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La recidiva di MTS nei pazienti HIV. Che fare?

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U.O. Malattie Infettive Forlì

(Direttore: dott. C. Cancellieri)

LA PERSISTENZA DI COMPORTAMENTI SESSUALI AD ALTO RISCHIO IN PAZIENTI HIV POSITIVI E L'INCIDENZA DI NUOVI CASI DI MST.

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Obiettivo

Alcuni recenti studi riportano che pazienti (pz) consapevoli di essere HIV positivi continuano ad avere comportamenti sessuali ad alto rischio (Diamond et al , American Journal of Public Health 2000; 90:115) ed una ricerca sulle urine di pz HIV positivi ma asintomatici per MST ha mostrato una incidenza cumulativa di gonorrea ed infezione da clamidia del 7,5% (Erbelding et al, AIDS 2000 Feb 18; 14:297-301). Tali studi però sono basati su studi epidemiologici attraverso questionario o su screening in pz asintomatici. Abbiamo voluto verificare se la persistenza di comportamenti sessuali ad alto rischio si traducesse nei nostri pz HIV positivi in nuovi casi di malattie sessualmente trasmesse (MST).

II° Congresso SIMaST – Sorrento maggio 2000

Metodo

Indagine retrospettiva sulla incidenza di nuovi casi di MST tra 206 pz con Infezione o Malattia da HIV seguiti nel nostro Modulo nel corso del 1999.

Risultati

Nel periodo esaminato tra i 206 pz abbiamo diagnosticato 12 nuovi casi di MST in 10 pz con un'incidenza cumulativa del 5,8%. Riportiamo nella tabella che segue le caratteristiche dei pz :

Pz	Sesso	Fatt. di rischio	Età	HIV+ da	Stadio	Inizio	HAART	MST
1	m	Omosessuale	58	3/1994	B1	4/1994	1/99	Sifilide secondaria
2	m	Bisessuale	51	12/1994	B2	2/1996	1/99	Epatite da HBV
3	f	Eterosessuale	34	10/1998	B2	2/1999	2/99	Sifilide secondaria
4	m	Omosessuale	33	4/1996	A1	7/1996	2/99 8/99	Pediculosi del pube Uretrite da Ent.spp
5	m	Omosessuale	27	6/1997	A1	2/1998	4/99 12/99	Gonorrea Uretrite polimicrobica
6	m	Omosessuale	29	7/1997	A1	11/1997	5/99	Uretrtrite polimicrobica
7	m	Omosessuale	60	12/1998	C3	2/1999	5/99	Sifilide secondaria
8	m	Omosessuale	33	3/1989	B3	4/1993	7/99	Sifilide primaria
9	m	Bisessuale	69	12/1997	C3	1/1998	9/99	Giardiasi intestinale
10	m	Omosessuale/Td	29	6/1993	A1	No terapia	10/99	Sifilide secondaria

Conclusioni

La nostra casistica è troppo esigua per ricavarne conclusioni generali e sarebbe necessario uno studio multicentrico per stimare l'incidenza di nuove MST in pz HIV positivi. Si sottolinea che 9/10 dei pz sono maschi e omo-bisessuali ed inoltre sono in terapia per la malattia da HIV e che quindi vengano visitati ogni 30-45 giorni senza che tuttavia emergesse dal colloquio la persistenza di comportamenti sessuali ad alto rischio. Questo dato ci induce a ritenere che la reale incidenza di MST nei pz con infezione da HIV, che vengono visitati ogni 3-4 mesi, possa essere più alta ed inoltre che i nostri pz non percepiscono con chiarezza il rischio di reinfettarsi con ceppi di HIV più aggressivi o multifarmacoresistenti. Ci sembra infine evidente che esiste nei nostri pz un problema di coping sessuologico che deve essere diagnosticato ed affrontato. Un recente studio controllato e randomizzato ha valutato, per la prima volta in modo quantitativo, l'impatto di un intervento comportamentale di riduzione del rischio riportando risultati incoraggianti (Shain et al,N Engl J Med 1999; 340:93-100). E' auspicabile che analoghi studi vengano condotti anche nella nostra realtà clinica e sociale.

Ma è solo un problema cognitivo ? Basta la consapevolezza ?

C.G.P. classe 1973, maschio omosessuale, laureato

Aprile-Maggio 2000 Blenorragia

06/10/2000 Ricovero per "EVA da HBV"

12/11/2001 dimesso dal DH "ECA da HBV grado 1 stadio 1"

25/11/2001 dimesso dal DH: "ECA da HBV (HBsAg+,HBeAg+,HBV-DNA+) grado 1, stadio 1, responder a terapia con IFN Alfa 2b. Prostatite acuta da Haemophilus parainflenzae intercorrente." (Dal 21/01/02 al 21/09/02 il pz ha praticato terapia con Interferone Alfa 2b alla dose di 5 M.U./die)

23/2/04 EVA da HAV (non si è vaccinato come era stato consigliato)

3/11/05 laserterapia di Condilomi anali e perianali

5/12/2005 conversione ad HBsAg negativo e contemporaneo riscontro di Sifilide recente

