	None
PR Other Mutations:	I13V, Q61H, L63P, I72IV*, V77I
Protease Inhibitors	
atazanavir (ATV/r)	Susceptible
darunavir (DRV/r)	Susceptible
fosamprenavir (FPV/r)	Susceptible
indinavir (IDV/r)	Susceptible
lopinavir (LPV/r)	Susceptible
nelfinavir (NFV)	Susceptible
saquinavir (SQV/r)	Susceptible
tipranavir (TPV/r)	Susceptible

* = possible mixture of populations

/r = ritonavir boosted

NB: In mixed populations, combinations of drug resistant mutations may vary between strains

PR Comments

- I13V is a common polymorphism that is more common in treated than untreated subtype B isolates. In several subtypes, it is the consensus residue.
- L63P is a common polymorphism that becomes even more common in persons receiving PIs.
- V77I is a common polymorphism that is associated with NFV therapy.

Reverse Transcriptase Resistance Interpretation

NRTI Resistance Mutations:	None		
NNRTI Resistance Mutations:	None		
RT Other Mutations:	V60I, I135L, S162C, K166KR*		
Nucleoside RTI		Non-Nucleoside RTI	
lamivudine (3TC)	Susceptible	delavirdine (DLV)	Susceptible
abacavir (ABC)	Susceptible	efavirenz (EFV)	Susceptible
zidovudine (AZT)	Susceptible	etravirine (ETR)	Susceptible
stavudine (D4T)	Susceptible	nevirapine (NVP)	Susceptible
didanosine (DDI)	Susceptible		
emtricitabine (FTC)	Susceptible		
tenofovir (TDF)	Susceptible		

RT Comments

- None

Mr BT

- **Problem list:**

- HIV - diagnosed October 2008, nadir CD4 58, commenced ART 29/11/08
 - CD4 count 39 (4%) (20/8/09), viral load 109,000 from 17/7/09
- Cryptococcal lung disease and meningitis (10/08) - on oral fluconazole 200 mg daily
- CMV pneumonitis (10/08) – resolved
- Perianal HSV (10/08) – quiescent
- HIV encephalitis – resolved
- *Mycobacterium avium intracellulare* right forearm infection (1/09)
 - (clarithromycin sensitive) - ongoing treatment - improved

- **Medications 9/09**

- Fluconazole 200 mg
- Azithromycin 500 mg daily (clarith Feb 09, ch to azith 23/3/09)
- Ethambutol 1200 mg daily
- Bactrim 1 DS tablet daily
- Aspirin 100 mg daily
- Rifabutin 300 mg daily (since Feb 09)

