

Treat Neuropsychiatric Effects of HIV

BY SHARON WORCESTER
Southeast Bureau

NEW ORLEANS — The neurologic and psychiatric aspects of HIV should be treated at least as aggressively as the impact of the disease on the liver, lungs, and heart, Dr. Marshall Forstein said at the American Psychiatric Association's Institute on Psychiatric Services.

HIV invades the brain beginning at the time of seroconversion, and can progress in the central nervous system independently of the peripheral progression of the disease, resulting in neurologic effects that can adversely affect the course of illness, adherence to treatment, secondary transmission, and survival, said Dr. Forstein, of the department of psychiatry at Harvard Medical School, Boston.

Central nervous system (CNS) dysfunction can occur as a result of the effects of HIV on metabolic and endocrine dysfunction. Hypoxia, anemia, hypothyroidism, adrenal insufficiency, and hypogonadism are more common in those who have HIV, for example.

Such dysfunction also can occur as a result of various treatments, such as antivirals, antimicrobials, and herbal medicines, and can range from subclinical cognitive impairment to mild neurocognitive disorder to HIV-related dementia, he noted, adding that without effective HIV treatment, long-standing adverse effects can occur as a result of subcortical and cortical insult.

The effects can be aggravated by psychiatric disorders, substance abuse, sleep deprivation, and pain—all of which are common in HIV patients and may contribute greatly to the cognitive problems.

Antiretroviral treatment can help improve neurocognitive function, as can psychostimulants, but it is important to remember that the CNS can be a sanctuary for the virus in the brain. There-

fore, it is also important to maintain “a sense of disconnect between what's going on in the periphery and what's going on in the nervous system,” he said.

For example, findings in HIV, as well as in other diseases such as hepatitis C, suggest that infections of the brain may stimulate inflammatory processes that adversely affect cognition. Bolstering this suggestion are recent findings of a relationship between HIV treatment and a halo effect in the CNS, reducing the consequences of inflammatory processes in the brain regardless of the progression or resistance of the virus in the periphery, Dr. Forstein said.

In addition, viral load does not appear to be linked with cognitive changes; some patients who have a low viral load have extensive cognitive impairment, and some who have a high viral load have no cognitive impairment.

“It may be a question of how much inflammation is in the brain itself,” he said.

As for psychiatric issues, many HIV patients experience depression, anxiety, and other psychiatric conditions. Mood disorders are the most common psychiatric complaint in those who have HIV, with studies suggesting that up to 60% have depression, half are substance abusers, and up to 25% have an anxiety disorder. Several factors are considered probable risk factors for depression in HIV (see box), such as a personal or family history of a mood disorder, and alcohol or drug use.

It may be that those at increased risk of HIV are also at increased risk of mood disorders, but in some cases the disorders can also be secondary to the disease, treatments, and/or physical manifestations of the disease, such as lipodystrophy, which can be a telltale sign of HIV infection.

Suicide also is a risk in HIV patients, and that risk is elevated across the trajectory of the disease; surviving into

Depression Risk Factors in HIV

- ▶ Personal history of a mood disorder.
- ▶ Personal or family history of alcoholism, substance use, suicide attempt, and/or anxiety disorders.
- ▶ Current alcohol or drug use.
- ▶ An inadequate social support system.
- ▶ Nondisclosure of HIV-positive status.
- ▶ Multiple losses.
- ▶ Disease progression.
- ▶ Treatment failure and, in some cases, treatment success (for example, when a patient expects to die but is treated successfully and is subsequently haunted by fears that the treatment will fail and that he or she will be faced with preparing again for death).

In addition, women are twice as likely as men to develop depression regardless of HIV status, and women with HIV and depression are twice as likely to die as are women without signs or symptoms of depression, Dr. Forstein noted.

middle and older years has been associated with increased risk, and in the era of antiretroviral therapy, such survival is more common. However, few studies have evaluated suicide risk in this period.

Other psychiatric disorders common in HIV patients include adjustment disorders and psychotic disorders. Somatic problems such as sleep and pain disorders, fatigue, and sexual dysfunction also occur frequently and, like mood and other psychiatric disorders, should be addressed in these patients. ■

Neuropsychiatric Events Not Tied To Oseltamivir

CHICAGO — Contrary to some reports, oseltamivir therapy appears not to affect the incidence of neuropsychiatric events in patients with influenza, according to data presented at the annual Interscience Conference on Antimicrobial Agents and Chemotherapy.

