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Growth failure is important factor in the survival rate of HIV-infected children

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Poor growth is common for human immunodeficiency virus (HIV) 1 infected children and growth failure carries a poor prognosis for survival. Between 50% to 80% of HIV-infected children show below average growth. HIV-infected children with growth failure have, in some studies, a five-fold risk of early death.^{1,2,3}

Differences in weight, length and head circumference between uninfected newborns born to HIV-infected mothers and HIV-infected newborns vary with at least one study⁴ showing no difference and others showing slightly lower birth weights and lengths in HIV-infected newborns.¹ Gestational age is slightly lower in HIV-infected newborns.⁴ In one study, uninfected infants born to HIV-positive mothers had similar weight for age at birth when compared to infants born to HIV-negative mothers. Length for age at birth was lower in HIV-exposed infants but this measure was not statistically significant when correcting for maternal smoking and drug use during pregnancy. Length for age remained lower for HIV-exposed babies at 18 months of age, even when corrected for maternal smoking and drug use during pregnancy.⁵

Although wasting greater than 10% weight loss over two months is seen in at least 17% of HIV-infected children,³ stunting (below average height for age with normal weight for height) is more likely to occur.^{6,7} Growth velocities are lower in HIV-infected children when compared to uninfected controls with

linear growth most affected. The changes in postnatal growth are evident as early as three months. Body composition changes in HIV-infected children are similar to HIV-infected adults with preferential loss of lean body mass.¹ Several possibilities exist for growth failure in HIV-infected children including poor intake, malabsorption due to gastrointestinal

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A clinician's dilemma: diminished capacity in HIV/AIDS patients

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Informed consent is the legal and ethical touchstone for all professionals practicing in the health care field. Making sure that the patient understands and consents to his or her course of treatment can be a difficult task under normal circumstances. This problem becomes much more complicated if the clinician has good reason to believe that the patient is not able to make informed decisions. For clients with

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Medicine

Changes in postnatal growth are evident as early as 3 months

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disease, increased energy utilization, micronutrient deficiencies, and endocrine dysfunction.

HIV-infected children have ample reasons for poor intake. Caloric intake may be limited due to poor socioeconomic conditions and/or anorexia. Children with HIV encephalopathy may have trouble swallowing or may suffer from aspiration. Oral and esophageal lesions may limit intake secondary to dysphasia. Despite many reasons for decreased intake, HIV-infected children in developed countries consume at or above RDA requirements for energy and micronutrients.^{3,7} Energy intake was lower in HIV-infected children with growth failure (GF+) than HIV-infected children without growth failure (GF-) in one study² but not another.⁸ Symptomatic children may have periods of decreased intake during acute infections which impair growth but studies in HIV-infected children have been conducted during periods of wellness. Nutritional supplementation with or without use of a gastrostomy tube has been shown to increase weight but not lean body mass in HIV-infected children.⁹

Gastrointestinal disease limits growth in children with other chronic diseases due to malabsorption, abdominal pain and vomiting. HIV-infected children develop lactose intolerance early and many have

steatorrhea.^{9,10} In addition, HIV-infected children are susceptible to many of the enteric infections acquired by HIV-infected adults. Many of these enteric infections can cause small bowel injury leading to malabsorption. Bacterial overgrowth due to immune deficiency, hypochlorhydria and/or acid-blocking agents increase the risk of enteropathy in HIV-infected children.⁷ Gastrointestinal disease may not be responsible for all growth problems. Sentongo et al¹⁰ did

In some studies, HIV+ children with growth failure have a five-fold risk of early death.

not see an association between steatorrhea and growth failure.

Growth failure in HIV-infected children may not only be the result of poor intake but may also be due to increased metabolic demand or "hypermetabolism." Studies on energy expenditure in HIV-infected children are limited. Resting energy expenditure (REE) reflects basal metabolism. Unlike in adults, children with HIV do not have increased REE. Furthermore, no difference in REE is seen between HIV-uninfected and HIV-infected

children or between GF+ HIV-infected children and GF- HIV-infected children. Total energy expenditure (TEE), which accounts for all energy required for daily living, may be a more accurate reflection of metabolism demand in children. Energy intake minus TEE was significantly lower in HIV GF+ children than HIV GF- children.^{2,8}

