XXXII Congreso Nacional de la SEMI
XIV Congreso de la Sociedad Canaria de Medicina Interna
26-28 Octubre 2011

Hospital Universitario Fundación Alcorcón
Comunidad de Madrid

JUEVES, 27 DE OCTUBRE

09:30-11:30 h **SALA C**

MESA REDONDA 13
EL INTERNISTA Y EL VIH: NUEVOS RETOS

Moderadora: **Dra. Adela Francés Urmeneta**
Unidad de Enfermedades Infecciosas y Medicina Tropical
Servicio de Medicina Interna
Hospital Universitario Insular de Gran Canaria. Las Palmas de Gran Canaria

¿Es posible diagnosticar antes el VIH en Medicina Interna?
Dr. Juan Emilio Losa García
Sección de Enfermedades Infecciosas
Hospital Universitario Fundación Alcorcón. Madrid

El VIH y el riesgo cardiovascular
Dr. Esteban Martínez Chamorro
Servicio de Enfermedades Infecciosas
Hospital Clínic. Barcelona

¿Qué interacciones entre antirretrovirales y otros fármacos debemos conocer?
Dr. José Sanz Moreno
Unidad de Enfermedades Infecciosas
Hospital Universitario Príncipe de Asturias. Alcalá de Henares, Madrid

COMUNICACIONES ORALES A LA MESA REDONDA

Juan E. Losa.
Hospital U. F. Alcorcón.
Universidad Rey Juan Carlos.

¿Es posible diagnosticar antes el VIH en Medicina Interna?

Guión

1.- Presentación tardía

2.- Necesidad de diagnóstico precoz

3.- ¿Suficiente Opt-In?

4.- ¿Mejor Opt-Out?

5.- Y en Medicina Interna, ¿qué?

6.- Conclusiones

1.- Presentación tardía

CDC Home | Search | Health Topics A-Z

MMWR

Weekly

June 5, 1981 / 30(21);1-3

Epidemiologic Notes and Reports

Pneumocystis Pneumonia --- Los Angeles

In the period October 1980-May 1981, 5 young men, all active homosexuals, were treated for biopsy-confirmed *Pneumocystis carinii* pneumonia at 3 different hospitals in Los Angeles, California. Two of the patients died. All 5 patients had laboratory-confirmed previous or current cytomegalovirus (CMV) infection and candidal mucosal infection. Case reports of these patients follow.

1981 July 4;30:305–8

Kaposi's Sarcoma and *Pneumocystis* Pneumonia Among Homosexual Men – New York City and California

During the past 30 months, Kaposi's sarcoma (KS), an uncommonly reported malignancy in the United States, has been diagnosed in 26 homosexual men (20 in New York City [NYC], 6 in California). The 26 patients range in age from 26-51 years (mean 39 years). Eight of these patients died (7 in NYC, 1 in California)—all 8 within 24 months

VOLUME 338 MARCH 26, 1998 NUMBER 13

DECLINING MORBIDITY AND MORTALITY AMONG PATIENTS WITH ADVANCED HUMAN IMMUNODEFICIENCY VIRUS INFECTION

FRANK J. PALELLA, JR., M.D., KATHLEEN M. DELANEY, M.S., ANNE C. MOORMAN, B.S.N., M.P.H., MARK O. LOVELESS, M.D., JACK FUHRER, M.D., GLEN A. SATTEN, PH.D., DIANE J. ASCHMAN, R.PH., M.S., SCOTT D. HOLMBERG, M.D., M.P.H., AND THE HIV OUTPATIENT STUDY INVESTIGATORS*

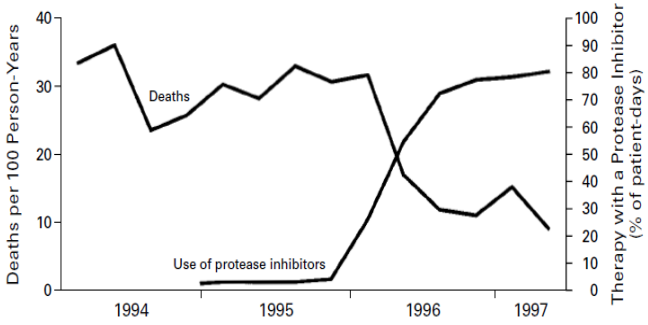
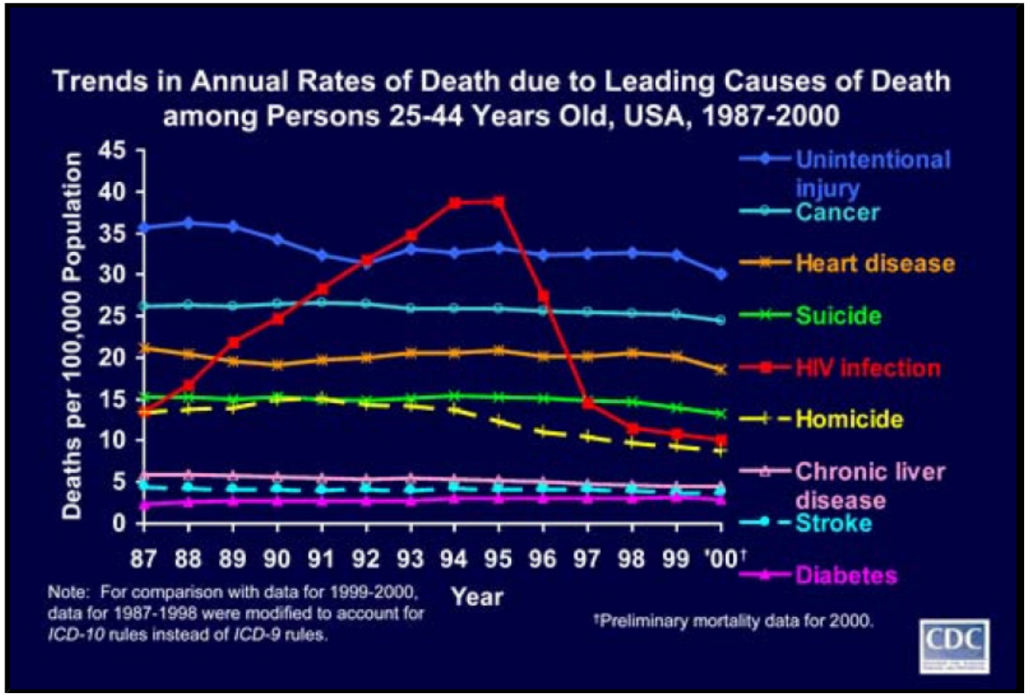
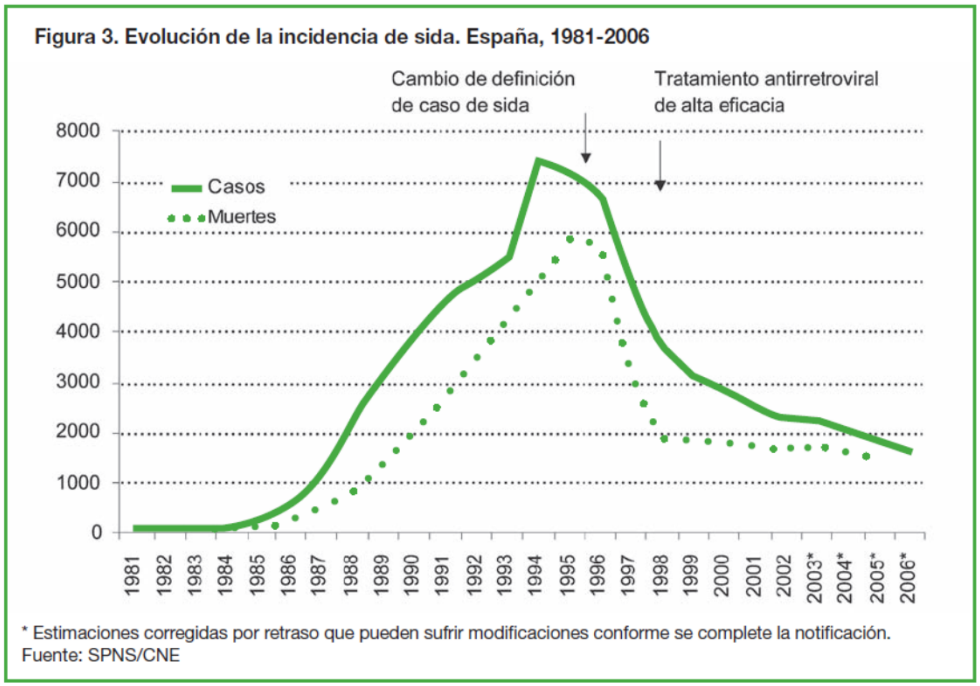


Figure 1. Mortality and Frequency of Use of Combination Antiretroviral Therapy Including a Protease Inhibitor among HIV-Infected Patients with Fewer Than 100 CD4+ Cells per Cubic Millimeter, According to Calendar Quarter, from January 1994 through June 1997.



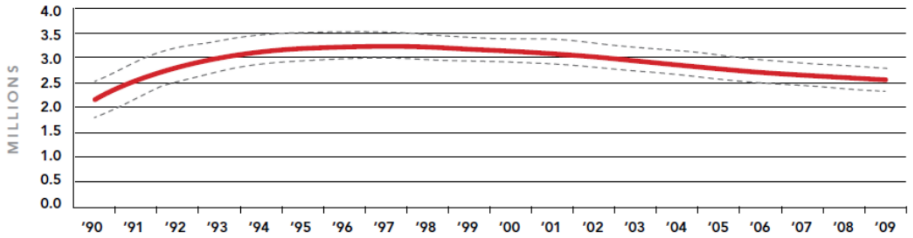


1.- Presentación tardía

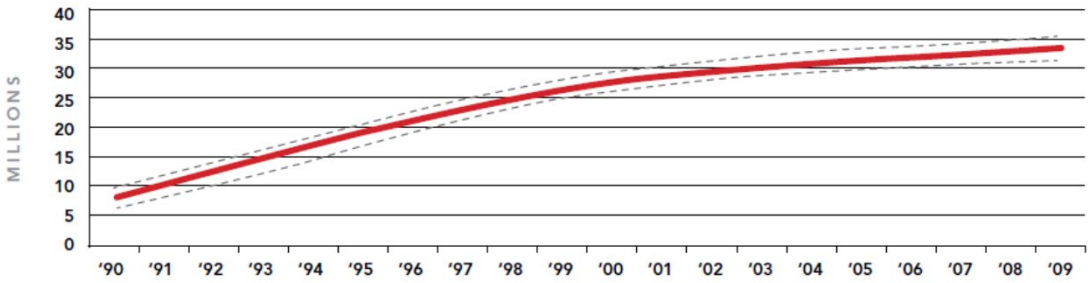
Unos 25 millones de personas han muerto por sida desde 1981

Figure 2.1

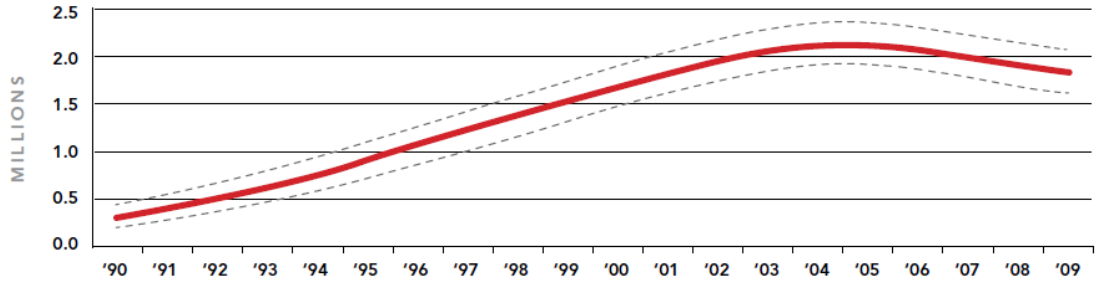
Number of people newly infected with HIV



Number of people living with HIV



Adult and child deaths due to AIDS

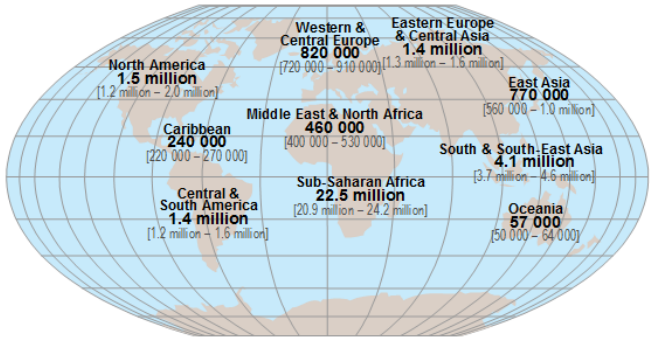


Incidencia VIH en España: 0,07/1000 habitantes-año.

Prevalencia 3/1000 habitantes.

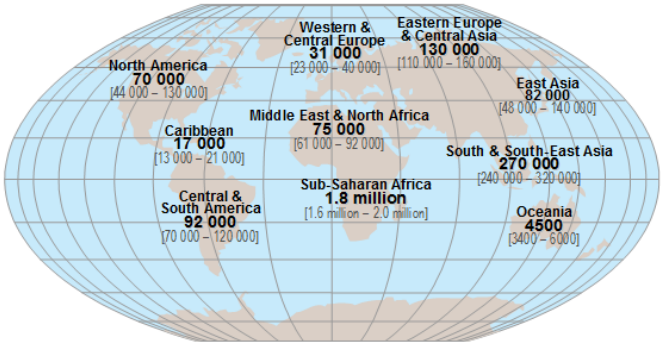
Castilla J; Epidemiol Infect 2000; 125: 159 .

