HIV Infection in Older Patients

Str—We read with interest a recent report by Shah et al. [1] on the care of 198 human immunodeficiency virus (HIV)–infected persons >55 years old seen in 3 New York City hospitals between 1990 and 1998. The limited data available on elderly HIV-infected patients in the era of highly active antiretroviral therapy (HAART) prompts us to report on a retrospective quality assurance study conducted at the CORE Center, Cook County Hospital, Chicago. Our study objective was to describe the epidemiology of HIV infection and treatment response in patients >60 years old who were receiving care in 2002.

Of 87 patients with a median age of 64 years (range, 60–78 years), 80% were men. Of those 87 patients, 75% were African-American, 16% were Hispanic, and 8% were white. HIV risk groups were as follows: heterosexual sex, 41%; injection drug use, 28%; men who have sex with men, 17%; unknown, 14%. Thirty-two percent were coinfected with hepatitis C virus. The median age at HIV diagnosis was 58 years (range, 46–73 years), and the mean CD4 cell count at diagnosis was 240 cells/mL (range, 1–717 cells/mL). The mean CD4 cell count was 377 cells/mL (range, 8–1021 cells/mL), and the mean change was +137 cells/mL. Less than one-quarter (22%) of the patients had CD4 cell counts of <200 cells/mL. Fifty-one (61%) of 85 patients had undetectable levels of HIV RNA (<50 copies/mL). Thirty-six percent of the 87 patients had documented adverse events while receiving HAART, including the following: neuropathy, 11% of patients; rash, 5%; anemia, 5%; hepatitis, 4%; and nephrolithiasis, 4%. For the 41 patients who had a lipid profile determined in the previous year, 22 (53%) had elevated cholesterol and/or triglyceride levels.

Our findings are similar to those of the study by Shah et al. [1], in that the majority of older HIV-infected patients received a diagnosis at age >50 years and, in most cases, advanced disease was diagnosed. The major differences observed in our study were the higher percentages of patients receiving HAART (91% in our study versus 74% in the study by Shah et al. [1]) and the lower number of patients receiving PI-containing regimens (54% versus 88%), which is likely a reflection of the different study periods (2002 versus 1998). We also noted a greater proportion of patients with undetectable virus loads (61% versus 34%), even though we used a more stringent criterion for undetectable virus load (<50 cells/mL).

It was very encouraging to find that the vast majority of our older patients were receiving HAART and had excellent immunologic and virologic responses, results similar to those reported for other elderly cohorts. [2–4]. Despite the presence of comorbid conditions and the receipt of concomitant medications to treat these conditions, the elderly patients were able to tolerate and adhere to standard HAART regimens with toxicities that in most cases were not dose- or treatment-limiting.

In conclusion, our study confirms the findings by Shah et al. [1] that, among older patients with HIV infection, heterosexual transmission is an important factor, emphasizing the need for improved efforts in HIV testing and prevention in older patients. We also found that, even with the late diagnosis of HIV infection and frequent comorbidities, older patients are able to tolerate, adhere to, and respond to standard HAART regimens.

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