The study used a large U.S. medical claims database to compare the incidence of neuropsychiatric events in the 30 days after an influenza diagnosis in patients who received oseltamivir versus those given no antiviral treatment.

Recent case reports from a variety of countries have linked oseltamivir to neuropsychiatric events. Although no causality has been established, the product label has been changed to include neuropsychiatric events in the European Union, Japan, Switzerland, and the United States, reported lead investigator Marsha A. Wilcox, Sc.D., and colleagues at i3 Drug Safety, in Waltham, Mass.

From Nov. 1, 1999, through April 30, 2005, 60,267 patients were treated with oseltamivir and 175,933 received no antivirals. The two cohorts were balanced for a variety of baseline variables including age, sex, health plan region, index date, number of hospitalizations, and vaccinations for influenza and pneumococcus during the 6 months prior to diagnosis.

The incidence of any neuropsychiatric event was 3.8% in the oseltamivir group and 4.3% in those not treated with antivirals (exposure-adjusted odds ratio 0.89).

The incidence was also comparable for major neuropsychiatric events (3.4% vs. 3.7%; OR 0.89) and for central nervous system stimulation events (2.5% vs. 2.8%; OR 0.88), the investigators reported.

The conference was sponsored by the American Society for Microbiology.

Dr. Wilcox did not disclose any relevant conflicts of interest.

—Patrice Wendling

Cancer Patients Miss Routine Vaccinations in PCP-Specialist Gap

BY JANE SALODOF MACNEIL
Senior Editor

LOS ANGELES — Primary care physicians cannot assume that cancer patients are receiving influenza or pneumonia vaccinations while in the care of oncology specialists.

When surveyed at the University of Pennsylvania in Philadelphia, a third of radiotherapy patients aged 50 years and older reported they never had an annual flu shot. Among those aged 65 years and older, 30% said they never were vaccinated against pneumococcal pneumonia.

National guidelines call for vaccination of persons in these age groups. Moreover, by dint of their cancers and the treatments they were receiving, the patients surveyed were susceptible to life-threatening infections. Yet many said they did not know about the vaccines, did not need them, or that the vaccinations were not recommended by a physician.

Such patients are falling into a gray zone, according to



Dr. Neha Vapiwala, who presented results of the 214-person survey in a poster at the annual meeting of the American Society for Therapeutic Radiation and Oncology. Cancer patients see multiple physicians, none of whom is taking responsibility for routine prevention and maintenance measures, she said.

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DR. VAPIWALA

“If there is ever a question about that cancer patient sitting in your office—a question about which routine health maintenance and prevention measures should or shouldn't be recommended—pick up the phone, send that e-mail, communicate with the oncologist,” Dr. Vapiwala urged primary care physicians during a press briefing at the meeting.

Although primary care physicians were more likely to recommend vaccinations than oncologists were, they did not do so routinely, according to the subgroup of patients who were vaccinated. Only 7% said a cancer specialist discussed vaccinations with them; 44% cited conversations with their primary care physicians.

Clearer mandates are needed on vaccinations for cancer patients and “which physician is responsible for what,” she said. “Until that happens, we have patients now every single day in our clinic where assumptions are being made that specialist X is taking care of this item and primary care physician Y is taking care of that.”

Though the study relied on patient responses, Dr. Vapiwala, a radiation oncologist at the university, said anecdotal experience supports the finding that vaccinations are being overlooked by oncologists. “We only have to survey the 12 physicians in our department to find the overwhelming majority are guilty. I include myself in that group,” she said.

Patients with a wide range of cancers were surveyed in outpatient clinics at the University of Pennsylvania. An unusually high proportion, 98%, completed usable questionnaires. Overall, 28% of patients reported having received one or two doses of the pneumococcal vaccine. More than half, 58%, said they had yearly flu shots. The median age was 56 years.

The investigators reported no difference among cancer types or treatment regimens with respect to inadequate vaccinations. “Somebody has to bring it up,” Dr. Vapiwala noted. ■