Adults and children estimated to be living with HIV | 2009



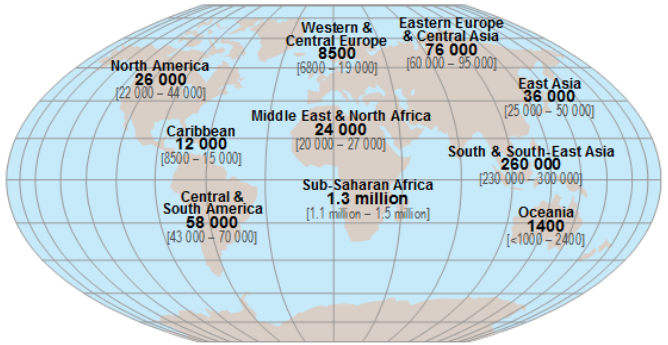
Total: 33.3 million [31.4 million – 35.3 million]

Estimated number of adults and children newly infected with HIV | 2009



Total: 2.6 million [2.3 million – 2.8 million]

Estimated adult and child deaths from AIDS | 2009

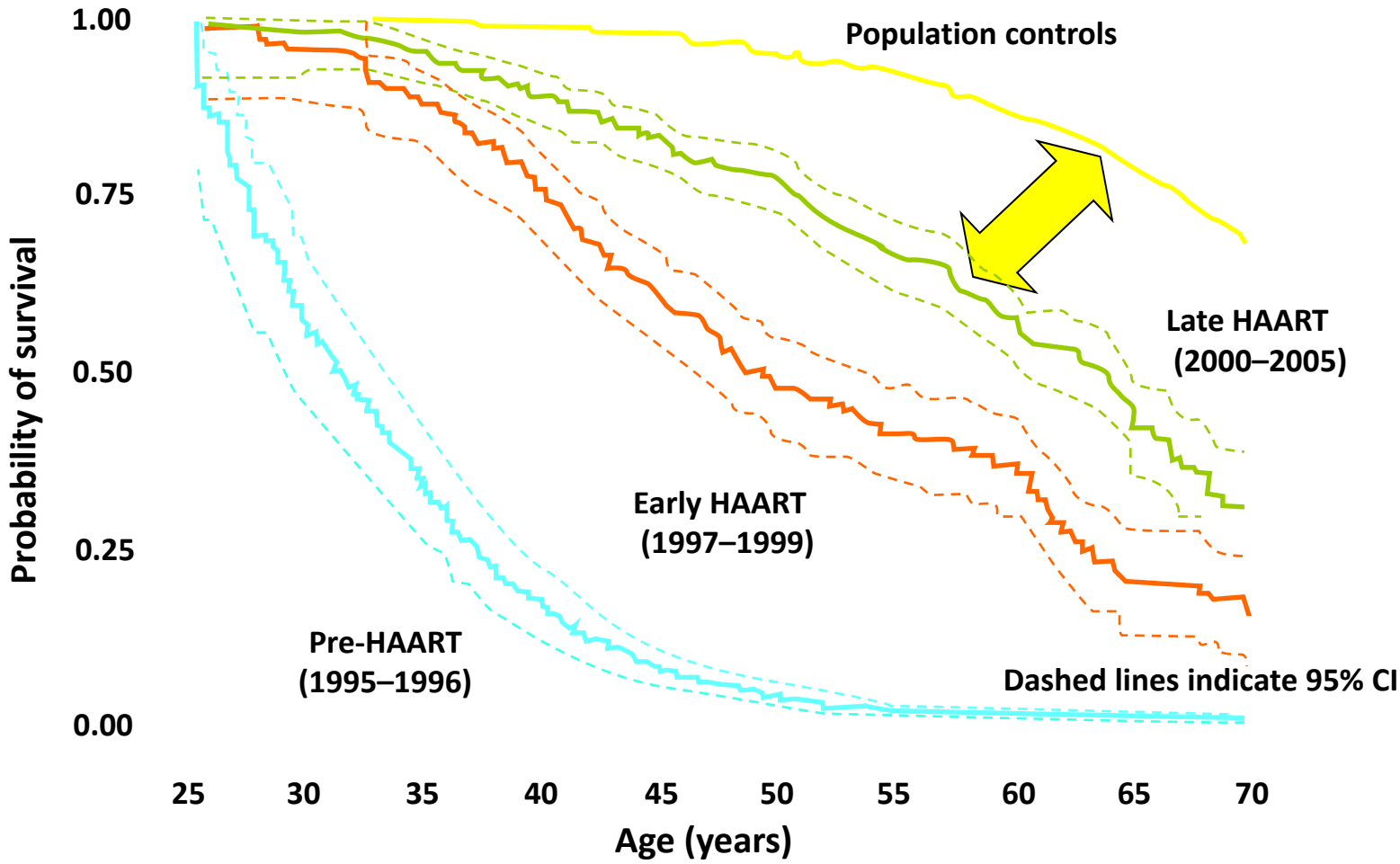


Total: 1.8 million [1.6 million – 2.1 million]

1.- Presentación tardía

Lifespan 10 years less

Survival Probability for Patients with HIV and General Population



[a]Without known hepatitis C coinfection

Lohse N, et al. Ann Intern Med 2007;146:87–95

1.- Presentación tardía

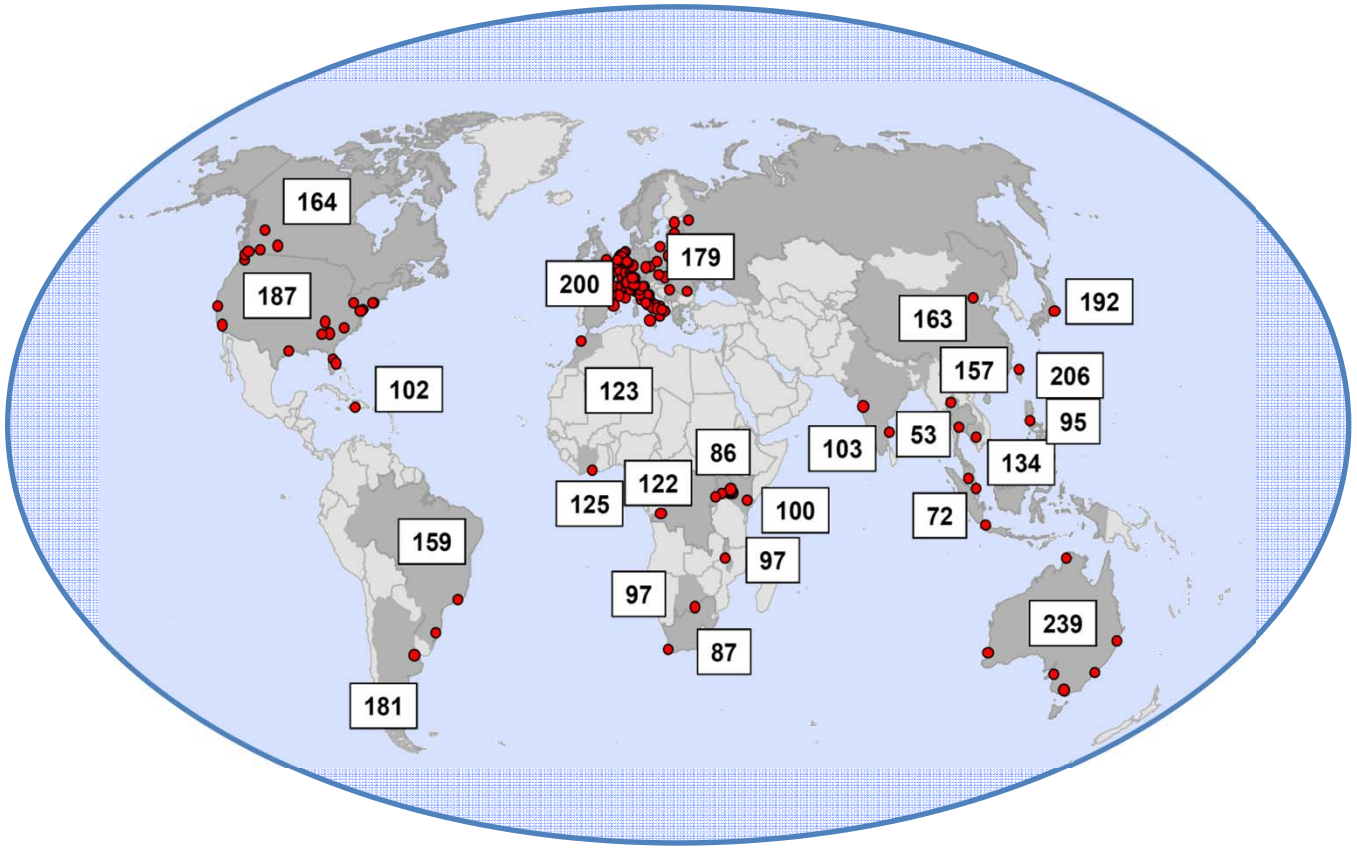
El **40%** de las personas VIH tienen menos de **200** CD4/μL al ser diagnosticados

Oliva J; Enferm Infecc Microbiol Clin 2010; 28: 583.

CD4 counts are low at start of HAART

2003–2005

- 42 countries, 176 sites, 33,008 patients
- Low CD4 count at start of treatment indicates that many patients have advanced disease



Egger M, 14th CROI, 2007. Abstract 62. ART Cohort Collaboration. http://www.art-cohort-collaboration.org

1.- Presentación tardía

Varón de 63 años, dx VIH en sep2011 en serología solicitada por MAP para confirmar + de donación

15/09/2011	10:29	ENFERMEDAD POR VIRUS DE INMUNOD...
11/01/2011	15:29	URGENCIAS
18/06/2010	16:38	UROLOGÍA.NUEVO -AT. PRIMARIA-
06/11/2009	16:16	TRAUMATOLOGÍA.
30/10/2009	15:37	URGENCIAS
26/10/2009	17:26	TRAUMATOLOGÍA.NUEVO -AT. PRIMA...
08/05/2009	16:11	Nevus Melanocítico (216.95) intradermico
21/10/2008	12:28	OFT URG
21/10/2008	10:38	URGENCIAS
13/10/2008	19:29	NEUROLOGÍA.NUEVO -AT. PRIMARIA-
06/10/2008	19:33	URGENCIAS
07/07/2008	18:05	DIAGNÓSTICO POR IMAGEN.Columna c...
02/01/2008	16:40	Gonalgia derecha
09/07/2007	16:46	URGENCIAS
04/07/2007	09:02	TRAUMATOLOGIA CURAS
27/04/2007	09:25	Anestesia
02/04/2007	09:56	APARATO DIGESTIVO.COLONOSCOPIA.
13/03/2007	09:54	LESION OIDO
13/03/2007	09:05	O.R.L..NUEVO -AT. PRIMARIA-
07/03/2007	06:30	RECTORRAGIA POSTHEMORROIDECTO...
07/03/2007	05:05	URGENCIAS
02/03/2007	13:54	CURAS. CIRUGIA
21/02/2007	11:46	HEMORROIDES + Rectorragia. Seguimie...

05/02/2007	09:59	TRAUMATOLOGÍA.	
11/01/2007	18:54	O.R.L..PACIENTE NUEVO -AT. PRIMARIA-	
22/12/2006	10:49	ANESTESIA Y REANIMACIÓN.PRIMERA ...	
22/12/2006	09:13	Hemorroides	
14/11/2006	19:28	CIRUGÍA GENERAL Y DEL APARATO DI...	
14/11/2006	19:24	TRAUMATOLOGÍA.PACIENTE NUEVO -...	
16/06/2006	13:27	posible neuroma superficial en region ti...	
06/09/2005	12:24	HIPOACUSIA	
04/08/2004	08:28	HEMORROIDES COMPLICADAS	
15/11/2003	10:00	LUMBOCIATALGIA AGUDA	
11/11/2003	00:00	ATENCIÓN PRIMARIA	
07/05/2001	07:57	FISURA ANAL	
23/10/2000	00:00	REHABILITACIÓN	
10/10/2000	00:00	Rectorragias	
02/08/2000	00:00	ENDOSCOPIA.	
29/02/2000	00:00	tendinitis de tibial posterior bilateral	
26/11/1998	09:30	BLOQUE QUIRURGICO	
26/10/1998	09:48	POSIBLE ABDOMINALGIA INESPECIFICA	
02/09/1998	16:45	LABORATORIO GENERAL	02/09/1998
10/08/1998	17:20	HERNIA INGINOESCROTAL ACHA INCIPI...	10/08/1998
01/12/1997	00:00	Histórico	17/06/2006

48TH ANNUAL MEETING
VANCOUVER
OCTOBER 21-24, 2010

1062. Avery A.
How Routine Is HIV Testing? Utilization of EMR to Measure Missed Opportunities

8 in 10 individuals
newly diagnosed
with HIV
in 2008 and 2009
had not been
previously tested
despite prior encounters
in the health system.

Lamentablemente los centros sanitarios son **entornos de retraso diagnóstico** porque los pacientes VIH consultan en **repetidas ocasiones antes de ser diagnosticados** [1,2,3]

1. CDC. MMWR 2006; 55: 1269.
2. Liddicoat RV; J Gen Intern Med 2004; 19: 349.
3. Klein D; J Acquir Immune Defic Syndr 2003; 32: 143

1.- Presentación tardía

P-37 I Congreso GeSIDA

¿Dónde y por qué son atendidos en el hospital los pacientes en los 10 años anteriores al diagnóstico de la infección VIH?

M. Pérez Rueda, B. Comeche Fernández, M. Delgado Yagüe, L. Moreno Núñez, R. Hervás Gómez, J. E. Losa García.

Hospital Universitario Fundación Alcorcón. Contacto: [redacted] ; 916219513

Objetivo

Analizar la atención sanitaria especializada que se produce en los 10 años anteriores al diagnóstico de la infección VIH.

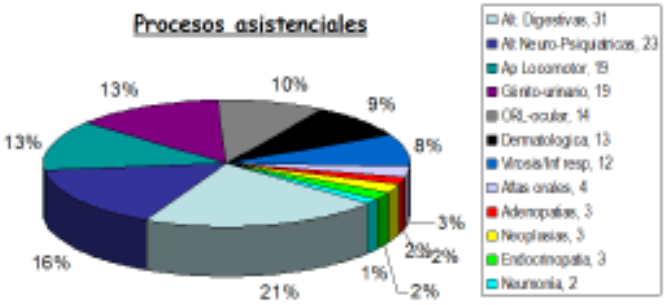
Métodos

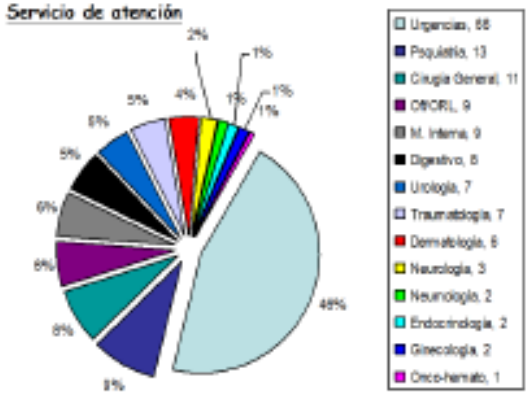
Estudio retrospectivo de todos los procesos asistenciales que se atendieron en un hospital en los 10 años anteriores a los diagnósticos de infección VIH realizados en 2007 y 2008. Los datos se recogieron de la historia clínica electrónica de cada caso incidente de VIH. Además se analizó el servicio hospitalario y el ámbito de la atención. Se utilizó el porcentaje para describir la distribución de las frecuencias.