<u>Il 18/07/2006 riscontro di HIVAb+ (il 07/02/06 test per HIV negativo)</u>

2009 novembre recidiva di Sifilide

2012 agosto recidiva di Sifilide

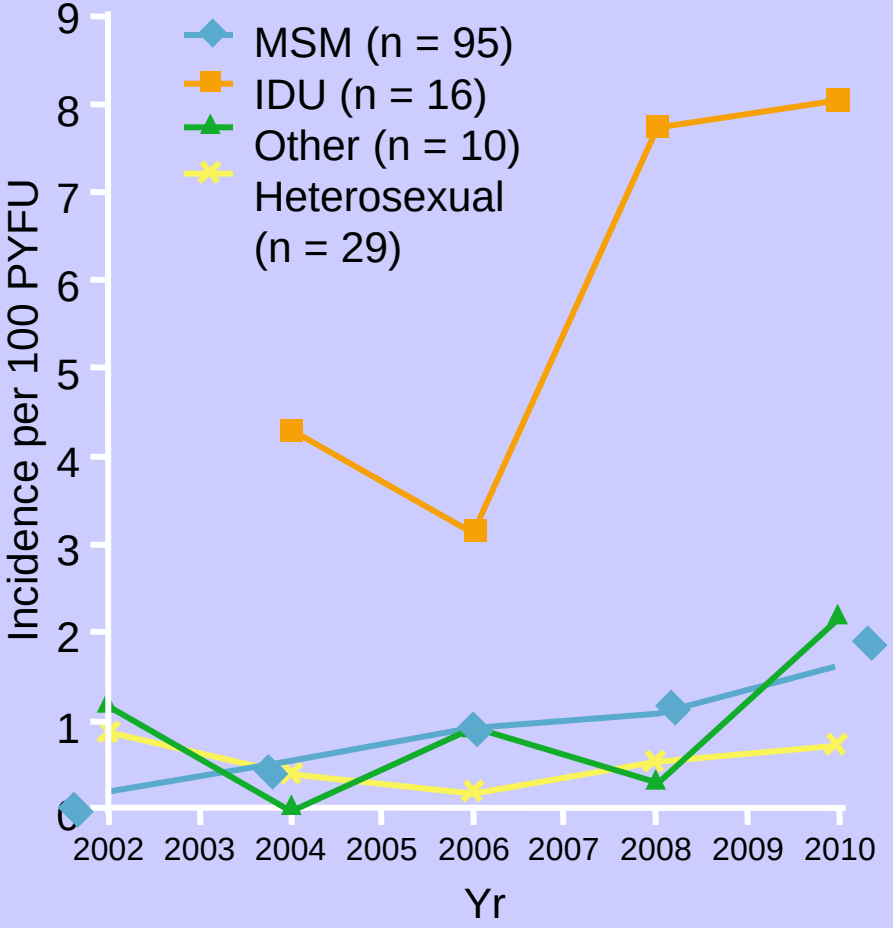
EuroSIDA: Acute HCV Incidence Among HIV-Infected Pts According to Risk Group

- Overall acute HCV incidence among 4296 HCV-negative pts in EuroSIDA cohort: 0.79/100 PYFU
  - 150 events during 19,178 PYFU

Significant increase in incidence over time

- Unadjusted IRR per 2 calendar yrs: 1.25 (*P* < .0001)
- Increases noted in all EuroSIDA regions
- Highest incidence in HIV-positive IDUs
- 54% higher incidence in MSM vs heterosexuals

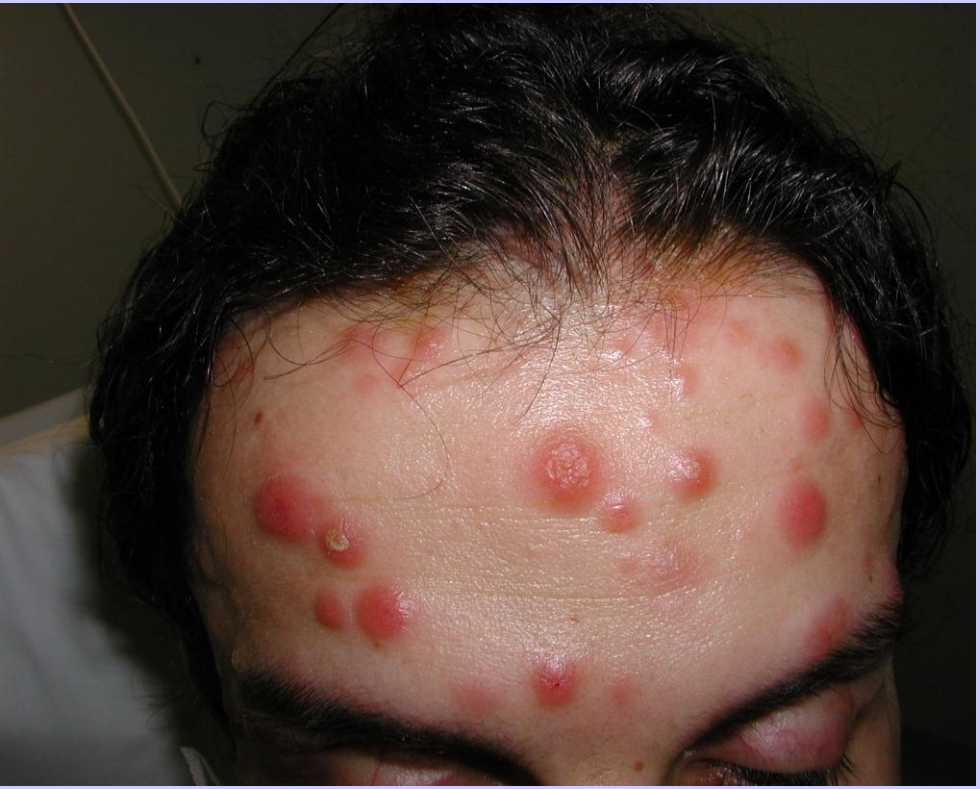
No differences in incidence based on HIV-1 RNA level or initiation of ART



Rockstroh J, et al. Glasgow 2012. Abstract O242.

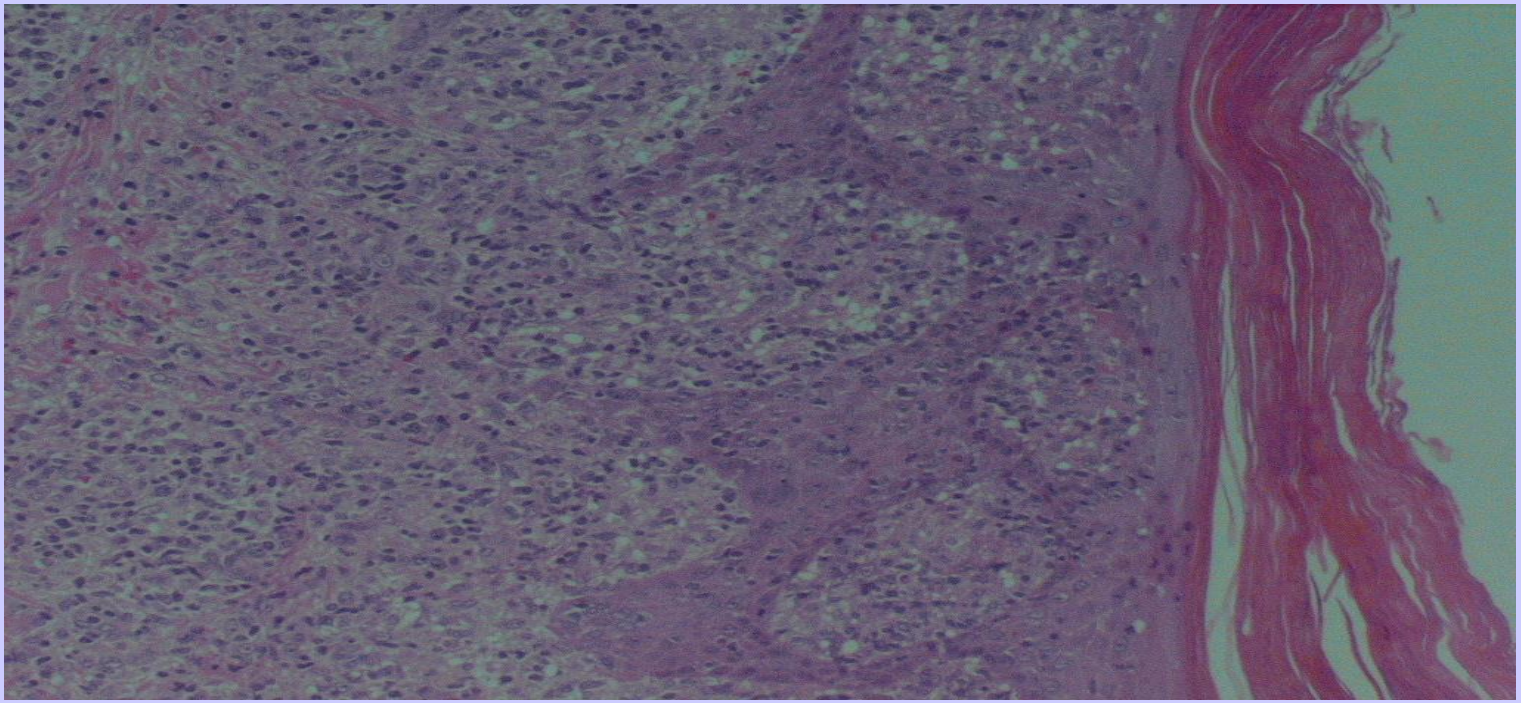
D.R.G., maschio, classe 1970, MSM (ora in transizione MTF)
05/1997 Blenorragia
07/1997 1° HIVAb+ In terapia anti HIV (2 NRTI) dal 12/1997