Micronutrient deficiencies are more frequent and pronounced in HIV-infected children living in developing nations. In developed countries, lower levels of micronutrients such as beta-carotene, retinol and vitamin E have been seen in a few studies. The role of micronutrients in HIV infection has been extensively evaluated with most studies performed in developing nations. The exact role micronutrients play in HIV infection remains unclear. Vitamin A-deficient mothers were more likely to transmit infection to their infants in some studies but not in others. In one large US study, lower maternal vitamin A levels were associated with more rapid disease progression in their HIV-infected infants. In some countries, vitamin A-deficient HIV-infected children were more likely to be stunted and/or have increased mortality. Causality between micronutrient deficiency and HIV disease progression is difficult to prove since whether micronutrient deficiency adversely affected health in HIV-infected children or whether HIV infection resulted in



micronutrient deficiency can not be elucidated from these studies. Results of clinical trials of micronutrient supplementation have been mixed. Trials of vitamin A supplementation have used varying doses of vitamin A and different dosing regimens. Most, but not all, show an overall improvement in HIV morbidity and mortality, especially in diarrhea-related illnesses. Zinc supplementation in many studies resulted in decreased rates of respiratory tract and diarrhea-related disease, although this benefit was not consistently seen. Improvement in growth parameters including weight, height and lean body mass occurred in vitamin A and zinc supplemented children in some studies. Other nutrient deficiencies found in HIV-infected children who live in developing countries include vitamin D, iron, and vitamin B6.^{11,12} The relationship between these micronutrients in HIV infection is largely unknown. More research is needed to evaluate the long-term effect of micronutrient supplementation in at-risk HIV-infected children.

Endocrine dysfunction has been detected in HIV-infected children. Frank thyroid or adrenocortical disease is rarely found but subtle biochemical abnormalities may be more common. The combination of low free thyroxine (T4), elevated thyroid-stimulating hormone (TSH), elevated thyroid-binding globulin (TBG) with normal reverse 3,5,3'-triiodothyronine is unique to HIV infection. Low levels of growth hormone as well as insulin-like growth factor (IGF 1) and somadomedin C have been detected in many studies of

HIV-infected children. Growth hormone deficiency has been implicated as a cause of wasting in HIV-infected adults and poor linear growth in HIV-infected children. Studies using growth hormone replacement in HIV-infected children have shown some improvement in linear growth and lean body mass.^{13,14} Poor calcium homeostasis may adversely affect bone mineralization contributing to poor growth. Bone mineral density (BMD) in HIV-infected females was low in one study. Findings associated with the low BMD were elevated serum parathyroid and 1,25-dihydroxyvitamin D. Calcium intake was below average for these girls. In addition, high urinary calcium excretion, high levels of urine N-telopeptide and elevated serum total alkaline phosphatase suggested increased bone reabsorption despite poor calcium intake.¹⁵ Sexual maturation is frequently delayed in HIV-infected children. Both males and females were affected in one study. Immunologic

status, clinical status and use of antiretroviral medications were not related to degree of pubertal delay.¹⁶ Use of testosterone derivatives in adult HIV-infected patients has resulted in improved muscle bulk, weight and strength. In HIV-infected children, use of an oral testosterone derivative, oxandrolone, for a short period showed transient increases in muscle mass and decreases in body fat.¹⁷ More studies on the long-term use of anabolic steroids in HIV-infected children are needed.

The most consistent finding in studies on growth in HIV-infected children is that growth is related to virologic and immunologic status. Viral RNA and CD4 count are inversely and directly related to rate of growth.^{1,4,18} Protease inhibitors (PI) have made a significant impact on morbidity and mortality rates in HIV-infected children. The impact of PI therapy on growth has been evaluated in many recent studies. Nachman et al¹⁸ noted a decline in height and weight z scores in antiretroviral (ARV)-experienced children after starting a ritonavir-containing regimen. Most studies, however, show improvement in growth parameters after PI therapy.¹⁹⁻²³ Improvement in growth was associated with virologic response in one study²² but not another.²³ ARV-experienced patients (non-PI) had no significant improvement in growth after starting PIs in one study.²² In another study, only growth-stunted patients under three years of age at start of PI therapy had improvement in growth.²¹ The growth parameter

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Medicine

Research needed on longterm effects of HAART on children

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most likely affected was height z score and height velocity.¹⁹⁻²³ Weight z score improved in some studies.^{19,20,22} Weight/height z score and muscle mass showed improvement in one study.¹⁹ Some children experienced “catch-up” growth after starting PIs while others experienced only a slower decline in growth.

Recovery of growth after PI therapy may be associated with improvement in endocrine function. Van Rossum et al²⁴ demonstrated increased IGF-1 and IGF's complexed to specific, structurally homologous binding proteins (IGFBP-3) levels after PI therapy and proposed that PI therapy restored normal sensitivity to growth hormone.

Metabolic complications of PI therapy seen in adult patients have been reported in children. Lipodystrophy syndrome, dyslipidemia and insulin resistance have been reported in HIV-infected children. It is unknown what long-term cardiovascular risk these metabolic complications place in children, but presumably the risks are similar to adults. Switching to a non-PI ARV regimen has resulted in improvement in lipid profiles in HIV-infected adults but data in children are limited. Mitochondrial toxicity resulting in hyperlactatemia has been reported in infants exposed to nucleoside reverse transcriptase inhibitors (NRTI) resulting in neurologic complications,

Decreased bone mineral density after PI therapy has been reported in a few studies. Both hyperlactatemia and osteopenia may impair growth.²⁵ Highly effective antiretroviral therapy (HAART) has improved the lives of HIV-infected children but more research on the long-term effects of these agents on growth and development is imperative.❖

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Legal

Getting informed consent can be difficult for HIV clinicians

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HIV, this may become particularly problematic.