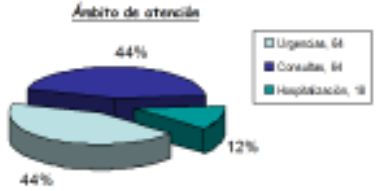
Resultados

146 procesos asistenciales en 48 casos nuevos de infección VIH (**3 procesos asistenciales en década anterior por caso VIH incidente**)

Tiempo medio entre cada proceso asistencial y el diagnóstico de infección VIH: **33 meses** (IC95% 27-38).





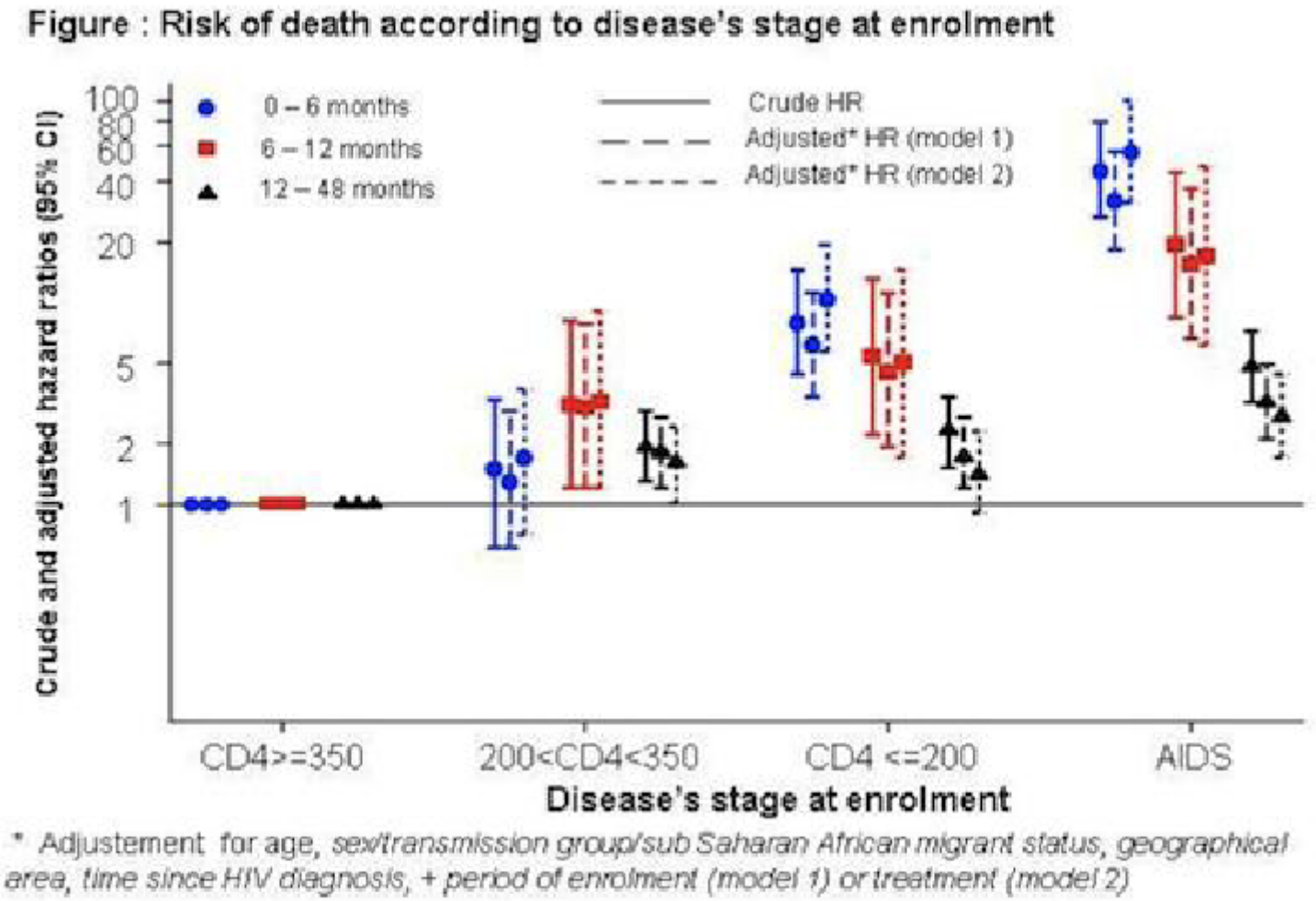


Conclusiones

El contacto con atención especializada es frecuente en los años anteriores al diagnóstico VIH.

Los servicios de urgencias y psiquiatría constituyen entornos de atención especializada en los que la promoción de la serología VIH puede adelantar su diagnóstico.

1.- Presentación tardía



Objectives: Studies on delayed access to care (DAC) are difficult to compare due to many different definitions of DAC. Most studies concerned patients presenting for care with AIDS or CD4 < 200 cells/mm^3. Recently, DAC has been defined as AIDS whatever the CD4 cell count or CD4< 350 cells/mm^3. Our objective was to assess the frequency of DAC and its impact on mortality using this new consensual definition.
Methods: We analysed the relationship between DAC and mortality in 19 911 patients enrolled in the French Hospital Database on HIV (FHDH) between 2003 and 2009 (median follow-up 33.4 months). The impact of DAC on mortality was analysed with Cox multivariable models adjusted for potential confounders dividing follow-up time from 0 to 6, 6 to 12 and 12 to 48 months.
Results: Overall, 10582 (53.2%) patients had DAC. As shown in the figure, compared to patient presenting for care with CD4 > 350 cells/mm^3, patients with AIDS had a very high risk of death with hazard ratio (HR) ranging from 45.6 in the first 6 months of follow-up to 4.8 for the 12-48 month period. For patients with CD4 < 200 cells/mm^3 the corresponding figures were 8.0 and 2.3. The negative prognostic value of DAC was also observed in patients with CD4 between 200 and 350 with a significantly higher risk of mortality after 6 months of follow-up with HR being 3.1 and 1.9 for the 6-12 month and the 12-48 month periods respectively. Adjustement for sociodemographics variables and for either period of enrolment or treatment did not modify the results.
Conclusions: DAC is still very frequent in France. Patients with DAC, including those with no major immunosuppression are at increased risk of mortality. Encouraging early testing and access to care is still urgently needed.

Montlahuc C. EACS2011. PS8/6

1.- Presentación tardía

13th EUROPEAN
AIDS CONFERENCE/EACS
OCTOBER 12 – 15, 2011 · BELGRADE, SERBIA

13th EUROPEAN
AIDS CONFERENCE
OCTOBER 12–15, 2011
BELGRADE - SERBIA

Oral Abstract Presentation

PS8/7 - Delayed Diagnosis of HIV Infection: Prevalence Risk Factors and Impact on Sanitary Costs

M. Martínez-Colubi[1], M.J. Pérez-Elías[1], A. Muriel[2], A.M. Cornejo Gutierrez[2], A. Moreno[1], M. del Palacio Tamarit[1], F. Dronda[1], J. Casado[1], S. Moreno[1]

[1]Hospital Ramón y Cajal, Infectious Diseases, Madrid, Spain, [2]Hospital Ramón y Cajal, Biostatistics, Madrid, Spain

Objectives: To asses the economic impact of Delayed HIV diagnosis (DHD) and its associated risk factors.
Methods: Prospective cohort study on 428 HIV-infected, HAART naïve subjects attended at a tertiary hospital in Madrid, Spain, between 2004-2009. DHD was defined in case of HIV diagnosis with a CD4 + lymphocyte count < 350 cells / microL and/or an AIDS-defining illness, whereas Early HIV Diagnosis (EHD) was considered for patients with CD4 + ≥ 350 cells / microL at HIV-infection diagnosis. The primary endpoint was total patient costs /months follow-up, defined as the sum of hospital visits costs, hospital admission costs on ward or in the ICU, and costs of HAART.
Results: The overall features of the cohort were as follows: mean age 34 years, 68% Spanish nationality, 65% injection drug users (IDUs) and 35% heterosexuals, 50% had secondary school education or university, 19% AIDS, and the prevalence of DHD was 54%. After multivariate analysis DHD was significantly associated to age at diagnosis (OR1.03 (1.01-1.06)) and route of HIV transmission: heterosexuals (OR 1.94 (1.25-3.03) and IDUs (OR 1.80 (1.03-3.18)). One month´s total costs for each DHD patient was 1412,59 ± 627,44€ as compared to 352,58 ± 57,41€ among EHD. One month´s medical services costs for each DHD patient was 792,34 ± 312,42€ and 80 ± 8.26€ for EHD patients (p=0.036). One month´s HAART drug costs for each DHD patient was 618,72 ± 560,80 € and 273,42 ± 372,67€ for EHD patient (p=0.0001).
Conclusions: DHD increased 1060,01 € (391,06 - 1728,93) per patient-month of follow-up compared to EHD. EHD saved nearly € 13 million/year.

1.- Presentación tardía

Cost-Effectiveness of Early Versus Standard Antiretroviral Therapy in HIV-Infected Adults in Haiti

Serena P. Koenig[1], Heejung Bang[2], Patrice Severe[3], Marc Antoine Jean Juste[3], Alex Ambroise[3], Alison Edwards[2], Jessica Hippolyte[3], Daniel W. Fitzgerald[4], Jolion McGreevy[3], Cynthia Riviere[3], Serge Marcelin[3], Rode Secours[3], Warren D. Johnson[4], Jean W. Pape[3,4], Bruce R. Schackman[2]*

1 Division of Global Health Equity, Brigham and Women's Hospital, Boston, Massachusetts, United States of America, **2** Department of Public Health, Weill Cornell Medical College, New York, New York, United States of America, **3** Groupe Haitien d'Etude du Sarcome de Kaposi et des Infections Opportunistes (GHESKIO), Port au Prince, Haiti, **4** Department of Medicine, Weill Cornell Medical College, New York, New York, United States of America

Abstract

Background: In a randomized clinical trial of early versus standard antiretroviral therapy (ART) in HIV-infected adults with a CD4 cell count between 200 and 350 cells/mm^3 in Haiti, early ART decreased mortality by 75%. We assessed the cost-effectiveness of early versus standard ART in this trial.

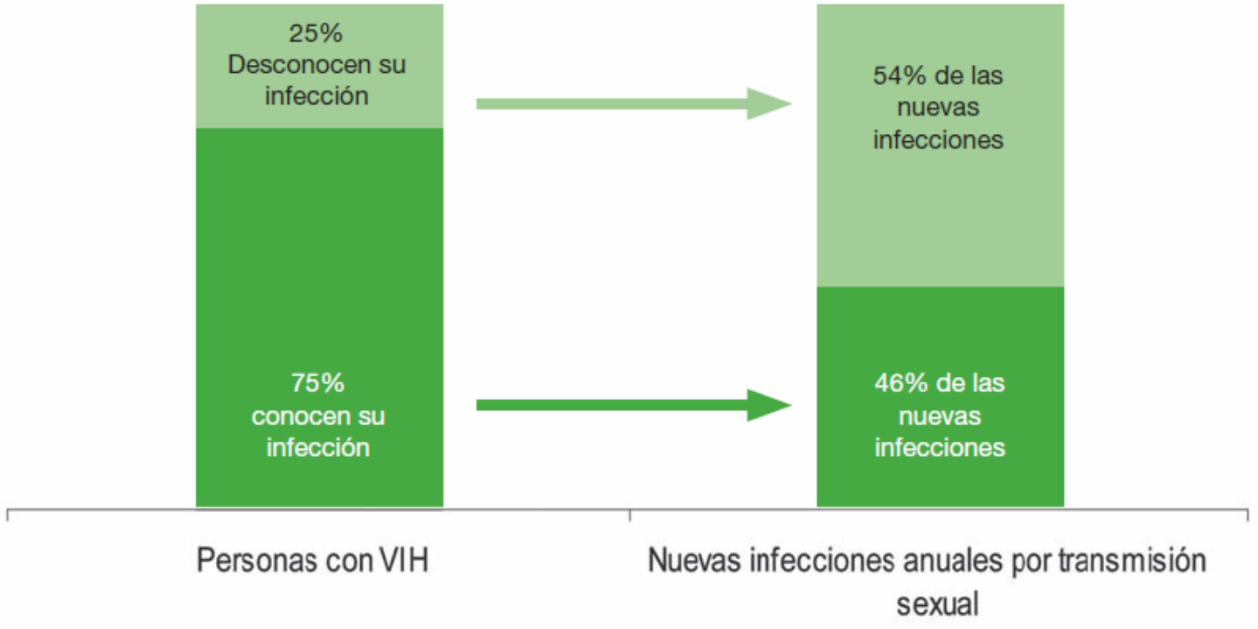
Methods and Findings: Trial data included use of ART and other medications, laboratory tests, outpatient visits, radiographic studies, procedures, and hospital services. Medication, laboratory, radiograph, labor, and overhead costs were from the study clinic, and hospital and procedure costs were from local providers. We evaluated cost per year of life saved (YLS), including patient and caregiver costs, with a median of 21 months and maximum of 36 months of follow-up, and with costs and life expectancy discounted at 3% per annum. Between 2005 and 2008, 816 participants were enrolled and followed for a median of 21 months. Mean total costs per patient during the trial were US$1,381 for early ART and US$1,033 for standard ART. After excluding research-related laboratory tests without clinical benefit, costs were US$1,158 (early ART) and US$979 (standard ART). Early ART patients had higher mean costs for ART (US$398 versus US$81) but lower costs for non-ART medications, CD4 cell counts, clinically indicated tests, and radiographs (US$275 versus US$384). The cost-effectiveness ratio after a maximum of 3 years for early versus standard ART was US$3,975/YLS (95% CI US$2,129/YLS–US$9,979/YLS) including research-related tests, and US$2,050/YLS excluding research-related tests (95% CI US$722/YLS–US$5,537/YLS).

Conclusions: Initiating ART in HIV-infected adults with a CD4 cell count between 200 and 350 cells/mm^3 in Haiti, consistent with World Health Organization advice, was cost-effective (US$/YLS <3 times gross domestic product per capita) after a maximum of 3 years, after excluding research-related laboratory tests.

Trial registration: ClinicalTrials.gov NCT00120510

1.- Presentación tardía

Figura 18. Estimación de la responsabilidad en las nuevas infecciones anuales por transmisión sexual entre las personas con VIH que conocen y las que desconocen su infección



Estimación asumiendo la hipótesis más conservadora realizada para EEUU por Marks G, Crepaz N. Janssen RS. *AIDS* 2006

- Prevalencia de VIH **oculto** en la población general de la Comunidad de Madrid: **0,32%**[1.]
- Este desconocimiento es muy **negativo** sobre la pandemia y cada paciente[2]
- El retraso diagnóstico afecta fundamentalmente a la transmisión **sexual**, que es la forma de contagio que predomina actualmente[3].
- El **17%** de la población entre 18 y 49 años mantiene relaciones sexuales con parejas ocasionales, y de ellos el **41%** no utiliza preservativo[4].