06/2004 Blenorragia
10/2004 pomfi eritematosi che si sono intensificati per n° e hanno assunto aspetto vescicoloso, compatibile con Varicella, ma dopo 3 cicli di terapia con Ganciclovir
15/12/04 Diagnosi di ingresso:Varicella ad andamento protratto in Mal. da HIV



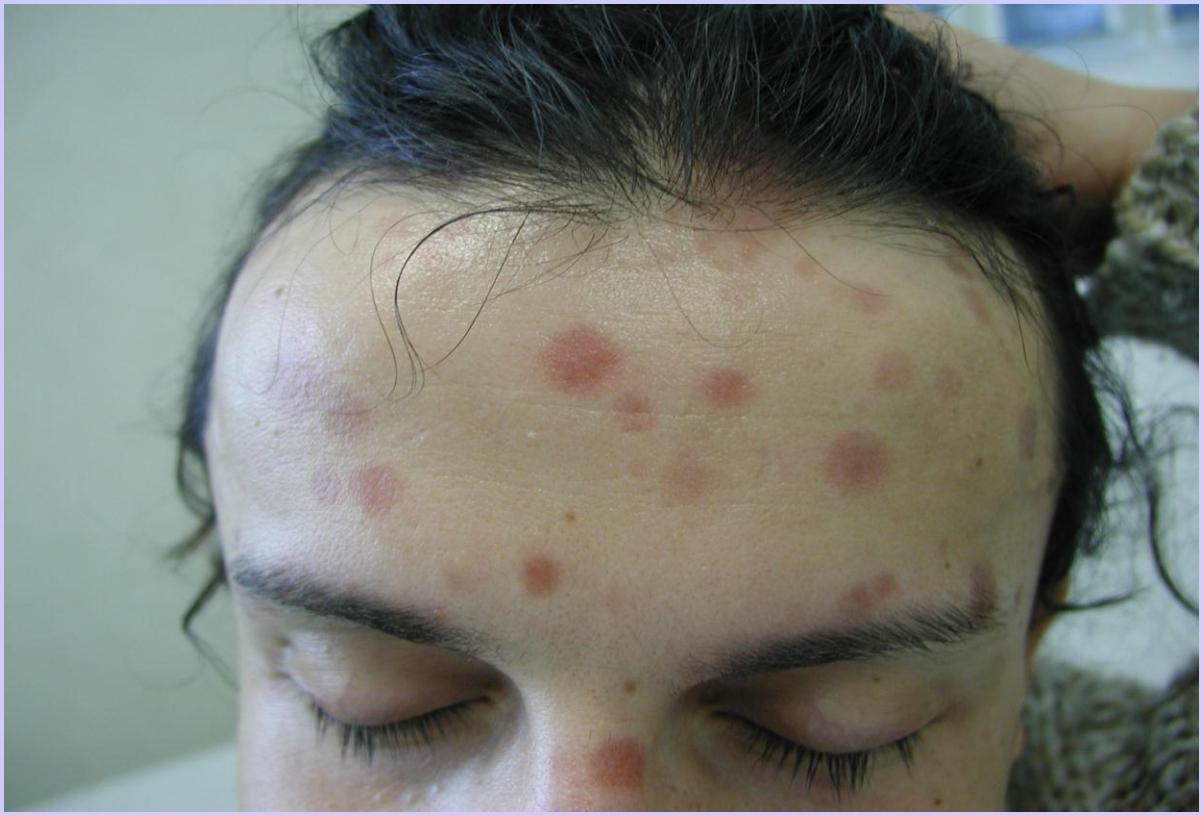
Durante il ricovero in attesa del risultato della biopsia inizia terapia empirica con Doxiciclina, dopo 6 ore dall'assunzione presenta febbre 39,8°C
L'esame istologico pone diagnosi di
Micosi fungoide
Nel frattempo gli esami per la Lue mostrano: Anti treponema (EIA) positivo, TPHA 1:20.480, VDRL: 1:64, Anti treponema (EIA) IgG 5.6 U.A. (VN 0-1) ed IgM 2.2 U.A (interpretiamo la febbre come reazione di Jarisch-Herxheimer) ed iniziamo la terapia per la Lue.