People infected with HIV often experience some form of cognitive/motor impairment. This malady has been referred to under several names, including AIDS Dementia Complex (ADC), AIDS-related neurologic impairment, HIV encephalopathy, and HIV-1-associated cognitive/motor complex. It has been estimated that approximately 90% of people who die with AIDS experience some degree of neuropathologic abnormalities. Recent estimates are that 20% to 30% of HIV-positive persons eventually develop impairments severe enough to support a diagnosis of AIDS dementia.¹

In addition, the general aging of the US population is reflected in statistics about the HIV/AIDS population. On a national basis, 1% of men and women are diagnosed with HIV when they are older than 65; 6% are 50 or older. For AIDS diagnoses, the figures are higher—12% of men and women are diagnosed with AIDS when they are over 50, and for women 5% are over 60 and 3% over 65 when they are diagnosed with AIDS.² In Louisiana, 3.2% of all people living with HIV/AIDS at the end of 2002 were over 60 years old.³

Making sure clients exercise informed consent

For clients having problems making decisions, the law

permits certain others to make decisions for them in the event they are unable to do so for themselves. Generally spouses may do so for each other, parents for children, and the like.⁴ But for many people, the laws designating those who can consent for them are not effective or desirable. They may be alienated from their next of kin, or their close relatives may live far away, or their relatives may be elderly and have serious health issues of their own. If there are several persons in the same degree of relation to the ill person, obtaining consent from all of them may pose problems. Many people with HIV may not have disclosed their status to family members due to the stigma associated with an HIV diagnosis. In addition, some people might want a long-term partner (to whom they are not married) to make these decisions. For individuals in such situations, medical powers of attorney may be the only solution, and the legislatures in Arkansas, Louisiana and Mississippi have provided a method for accomplishing this purpose.

The Arkansas “Durable Power of Attorney for Health Care Act” allows an individual (hereinafter called “the patient”; in legal terminology the person executing a power of attorney is usually called “the principal”) to designate another to make medical decisions in the event the patient no longer can do so.⁵ This document can cover any

care, treatment, service, or procedure to maintain, diagnose, treat, or provide for the patient’s physical or mental health or personal care. The power of attorney must be in writing and signed by the patient, or by someone acting at the patient’s direction and in the patient’s presence. The document must also be signed in the presence of at least two competent witnesses who are at least eighteen years old. A notary public is not required. Patients need to state clearly what conditions will trigger the directive—terminal illness, permanent unconsciousness, incurable debilitating diseases or injuries for which there is no hope of recovery, or a prolonged “intolerable quality of life.” The durable power of attorney for health care does not include the authority to refuse life-sustaining treatment unless the instrument specifically gives this authority or is used in conjunction with an advance directive that specifies the patient’s medical treatment decisions. The authority is separate from a living will or a do not resuscitate (DNR) order which is covered by the Arkansas Rights of the Terminally Ill and Permanently Unconscious Act⁶ and Arkansas Emergency Medical Services Do Not Resuscitate Act.⁷

In Louisiana, a power of attorney for health care may authorize another to “make health care decisions such as surgery, medical expenses,

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Legal

Patients are sometimes reluctant to take appropriate legal steps

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nursing home residency, and medication.”⁸ This power of attorney can consist of an act before a notary public and two witnesses, or any writing, or may even be oral (not recommended due to problems of proof).⁹ The agent must agree to act on the patient’s behalf, but acceptance does not have to be in writing and can be inferred from the agent’s actions. A power of attorney for health care must contain a special provision if the agent is to have the authority to make end-of-life decisions, and in that event the health care power of attorney must follow the requirements for a living will.¹⁰ In Louisiana, health care powers of attorney generally go into effect immediately. However, the act can be written so that it goes into effect only upon the patient’s disability, in which case two physicians who have personally examined the patient must sign a document certifying to the patient’s disability before a notary public.¹¹ (The medical power of attorney may provide that this certification be signed by just one physician and the agent.)¹² Note that in 2001, Louisiana enacted a separate set of laws for advance medical directives for mental health care, and a regular medical power of attorney is probably insufficient to cover mental health treatment.¹³

In 1998, Mississippi adopted the Uniform Health-Care

Decisions Act.¹⁴ Under this law, an adult or emancipated minor may execute a power of attorney for health care. Unless otherwise specified, the agent’s authority becomes effective only upon a determination that the patient lacks capacity, and ceases to be effective upon a determination that the patient has recovered capacity. Unless otherwise specified, both of these determinations must be made by the primary physician. The agent is to make health-care decisions in accordance with the patient’s instructions and best interest, and the agent’s decisions do not need approval by a judge or court. The document can also include the patient’s nomination of a guardian if one is needed. To prevent abuse, nursing home residents cannot name owners and employees of the facility as their agents, unless they are related to the patient.