1. Moreno S; International AIDS Conference; 2010. Abstract LBPE28
2. Moreno S; Antivir Ther 2010;15 Suppl 1: 9.
3. Oliva J; Enferm Infecc Microbiol Clin 2010; 28: 583.
4. http://www.ine.es/prodyser/pubweb/saludyhs03/saludyhs03.htm

Enfermedad por VIH: de 1981 a 2011

¿Del pánico a la indiferencia?

De enfermedad mortal a crónica

De las infecciones a la inflamación

De las 4 H a la infección oculta

Homosexual
Haitiano
Heroinómano
Hemofílico

→ **30%** de VIH lo **desconocen**

2.- Necesidad de diagnóstico precoz

DOI: 10.1111/j.1468-1293.2009.00708.x
HIV Medicine (2009), **10**, 432–438

ORIGINAL RESEARCH

Reductions in HIV transmission risk behaviour following diagnosis of primary HIV infection: a cohort of high-risk men who have sex with men

Julie Fox,[1] Peter J White,[2,3] Neil Macdonald,[4] Jonathan Weber,[1] Myra McClure,[1] Sarah Fidler[1] and Helen Ward[4]

Results

A total of 98 of 104 eligible MSM (94%) participated in the study, with 100% follow-up. PHI was associated with high levels of recreational drug use, low levels of condom use, high numbers of sexual partners and a history of sex work. In the 12 weeks post-diagnosis, 76% of participants eliminated risk of onward transmission entirely and, overall, there was a significant reduction in transmission-risk behaviour, with patients reporting greater condom use and fewer sexual partners. Those with continued transmission-risk behaviour were more likely to have another sexually transmitted infection (STI), use ketamine and have more sexual partners at baseline.

2.- Necesidad de diagnóstico precoz

Principio fundamental de las enfermedades infecciosas:

**"El tamaño del inóculo determina
la probabilidad de infección"**

"The viral load is the **chief predictor**

of the risk of heterosexual transmission of HIV-1,

and transmission is rare among persons with levels of less

than 1500 copies of HIV-1 RNA per milliliter"

(Quinn TC; N Engl J Med 2000; 342: 921)

From "**Treatment is Prevention**"
To "**Treatment as Prevention**"?

2.- Necesidad de diagnóstico precoz

"Treatment as Prevention"...in mother to child transmission

The New England
Journal of Medicine

Volume 331 NOVEMBER 3, 1994 Number 18

REDUCTION OF MATERNAL–INFANT TRANSMISSION OF HUMAN IMMUNODEFICIENCY VIRUS TYPE 1 WITH ZIDOVUDINE TREATMENT

EDWARD M. CONNOR, M.D., RHODA S. SPERLING, M.D., RICHARD GELBER, PH.D., PAVEL KISELEV, PH.D., GWENDOLYN SCOTT, M.D., MARY JO O'SULLIVAN, M.D., RUSSELL VANDYKE, M.D., MOHAMMED BEY, M.D., WILLIAM SHEARER, M.D., PH.D., ROBERT L. JACOBSON, M.D., ELEANOR JIMENEZ, M.D., EDWARD O'NEILL, M.D., BRIGITTE BAZIN, M.D., JEAN-FRANÇOIS DELFRAISSY, M.D., MARY CULNANE, M.S., ROBERT COOMBS, M.D., PH.D., MARY ELKINS, M.S., JACK MOYE, M.D., PAMELA STRATTON, M.D., AND JAMES BALSLEY, M.D., PH.D., FOR THE PEDIATRIC AIDS CLINICAL TRIALS GROUP PROTOCOL 076 STUDY GROUP*

were 8.3 percent (95 percent confidence interval, 3.9 to 12.8 percent) in the zidovudine group and 25.5 percent (95 percent confidence interval, 18.4 to 32.5 percent) in the placebo group. This corresponds to a 67.5 percent (95 percent confidence interval, 40.7 to 82.1 percent) relative reduction in the risk of HIV transmission ($Z = 4.03$, $P = 0.00006$). Minimal short-term toxic ef-

2.- Necesidad de diagnóstico precoz

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Prevention of HIV-1 Infection with Early Antiretroviral Therapy

Myron S. Cohen, M.D., Ying Q. Chen, Ph.D., Marybeth McCauley, M.P.H.,

The authors' affiliations are listed in the Appendix. Address reprint requests to Dr. Cohen at the University of North Carolina at Chapel Hill, Institute for Global Health and Infectious Diseases, Suite 2115, Bioinformatics Bldg., 130 Mason Farm Rd., CB 7030, Chapel Hill, NC 27599, or at mscohen@med.unc.edu.

*Other members of the HIV Prevention Trials Network (HPTN) 052 Study Team are listed in the Supplementary Appendix, available at NEJM.org.

This article (10.1056/NEJMoa1105243) was published on July 18, 2011, at NEJM.org.

N Engl J Med 2011.

ABSTRACT

BACKGROUND

Antiretroviral therapy that reduces viral replication could limit the transmission of human immunodeficiency virus type 1 (HIV-1) in serodiscordant couples.

METHODS

In nine countries, we enrolled 1763 couples in which one partner was HIV-1–positive and the other was HIV-1–negative; 54% of the subjects were from Africa, and 50% of infected partners were men. HIV-1–infected subjects with CD4 counts between 350 and 550 cells per cubic millimeter were randomly assigned in a 1:1 ratio to receive antiretroviral therapy either immediately (early therapy) or after a decline in the CD4 count or the onset of HIV-1–related symptoms (delayed therapy). The primary prevention end point was linked HIV-1 transmission in HIV-1–negative partners. The primary clinical end point was the earliest occurrence of pulmonary tuberculosis, severe bacterial infection, a World Health Organization stage 4 event, or death.

RESULTS

As of February 21, 2011, a total of 39 HIV-1 transmissions were observed (incidence rate, 1.2 per 100 person-years; 95% confidence interval [CI], 0.9 to 1.7); of these, 28 were virologically linked to the infected partner (incidence rate, 0.9 per 100 person-years, 95% CI, 0.6 to 1.3). Of the 28 linked transmissions, only 1 occurred in the early-therapy group (hazard ratio, 0.04; 95% CI, 0.01 to 0.27; P<0.001). Subjects receiving early therapy had fewer treatment end points (hazard ratio, 0.59; 95% CI, 0.40 to 0.88; P=0.01).

CONCLUSIONS

The early initiation of antiretroviral therapy reduced rates of sexual transmission of HIV-1 and clinical events, indicating both personal and public health benefits from such therapy. (Funded by the National Institute of Allergy and Infectious Diseases and others; HPTN 052 ClinicalTrials.gov number, NCT00074581.)

Early ART that suppresses viral replication led to 96% reduction of sexual transmission of HIV-1 in serodiscordant couples

2.- Necesidad de diagnóstico precoz

www.thelancet.com Published online July 15, 2011 DOI:10.1016/S0140-6736(11)61136-7

*Salim S Abdool Karim, Quarraisha Abdool Karim

Eficacia de estrategias de prevención de VIH en ensayos clínicos aleatorizados

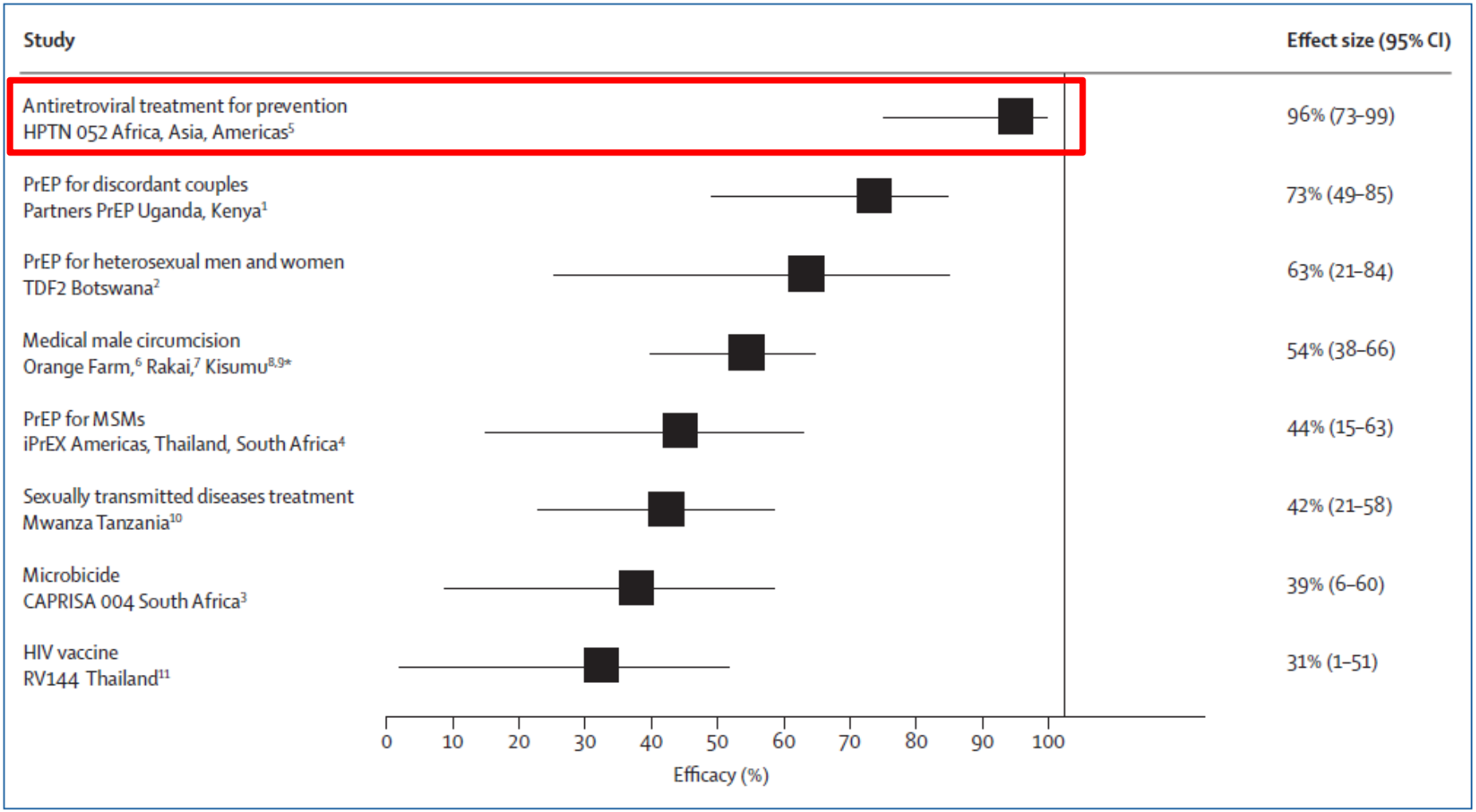


Figure: HIV prevention technologies shown to be effective in reducing HIV incidence in randomised controlled trials[1–11]
PrEP=Pre-exposure prophylaxis. *Meta-analysis of circumcision trials.

Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model

Reuben M Granich, Charles F Gilks, Christopher Dye, Kevin M De Cock, Brian G Williams

Lancet 2009; 373: 48–57

Methods We used mathematical models to explore the effect on the case reproduction number (stochastic model) and long-term dynamics of the HIV epidemic (deterministic transmission model) of testing all people in our test-case community (aged 15 years and older) for HIV every year and starting people on ART immediately after they are diagnosed HIV positive. We used data from South Africa as the test case for a generalised epidemic, and assumed that all HIV transmission was heterosexual.

Findings The studied strategy could greatly accelerate the transition from the present endemic phase, in which most adults living with HIV are not receiving ART, to an elimination phase, in which most are on ART within 5 years. It could reduce HIV incidence and mortality to less than one case per 1000 people per year by 2016, or within 10 years of full implementation of the strategy, and reduce the prevalence of HIV to less than 1% within 50 years. We estimate that in 2032, the yearly cost of the present strategy and the theoretical strategy would both be US$1·7 billion; however, after this time, the cost of the present strategy would continue to increase whereas that of the theoretical strategy would decrease.

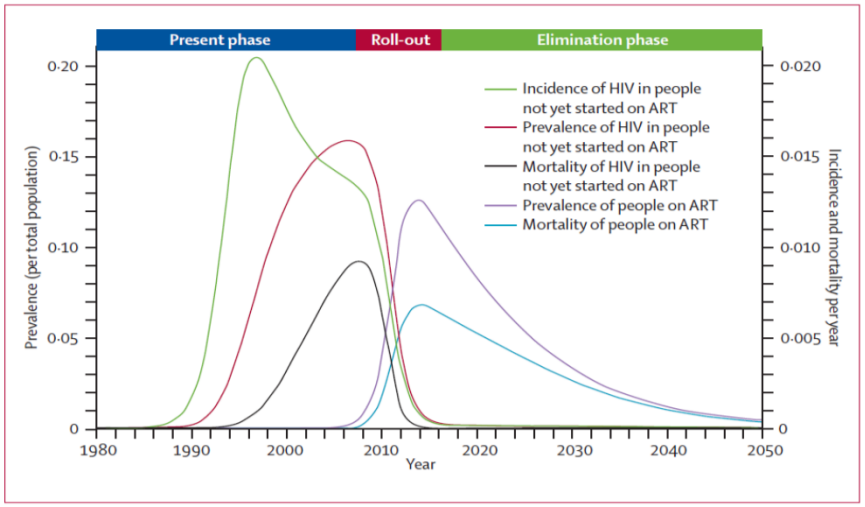


Figure 5: **Time trends resulting from application of universal voluntary HIV testing and immediate ART strategy for people who test HIV positive, in combination with other adult prevention interventions that reduce incidence by 40%**
The programme implementation start date is arbitrarily set as immediate, with coverage increasing logistically to 50% by 2012 and 90% by 2016. The parameters are τ=1·0 per year; □=0·08; □=0·015 per year; and η=0·10. See figure 2 legend for description of these variables.