Ad ulteriore conferma della diagnosi di Sifilide le colorazioni immunoistochimiche eseguite sulla biopsia mostrarono che l'infiltrato flogistico era "composto da una grande quantità di istiociti (CD68+) con frammiste plasmacellule (CD79a+,K+,Lambda+) con presenza di alcuni linfociti B (CD79a+) ed una grande quantità di linfociti T (CD3+) con rapporto CD3/CD8 conservato in sede dermica, con prevalente presenza di elementi CD8+ a livello epidermico"
era già stato descritto come negli HIVAb+ che presentano infiltrati cutanei linfoidi la predominanza di linfociti CD8+ nel derma può simulare una Micosi Fungoide (Zhang P et al, Mycosis fungoideslike T-cell cutaneous lymphoid infiltrates in patients with HIV infection, Am J Dermatopathol 1995 Feb; 17(1):29-35)



(Ematossilina eosina 40x)

Il successivo miglioramento delle lesioni cutanee fu estremamente lento e a distanza di 2 mesi le lesioni erano migliorate ma ancora visibili e sono completamente scomparse solo dopo 7 mesi



Da una ricerca Medline negli ultimi dieci anni risultano solo 2 casi di Sifilide secondaria in HIV+ simulanti una Micosi Fungoide ma, a differenza del nostro caso, su cute nera (Lotta EA et al Unusual presentation of secondary syphilis in 2 HIV-1 patients in Cutis 2000 Nov;66(5):383-6, 389)

Sexual transmission of HIV

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STDs as indicator or risk factor for HIV acquisition

Alberto Matteelli
Institute for Infectious and Tropical Diseases
University of Brescia

rate

β	c	D
Probability of transmission of infection	Rate of sex partner change	Duration of infectiousness

X X

STI as an enhancing co-factor

The Swiss statemen to safe sex without condom

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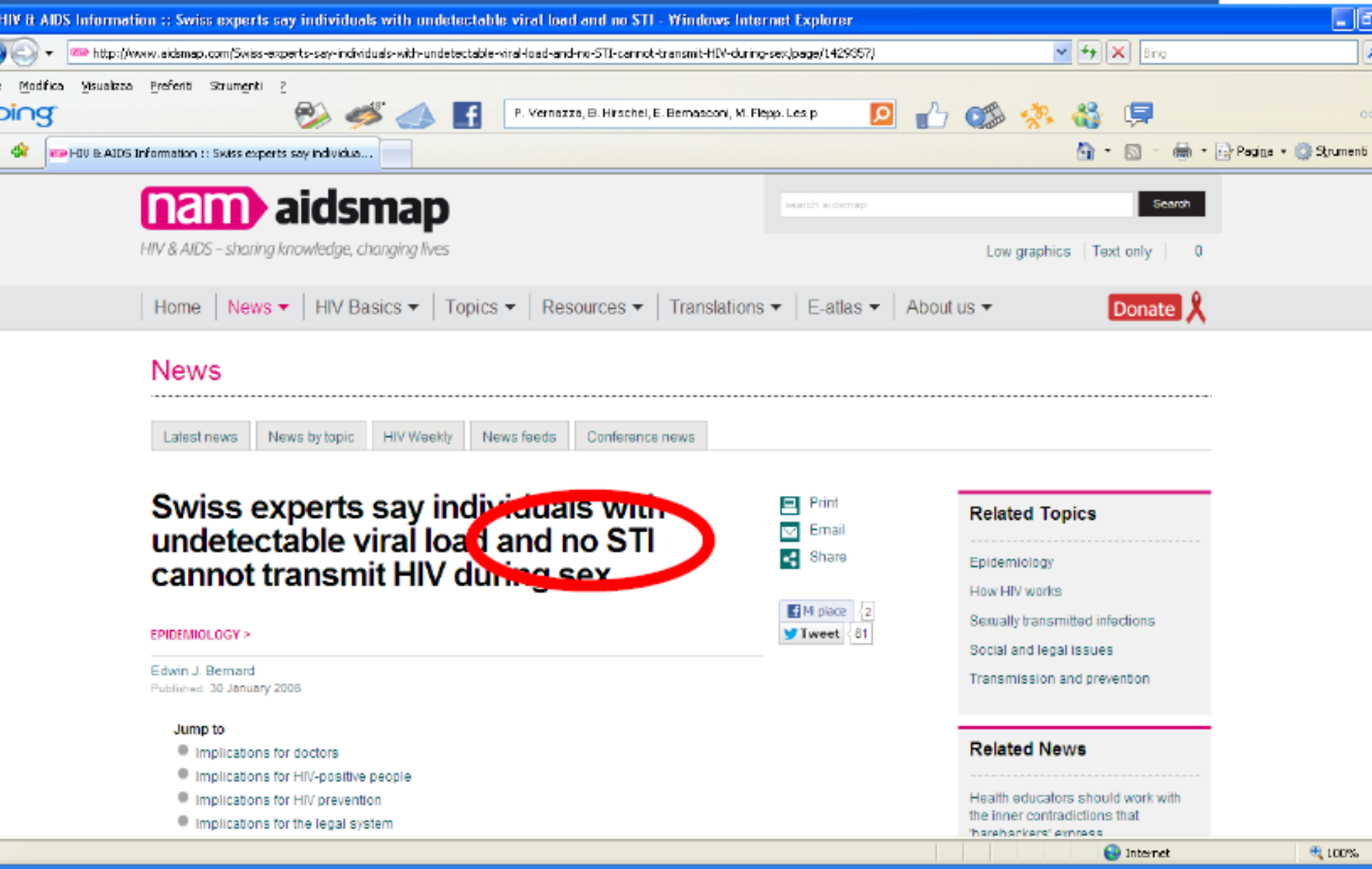

PREVENTION AND TREATMENT OF HIV AND OTHER SEXUALLY TRANSMITTED INFECTIONS AMONG MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE

Recommendations for a public health approach

2011

From a health systems' perspective, MSM and transgender people may delay or avoid seeking health, STI or HIV-related information, care and services as a result of perceived homophobia, transphobia, ignorance and insensitivity. MSM and transgender people may be less inclined to disclose their sexual orientation and other health-related behaviours in health settings that may otherwise encourage discussions between the provider and patient to inform subsequent clinical decision-making. Providers are likely to feel biased when their own cultural, moral or religious leanings are incongruent with a patient's reported sexual orientation, behaviours or gender identity. Additionally, enquiry into the level of knowledge among physicians, nurses and other health care providers on MSM and transgender-related health issues has shown that the clinical curriculum, particularly in low- and middle-income countries, do not address these knowledge gaps.

Sexuality and sexual risk

When planning to scale up services for MSM and transgender people, a key problem is that they are often presumed to be a homogeneous community, whereas in reality they represent a range of diverse identities and forms of social and sexual associations. These differences are important in terms of the implications for HIV risk and vulnerability, and should be taken into consid-

Summary of findings

The systematic evidence review included information on two outcomes of interest: HIV incidence (five studies) and STI incidence (one study). The overall relative effect of condom use on HIV transmission was relative risk (RR): 0.36 (95% confidence interval [CI]: 0.20–0.67), and for STI transmission it was RR: 0.58 (95% CI: 0.54–0.62). Consistent condom use was found to reduce HIV transmission by 64%. For STI transmission, consistent condom use was found to reduce the risk by 42%.