As a matter of form, the power of attorney must be in writing, contain the date of its execution, be signed by the patient, and be witnessed by at least two individuals who saw the patient either sign the document or acknowledge it. The witnesses must sign a declaration under penalty of perjury that they are not the agent and that they are not a health-care provider, or an employee of a health-care provider or facility. In addition, one of the witnesses must not be related to the patient by blood, marriage or adoption, or be entitled to any part of the patient’s estate under a will in

existence or by operation of law. A second option provides that the power of attorney may be acknowledged before a notary public.

In addition to authorizing someone else to make medical decisions, all three States permit a person to designate another to take care of his or her financial affairs.¹⁵ Clinicians will rarely need to look at such documents, but they should be aware that their patients may have given this authority to someone else.

Interdictions and Curatorships

A health care power of attorney provides a clear course for the practitioner. But if the patient has not executed one before becoming incompetent (and of course may not do so *while* incompetent), the general laws on medical consent come into play.¹⁶ But, as mentioned earlier, there are a number of reasons why many patients may not have spouses or relatives available to make decisions for them—distance, expenses of travel and taking off work, poor relationships, the lack of legal status for unmarried partners. Distant relatives may be particularly reluctant to make such decisions. Clinicians should note that these laws permit spouses and relatives to make health care decisions, but the laws do not require them to do so.

For patients in this situation, the only alternative may be a guardianship, called an interdiction in Louisiana. In



Arkansas, guardianship is necessary if a court finds someone incapacitated and that person has not already given someone else the authority to make decisions. Since the capabilities and needs of individuals vary greatly, the Arkansas legislature provided for flexibility in the guardianship statute. There are two basic types of guardianship duties: those pertaining to the person, like medical treatment received and where the person lives; and those pertaining to the estate, or financial decisions. Some people may need only one type of guardian, while others may require a guardian both for the person and the estate. Most importantly, the statute allows for different degrees of guardianship. A plenary (total) guardian is appointed only when the court determines that the patient (called the “ward”) is totally without the capacity to care for him/herself. An order establishing a plenary guardianship over an individual has far-reaching effects, and keeps the ward from being able to make any important decisions for him/herself without the guardian’s consent.¹⁷ Guardianship also may be limited, giving only specifically described powers to the guardian. Thus, a person could have a limited or plenary guardian of the person and/or a limited or plenary guardian of the estate

A court in Arkansas can appoint a temporary guardian, but only for emergencies—“imminent danger to the life or health of the incapacitated person or of loss, damage, or waste to the property of an

incapacitated person.” The appointment can be made without notice, but notice must be served on the ward within seventy-two hours of the entry of temporary guardianship. A guardian’s duties also may be modified whenever the individual’s capacity to care for his/her person and/or estate has changed so as to warrant modification or discharge.¹⁸

In Louisiana, an interdiction takes decision-making ability away from an incompetent person and hands it over to a third party. The law regarding interdiction in Louisiana has

Clinicians should inform patients of the pitfalls of failing to make advance medical directives.

recently undergone a major revision, and new revisions went into effect on July 1, 2001. Interdiction is a harsh remedy; one Louisiana court noted, “A judgment of interdiction is, in the final analysis, a pronouncement of civil death without the dubious advantage of an inscription thereof on a tombstone.”¹⁹ The interdict loses control over where he will live, how he will spend his money, medical decisions, and virtually every aspect of his life. A court may order the full interdiction of someone who “is unable consistently to make reasoned decisions regarding the

care of his person and property, or to communicate those decisions, and whose interests cannot be protected by less restrictive means.”²⁰ The new standard for full interdiction focuses on the defendant’s capacity to care for himself and his property rather than on labeling the defendant as one suffering from a specific mental or physical disability. Louisiana also provides for a limited interdiction which can be ordered when there is incapacity concerning the “person or property, or any aspect of either.”²¹ Courts can also order a 10-day temporary or a 30-day preliminary interdiction “... when there is a substantial likelihood that grounds for interdiction exist and substantial harm to the health, safety, or property of the person sought to be interdicted is imminent.”²²

A temporary interdiction can be granted without a hearing if “immediate and irreparable injury, loss, or damage” will occur before a hearing can be held.²³ A preliminary interdiction requires a hearing. An interdiction may be modified or terminated as necessary.²⁴

In Mississippi, guardians can be appointed for incompetent adults, a person of unsound mind, as well as for alcoholics and drug addicts.²⁵ The term “unsound mind” includes “idiots, lunatics and persons *non compos mentis*.”²⁶ Guardians may be appointed over the person and/or over the property of the “ward” under court authority and direction, and the guardian must make an annual accounting to the court.²⁷ The court must examine the alleged incompetent in person.²⁸

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Laws can differ in the three Delta states