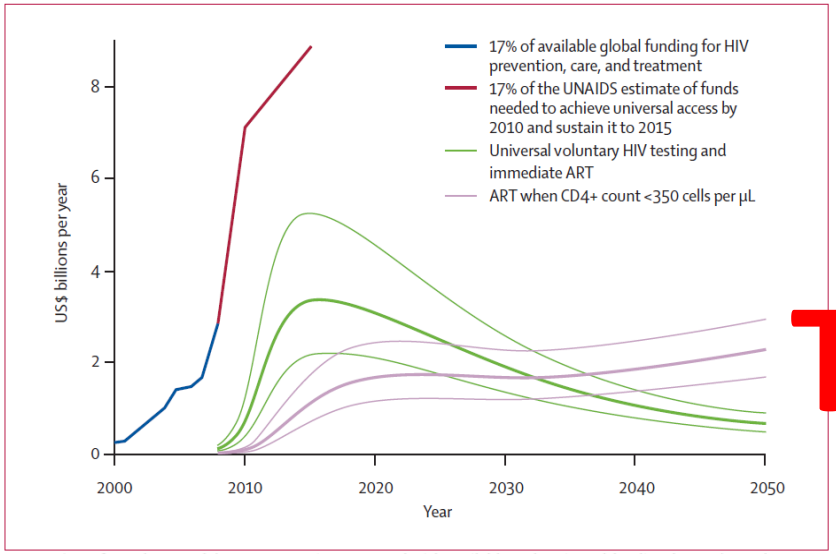
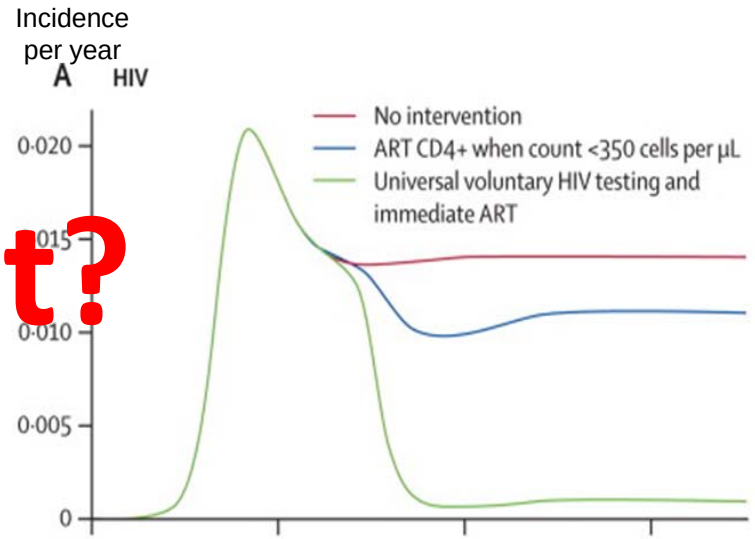


Figure 6: **Yearly cost of the two strategies compared with available and projected funding for HIV/AIDS for the test-case country**
Heavy lines correspond to expected treatment costs, light lines to high and low estimates of treatment costs for the hypothetical epidemic representing 17% of worldwide HIV prevalence, as described in the methods section. Blue line: 17% of available global funding for HIV prevention, care and treatment;[44] brown line: 17% of the UNAIDS estimate of funds needed to achieve universal access by 2010 and to sustain it to 2015.[36]

¿Test & Treat?



3.- ¿Suficiente Opt-In?

The NEW ENGLAND JOURNAL of MEDICINE

Routine Screening for HIV Infection —

N ENGL J MED 352;6 WWW.NEJM.ORG FEBRUARY 10, 2005

Samuel A. Bozzette, M.D., Ph.D.

Cost-Effectiveness of Screening for HIV in the Era of Highly Active Antiretroviral Therapy

Gillian D. Sanders, Ph.D., Ahmed M. Bayoumi, M.D., Vandana Sundaram, M.P.H., S. Pinar Bilir, A.B., Christopher P. Neukermans, A.B., Chara E. Rydzak, B.A., Lena R. Douglass, B.S., Laura C. Lazzeroni, Ph.D., Mark Holodniy, M.D., and Douglas K. Owens, M.D.

CONCLUSIONS

The cost-effectiveness of routine HIV screening in health care settings, even in relatively low-prevalence populations, is similar to that of commonly accepted interventions, and such programs should be expanded.

Expanded Screening for HIV in the United States — An Analysis of Cost-Effectiveness

A. David Paltiel, Ph.D., Milton C. Weinstein, Ph.D., April D. Kimmel, M.Sc.,

CONCLUSIONS

In all but the lowest-risk populations, routine, voluntary screening for HIV once every three to five years is justified on both clinical and cost-effectiveness grounds. One-time screening in the general population may also be cost-effective.

3.- ¿Suficiente Opt-In?

Opt-In: Limitar el dx a aquellas personas que tienen más probabilidades de infección

Table 1 AIDS-defining illness and other illnesses strongly associated with immunodeficiency in HIV-infected populations [13,14]

Candidiasis of the bronchi, trachea, or lungs	Kaposi's sarcoma
Candidiasis (esophageal)	Lymphoma, Burkitt's
	Lymphoma (immunoblastic)
Cervical cancer (invasive)	Lymphoma (primary) of the brain
Coccidioidomycosis (disseminated or extrapulmonary)	*Mycobacterium avium* complex or *Mycobacterium kansasii* (disseminated or extrapulmonary)
Cryptococcosis (extrapulmonary)	*Mycobacterium tuberculosis*, any site (extrapulmonary or pulmonary)
Cryptosporidiosis, chronic intestinal (>1 month's duration)	*Mycobacterium*, other species or unidentified species (disseminated or extrapulmonary)
Cytomegalovirus disease (other than liver, spleen, or nodes)	*Pneumocystis jirovecii* pneumonia
Cytomegalovirus retinitis (with loss of vision)	Pneumonia (recurrent)
Encephalopathy (HIV-related)	Progressive multifocal leukoencephalopathy
Herpes simplex: chronic ulcer(s) (>1 month's duration); or bronchitis, pneumonitis, or esophagitis	*Salmonella* septicemia (recurrent)
Histoplasmosis (disseminated or extrapulmonary)	Toxoplasmosis of the brain
Isosporiasis (chronic intestinal [>1 month's duration])	Wasting syndrome due to HIV

Table 2 Prevalence of HIV in patients presenting with various indicator diseases (European studies)

Disease	HIV prevalence	References
1. Candidiasis	6–23%	[20,21]
2. Herpes zoster	Unknown	
3. Fungal infections of the skin		
Cryptococcosis	77%	[22]
4. Oral manifestations of HIV disease	Unknown	
5. Sexually transmitted infections		
Hepatitis B	Unknown	
Hepatitis C	8–59%	[23–26]
Lymphogranuloma venereum	74%	[27]
6. Pregnancy		
France	0.34%	[28]
Greece	0.1%	[28]
Italy	0.1–0.3%	[28]
Netherlands	0.3%	[29]
Romania	0.2%	[30]
Scotland	0.2%	[28]
UK	0.01–0.26%	[28]
7. Respiratory infections		
Tuberculosis	10–25%	[17,31,32]
CAP	19–24%	[33,34]
8. Neurological disease		
Meningitis (cryptococcosis)	68–94%	[22,35,36]
Perinatal listeriosis	3%	[37]
9. Gastroenterology		
Nosocomial diarrhoea	10–12%	[38,39]
10. Constitutional symptoms		
Unexplained fever	3%	[40]
11. Mononucleosis	7%	[41]
12. Laboratory indicators	Unknown	
13. Tumours		
Kaposi's sarcoma	45.4%*	[42]

*Presence of Human Herpesvirus-8 antibodies.
CAP, community acquired pneumonia.

DOI: 10.1111/j.1468-1293.2008.00592.x
HIV Medicine (2008), 9 (Suppl. 2), 34–40

ORIGINAL RESEARCH

Indicator disease-guided testing for HIV – the next step for Europe?

B Gazzard,[1] N Clumeck,[2] A d'Arminio Monforte[3] and JD Lundgren[4]

3.- ¿Suficiente Opt-In?

HIV Testing and Diagnosis Among Adults-United States, 2001–2009. MMWR / December 3, 2010 / Vol. 59 / No. 47

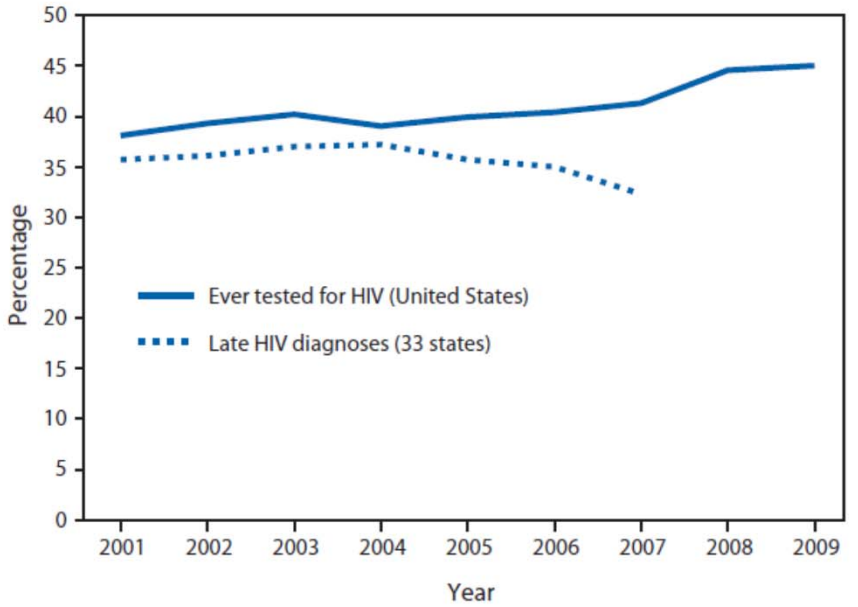
TABLE 1. Estimated number,* percentage, and rate of HIV diagnoses among persons aged 18–64 years (37 states†), and percentage who reported ever being tested for HIV (United States§), by selected characteristics, 2008

Characteristic	HIV diagnoses (37 states) No.	(%)	Rate per 100,000	% ever tested for HIV (United States)
Total	39,857	(100.0)	29.9	44.6

Key Points

- Approximately 56,000 persons in the United States are newly infected with HIV each year.
- The number of adults aged 18–64 years who have ever been tested for HIV increased by 11.4 million during 2006–2009; however, an estimated 55% of adults have never been tested.
- An estimated 32% of all HIV diagnoses in 2007 were late diagnoses, occurring shortly before persons developed AIDS, making early treatment impossible.
- Early HIV testing reduces the spread of disease, extends life expectancy, and reduces costs of care. Every new HIV infection averted saves approximately $367,000 in lifetime medical costs.
- Everyone should be tested for HIV. Persons at higher risk and in high-prevalence populations should be tested more often than others.
- Additional information is available at http://www.cdc.gov/vitalsigns.

FIGURE 1. Percentage of persons aged 18–64 years who reported ever being tested for HIV (United States, 2001–2009*), and percentage of late HIV diagnoses (AIDS diagnosis within 12 months of initial HIV diagnosis) (33 states, 2001–2007†)

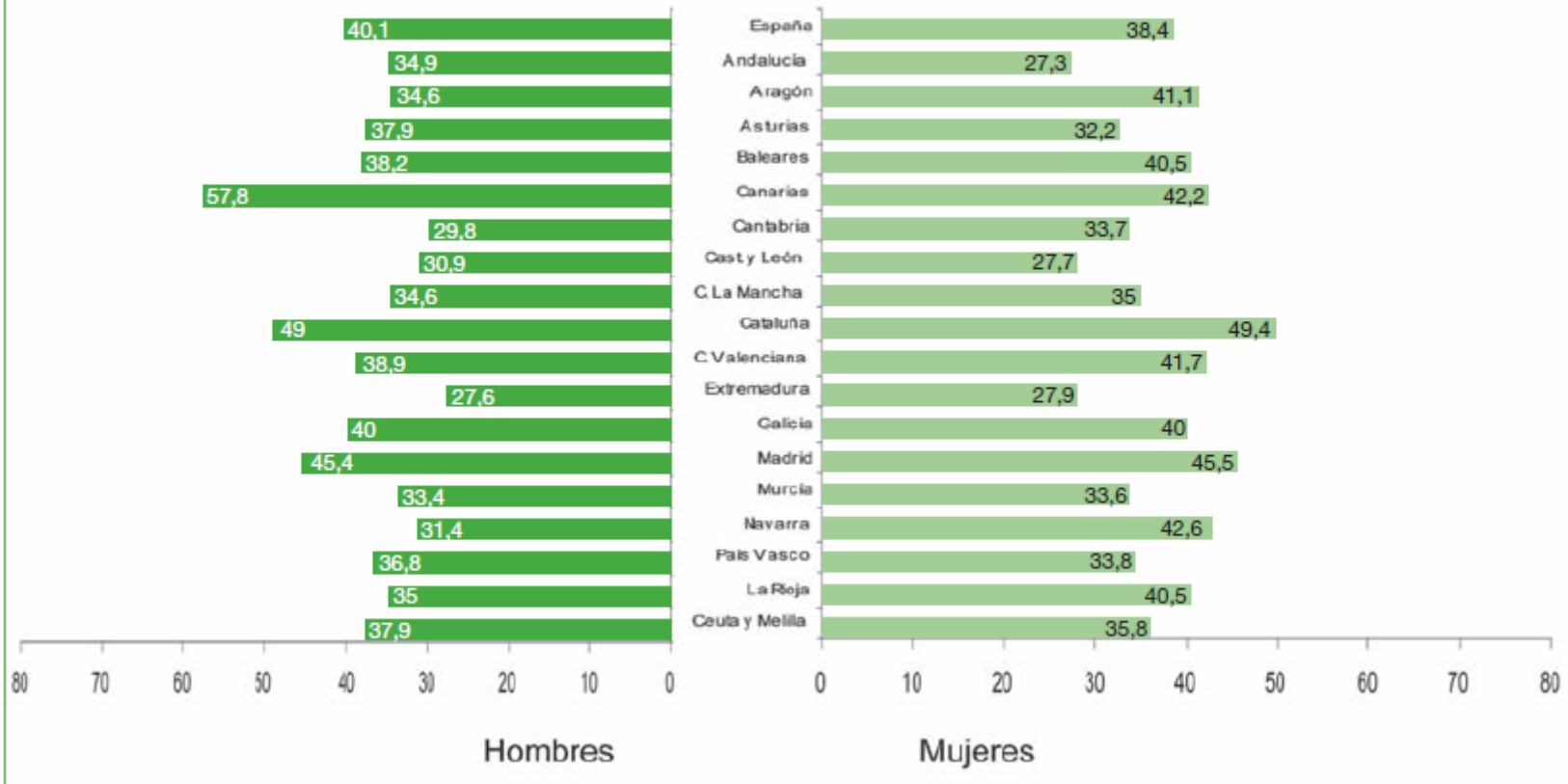


* Data from the National Health Interview Survey. Available at http://www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm.

