#388 HIV in Primary Care with Dr. Jonathan J. “JJ” Nunez MD

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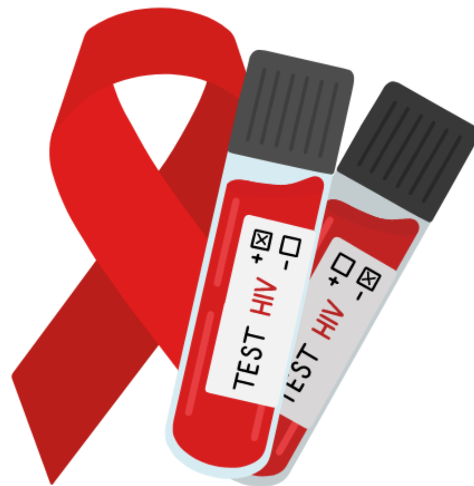
INTERNAL MEDICINE

HIV IN PRIMARY CARE

LIVE! Updates in HIV management at Hershey



with Dr. JJ Nunez MD

Matt: Paul, we're in Hershey, Pennsylvania. And Paul, I don't know if I've talked about this before, but I had a real problem with chocolate, nuts, and marshmallows. But Paul, I got over it, but it was a rocky road.

Paul: [chuckles] They're going to rescind my job offer.

Matt: [laughs] All right, let's get started.

[Disclaimer]

[Curbsiders theme]

Matt: Welcome back to The Curbsiders. I'm Dr. Matthew Watto, here with my great friend, Dr. Paul Nelson Williams. Today, we're going to be talking about HIV. What should we know about this as generalists in primary care? And we have a great guest, Dr. JJ Nunez. Paul, before we introduce our wonderful guests, would you tell people what is it that we do on The Curbsiders?

Paul: Yeah, I often ask myself, but thank you, Matt. And also, by the way, thank you, John, for that nice introduction. I have never been introduced first in my entire life, by the way. So, that was a real thrill for me.

Matt: [laughs]

Paul: It's nice to have that recorded for posterity. We are *the* Internal Medicine podcast. We use expert interviews to bring you clinical pearls, and practice-changing knowledge. What an expert we have for you? I can say, on a personal note, I've known Dr. Nunez for years, and he is one of those people who is annoyingly good. I don't know if you know people like that, but he's nice and then also competent and takes good care of patients, and is smart, and the type of person who makes you feel bad about yourself if you're me, at least. So, we're thrilled to have him, but I'll give a more formal bio now.

So, Dr. Nunez received his medical degree from the University of Connecticut School of Medicine, and went on to do his internal medicine residency at Yale-New Haven Medical Center and completed his fellowship in infectious disease at the University of Pennsylvania with Penn Medicine. Dr. Nunez is interested in health equity and medical education. In addition, he has an interest in improving access to medications for opioid use disorder, medical student resident education that was probably supposed to be, HIV primary care and HIV preventive medicine. So, without further ado, let's bring up Dr. Nunez. JJ?

[applause]

Matt: All right, let's get right to a case, right down to business.

Paul: All right. JJ, we're going to tell you about Mr. Jones. He's a 24-year-old gentleman, self-identifying male who presents to your primary care office for the establishment of care. He is transferring care to your office after moving to your city from out of the state. Medical records are not available at this visit. He is without specific somatic concerns, and he reports a medical history significant for HIV for which he takes bictegravir, emtricitabine, tenofovir, otherwise known as Biktarvy. For the purposes of this case, you're not an expert, you are me, which means you are well meaning and you don't have a lot of experience taking care of HIV, but you have ready access to competent colleagues like yourself who are able to do so.

I feel like one of the reasons I chose this case is this comes up in my practice. I'll know about you, Watto a lot, where I have someone who say their HIV is well managed by an ID doc, but they still want somebody else for their primary care. It's the lines get blurred and I feel like I need a little bit of help. But for you at a first visit like this, where you're meeting this patient for the first time, what are your goals and what does this first conversation look like for you?