Recommendation

Using condoms consistently during anal intercourse is strongly recommended for MSM and transgender people over not using condoms.

Strong recommendation, moderate quality of evidence

Complementary remarks

Water- and silicone-based lubricant use is key for the correct functioning of condoms during anal sex.

Key points

- Serosorting is defined as "a person choosing a sexual partner known to be of the same HIV serostatus, often to engage in unprotected sex, in order to reduce the risk of acquiring or transmitting HIV".
- Serosorting increased HIV transmission by 79% and increased STI transmission by 61%. When compared with no condom use, the benefits outweighed the harms. Serosorting reduced HIV transmission by 53% and reduced STI transmission by 14%.
- The risks of serosorting outweigh the benefits when compared with consistent condom use. When compared with no condom use, the benefits of serosorting outweigh the harms.
- Acceptability and feasibility depend on the individual and the setting. Serosorting is feasible only in contexts where quality HTC is available, HIV retesting rates are high, and the legal and social environment is supportive of HTC and serostatus disclosure.

Recommendations

Using condoms consistently is strongly recommended over serosorting for HIV-negative MSM and transgender people.
Strong recommendation, very low quality of evidence

Serosorting is suggested over not using condoms by HIV-negative MSM and transgender people under specific circumstances as a harm reduction strategy.
Conditional recommendation, very low quality of evidence

Complementary remarks
Individuals and couples using serosorting as a harm reduction strategy need to be screened regularly for HIV and STIs. There is a need for additional research on serosorting for MSM and transgender people and their sexual partners.

8.2.1 HIV testing and counselling

Key points

- Since the HIV test became available, HTC has been considered a key intervention for HIV prevention.
- There was a 21% reduction in risk behaviour among those undergoing HTC.
- The benefits outweigh the risks. The use of resources is not a concern since HTC is a standard intervention in most settings.
- Acceptable and feasible.

Recommendation

Offering HIV testing and counselling to MSM and transgender people is strongly recommended over not offering this intervention.
Strong recommendation, low quality of evidence

Complementary remarks
HTC should be linked to care and treatment.

8.2.2. Community-based HIV testing and counselling linked to care and treatment

Key points

- The community-based HTC approach focuses on the active promotion of HTC linked to expedited access to care and treatment for those who test positive for HIV infection.
- One observational study found that after implementation of voluntary HTC in health-care settings, there was a decrease in HIV diagnoses, an increase in the proportion of people tested, and decreased time between diagnosis and first CD4 count.[88]
- Although HTC can increase the risk for stigma, the potential benefits outweigh the risks.
- Communities value testing and counselling and earlier access to care and treatment. However, there are concerns regarding stigma and discrimination, and limited capacity of health-care personnel to manage issues pertinent to MSM and transgender people.

Recommendation

Offering community-based programmes for HIV testing and counselling linked to care and treatment to MSM and transgender people is suggested over not offering such programmes.
Strong recommendation, very low quality of evidence

Complementary remarks
Further research is needed.

8.3.5. Sex venue-based outreach strategies

Key points

- An important subgroup of MSM report high-risk behaviour in sex venues, i.e. environments outside the home where men meet other men for casual, usually anonymous, sexual encounters. Prevention interventions at sex venues could possibly make a difference in reducing the spread of HIV among high-risk MSM.
- A 40% reduction was reported for those who received the intervention compared with those who did not.
- The benefits outweigh the risks.
- Acceptability was not assessed. However, an enabling environment is necessary for implementing behavioural interventions at sex venues.

Recommendation

Implementing sex venue-based outreach strategies to decrease risky sexual behaviour and increase uptake of HIV testing and counselling among MSM and transgender people is suggested over not implementing such strategies.
Conditional recommendation, very low quality of evidence

Complementary remarks

There is no evidence of the effect of this intervention on HIV or STI incidence or prevalence. New studies done in low- and middle-income countries should address these questions. Further research is needed on the effect of including other interventions such as condom distribution and use, and HTC.

Behavioural interventions, information, education, communication

8. Implementing individual-level behavioural interventions for the prevention of HIV and STIs among MSM and transgender people is suggested over not implementing such interventions.
   Conditional recommendation, moderate quality of evidence

9. Implementing community-level behavioural interventions for the prevention of HIV and STIs among MSM and transgender people is suggested over not implementing such interventions.
   Conditional recommendation, low quality of evidence

10. Offering targeted internet-based information to decrease risky sexual behaviours and increase uptake of HIV testing and counselling among MSM and transgender people is suggested over not offering such information.
    Conditional recommendation, very low quality of evidence

11. Using social marketing strategies to increase the uptake of HIV/STI testing and counselling and HIV services among MSM and transgender people is suggested over not using such strategies.
    Conditional recommendation, very low quality of evidence

12. Implementing sex venue-based outreach strategies to decrease risky sexual behaviour and increase uptake of HIV testing and counselling among MSM and transgender people is suggested over not implementing such strategies.
    Conditional recommendation, very low quality of evidence

Recommendations on prevention and care of other sexually transmitted infections

18. MSM and transgender people with symptomatic STIs should seek and be offered syndromic management and treatment.
In line with existing WHO guidance

19. Offering periodic testing for asymptomatic urethral and rectal *N. gonorrhoeae* and *C. trachomatis* infections using NAAT is suggested over not offering such testing for MSM and transgender people.
Conditional recommendation, low quality of evidence

Not offering periodic testing for asymptomatic urethral and rectal *N. gonorrhoeae* infections using culture is suggested over offering such testing for MSM and transgender people.
Conditional recommendation, low quality of evidence

20. Offering periodic serological testing for asymptomatic syphilis infection to MSM and transgender people is strongly recommended over not offering such screening.
Strong recommendation, moderate quality of evidence

21. MSM and transgender people should be included in catch-up HBV immunization strategies in settings where infant immunization has not reached full coverage.
In line with existing WHO guidance

Senza dimenticare il Vaccino anti HAV

Frequent Screening for Syphilis as Part of HIV Monitoring Increases the Detection of Early Asymptomatic Syphilis Among HIV-Positive Homosexual Men

Bissessor, Melanie; Fairley, Christopher K; Leslie, David; Howley, Kerri; Chen, Marcus Y

Studies throughout Europe, Australia and the United States have found that rates of syphilis have increased dramatically among HIV-positive MSM in the past decade. In California, for example, the total number of syphilis diagnoses increased by 700 percent between 1999 and 2005**, with 61 percent of the new cases in 2005 occurring in HIV-positive MSM.**

Frequent testing caught many more syphilis cases, particularly those where the men had **no symptoms**. The percentage of men diagnosed with early syphilis during the 18 months before and after the intervention was 3.1 percent and 8.1 percent respectively. **The proportion of men diagnosed with syphilis who had no symptoms increased from 21 percent to 85 percent.**

The median number of days that the men went without a diagnosis decreased from 107 before the intervention to 45 after more frequent testing was adopted. This decrease in the duration of time spent without a diagnosis could result in fewer opportunities to pass on syphilis to others—potentially decreasing new syphilis infections in the community.