† Data from the National HIV Surveillance System. Includes data reported from 33 states with confidential, name-based reporting of HIV infection since at least December 2000: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana,

3.- ¿Suficiente Opt-In?

Figura 19. Porcentaje de personas de 18 a 49 años que se ha realizado la prueba del VIH alguna vez en la vida según sexo y comunidad autónoma. España, 2003.



Fuente: Encuesta de Salud y Hábitos Sexuales. INE/SPNS

3.- ¿Suficiente Opt-In?

4 Recommendations for testing

4.1 Who can test?

It should be within the competence of any doctor, midwife, nurse or trained healthcare worker to obtain consent for and conduct an HIV test.

4.2 Who should be offered a test?

A. Universal HIV testing is recommended in all of the following settings:

1. GUM or sexual health clinics
2. antenatal services
3. termination of pregnancy services
4. drug dependency programmes
5. healthcare services for those diagnosed with tuberculosis, hepatitis B, hepatitis C and lymphoma.

B. An HIV test should be considered in the following settings where diagnosed HIV prevalence in the local population (PCT/LA) exceeds 2 in 1000 population (see local PCT data[1]*):*

1. all men and women registering in general practice
2. all general medical admissions.

The introduction of universal HIV testing in these settings should be thoroughly evaluated for acceptability and feasibility and the resultant data made available to better inform the ongoing implementation of these guidelines.

C. HIV testing should be also routinely offered and recommended to the following patients:

1. all patients presenting for healthcare where HIV, including primary HIV infection, enters the differential diagnosis (see table of indicator diseases and section on primary HIV infection)
2. all patients diagnosed with a sexually transmitted infection
3. all sexual partners of men and women known to be HIV positive
4. all men who have disclosed sexual contact with other men
5. all female sexual contacts of men who have sex with men
6. all patients reporting a history of injecting drug use
7. all men and women known to be from a country of high HIV prevalence (>1%*)
8. all men and women who report sexual contact abroad or in the UK with individuals from countries of high HIV prevalence.*

* for an up to date list see http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/latestEpiData.asp

Table 1: Clinical indicator diseases for adult HIV infection

	AIDS-defining conditions	Other conditions where HIV testing should be offered
Respiratory	Tuberculosis Pneumocystis	Bacterial pneumonia Aspergillosis
Neurology	Cerebral toxoplasmosis Primary cerebral lymphoma Cryptococcal meningitis Progressive multifocal leucoencephalopathy	Aseptic meningitis/encephalitis Cerebral abscess Space occupying lesion of unknown cause Guillain–Barré syndrome Transverse myelitis Peripheral neuropathy Dementia Leucoencephalopathy
Dermatology	Kaposi's sarcoma	Severe or recalcitrant seborrhoeic dermatitis Severe or recalcitrant psoriasis Multidermatomal or recurrent herpes zoster
Gastroenterology	Persistent cryptosporidiosis	Oral candidiasis Oral hairy leukoplakia Chronic diarrhoea of unknown cause Weight loss of unknown cause Salmonella, shigella or campylobacter Hepatitis B infection Hepatitis C infection
Oncology	Non-Hodgkin's lymphoma	Anal cancer or anal intraepithelial dysplasia Lung cancer Seminoma Head and neck cancer Hodgkin's lymphoma Castleman's disease
Gynaecology	Cervical cancer	Vaginal intraepithelial neoplasia Cervical intraepithelial neoplasia Grade 2 or above
Haematology		Any unexplained blood dyscrasia including: • thrombocytopenia • neutropenia • lymphopenia
Ophthalmology	Cytomegalovirus retinitis	Infective retinal diseases including herpesviruses and toxoplasma Any unexplained retinopathy
ENT		Lymphadenopathy of unknown cause Chronic parotitis Lymphoepithelial parotid cysts
Other		Mononucleosis-like syndrome (primary HIV infection) Pyrexia of unknown origin Any lymphadenopathy of unknown cause Any sexually transmitted infection

13th EUROPEAN
AIDS CONFERENCE/EACS
OCTOBER 12 – 15, 2011 · BELGRADE, SERBIA

13th EUROPEAN
AIDS CONFERENCE
OCTOBER 12–15, 2011
BELGRADE - SERBIA

Oral Abstract Presentation

PS8/1 - HIV Testing: How Are We Doing? Results of British HIV Association (BHIVA) National Audit 2010. On the behalf of BHIVA Audit and Standards Sub-committee

S. Ellis[1], H. Curtis[2], E. Ong[3]
[1]Royal Victoria Infirmary, Infection & Tropical Medicine, Newcastle Upon Tyne, United Kingdom, [2]BHIVA, Audit and Standard Subcommittee, London, United Kingdom, [3]Royal Victoria Infirmary, Department of Infection & Tropical Medicine, Newcastle Upon Tyne, United Kingdom

Objectives: UK National HIV Testing Guidelines (2008) aim to increase testing in all healthcare settings. In 2010 BHIVA's national audit programme assessed adherence to these guidelines in clinical practice. This included
(1) a clinic survey and
(2) a case-note audit.
Methods: Survey - Online survey of testing practice completed by UK sites providing adult HIV care.Case-note audit - Sites reviewed case-notes retrospectively for consecutive patients aged 16 or over seen for initial work-up after testing HIV positive between 1st August and 31st September 2010 (max. 40 patients per site). Data collected included demographic details, circumstances of testing and baseline clinical data.
Result: Survey (132 sites). HIV testing was offered routinely in genitourinary medicine (GUM) and antenatal services (100% of sites). Fewer sites offered testing routinely in TB (70%), hepatitis (50%) or termination of pregnancy services (24%). 91% of sites routinely use a fourth generation antigen/antibody testing to diagnose HIV. 28% of sites exceed national guidelines (< 72hours) for laboratory reporting of non-urgent HIV test.Case-note audit (1112 patients). 52.2% were diagnosed late (CD4 < 350cells/mm^3).Most (53.8%) were diagnosed in GUM. Compared with a 2003 audit, the proportion of diagnoses had increased in general practice, inpatient admissions and outpatients though the latter remained low at 7.1% (2.8% in 2003). 79.1% of patients diagnosed in GUM had a CD4>200cells/mm3 compared with 31.9% of inpatient. ($p < 0.001$). Between January 2008 and testing positive, 36.9% of patients had indicator conditions that should have prompted HIV testing. However, in 24.5% of cases, testing was not offered for these conditions and in some cases was offered only after prolonged investigation.

CLINICAL SETTING	2010 AUDIT(%)	2003(%)
GUM/Sexual Health	53.8	66.0
HIV Clinic (non-GUM)	1.5	2.3
General Practice	10.4	4.8
Inpatient/Acute Admissions	14.7	11.0
Emergency Department	0.7	0.2
Outpatients	7.1	2.8
Antenatal Clinic	4.6	8.6
Community HIV Testing Service	2.1	N/A
Drug Dependency Service	0.5	N/A

[Table:Clinical Setting]

Conclusion: While the 2008 guidelines have had some impact, more needs to be done to increase testing across clinical settings to reduce the proportion of patients living with undiagnosed infection.

4.- ¿Mejor Opt-Out?

Opt-Out: realizar la prueba a todas las personas que acuden a un servicio de salud

Promover un diagnóstico **precoz** es clave en el control de la pandemia.

Además:
a) se puede detectar con pruebas **fiables, baratas y no invasivas**,
b) su cribado, prevención y tratamiento tiene un buen **coste-beneficio,**
c) puede ser diagnosticada **antes** de que aparezcan complicaciones,
d) su tratamiento a tiempo conlleva la ganancia de muchos **años** de vida[1].

CDC 2006[2]:
test VIH en todas las personas de 13 a 64 años que acudieran a los servicios de salud **independientemente** de la existencia de prácticas de riesgo y de la prevalencia del VIH, y se llevaría a cabo salvo que el paciente exprese su negativa ("**opt-out**").

OMS y sociedades médicas USA recomiendan esta estrategia de normalización del test[3-5].

El cribado rutinario se implantó años antes en **gestantes**, con resultados muy positivos[6].

1. ECDC: http://www.ecdc.europa.eu/en/publications/Publications/0703_TER_HIV_in_Europe_25_Years_Pandemic.pdf
2. Branson BM.MMWR 2006; 55(RR14);1.
3. WHO/UNAIDS: http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf
4. Lubinski C; Clin Infect Dis 2009; 48: 1335.
5. Qaseem A; Ann Intern Med 2009; 150:125.
6. Stringer EM; Obstet Gynecol 2001; 98: 1104.

4.- ¿Mejor Opt-Out?

Ofrecer sistemáticamente la serología VIH a los pacientes de atención primaria
a quienes se va a solicitar una analítica de sangre y
reconozcan haber mantenido una relación sexual no protegida
con una persona de la que se desconocían su estado serológico frente al VIH,
aumenta significativamente su realización (**del 3 al 27%**)[1]

Cuando se incorpora una **anamnesis sexual** básica en la consulta de AP,
la inmensa mayoría (**93%**) de la población estudiada reconoce
haber mantenido una relación sexual no protegida
con una persona de la que se desconocían su estado serológico frente al VIH
y **excepcionalmente rechaza la realización de la prueba (1.5%)** [2]**.**

La **aceptación** del cribado rutinario es mejor que
el tradicional basado en poblaciones de alto riesgo[3].

1. Martín De Cabo; Congreso Gesida 2009; P38
2. Martín De Cabo; Congreso Gesida 2009; PO21.
3. Mahoney MR; Am Fam Physician 2009; 80: 1441.

4.- ¿Mejor Opt-Out?

Enferm Infecc Microbiol Clin. 2011;29(7):490–496

ELSEVIER DOYMA

Enfermedades Infecciosas y Microbiología Clínica

www.elsevier.es/eimc

Original

Actitudes y prácticas de los médicos de atención primaria ante el diagnóstico de la infección por virus de la inmunodeficiencia humana

María José Busto[a,b,*], Lucía García San Miguel[b], María Elena Castelao[a,c] y Elena Bermúdez[d]

[a] Centro de Salud de San Martín de Valdeiglesias, Área 8, Madrid, España
[b] Facultad de Ciencias Biomédicas, Universidad Europea de Madrid, Madrid, España
[c] Facultad de Ciencias de la Salud, Universidad Europea de Madrid, Madrid, España
[d] Servicio de Microbiología, Unidad de Seguimiento Cercano y Atención a Domicilio, Hospital General Universitario Gregorio Marañón, Madrid, España

INFORMACIÓN DEL ARTÍCULO

Historia del artículo:
Recibido el 2 de agosto de 2010
Aceptado el 11 de febrero de 2011
On-line el 20 abril 2011

Palabras clave:
Retraso diagnóstico
Serología virus de la inmunodeficiencia humana
Opt-out prueba rutinaria
Cribado virus de la inmunodeficiencia humana
Atención primaria

RESUMEN

Objetivo: Explorar las actitudes y prácticas de los médicos del primer nivel asistencial del Servicio Madrileño de Salud respecto al diagnóstico de la infección por VIH según los protocolos actuales y el grado de aceptación de la introducción de el diagnóstico de la infección VIH de forma simplificada (sin un documento aparte de consentimiento informado ni el interrogatorio acerca de las prácticas de riesgo).
Material y métodos: Estudio observacional descriptivo transversal realizado en atención primaria de salud de la Comunidad Autónoma de Madrid. La recogida de datos se hizo mediante encuestas telefónicas durante 2009.
Resultados: Se consultó a 210 médicos. El 21% ya realizaba el diagnóstico de la infección VIH de forma simplificada y el 28,6% manifestó una actitud favorable hacia las nuevas recomendaciones. El 71,4% no pedía consentimiento informado por escrito aparte y un 42% no manifestó dificultades de comunicación. Una gran mayoría opinó que la excepcionalidad en el manejo del diagnóstico de la infección por VIH, comparándola con otras infecciones de similar forma de transmisión, podría contribuir a mantener el estigma. Para un 75,2% la falta de tiempo en la consulta no representaba un problema y un 97,1% tenía la autopercepción de ser un agente esencial en el diagnóstico de la infección por el VIH.
Conclusiones: La simplificación del diagnóstico de VIH es aceptable para un porcentaje elevado de los encuestados y uno de cada cinco médicos ya lo está realizando en las consultas de atención primaria.

5.- Y en Medicina Interna, ¿qué?

SEMI
SOCIEDAD ESPAÑOLA DE MEDICINA INTERNA

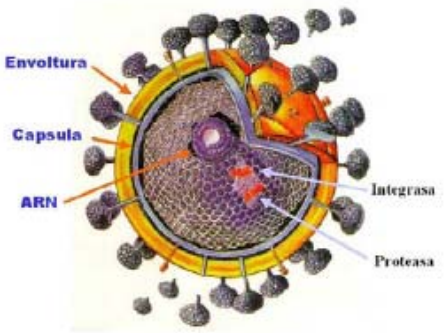
Infección VIH

Para detectar pacientes con infección VIH podemos utilizar el código de diagnóstico 042 o el V08 (infección VIH asintomática).

Durante el bienio se codificaron 21.672 (2,2%) episodios en seropositivos/infectados en MI.

El 52% de los pacientes son varones.

	Infección VIH	general
EM	12,63	9,94
edad	41,35	71,32
Peso	2,58	1,72
coste	4927€	3641€



Se trata de pacientes significativamente más jóvenes, más complejos, que están más tiempo ingresados y consumen más recursos.

Aunque sólo fallecen el 6,3% de los pacientes infectados, cuando la probabilidad de fallecer se ajusta por variables como la edad, el sexo o la comorbilidad el paciente VIH tiene 3,1 veces (IC 95% 2,9-3,3) veces más posibilidades de fallecer.

Barba R. V Jornadas en Enf Infecciosas GTEI. 2009

5.- Y en Medicina Interna, ¿qué?

428 International Journal of STD & AIDS Volume 20 June 2009

Partridge DG, et al.