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The Mississippi version of guardianship is more restrictive and less flexible than the laws in Louisiana or Arkansas. Mississippi law makes no distinction between a full or limited guardianship, and guardians cannot be appointed on a temporary or limited basis. Despite the limited scope of Mississippi's guardianship laws, Mississippi's medical consent laws are more flexible, and situations which would otherwise be covered by temporary, limited or preliminary interdiction or guardianship in Louisiana or Arkansas are handled under medical consent laws. Mississippi permits a clerk of court or judge to enter an order authorizing medical or surgical treatment for an adult of unsound mind solely on the basis of a written certification by a licensed physician that there is an immediate or imminent necessity for the treatment or procedures.²⁹

Conclusion

While many patients may want to protect their right to maintain control over their medical care, those same patients may be reluctant to take the appropriate steps to do so. Clinicians should inform their patients of the pitfalls of failing to make advance medical directives—that decisions may be made for them by relatives

from whom they are estranged, or in extreme circumstances that a court may have to appoint someone to make medical decisions for them. Clinicians should also encourage patients to take steps early in the disease stage so that there is no question about their competence to execute the documents in question.❖

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11. La. R.S 9:3890
12. La. R.S 9:3890
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15. Miss. Code Ann. § 87-3-101 et seq.; A.C.A. § 28-68-401 et seq.; La. C.C. Art. 2997.
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27. Miss. Code Ann. § 93-12-121.41-41-205
28. *Id.*
29. 14. Miss. Code Ann. § 41-41-9

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Dentistry

Complication risks of invasive procedures on HIV+ patients

Kishore Shetty, DDS

Complications may result from dental procedures in any healthy individual. There is an abundance of literature on the risks of prolonged postoperative bleeding, delayed wound healing, alveolitis, oral wound or distant site infection whenever dental procedures are performed. However, there is very limited published scientific evidence available to guide clinicians in regard to possible increased risks of oral procedures associated with the HIV status of the patient. A review conducted in 2000 by the Agency for Healthcare Research and Quality concluded that only a few studies have been reported, and only two types of procedures, root canal therapy and simple extractions, have been investigated. This article is an attempt to review the scientific literature since then, and make general recommendations. This review also lists treatment planning guidelines to help the dental provider while providing care to the HIV-positive patient.

Dental Extractions

Immunologically-compromised patients are unable to generate sustained, controlled and effective immune responses when subjected to external trauma. This universally accepted notion is in turn reflected by the high risk of postsurgical complications in these subjects. Consequently, it has been suggested that the risk of complications in HIV-positive patients subjected to dental extractions is presumably much

higher than in the general population.

In 1997, Dodson reported finding no difference in a prospective study of complication rates between HIV-positive and HIV-negative patients undergoing tooth extractions at Grady Memorial Hospital, Atlanta, from 1993 to 1996. Post extraction complications that varied in prevalence between the studies included persistent bleeding, persistent pain, localized alveolitis, local wound infection and delayed wound healing. However, a retrospective study conducted by the same author in 1988-89 at the Veterans Affairs Medical Center, San Francisco, found that the postextraction complication rates among groups of HIV-positive patients were higher and that the risks increased with increased levels of immune suppression. When these results were adjusted for age, preoperative antibiotic coverage and tobacco use, the difference in complication rates was no longer statistically significant. Two other studies found no significant difference between postoperative complications in the HIV-positive and HIV-negative groups, although the HIV-positive groups tended to have more complications. Nevertheless, across all studies, the postoperative complications were rather minor, and were treated on an outpatient basis.

Implant Surgery

Although there has been relatively little research on the

effects of providing dental implants for individuals with HIV, it appears that implant surgery can be successfully provided for many patients. Experts have suggested that there is no difference in the rate of postoperative complications or osseous integration for implant patients with or without HIV infection. Treatment planning must be done on an individual basis in therapeutic partnership between providers and patient.

Endodontics and Apex Surgery

It has been suggested that endodontics and apex surgery in HIV-positive patients should be carried out early, and that the management approach is conditioned by the symptoms, the existence of prior endodontics, the importance of the affected tooth, the oral condition of the patients, and state of immune suppression. The incidence of complications derived from conventional endodontics in the HIV-positive patient is similar to that reported in the general population. Consequently, it has been suggested that no special precautions are required in HIV-positive individuals, and prophylactic antibiotics and anti-inflammatory medication are not recommended unless indicated.

Periodontal treatment

The treatment of periodontal lesions is complex, for the aims of management range from

See *Complication risks* next page



Dentistry

Literature review shows limited evidence to guide dentists

Complication risks, from page 9

immediate control of pain and gingival bleeding during the acute phase of the process, to the elimination of infectious etiologic agents, prevention of tissue destruction, and the promotion of gingival health. The measures adopted basically comprise local mechanical treatment, the administration of antimicrobials, and the maintenance of oral hygiene. Although mechanical treatment produces transient iatrogenic bacteremia, the risk of sepsis is fortunately not increased, and symptomatic complications only exceptionally arise. ❖

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Treatment planning guidelines for use by dental providers who are providing care to HIV-infected patients