JAIDS Journal of Acquired Immune Deficiency Syndromes. 55(2):211-216, October 1, 2010.

Risk of HIV or second syphilis infection in Danish men with newly acquired syphilis in the period 2000-2010.

Salado-Rasmussen K, et al. Department of Infectious Diseases, Copenhagen University Hospital, Rigshospitalet, Copenhagen, Denmark.

OBJECTIVES:
Risk of subsequent diagnosis of HIV in persons diagnosed with newly acquired syphilis, **and syphilis in HIV-infected persons**, are of interest as **these infections are markers of unsafe sex**.
METHODS:
From a nationwide register, all Danish men aged >16 years diagnosed with syphilis in the period 2000-2010 (n=1217) were identified, and subsequently data on HIV status was extracted from the Danish HIV Cohort Study. We used Kaplan-Meier analysis to estimate the 5-year risk of HIV and second syphilis infection, and Cox regression to determine incidence rate ratios (IRR).
RESULTS:
The 5-year risk of HIV diagnosis was 9.8% (95% CI 7.0% to 12.6%). Those with a second diagnosis of syphilis had a higher risk of being diagnosed with HIV (IRR=3.1, 95% CI 1.2 to 8.0). The 5-year risk for a second diagnosis of syphilis was 14.8% (95% CI 12.1% to 17.4%) **and HIV-infected persons had a higher risk of a second syphilis diagnosis (IRR=4.0, 95% CI 2.8 to 5.9).** Sixty-five percent of the persons were men having sex with men (MSM). Thirty-four percent of the HIV-infected persons had viral load >1000 copies/ml at time of syphilis diagnosis.
CONCLUSIONS:
The substantial risks of syphilis and HIV infection in men diagnosed with one of these sexually transmitted diseases **indicate a high frequency of unsafe sex in the Danish MSM population. As one-third of the HIV-infected persons diagnosed with syphilis had high viral loads**, our data support initiation of antiretroviral therapy in all HIV-infected MSM to reduce HIV transmission.

Sex Transm Infect. 2012 Dec 27. [Epub ahead of print]

Variations in Patterns of Sexual Risk Behavior among Seattle-Area MSM Based on their HIV Status, the HIV Status of their Partner and Partner Type

Richard D. Burt · Hanne Thiede

AIDS Behav (2012) 16:599–607
DOI 10.1007/s10461-011-9979-x

Abstract We evaluated sexual risk behavior in 368 Seattle-area MSM recruited in the 2008 National HIV Behavioral Surveillance survey. We found significant concordance between participants' self-reported HIV status and that of their sexual partners. Persons unaware of partners' HIV status were more likely to report only oral sex. Those aware were less likely to report non-concordant unprotected anal intercourse (UAI). Participants reporting themselves HIV-positive were more likely than those self-reporting HIV-negative status to report non-concordant UAI and several other sexual risk behaviors. The level of non-concordant UAI did not materially differ by whether their partner was a main or casual partner.

Relationship Characteristics Associated with Sexual Risk Behavior Among MSM in Committed Relationships.

Hoff CC, Chakravarty D, Beougher SC, Neilands TB, Darbes LA.

1 Center for Research and Education on Gender and Sexuality, San Francisco State University , San Francisco, California.

Abstract

Understanding situations that increase HIV risk among men who have sex with men (MSM) requires consideration of the context in which risky behaviors occur. Relationships are one such context. This study examines the presence and predictors of unprotected anal intercourse (UAI) in the past 3 months among 566 MSM couples. A majority of couples allowed sex with outside partners. Overall, 65% of the sample engaged in UAI with primary partner, including nearly half of discordant couples. Positive relationship factors, such as attachment and intimacy, were associated with an increased likelihood of UAI with primary partner.

Meanwhile, 22% of the sample engaged in at least one episode of UAI with an outside partner, half of whom were discordant or unknown HIV status outside partners.

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AIDS Patient Care STDS. 2012 Dec;26(12):738-45.

Dunque non è sufficiente sapere se un pz è in coppia e se la coppia è o non sierodiscordante ma è anche necessario indagare le dinamiche della coppia

Sexual Risk Behavior Among Youth With Perinatal HIV Infection in the United States: Predictors and Implications for Intervention Development

Clinical Infectious Diseases 2013;56(2):283–90

Katherine Tassiopoulos,[1] Anna-Barbara Moscicki,[2] Claude Mellins,[3] Deborah Kacanek,[4] Kathleen Malee,[5] Susannah Allison,[6] Rohan Hazra,[7] George K. Siberry,[7] Renee Smith,[8] Mary Paul,[9] Russell B. Van Dyke,[10] and George R. Seage III,[1] for the Pediatric HIV/AIDS Cohort Study

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Background. Factors associated with initiation of sexual activity among perinatally human immunodeficiency virus (HIV)–infected ($PHIV^+$) youth, and the attendant potential for sexual transmission of antiretroviral (ARV) drug-resistant HIV, remain poorly understood.

Methods. We conducted cross-sectional and longitudinal analyses of $PHIV^+$ youth aged 10–18 years (mean, 13.5 years) enrolled in the US-based Pediatric HIV/AIDS Cohort Study between 2007 and 2009. Audio computer-assisted self-interviews (ACASI) were used to collect sexual behavior information.

Results. Twenty-eight percent (95% confidence interval [CI], 23%–33%) (92/330) of $PHIV^+$ youth reported sexual intercourse (SI) (median initiation age, 14 years). Sixty-two percent (57/92) of sexually active youth reported unprotected SI. Among youth who did not report history of SI at baseline, ARV nonadherence was associated with sexual initiation during follow-up (adjusted hazard ratio, 2.87; 95% CI, 1.32–6.25). Youth living with a relative other than their biological mother had higher odds of engaging in unprotected SI than those living with a nonrelative. Thirty-three percent of youth disclosed their HIV status to their first sexual partner. Thirty-nine of 92 (42%) sexually active youth had HIV RNA ≥5000 copies/mL after sexual initiation. Viral drug resistance testing, available for 37 of these 39 youth, identified resistance to nucleoside reverse transcriptase inhibitors in 62%, nonnucleoside reverse transcriptase inhibitors in 57%, protease inhibitors in 38%, and all 3 ARV classes in 22%.