Jonathan: Yeah. So, I think usually when I'm first seeing any new patient, I always try to break the ice. I introduce myself. Mostly I try to tell them two things. I'm slow. So, I'm like molasses. So, I usually tell them, probably don't want to schedule an appointment after that, mostly because it gives me time to really dive into a little bit of the psychosocial stuff that's necessarily going on. Second thing, I always tell them, I'm like Colombo. So, I tend to repeat myself a lot. And mostly, I feel like it's mostly just to pick up things that might not have come up the first time or maybe I did not actually pick up when they were talking.

So, I think from the first visit, I really try to get a sense of what brought them here today. If they're transferring their care, what was the reason that they're transferring care? Were there barriers to the last practice that they were necessarily at? I think the other things, if they're moving from a different state, what brought them to the state? Is it work? Is it employment? I feel like starting off with some of those questions gives me a little bit more about the social support, as I try to ask these questions overall. Then during the actual visit, I think focusing a little bit more on the HPI mostly of HIV, the big things I'm looking for mostly is time of diagnosis, how long have they been diagnosed, are they actually on medication, are they taking their medication, are they struggling with adherence? Those are the kind of the questions I'm necessarily asking overall, mostly to think about barriers to care. I think we do excellent job of screening patients for HIV. It's just retaining patients in care where it's a little bit more difficult.

Matt: I noticed you mentioned Colombo. I'm 40 years old and I barely get that reference.

Paul: [laughs]

Matt: So, I'm sure your patients really appreciate it. At that first visit, how much time are you getting and how much detail are you getting into about--? You mentioned the psychosocial stuff. So, can you give an example of, like, where you might spend the time on those, which specific issues?

Jonathan: Sure. I think usually I start off with just asking about the social history in the beginning, really getting a chance to learn my patients. It makes it easier for me to remember who they are, especially when they're calling.

Matt: Yeah.

Jonathan: So, I can really remember one or two special facts necessarily about them. But I think the things I'm really focusing on is living situation, things about how they interpret and look at their disease, how do they feel about their disease, how do they feel about their medication management? Are there things where they feel that they're empowered or they feel like they're being listened to? Those are some of the things I'm actually necessarily going through as well. As I focus on that, I'm also just trying to figure out if there're issues with housing, or if there're issues with changing insurance, or making sure that there's coverage for the medications. Are they having trouble with side effects or any reportable side effects that I don't know about medications?

So, as I go through with that, I also try to focus a little bit more on mental health just to try to see where they're necessarily at. Have they been treated before in the past for any mental

health? Are they having any barriers right now? So, a lot of times I think of it as more like a biopsychosocial assessment than necessarily like a true social history, actually. Then that's where I segue and make that introduction to the more personal questions. I don't usually to start off with just the HIV questions, because sometimes, they can be a little bit more personable or intrusive. So, then I move into the history of when they were diagnosed, where they've been diagnosed. A couple of questions I might focus on for that is, have they been on medications that worked for them, have they been on medications that hadn't worked for them, are there any side effects for me to know about, what do they look for in a provider? Those are the things I focus on during the visit.

Usually, I have about 40 to 60 minutes for new patients, which is lovely. I also run slow, so it's going to be a little bit longer than that. In my practice, there're days I have social worker and case managers. So, I think we're all working together as they work with the patients. I think at the end, we try to debrief and see if there're any issues that we might have missed. Other days, I'm just by myself. I feel like the first visit is really a job interview. That's really what it is for me. I got to make sure that this patient feels comfortable to come back. No one really wants to go to the doctor.

I don't want to go to a doctor. The only thing I'm more popular than, maybe the dentist. Okay. But I feel like how much I try to focus on that visit, I might have my expectations, but it's really measuring what expectations my patient has. If there's an ongoing issue or medical concern that they have, I'm going to push some of that aside and really just focus on that, because I think one of the big things trying to retain them in care is making sure that we're taking care of the issues that they have.

Paul: You are [unintelligible [00:07:55] the next question about retention and care. This is sort of a broad question, but I guess, other than being your usual charming, excellent doctorly self, is there any systemic or like clinic level stuff that you can do to encourage retention and care? I guess, what can we do to keep these people engaged in treatment, because I know that this can be a challenge at times?