- The medical history should include determination of CD4 counts and viral loads and a review of all drugs that the patient is taking.
- All surgical procedures should be performed in a manner that minimizes bleeding and avoids introducing oral pathogens into the deeper fascial planes and oral spaces.
- Antibiotics should be used judiciously in patients with HIV disease. The clinical decision to prescribe antibiotic therapy should be made on an individual basis. Routine antibiotic prophylaxis is contraindicated.
- If the neutrophil count in a patient is <500 cells/mm³, the dental provider should administer antibiotics pre-operatively and post-operatively in consultation with the primary care provider
- For HIV-patients with heart valve abnormalities or other indications for increased risk of bacterial endocarditis, dentists should use the standard protocol established by the American Dental Association and the American Heart Association.
- Oral surgery should be postponed, if possible, when hemoglobin levels decrease to 7 g/dL or lower
- An increased bleeding time (>9 minutes) indicates a need to assess quantitative and qualitative platelet function.
- Elective dental extractions in HIV-patients who have a platelet count <50,000/mm³ should be delayed until the primary care provider can be consulted and appropriate treatment strategies are selected.
- The treatment of periapical lesions should be early and aggressive in patients with HIV infection, in order to avoid exacerbations in advanced stages of the disease.



Nursing

How one clinic met a new demand without additional resources

Deborah J. Konkle-Parker, PhD,
FNP, ACRN

Every nurse has been confronted by those situations where something new is required by the powers-that-be, yet there is no time or money given to achieve this new task. The HIV clinic where I work was confronted by this in a site visit by a funding agency. It was determined that a psychosocial assessment of all clients would be very beneficial, yet there is no additional staff to perform it, to score it, or resources to deal with any issues that might be uncovered with this assessment process. This article describes how we dealt with this problem.

Psychosocial Assessment

A proactive psychosocial assessment of all clients can be very useful. Some reasons for doing it are to characterize the population of the clinic, which might help with further funding as widespread problems are identified; to have a systematic way of finding out about client needs, which might not always be expressed by the client; and to improve adherence to antiviral medications by assessing depression and intervening if it is problematic.

A number of options for this assessment were explored, and three of these will be reported in this article.

Limitations that influenced the options explored were the following:

1) Some grant money was available for this purpose in the current fiscal year, but that

money would not exist for any future years, thus the costs would have to be up-front or minimal.

2) The clinic is a large one, with more than 1000 clients, but with only one social work case manager and only one nurse case manager, who are both already very busy managing the essential needs of this large clinic population. There is only limited availability of time by three consumer advocates, who are not clinical professionals. Health care providers are already over-burdened with comprehensive primary care.

3) The clinic space is also limited, with only six exam rooms and one "interview room," which is used for many purposes, resulting in inconsistent available space.

ASI-MV

The first option considered was the Addiction Severity Index, which has a multi-media computer-based version, allowing the client to complete the survey by him/herself, with some instruction on how to use a mouse (Budman, 2002). This survey is a well-respected assessment tool, covering issues such as medical status, substance abuse, mental health issues (depression, anxiety, psychosis), employment, family, and legal issues. A benefit of this route was that we could buy the hardware, software, and a large number of tests up-front, and then would have little on-going cost. The multi-media scale had been determined to be reliable

and valid in substance abuse, as well as primary care settings, and it would require little staff, at least theoretically. Moreover, it had been tested on individuals with low levels of education and with illiteracy and had been deemed valid.

CDQ

The next survey that was considered was one that was presented at the 2002 Ryan White Cross-Titles Conference: the Client Diagnostic Questionnaire (HRSA; HIV/AIDS Bureau). This questionnaire had been extensively tested for the exact purpose that we had, and particularly had been tested to be valid and reliable in the HIV-infected population. It was also quite comprehensive, and supported by the HIV/AIDS Bureau.

Unfortunately, it is done by an interview format, which takes a significant amount of staff time for each administration. With two case managers for a clinic of more than 1,000 clients, with both case managers already working full-time just to maintain a bare level of support for the clientele, this was clearly impossible. Therefore, a search for a brief paper-and-pencil self-report questionnaire was resumed, reluctantly, because all involved recognized that self-report questionnaires are not the most reliable.

PHQ

The final option that we explored was a questionnaire that has been found to be valid

See Clinic meets demand next page



Nursing

HIV clinics may be able to identify problems, then lack resources

Clinic meets demand, from page 11

and reliable in a primary care setting: the PRIME-MD. The PRIME-MD is a self-report questionnaire that is designed to be further screened by the primary care provider. It assesses depression, anxiety, alcohol, eating and somatoform disorders. Because the time required by providers for the follow-up screening was considered excessive (8.4 minutes), the self-report questionnaire, called the Patient Health Questionnaire (PHQ), was tested to determine if it was useful by itself. It was found to be useful for this purpose, with acceptable sensitivity and specificity of results (Spitzer, Kroenke, Williams, and the Patient Health Questionnaire Study Group, 1999). An additional benefit of this questionnaire is that it is out in the public domain, therefore not costly, and editing is acceptable to the authors. Once edited, however, the validity would be questionable unless the edited version is further tested.