HIV testing: the boundaries. A survey of HIV testing practices and barriers to more widespread testing in a British teaching hospital

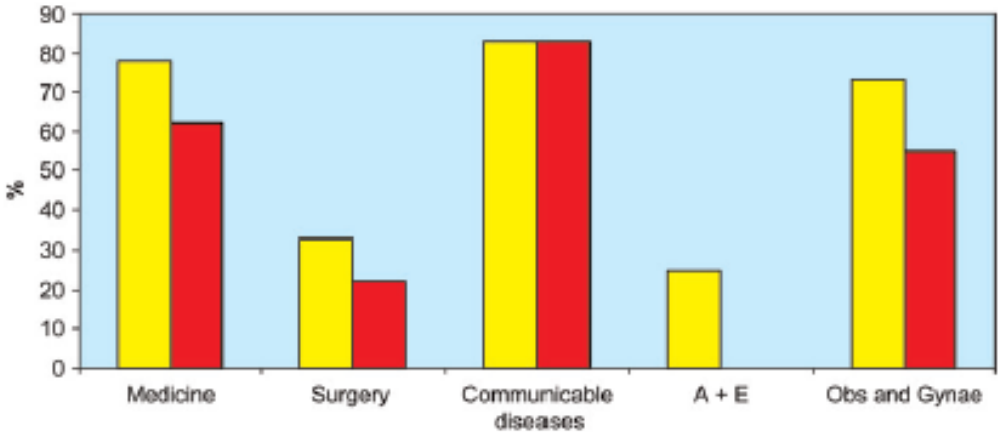


Figure 1 Percentage of respondents from individual specialty groups who had considered (light) and performed (dark) at least one HIV test over the preceding six months period. Medical registrars were significantly more likely to have performed a test than those training in surgical specialties ($P < 0.001$ consider, $P < 0.01$ perform)

A survey of HIV testing practices among registrars of all admitting specialties within Sheffield Teaching Hospitals National Health Service Trust was performed in 2007. Respondents from most specialties tested patients for HIV infrequently and several barriers were identified, which prevented testing even when the diagnosis was considered.

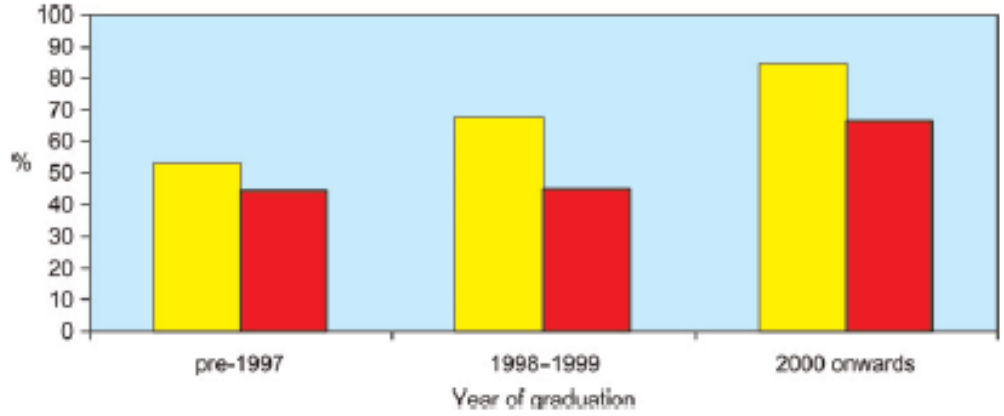
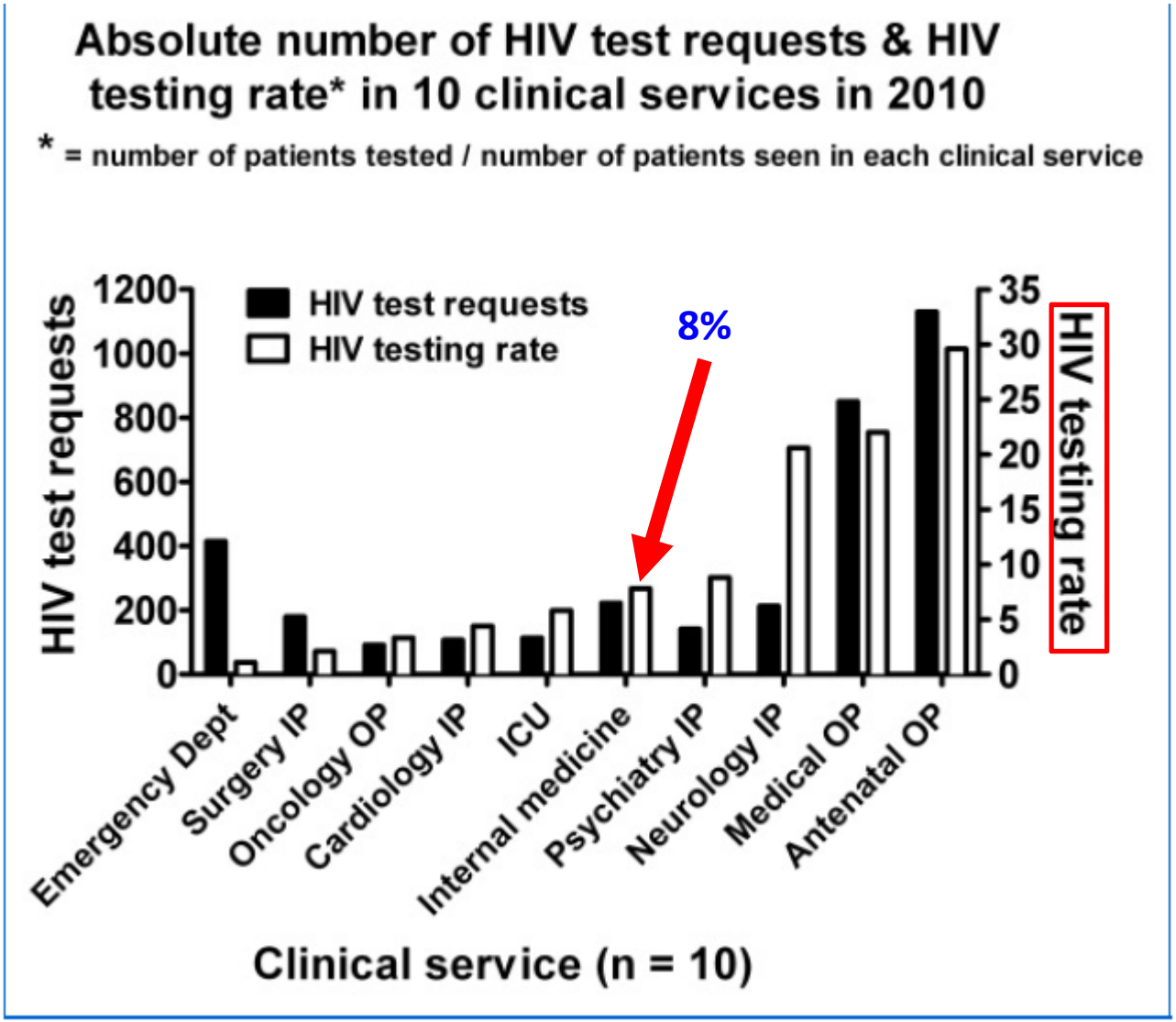


Figure 2 Relationship between year of graduation and percentage of respondents considering (light) and performing (dark) at least one HIV test over the preceding six months period. Those who qualified after 2000 were significantly more likely to have considered (85% versus 50%, $P < 0.01$) and performed (67% versus 42%, $P = 0.03$) a HIV test than those graduating prior to 1998. This difference persisted when communicable diseases and obstetric trainees were excluded

5.- Y en Medicina Interna, ¿qué?

H1-1405 - A Study of HIV Testing Practices by Clinical Service Before and After Revised Testing Guidelines in a Swiss University Hospital



K. E. Darling

CHICAACGO
51st ICAAC ~ SEPT. 17-20, 2011 ~ CHICAGO

AIDS PATIENT CARE and STDs
Volume 24, Number 3, 2010

DOI: 10.1089/apc.2009.0302

5.- Y en Medicina Interna, ¿qué?

A Multicenter Study of Internal Medicine Residents' Perceptions of Training, Competence, and Performance in Outpatient HIV Care

Karran A. Phillips, M.D., M.Sc.,[1] Joseph Cofrancesco, Jr., M.D., M.P.H.,[2] Stephen Sisson, M.D.,[2] Albert W. Wu, M.D., M.P.H.,[2] Eric B. Bass, M.D., M.P.H.,[2] and Gail Berkenblit, M.D., Ph.D.[2]

Abstract

Routine HIV screening is recommended by the Centers for Disease Control and Prevention (CDC), but it is unknown how well internal medicine residents are trained in HIV risk assessment, testing, counseling, and initial management of HIV patients. We sought to determine internal medicine residents' attitudes about HIV training and the factors that influence their HIV care performance utilizing a cross-sectional survey of 321 second- and third-year internal medicine residents from four programs in Baltimore, Boston, Detroit, and New York City between March and June 2006. Measurements included HIV care experience; attitudes, competency, and adequacy of HIV training; and basic HIV care performance and factors impacting performance. Two hundred twenty-three residents (69%) completed the survey. While 50% of residents reported over 30 HIV inpatient encounters in the past year, the majority of residents had limited outpatient exposure providing care for only 1–5 HIV outpatients. Managing HIV patients was rated an excellent educational opportunity by 89% of residents and 77% planned to care for HIV patients in the future. However, 39% stated that they did not feel competent to provide HIV outpatient care. Higher rates of residents reported deficiency in oupatient HIV training compared to outpatient non-HIV training ($p < 0.05$) or inpatient HIV training ($p < 0.05$). Residents reported substandard HIV risk assessment, testing, counseling, and initial management performance. Self-reported proficiency correlated with the number of HIV outpatients cared for and perceived training adequacy. Current residency training in HIV care remains largely inpatient-based and residents frequently rate HIV outpatient training as inadequate.

Item asked about or discussed	*All residents* % *Report performing*
Self-perceived risks for HIV	55
Sexual orientation	44
# sexual partners	47
Partners' HIV risk factors	35
History of STDs	58
Prior HIV testing	55
History of incarceration	26
HIV prevention strategies	57
Referral to HIV prevention counselor	35
HIV transmission prevention	60
Partner notification	58

TABLE 3. RESIDENTS' PERFORMANCE OF HIV RISK FACTOR ASSESSMENT, COUNSELING, AND PREVENTION BY LEVEL OF OUTPATIENT EXPOSURE AND TRAINING SATISFACTION

Item asked about or discussed	*All residents* % *Report performing*	*Residents who cared for >10 HIV outpatients vs. ≤10 HIV outpatients in past year* Odds ratio	95% Confidence interval	*Residents who perceived their HIV/AIDS ambulatory training as adequate vs. those who did not* Odds ratio	95% Confidence interval
Self-perceived risks for HIV	55	1.7	0.9, 3.3	3.3[a]	1.8, 6.0
Sexual orientation	44	1.9	0.97, 3.9	4.4[a]	2.3, 8.4
# sexual partners	47	1.8	0.95, 3.4	5.7[a]	3.0, 11
Partners' HIV risk factors	35	2.3[a]	1.1, 4.7	6.5[a]	3.2, 14
History of STDs	58	1.7[a]	0.88, 3.2	3.2[a]	1.7, 5.9
Prior HIV testing	55	2.6[a]	1.3, 5.2	3.3[a]	1.7, 6.4
History of incarceration	26	2.0[a]	0.92, 4.2	1.9[a]	0.89, 4.0
HIV prevention strategies	57	1.9[c]	1.0, 3.7	3.5[a]	1.9, 6.5
Referral to HIV prevention counselor	35	5.9[a]	2.7, 13	4.8[a]	2.4, 9.8
HIV transmission prevention	60	2.2[b]	1.2, 4.2	3.5[b]	1.9, 6.6
Partner notification	58	6.0[a]	2.7, 13.1	3.4[a]	1.8, 6.6

Adjusted for level of exposure to HIV/AIDS inpatient care, Post Graduate Year, and program.
[a]$p < 0.001$, [b]$p < 0.01$, [c]exposure to HIV/AIDS inpatient care also significant. N = 213, excludes "Don't know".

AIDS PATIENT CARE and STDs
Volume 23, Number 3, 2009

DOI: 10.1089/apc.2008.0130

5.- Y en Medicina Interna, ¿qué?

Knowledge of the Centers for Disease Control and Prevention's 2006 Routine HIV Testing Recommendations among New York City Internal Medicine Residents

Charu L. Jain, M.D., M.P.H.,[1,2] Christina M. Wyatt, M.D.,[2] Ryan Burke, M.P.H.,[1]
Kent Sepkowitz, M.D.,[1] and Elizabeth M. Begier, M.D., M.P.H.[1]

Abstract

In 2006, the Centers for Disease Control and Prevention (CDC) endorsed routine voluntary HIV testing in health care settings to identify the many HIV-infected but undiagnosed persons. Realizing this goal will require primary care providers including internal medicine physicians to order HIV tests routinely. In particular, urban internal medicine trainees who work in high HIV prevalence settings need to adopt this approach. We therefore examined the practice of routine HIV testing and to identify factors that correlate with offering HIV testing to this group. We conducted a self-administered electronic cross-sectional survey of New York City's (NYC) internal medicine residents on HIV testing-related knowledge, attitudes, and behaviors with 29 close-ended questions. Fifteen of 42 NYC internal medicine residency programs participated in early 2007. Of 1175 residents, 450 (38.3%) responded. Most (64.1%) ordered 10 or less HIV tests in the past 6 months; 32.6% were aware of the 2006 guidelines; 35.8% utilized a routine testing approach. Respondents aware of current guidelines were more likely to practice routine testing (odds ratio [OR] 3.7, 95% confidence interval [CI]: 2.4–5.6). Two common barriers to testing were procedural: time-consuming consent process (27.1%); difficulty locating consent forms (19.3%). Most (68.4%) respondents indicated that oral consent would facilitate more testing. Most NYC internal medicine residents are not routinely offering HIV tests as advised by the 2006 CDC HIV testing guidelines and continue to test patients according to perceived patient HIV risk. This is likely contributing to their low testing rates. Most identified institutional and policy barriers to routine testing. Efforts should be made to improve dissemination of guidelines and address institutional and policy barriers to allow more people to learn their HIV status.

