# HIV

## *Executive summary*

## Introduction

Although we do not provide ongoing care of HIV-related disease, many patients present to us with symptoms and signs of undiagnosed HIV. It is important that this diagnosis is recognized and that patients are appropriately referred on to HIV-care services.

## Target users

* Nurses
* Doctors

## Target area of use

* Gate Clinic
* OPD
* Ward

## Key areas of focus / New additions / Changes

This guideline provides information on the counseling, diagnostic and treatment processes involved in HIV care. HIV infection may be asymptomatic at presentation.

HIV counseling and testing (HCT) has replaced voluntary counseling and testing (VCT). Provider-initiated HCT should be offered to all inpatients, all outpatients with features of chronic disease and all children with malnutrition.

Commence seropositive patients on co-trimoxazole if sulfa allergy is absent, manage their acute/opportunistic conditions and refer for antiretroviral therapy (ART).

The current policy in The Gambia is to provide ART to all patients with HIV after diagnosis irrespective of their CD4 count. However, this may delayed to allow for treatment of opportunistic infections.

## Limitations

Antiretroviral therapy and CD4 testing are not routinely available in our facility.

## Presenting symptoms and signs

There may be no signs or symptoms, however, common presentations whichshould raise the possibility of HIV-related disease are listed here:

* unexplained weight loss
* fevers
* persistent diarrhoea
* oral candida
* oral hairy leukoplakia
* herpes zoster
* Kaposi’s sarcoma
* persistent generalized rashes
* generalized lymphadenopathy
* peripheral neuropathy
* aseptic meningitis
* unexplained cytopenia
* dementia in a young or middle-aged person
* any opportunistic infection.

## Examination findings

No physical findings are specific to HIV infection. The physical findings are those of the presenting infection or illness. Generalized lymphadenopathy is common. Weight loss may be apparent. Herpetic lesions on the groin or widespread oral candidiasis may also be clues to HIV infection.

## Screening and HIV counselling and testing (HCT)

HIV counselling and testing (HCT) is the current recommended nomenclature for this (replacing VCT). It includes both provider-initiated testing (when there are clinical indications) and patient-initiated testing (when the patient requests a test).

International guidelines suggest that in areas where the HIV prevalence is above 1%, the best practice is to offer HIV counselling and testing to all adults who are sick enough to be admitted to hospital. Therefore, unless there is a clear non-HIV related reason for admission, **an HIV test should be considered as part of the initial management of all admitted adult patients in our setting.**

HCT should also be offered to all outpatients with signs of chronic disease and to all children with malnutrition or failure to thrive. Where the child is still breastfed, if they are extremely ill and an immediate diagnosis will change management, then the molecular diagnostics laboratory may be able to help with a viral PCR.

All patients tested for HIV should be counselled before and after testing.

Other test that may be performed at treatment centres to assist with diagnosis or staging includes the following:

* Viral culture
* Lymph node biopsy
* Genotyping of viral DNA/RNA.

## Management

### Post-test counselling

It is important to emphasise to patients who are HIV-positive that this diagnosis is no longer a death sentence – it is treatable and even in Africa many patients will have a near-normal life expectancy, so long as they take their medications as prescribed. They should be encouraged to seek further help at an ART centre.

The modes of transmission must be explained and patients should be encouraged to consider how they can avoid passing the virus on to others.

Studies in Gambia have demonstrated that patients who share their diagnosis with someone they trust live longer than those who keep it a secret from everyone. Ideally, this trusted person should live in the same compound. They can act as a treatment supporter, encouraging the patient to take their medicine, and can ensure the patient is taken to a centre who knows how to treat HIV if they deteriorate or are unwell. Counsellors should do all they can to help patients identify a treatment supporter and to facilitate disclosure.

### Initial treatment

All patients diagnosed with HIV should initially be put on septrin (cotrimoxazole) at a dose of 36-48 mg/kg (max 960 mg OD) unless contraindicated (e.g sulfa allergy).

Patients who are malnourished or wasted will also benefit from regular multivitamins.

Any opportunistic infections should be appropriately treated.

### Anti-retroviral therapy (ART)

In most cases, ART does not need to be started in a hurry – it is more important to stabilise the patient, counsel them and give them time to understand their diagnosis and future treatment. These patients should be referred to their local ART centre for further assessment and treatment once they have recovered from their initial illness. **The current policy in The Gambia is “Test and Treat” which means that once a client is diagnosed with HIV infection, treatment can be commenced irrespective of CD4 count.**

CD4 count is not routinely available in MRCG. There are a few exceptions to this general rule which include patients with TB, patients with cryptococcal meningitis and children with malnutrition or failure to thrive. In these cases, it is possible to get a CD4 count done in discussion with the TB team.

Patients with both HIV and TB are usually started on TB medication prior to ART. If their CD4 count is less than 100, it has been shown that once TB treatment is started, ART should be started about 2 weeks later – any further delay is associated with an increase in mortality. Patients may experience an increase in symptoms when TB treatment is started. This is a form of IRIS (immune reconstitution inflammatory syndrome). It is important to continue their medication.

Patients with cryptococcal meningitis should not start ART until they have received at least 6 weeks’ treatment for their meningitis. Prior to this, ART often causes IRIS and this is usually fatal.

Children with malnutrition or failure to thrive who are HIV positive and do not have TB are difficult to treat and typically do not improve until ART is started.

Therefore, patients with TB or children with malnutrition may need to be referred to an ART centre before they are ready for discharge – the nearest centre to Fajara is Serekunda General Hospital while the nearest centres to Keneba are Bwiam General Hospital and Soma District Hospital. Other centres are found in Banjul, Bundung and Brikama.

## Key Issues for Nursing care

**It is important to** recognize suspected cases of HIV and perform **s**creening and HIV counselling and testing (HCT).

Refer stable patients to an ART centre, while sick patients should first be referred to a doctor.

## References

Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in The Gambia 2015. WHO/Ministry of Health & Social Welfare.

Qaseem A, Snow V, Shekelle P, Hopkins R Jr, Owens DK. Screening for HIV in Health care settings: a guidance statement from the American college of Physicians and HIV Medicine Association. Ann Intern Med.2009 Jan 20.150(2):125-31.

Panel on ARV guidelines for Adults and Adolescents. Guidelines for the use of ARV agents in HIV-1 infected adults and adolescents. Department of health and human services. October 17, 2017.

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