For our clinic, we did edit the PHQ, taking out the questions about somatoform disorder, eating disorders, and the questions for women, and adding questions about drug use and tobacco use. The final version was thought to be an acceptable length at four pages, took approximately five to eight minutes when tested by our consumer advocates, was comprehensive enough for our purposes, and was easily scored

by non-clinical personnel using a scoring algorithm published by the authors of the PHQ. At this time, data from the questionnaire is not available, so its acceptability will have to be further evaluated. For further information, the author of this modification can be reached at dkparker@medicine.unsmmed.edu. For a complimentary copy of PHQ materials that can be reproduced, e-mail Dr. Spitzer at rls8@columbia.edu.

A problem identified after initiating the PHQ was the need to develop a system for rapid response when individuals indicate that they are having frequent "thoughts that you would be better off dead or of hurting yourself in some way." Since the questionnaire is given to the clients when they first enter the exam room, they have usually completed this question before the provider enters the room. Therefore, we established a protocol where the provider scans the questionnaire for the response to this question and other depression questions, and is able to intervene if there are any problems indicated. When a client is not able to complete the questionnaire by him or herself, a consumer advocate is asked to go into the room to help.

Another systemic problem identified was that a database was needed to reliably score the questionnaire by the scoring algorithm, to keep aggregate data, and to print a progress note for the provider, indicating the problems identified on the PHQ, so that the provider does

not have to take the time to review the actual questionnaire and score it him or herself. Fortunately, our institution provided this database, and the information can be entered by non-clinical personnel, thus saving clinician time and cost.

Another problem at this clinic is the lack of resources for addressing the problems identified: there are few mental health or substance abuse treatment facilities that are accessible, and very little case management time for addressing problems identified. At the very least, however, the health care provider is able to prescribe pharmacological treatment for depression, and thus able to address some of the problems. There is hope, also, that the aggregate data may make funding for further services more accessible to the population of the clinic.❖

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- To order the Client Diagnostic Questionnaire: HRSA Information Center
Attn: Carla Bustillo
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Vienna, Virginia 22182
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Psychosocial

Harm reduction, substance use and the immune system

Danny Sansovich, LCSW

In our last episode (see *HIV Clinician*, Winter 2003), we met the Doe family and looked at how their drug problems complicated their medical care, specifically pain management issues. Behaviors were listed that often identified the potential drug-abusing patient, and strategies were suggested for working with the drug-abusing patient. This article will look at harm reduction, a more controversial intervention for the substance abusing patient, and the possible complications of this strategy with the substance abusing HIV patient.

While there is a growing body of literature devoted to harm reduction as a substance abuse intervention, there is little agreement among harm reduction (HR) practitioners about a uniform definition. There are some themes, however, that are commonly associated with HR as a substance abuse intervention. HR recognizes that drug use is, and will probably always be, a part of society. HR accepts that drug users will continue to use drugs, with interventions focused on reducing the harms associated with drug use. Examples might include seeking a reduction in the amount of drug used, changing the method of drug use (e.g., from IV drug use to smoking or snorting), or participating in a needle exchange program. Drug use occurs on a continuum from severe use to total abstinence

and recognizes any positive movement on this continuum as potentially reducing harm. HR is often seen as more community based, going to the user, and being more approachable since abstinence is not required. In this regard, HR “meets the client where the client’s at” both figuratively and literally. It is seen as a less judgmental philosophy and thus is less punitive toward the user. This does not mean that substance use is condoned, but rather that drug use is accepted as fact and the user is not condemned for using. Abstinence can be a desired goal, but is recognized to be not a continuous

Overwhelming evidence indicates that drug use is especially damaging to the immune systems of HIV+ patients.

achievement, but an ongoing process involving multiple successes and failures. HR expects drug users to have a say in their treatment plan and to accept responsibility for reducing harm.

Although HR isn’t a new concept, it is not considered to be the mainstream philosophy of substance abuse treatment programs. Many traditional

residential and outpatient substance abuse treatment programs require referrals to be abstinent and detoxed prior to admission. I know you’re asking yourself “doesn’t abstinence by default imply a reduction in harm?” Yes, but philosophically, abstinence-based programs have little tolerance for relapse, while HR programs recognize relapse as part of the continuum described above. The difference is basically “no harm” vs. “reduced harm.”

Relative to HIV/AIDS, HR has most often been associated with needle exchange programs that hope to reduce the spread of HIV in injection drug users. However, in the US, needle exchange programs are the exception and not the rule.

Because HR is less confrontational and less judgmental, it offers at least the possibility for quitting drugs simply by introducing the concept of reduced harm versus total abstinence. It provides an opportunity for dialogue with drug users that perhaps would otherwise be missed. It also provides an opportunity for developing a relationship with the client, the first step in any successful therapeutic intervention. It is a “glass is half full” approach that recognizes any reduction in harm as a success story.