09:30-11:30 h. Sala C

MESA REDONDA 13
EL INTERNISTA Y EL VIH: NUEVOS RETOS

Comunicaciones Orales a la Mesa Redonda:

A-252 **PROTOCOLO DIAGNÓSTICO Y SEGUIMIENTO LESIONES DE ALTO GRADO DE MALIGNIDAD DE LA MUCOSA DEL CANAL ANAL DE HSH VIH (+)**
C. Hidalgo Tenorio[1], M. Rivero Rodríguez[1], C. Gil Anguita[1], M. López de Hierro[2], P. Palma[3], A. Concha[4], J. García Castro[1], V. Sotorrio[1]
[1]Unidad de Gestión Clínica de Enfermedades Infecciosas, [2]Servicio de Digestivo, [3]Servicio de Cirugía General, [4]Servicio de Anatomía patológica. Hospital Universitario Virgen de las Nieves. Granada

A-166 **FACTORES DE RIESGO PARA LA DEFICIENCIA DE VITAMINA D EN ADULTOS INFECTADOS POR VIH**
V. Achaval-Rodriguez, C. Rinascente, M. Cervero Jiménez
Servicio de Medicina Interna. Severo Ochoa. Leganés (Madrid)

A-154 **PERSISTENCIA DE HIPERGAMAGOBULINEMIA EN PACIENTES CON INFECCIÓN POR VIH Y RELACIÓN CON LA INMUNODEPRESIÓN**
L. Engonga Obono, G. Hernando Benito, D. Bernal Bello, L. Abejón López, P. Chacón Téstor, C. Betancort Plata, E. Águila Fernández-Paniagua, M. Torralba González de Suso
Servicio de Medicina Interna. Hospital Universitario. Guadalajara

A-221 **CARACTERÍSTICAS DE PACIENTES VIH MAYORES DE 55 AÑOS QUE INICIAN TRATAMIENTO ANTIRRETROVIRAL EN LA ACTUALIDAD**
V. Núñez[1], M. Marcos[1], A. Aguilar[1], A. Del Arco[1], J. Olalla[1], J. Prada[1], M. Grana[2], J. De La Torre-Lima[1]
[1]Unidad de Medicina Interna. Hospital Costa del Sol (1). Marbella (Málaga)
[2]Servicio de Medicina Interna. Hospital de la Serranía. Ronda (Málaga)

A-228 **ESTUDIO CONFORT: ESTUDIO MULTICÉNTRICO PARA DEMOSTRAR LA EFICACIA Y SEGURIDAD DE DIFERENTES RÉGIMENES TERAPÉUTICOS CON ATAZANAVIR (ATV) NO POTENCIADO**
E. Pedrol[1], S. Ruiz[1], M. Tasias[1], 0. Araújo[1], E. Deig[2], J. Cucurull[3], A. Delegido[1], J. Blanco[4]
[1]Servicio de Medicina Interna. Hospital de Sant Pau i Santa Tecla. Tarragona
[2]Unitat VIH. Hospital General de Granollers. Granollers (Barcelona)
[3]Servicio de Medicina Interna. Hospital de Figueres. Figueres (Girona)
[4]Unidad de Infecciosas. Hospital San Pedro. Logroño (La Rioja)

A-211 **NUEVOS DIAGNÓSTICOS DE INFECCIÓN POR EL VIRUS DE LA INMUNODEFICIENCIA HUMANA (VIH) ¿QUÉ HA CAMBIADO EN LOS ÚLTIMOS AÑOS?**
E. López Tinoco[1], A. Fernández Rodríguez[1], M. Soto Cárdenas[1], P. Romero Cores[1], C. Fernández Gutiérrez del Álamo[2], F. Guerrero Sánchez[1], J. Girón González[1]
[1]Servicio de Medicina Interna, [2]Servicio de Microbiología Clínica. Hospital Universitario Puerta del Mar. Cádiz

A-236 **CARACTERÍSTICAS CLÍNICAS Y EPIDEMIOLÓGICAS DE LOS PACIENTES CON NUEVO DIAGNÓSTICO DE VIH VISTOS EN UNA CONSULTA DE ENFERMEDADES INFECCIOSAS**
V. Sendín Martín, P. Ruiz Artacho, N. Sánchez Martínez, B. González Casanova, E. Agrela Rojas, P. González de Lara, Á. Molino González, J. Vergas García
Servicio de Medicina Interna III. Hospital Clínico San Carlos. Madrid

A-161 **INFESTACIÓN POR STRONGYLOIDES STERCORALIS EN PACIENTES CC INFECCIÓN POR EL VIH**
M. Martínez Sela[1], N. Morán Suárez[1], M. Rodríguez[2], F. Pérez González[2], V. Cárcaba[1], J. Cartón[1], A. Rodríguez Guardado[1]
[1]Servicio de Medicina Interna, [2]Servicio de Microbiología. Hospital Universitario Central de Asturias. Oviedo (Asturias)

A-21 **EL PAPEL DE LOS CD4 NADIR EN LA APARICIÓN DE ATEROSCLEROSIS SUBCLÍNICA EN PACIENTES INFECTADOS POR EL VIH**
C. Hidalgo Tenorio[1], F. Jarilla Fernández[1], M. Arenas Miras[2], P. Baños[2], M. Rivero[2], J. Pasquau[1], C. García[1], M. López Ruz[1]
[1]Unidad de Enfermedades Infecciosas, [2]Servicio de Medicina Interna. Hospital Universitario Virgen de las Nieves. Granada

A-217 **ANÁLISIS DEL PAPEL DE LA SIMPLIFICACIÓN DEL TRATAMIENTO ANTIRRETROVIRAL EN PACIENTES VIH EN LA ACTUALIDAD**
V. Núñez[1], F. Jiménez-Oñate[2], J. Santos[1], D. Narankiewicz[2], R. Palacios[3], M. Marcos[1], A. Aguilar[1], J. de la Torre-Lima[1]
[1]Unidad de Medicina Interna. Hospital Costa del Sol (1). Marbella (Málaga)
[2]Servicio de Enfermedades Infecciosa. Complejo Hospitalario Carlos Haya. Málaga
[3]Unidad de Gestión de Enfermedades Infecciosas. Complejo Hospitalario Virgen de la Victoria. Málaga

A-190 **SÍNDROME DE RECONSTITUCIÓN INMUNE EN LOS PACIENTES CON INFECCIÓN VIH**
A. Arca, M. Camba, L. Novoa, H. Enríquez, S. Araújo, J. De la Fuente
Servicio de Medicina Interna. Hospital Povisa S.A. Vigo (Pontevedra)

A-16 **VIRUS DEL PAPILOMA HUMANO Y ANORMALIDADES CITOLÓGICAS EN LA MUCOSA DEL CANAL ANAL DE HOMBRES QUE TIENEN SEXO CON HOMBRES (HSH) INFECTADOS POR EL VIRUS DE LA INMUNODEFICIENCIA HUMANA (HIV)**
C. Hidalgo Tenorio[1], M. Rivero Rodríguez[1], A. Concha[2], R. López Castro[2], M. López de Hierro[3], J. Pasquau[1], M. López Ruz[1], C. Gil[1]
[1]Unidad de Gestión Clínica de Enfermedades Infecciosas, [2]Servicio de Anatomía Patológica, [3]Servicio de Digestivo. Hospital Universitario Virgen de las Nieves. Granada

RV-115 **LAS TABLAS SCORE SUBESTIMAN EL RIESGO CARDIOVASCULAR EN PACIENTES CON VIH**
S. Serrano[1], V. Estrada[1], D. Gómez-Garre[1], M. Ávila[1], M. Fuentes-Ferrer[2], C. Sánchez-Parra[1], T. Sainz[3], M. De Carranza[1]
[1]Servicio de Medicina Interna, [2]Servicio de Medicina Preventiva. Hospital Clínico San Carlos. Madrid
[3]Laboratorio de Inmunobiología. Hospital General Gregorio Marañón. Madrid

RV-117 **LAS TABLAS DE FRAMINGHAM SUBESTIMAN EL RIESGO CARDIOVASCULAR EN PACIENTES CON VIH**
S. Serrano[1], V. Estrada[1], D. Gómez Garre[1], M. Fuentes Ferrer[2], T. Sainz[3], C. Sánchez[1], M. De Carranza[1], A. Fernández Cruz[1]
[1]Servicio de Medicina Interna, [2]Servicio de Medicina Preventiva, [3]Laboratorio de Inmunobiología. Hospital Clínico San Carlos. Madrid

A-56 **PRESENTACIÓN Y EVOLUCIÓN DE LA HIPERTENSIÓN PORTAL IDIOPÁTICA EN PACIENTES VIH. COMPARACIÓN CON HTP CIRRÓTICA POR VHC**
O. Marín Casajús[1], M. Sánchez[2], J. Berenguer[2], D. Rincón[3], R. Bañares[3], B. Padilla[2], P. Miralles[2]
[1]Servicio de Medicina Interna (UMID). Hospital General Gregorio Marañón. Madrid
[2]Servicio de Enfermedades Infecciosas-VIH, [3]Unidad de Hepatología. Hospital General Universitario Gregorio Marañón. Madrid

A-125 **PREVALENCIA DE ATEROSCLEROSIS SUBCLÍNICA, EVALUADA A TRAVÉS DEL GROSOR ÍNTIMA-MEDIA CAROTÍDEO, EN PACIENTES INFECTADOS POR VIH TRATADOS CON ZIDOVUDINA**
A. Gullón, D. Real de Asúa, A. Salas, J. Sanz, I. De los Santos
Servicio de Medicina Interna y Enfermedades Infecciosas. Hospital Universitario de la Princesa. Madrid

A-287 **DIFERENCIAS DE GÉNERO EN LA TOLERANCIA Y TOXICIDAD DEL PACIENTE VIH FRENTE A EFAVIRENZ ¿UNA CUESTIÓN DE SEXO?**
M. Marcos Herrero[1], M. Márquez[2], J. Colmenero[4], M. Grana[5], S. Fernández[6], F. Rivas[3], A. Del Arco[1], J. De la Torre[1]
[1]Servicio de Medicina Interna, [3]Unidad de Investigación. Hospital Costa del Sol (1). Marbella (Málaga)
[2]Servicio de Enfermedades Infecciosas. Complejo Hospitalario Virgen de la Victoria. Málaga
[4]Servicio de Enfermedades Infecciosas. Complejo Hospitalario Carlos Haya. Málaga
[5]Servicio de Medicina Interna. Hospital de la Serranía. Ronda (Málaga)
[6]Servicio de Medicina Interna. Hospital Comarcal de la Axarquía. Vélez-Málaga

A-207 **COMPLICACIONES NO INFECCIOSAS EN LA INFECCIÓN POR VIH**
F. Sánchez-Barranco Vallejo[1], C. Ferrer Perales[1], M. Martín Macho[2], Y. Bombín Molinero[1], R. Carvajal Martínez[1], P. Benito García[1], J. Gómez Barquero[1], J. Sánchez Navarro[1]
[1]Servicio de Medicina Interna, [2]Servicio de Medicina Intensiva. Complejo Asistencial de Palencia. Palencia

A-204 **CAUSAS DE INGRESO HOSPITALARIO Y MORTALIDAD EN PACIENTES VIH EN ERA TARGA**
F. Sánchez-Barranco Vallejo[1], Y. Bombín Molinero[1], S. Maestro Antolín[1], M. Martín Macho[2], C. Ferrer Perales[1], J. Sánchez Navarro[1], J. Da Cruz Soares[1], R. Carbajal Martínez[1]
[1]Servicio de Medicina Interna, [2]Servicio de Medicina Intensiva. Complejo Asistencial de Palencia. Palencia

A-31 **CARACTERÍSTICAS CLÍNICAS DE LA TUBERCULOSIS EN LA ACTUALIDAD EN ARAGÓN. IMPLICACIONES DE LA INFECCIÓN POR VIH, LA INMIGRACIÓN Y LAS RESISTENCIAS**
M. Crespo Avellana, P. Casanova Esteban, A. Comin Orce, N. Guiral Fernández, A. Pardillos Tome, C. Ramos Paesa, A. Pascual Catalán, A. Ballester Luna
Servicio de Medicina Interna. Hospital Universitario Miguel Servet. Zaragoza

A-279 **¿POR QUÉ INGRESAN LOS PACIENTES CON INFECCIÓN VIH/SIDA 30 AÑOS DESPUES DEL COMIENZO DE LA PANDEMIA?**
C. Maldonado Úbeda, P. Sánchez López, M. Esteban Moreno, G. Parra García, B. Hernández Sierra, S. Domingo Roa, A. García Peña, L. Díez García
Servicio de Medicina Interna. Complejo Hospitalario Torrecárdenas. Almería

A-96 **RETRASO EN EL DIAGNÓSTICO DE NUEVOS CASOS DE INFECCIÓN POR VIH GRUPO ACYLEI**
E. Martínez Velado, A. Chocarro Martínez, C. Martín Gómez, F. Álvarez Navia, M. Chimeno Viñas, A. De la Vega Lanciego, J. Soto Delgado, F. Martín Cordero
Servicio de Medicina Interna. Complejo Asistencial de Zamora. Zamora

JUEVES, 27 DE OCTUBRE

17:45-18:30 h **SALA C**
CONFERENCIA 4
EL ZURDO Y LA MEDICINA
Moderadora: Dra. Adela Francés Urmeneta
Unidad de Enfermedades Infecciosas y Medicina Tropical
Hospital Universitario Insular de Gran Canaria
Las Palmas de Gran Canaria
Ponente: Dr. Manuel Sosa Henríquez
Unidad Metabólica Ósea. Servicio de Medicina Interna
Hospital Universitario Insular de Gran Canaria
Las Palmas de Gran Canaria

18:30-19:00 h **PAUSA-CAFÉ**

18:30-20:30 h **SALA 7**
REUNIÓN DE RESIDENTES DE MEDICINA INTERNA
Moderadores: Dra. Blanca Pinilla Llorente
Servicio de Medicina Interna
Hospital General Universitario Gregorio Marañón. Madrid
Dr. Sergio Serrano Villar
Servicio de Medicina Interna
Hospital Clínico San Carlos. Madrid
Dr. Cristian Gómez Torrijos
Servicio de Medicina Interna
Hospital de la Plana. Villareal, Castellón

18:30-19:15 h **Mesa Redonda 1**
Caso clínico interactivo VIH. Varón de 25 años con recién diagnóstico de VIH. ¿Cuándo y con qué empezar el tratamiento antiretroviral?
Ponente: Dr. Rafael Rubio García
Servicio de Medicina Interna
Hospital 12 de Octubre. Madrid

6.- Conclusiones

Recomendaciones para Población General

- Es **recomendable realizarse una prueba de VIH** si:
  - Se han mantenido **relaciones sexuales con penetración sin usar el preservativo** con una o varias parejas de las cuales se desconocía si estaban infectadas o no. Debería utilizarse siempre el preservativo, también con la pareja estable a no ser que las dos personas sepan que no tienen el VIH.
  - Se ha **compartido el material utilizado para inyectarse drogas**.
  - Se ha tenido **alguna infección de transmisión sexual**.
  - Se está **embarazada o piensa tener un hijo**.
  - Se tiene **una pareja estable y se quiere dejar de utilizar el preservativo** en las relaciones sexuales.

XXXII Congreso Nacional de la SEMI
XIV Congreso de la Sociedad Canaria de Medicina Interna
26-28 Octubre 2011

6.- Conclusiones

¿Es posible diagnosticar antes el VIH en Medicina Interna?

Sí

Opt-Out u Opt-In

pero

OptA

por pedir más la serología VIH

Juan E. Losa.
Hospital U. F. Alcorcón. Universidad Rey Juan Carlos.