Conclusions. As $PHIV^+$ youth become sexually active, many engage in behaviors that place their partners at risk for HIV infection, including infection with drug-resistant virus. Effective interventions to facilitate youth adherence, safe sex practices, and disclosure are urgently needed.

Stable incidence of HIV diagnoses among Danish MSM despite increased engagement in unsafe sex

Methods: Study period was 1995-2010. Data were obtained from two Danish nationwide registries of HIV and syphilis, and five consecutive surveys on sexual behavior in Danish MSM.
Results: From 1995-2010 the prevalence of Danish MSM diagnosed with HIV increased from 1,035 to 1,813 (75%), while the number of HIV-positive MSM with detectable viral load (VL) (>400 HIV-RNA copies/ml) decreased by 75% from 1,035 to 262. The incidence of syphilis and unprotected anal intercourse rose dramatically in the same period, while Cohort Community Reproductive Rate decreased from 0.099 (CI95% 0.092-0.108) to 0.071 (CI 95% 0.065-0.079).

Conclusions: Our results strongly indicate that **HAART has decreased the risk of transmission of HIV despite increased practice of unsafe sex** and thereby substantiate that HAART should be offered to MSM to reduce risk of transmission of the disease.
Cowan SA et al; JAIDS 2012

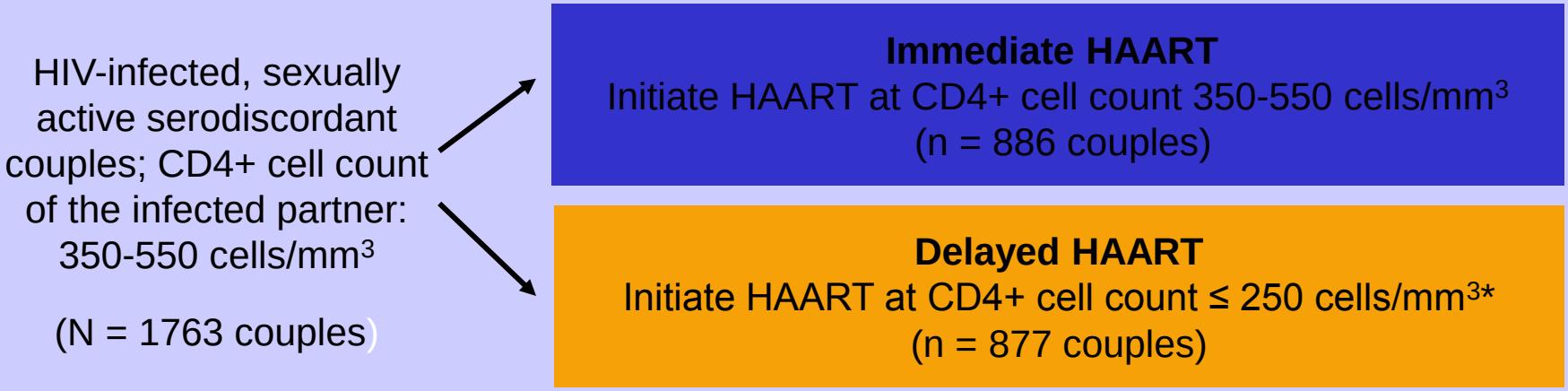
Percezione del paziente relativa al suo bisogno personale di assumere la terapia e ruolo della stessa nella prevenzione della trasmissione secondaria

L'inizio della terapia antiretrovirale non è necessariamente legato alla presenza di una sintomatologia clinica. Pertanto è possibile che il paziente asintomatico abbia una non corretta percezione relativa alla sua necessità/indicazione ad assumere la terapia. È fondamentale in questa situazione esplicitare i criteri che suggeriscono o impongono l'inizio dei farmaci antiretrovirali chiarendo che l'evoluzione della malattia non è necessariamente correlato con la presenza di disturbi clinici avverti dal paziente. E' anche necessario informare il paziente del ruolo della terapia antiretrovirale nella prevenzione della trasmissione secondaria dell'infezione (TasP, Treatment as Prevention), indagando quindi se vi sono condizioni che comportino elevato rischio di trasmissione: coppia siero discordante oppure in caso di soggetti che riportano ripetuti episodi di rapporti non protetti e/o con patologie acute a trasmissione sessuale. L'inizio della terapia in questo contesto, in assenza di ragioni cliniche, può avvenire sempre solo in caso di paziente motivato (si veda il

La comunicazione fra paziente e medico è il cuore stesso della medicina. Senza una buona relazione la diagnosi e la terapia presentano notevoli barriere. La comunicazione medico-paziente può influenzare positivamente l'aderenza alle terapie e l'efficacia dei trattamenti antiretrovirali nonchè il benessere fisico e psicologico delle persone con malattie croniche [35-36], inclusa l'infezione da HIV [37-38]. E' pertanto un ambito privilegiato cui prestare la massima attenzione. E' auspicabile l'incremento di percorsi formativi per operatori sanitari su questo tema. Gli obiettivi o le funzioni della comunicazione medico-paziente sono identificabili in 6 tappe sintetizzate in Tabella 1, che possono essere considerate i momenti imprescindibili della comunicazione stessa (modello di Bird e Cohen-Cole's [38]).

La comunicazione medico-paziente è cruciale nella gestione clinica della persona con infezione da HIV. Anche in considerazione dell'impatto favorevole che una buona comunicazione può avere sui risultati clinici del paziente (inclusa l'aderenza alle terapie), sul suo benessere psico-fisico e sulla soddisfazione, è di particolare importanza prestare ampia attenzione alle fasi comunicative in ogni visita clinica e alla formazione continuativa del medico in tale ambito [AII].