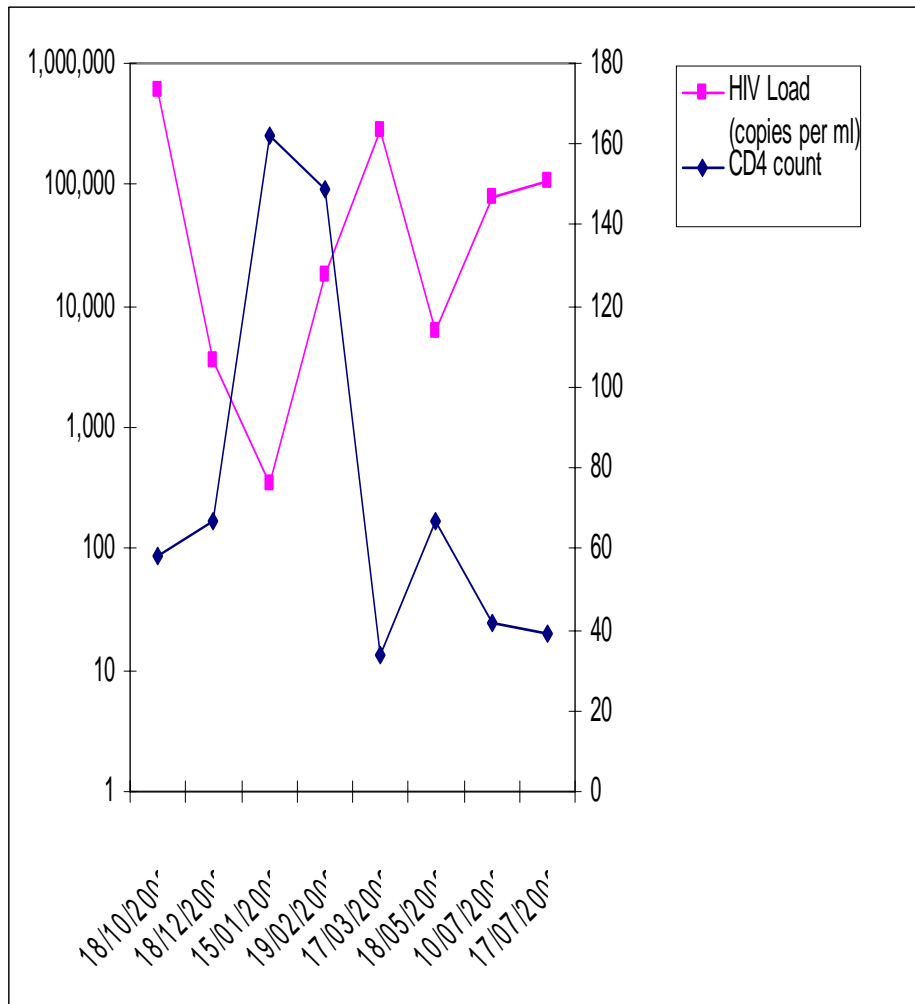
HAART

- Commenced on Kaletra 400/100 mg 5 mls twice daily of syrup or crushed tablets 29/11/08->9/2/09

HIV RNA PCR (VIRAL LOAD)

	Request Number	Collection date	Specimen	HIV Load (copies of HIV RNA/MI)
• Truvada 29/11/08-->9/2/09				
• Truvada 1 tablet daily 23/3/09-->5/8/09				
• Nevirapine 200 mg bd (23/3/09-->21/7/09)	19913219	17/07/09	Blood	109,000
	16895436	10/07/09	Plasma	79,900
• Chosen for small size of tablets, able to be crushed	18906797	18/05/09	Plasma	6100
	18264262	17/03/09	Serum	280,000
• Concern for lower threshold of NNRTIs for resistance....	18265638	19/02/09	Plasma	18,500
	18409492	15/01/09	Blood	337
	18409491	18/12/08	Plasma	3560
	18274627	18/10/08	Plasma	611,000

HAART



- Non-compliance led to increased viral load counts and a fall in CD4 count
- Therapy was stopped in July 2009 as resistance to antiretroviral therapy emerged and patient did not want ongoing HAART
- Became depressed and was treated in January 2010 by psychiatric unit
- Admitted under ID unit in April 2010 for failure to cope at home, and depressive symptoms

?Palliative Care

- BT wished for Nursing Home supportive care and a place “to die”
- After a review by 3 consultants, including a psychiatrist, it was decided he had capacity to make decisions and was allowed Aged Care Assessment
- He went into Phillip Kennedy Hospice in April for end of life care
- Ongoing issues:
 - dysphagia with frequent vomiting
 - existential distress and demoralisation
 - delirium / terminal restlessness
- BT died peacefully in the Hospice on 7th May 2010

Ethical Issues

- Confidentiality
 - Sometimes competed with need for universal precautions, especially when vomiting outside his own room
- Autonomy
 - the patient's right to make decisions
 - requested the withdrawal of active therapy
 - careful assessment of neuro-cognitive status
- Nonmaleficence
 - the principle of not doing harm
 - applied by withdrawing HAART, minimising side effects of other medication
 - Only symptom control given while in the Hospice.
- Beneficence
 - care near his brother's house meant he had emotional support
 - symptom control and spiritual and counselling support gave some respite to existential distress.
- Justice
 - speedy assessments while in hospital and in the community, and a transfer to community hospice closer to his brother enabled efficient use of resources

End of Life Care

- Dysphagia
 - underlying causes
 - Decision not to investigate
 - Treatment options: prokinetics, diet modification
- Pain – managed with simple analgesia and opioid prn
- Depression – counselling and soluble mirtazepine
Community support by the psychiatry team.
- Existential distress – emotional and behavioural support, single room environment. Encouragement to take part in common room activities.
- Delirium – pharmacological
 - supportive
- Bereavement – ongoing support to staff and bereaved brother

Palliative Care in HIV patients

- Mainly in hospitals, often under the infectious diseases units
- Home care offers an alternative
 - more cost-effective at home (A Tramarin AIDS 1992)
 - benefit of emotional support availability,
 - access to palliative care outreach team at home and hospice team,
 - ability to improve quality of life
 - minimising risk of adverse events from unnecessary therapies (R George in AIDS 1992)
- Risk of confidentiality breaches, especially in shared accommodation
- High risk to staff of emotional burnout when dealing with high levels of existential distress amongst HIV patients (P Chandra in 2004)
 - staff education, and access to debriefing, as well as additional supports in terms of community social work counselling services.

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