However (you knew this was coming, didn’t you?!), there are some issues that must be mentioned when considering HR with the HIV-positive patient that would not be so critical with

See Harm Reduction next page



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Psychosocial

Is there a place for harm reduction in HIV?

Harm reduction, from page 13

the HIV-negative drug user. There's more research available than I can even begin to identify in this limited space that presents overwhelming evidence that drug use compromises the immune system in general and is inherently even more damaging to the immune system of HIV-positive patients. Cocaine has even been shown to facilitate the replication of HIV. Cocaine, heroin and alcohol have all been associated with decreased cognitive functioning and possibly increasing the progression of AIDS dementia.

Drug/alcohol abuse has clearly been associated with behaviors that increase the possibility of unsafe sex and exposure to HIV. Patients who actively abuse drugs and alcohol are more likely to be in adherent to drug regimens, increasing the potential for antiretroviral drug resistance and possible ARV failure. This in turn increases the possibility of developing opportunistic infections that can be fatal. Alcoholism and drug addiction are frequently identified as terminal diseases if left untreated.

Point-counterpoint. Is there a place for harm reduction in the treatment of the HIV substance abuser? Or is harm reduction an oxymoron when considering the HIV+ drug abuser? The beauty of writing this article is that I only have to ask these questions, you get to answer them! The goal of this series has been twofold: to provide strategies for working with the HIV+ substance user

and to stimulate discussion of the issues raised here. Harm reduction, pain contracts, urine toxicology screens, identifying drug seeking behaviors are strategies that have all been used at the clinic where I work with varying degrees of success and failure in working with the substance-using patient. Perhaps the most important strategy is to never give up looking for answers.

In the last issue of *HIV Clinician*, my email address was provided for readers to request a copy of the referenced pain contract. Those who requested a copy should be receiving it by the time this article is published. We have also reproduced the contract on the facing page.

This topic (HIV and Substance Use) may be continued in future issues, particularly if readers have specific questions or topics they would like to see addressed (how's that for blackmailing you?) or if you have a particularly problematic case that can be anonymously presented for possible feedback and strategies for intervention. Email me at dsansovich@aol.com. ❖

RECOMMENDED READING

- Harm Reduction: <http://www.harmreduction.org.prince.html>
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Patient Contract for Controlled Substances

I, _____, understand that I am being prescribed a controlled substance medication by my provider for _____.

To avoid potential complications due to the prescribed medication regimen, I am willing to comply with the following guidelines:
(Patient to initial each section below)

1. I will take only those controlled medications and in the doses prescribed by my clinic provider.
2. I will not increase, stop or alter my dose of controlled substance medication without prior approval of my provider. I understand that increasing my dose without authorization or obtaining controlled prescriptions outside of this clinic may result in the discontinuation of all controlled substance prescriptions.
3. I will inform other providers and dentists involved in my care which controlled medications I am taking.
4. I will submit to drug testing on a random basis as requested by clinic health care providers including doctors, nurse practitioners, social workers, and nutritionists. If drugs which have not been prescribed are found in my blood or urine, or excessive levels of prescribed drugs are found, or if prescribed drugs are not found, all controlled substance medication prescriptions may be discontinued at the discretion of my primary provider.
5. I understand I must keep my follow-up appointments at a minimum of every ___ week(s).
6. I will not obtain any narcotics or other controlled substance prescriptions from other doctors or dentists. I will obtain controlled substance medications from Dr./NP _____ only.
7. I agree to actively participate in physical therapy, counseling, and undergo psychological and/or psychiatric evaluations or any other forms of treatment as recommended by providers.
8. I will not ask for controlled substance medications refills from any clinic health care providers until my scheduled appointment, unless otherwise instructed to do so.
9. I will fill all controlled substance prescriptions at one pharmacy: Name of Pharmacy: _____ Phone: _____.
10. I authorize Dr./NP _____ or her/his designee to call any pharmacy or other health care provider treating me, to verify compliance with these guidelines.
11. I understand the side effects of these medications may include dizziness, sleepiness, and altered consciousness. I understand that my ability to operate heavy machinery and/or drive may be affected and by doing so I may cause injury to myself or others while taking this medication. I will not perform potentially hazardous tasks while taking this medication.
12. I understand that lost or stolen medications or prescriptions may not be replaced.
13. I understand my provider may stop prescribing controlled substance medications if it is felt there is not continued need, or if the risks of this medication are greater than the possible benefits.

My signature below indicates that I understand the above guidelines and that the controlled substances may be stopped for medical reasons. I understand an infraction of any of the above may be cause for discontinuation of my controlled substance medications.

_____ Patient signature	_____ Date	_____ Primary Provider or Palliative Care Specialist	_____ Date
	_____ Witness	_____ Date	



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▲ Gerberding JL. Occupational exposure to HIV in health care settings. *New England Journal of Medicine*. 348(9):826-33, 2003 Feb 27.

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