HPTN 052: Immediate vs Delayed ART for HIV Prevention in Serodiscordant Couples

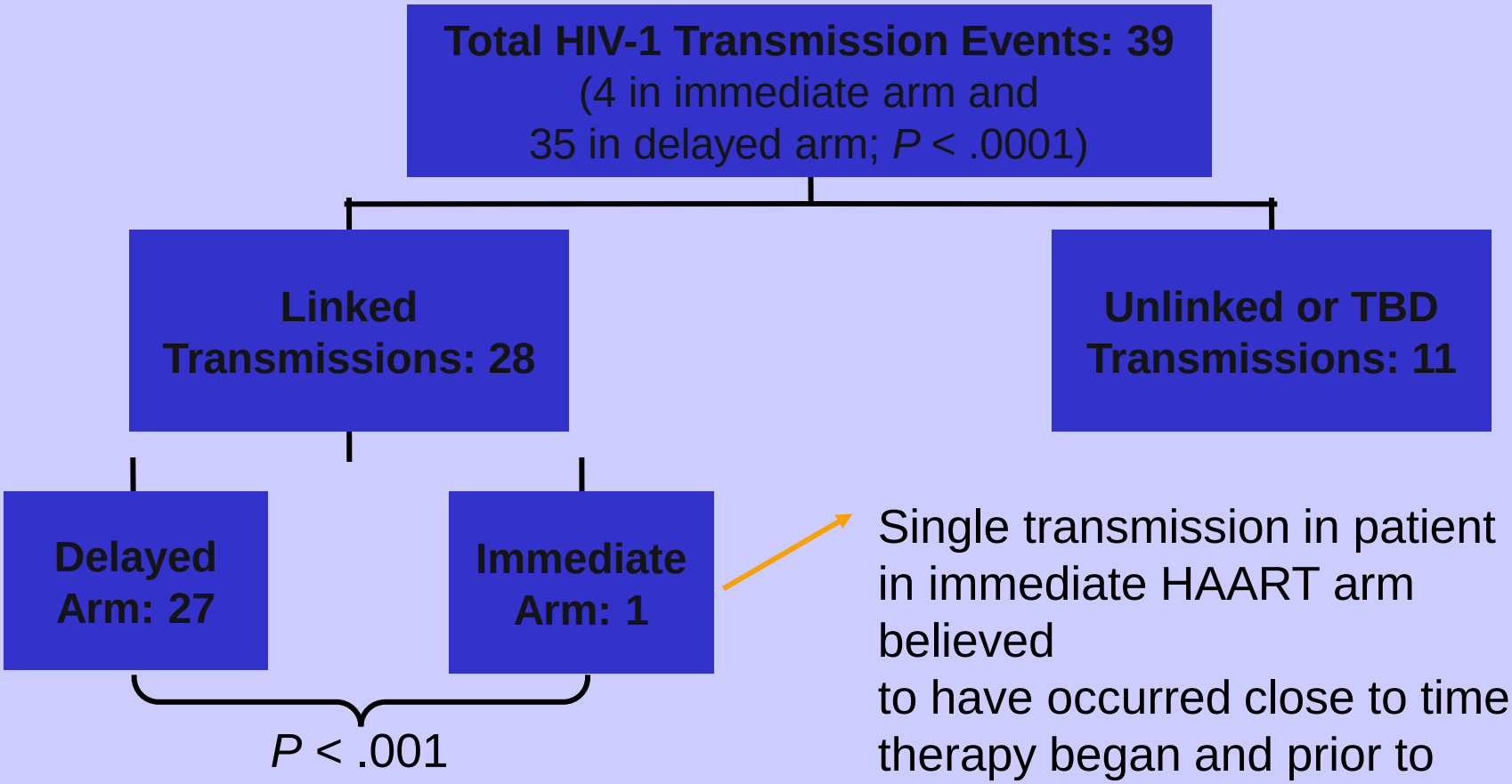


*Based on 2 consecutive values ≤ 250 cells/mm^3.

- Primary efficacy endpoint: virologically linked HIV transmission
- Primary clinical endpoints: WHO stage 4 events, pulmonary TB, severe bacterial infection and/or death
- Couples received intensive counseling on risk reduction and use of condoms

Cohen MS, et al. N Engl J Med. 2011;365:493-505.

HPTN 052: HIV Transmission Reduced by 96% in Serodiscordant Couples



Single transmission in patient in immediate HAART arm believed
to have occurred close to time therapy began and prior to suppression of genital tract HIV

Cohen MS, et al. N Engl J Med. 2011;365:493-505.

What Do These Results Mean for Others?

Likely that ART prevents transmission in others, although

- Only 2 couples from US in HPTN 052
- Other routes of transmission (needles, anal intercourse) and clades (HIV subtypes) may have different transmission biology
- No protection for outside partnerships (28% of infections)

Position statement on the use of antiretroviral therapy to reduce HIV transmission January 2013. The British HIV Association (BHIVA) and the Expert Advisory Group on AIDS (EAGA) †

3. The risk of a person living with HIV, who is taking effective ART, passing HIV on to sexual partners through vaginal intercourse is extremely low, provided the following conditions are fulfilled:

   - There are no other sexually transmitted infections (STIs) in either partner*.
   - The person who is HIV positive has a sustained plasma viral load below 50 HIV RNA copies/mL for more than 6 months and the viral load is below 50 copies/mL on the most recent test.
   - Viral load testing to support the strategic use of ART as prevention should be undertaken regularly (3–4-monthly) ‡.

4. The published data are largely from heterosexual couples and there are insufficient data to conclude that successful ART use can provide similar levels of protection in relation to other sexual practices, including unprotected anal intercourse between men or between men and women. However, it is expert opinion that an extremely low risk of transmission can also be anticipated for these practices, provided the same conditions stated above are met.

It must be noted that no single prevention method can completely prevent HIV transmission. Antiretroviral therapy reduces the risk of transmission only of HIV. Irrespective of antiretroviral therapy, condoms remain the most effective way to prevent the spread of other sexually transmitted infections.

Notes:

a) *Sexually transmitted infections (STIs) within a couple can only be reliably excluded if:

- both partners have had a comprehensive STI screen and all results are negative;
- neither partner has had sex with anyone else since the screen;
- the screen is repeated for each individual following sexual exposure with every new sexual partner and a negative result is obtained within the relevant 'window' period for each STI before the couple have sex again.

b) These conditions can only apply if there is complete disclosure within the couple about sexual relationships outside the partnership.

Conclusioni e proposte:

1) Eseguire anche nei pz HIV+ asintomatici esami per sifilide ogni 4-6 mesi

2) l'anamnesi sessuologica deve essere più dettagliata (un conto è registrare il fattore di rischio per scopi epidemiologici ed un altro conto per scopi clinici e di prevenzione)

3) i Medici debbono essere addestrati ad eseguire questo tipo di anamnesi

4) individuati i pz a più alto rischio debbono essere riferiti ad uno Psicologo esperto in questo campo perché non è sufficiente una Psicoterapia breve

5) Misurare l'incidenza e la prevalenza di MTS in pz HIV+
(il modulo di notifica di MTS non è adeguato e non è sufficiente)

Grazie per l'attenzione !