Jonathan: Yeah, I feel like jumping around a lot in the sense that I mentioned what I do. I think the first thing I also make sure is just making sure that we're using right pronouns. So, for some of my patients, it might be fluid. So, I might ask during each particular visit. I think that might be one part where I would start. I think one of the big things that I try to make sure during the visit is ways I can contact my patient. There was a study that was done at one of the Ryan Wright Conferences I want to say, like, years ago that was one of the biggest predictors was change in phone number in a year.

So, I think for me, trying to focus out where they're at, where I can contact them, how I can contact them, recognizing especially for my younger adolescent or young adult patient population, cell phone calling them is archaic. No one calls them, right? So, it's usually through text. So, I try to find other ways in theirs as well. I think the other thing systemically I try to do is see them without medical records. If I have it, lovely, awesome. If it's not, that's fine too. I don't find that they're overall super helpful. You get 200 pages of stuff that you don't necessarily need.

Matt and Paul: Yeah.

Matt: Yeah, it's more helpful if you have a specific question when you get that 200-page document dump of prior records. But I wanted to point out to the audience, because I think about this a lot. I'm a doctor, but I try to read and listen to stuff that's way outside of medicine and try to apply it to medicine. But I think if you're in the audience and you don't see anyone who has HIV, I think a lot of what you talked about is just good doctoring where you're just

like, "I start off. I want to get details about the person, so I remember who they are. I remember their story." You're building your memory palace of like, "Who is this person?" I think that's great. So, I think people can apply that to whatever they're doing even if they're not seeing any HIV in their clinic.

Paul: You mentioned some of the things, but I wonder if you could just role model for us what your specific HIV history looks like. So, once you have the patient comfortable with you in terms of things like date of diagnosis and sort of acquisition, are there any--? I think you touched on most of those points, but you can just bullet point out what you ask about when you're asking about the HIV history specifically.

Jonathan: Yeah, sure. So, I try to figure out where they're necessarily coming from, when they were diagnosed, if they've ever been hospitalized or non-hospitalized. This gives me an idea if there've been complications. Usually, I go back to see if they've been on history of any opportunistic infections. So, it can give me an idea what stage of HIV or AIDS or complications they might have had before in the past, medications we talk about. I really want to make sure that we're aware of resistance, which most patients may not necessarily know. They just may remember, "Hey, this medication, I was told does not work for me overall."

I want to get a sense if they have an understanding of what the name of their medication is, realistically, they're probably going to know more about their medication than some of the providers. We just don't see it as often. Then what pharmacy that we've been using it, how have they been getting it, have they had any issues for the barriers for the pharmacy? Because sometimes, if it's smaller mom and pop shops, the medication can sometimes be delayed for getting it compared to some of the bigger institutions. As for additional HIV history, other things I try to get a sense of as well as any other co-infections, mostly thinking about hepatitis B and hepatitis C, because it's going to determine what I do for treatment, and then want to make sure that we really treat hep C very early on because with co-infection, the progression to liver disease is much higher.

I also want to make sure there's social support actually. So, just making sure as we're working about things, are people aware of their diagnosis, are they not aware of diagnosis, are they secretive about their diagnosis stigma? The way I ask that is mostly like, "What's been barriers for you about taking care of your medical condition actually?

Matt: Paul and I were talking about this on the drive up here. I feel like that it's a chronic disease. We have such good treatment for it, but the stigma and people just remember the 1980s and 1990s when everyone was dying from it, and people are still just so secretive about it, or I've still had patients tell me, "Please don't test me for HIV." I'm like "What are you worried about getting tested?" And they're like, "I don't even want to go there." I'm like, "Well, it's a chronic disease. You could get treated." I think there's still a lot of misinformed patients.

Jonathan: You brought up an excellent point, Matt, because how I always mention is it's in chronic disease that's easy to treat, easier than diabetes. That may be true for me as the provider, but it may not be the truth for the patient.

Matt: Right.

Jonathan: I think a couple of times, I always touch base with them is just that they can tell you the exact date that they were diagnosed. They can tell you the exact situation that they were in when they were diagnosed. And for many, it was really, really traumatic actually. It was in a very awkward situation or the other thing was the involvement with the healthcare system at that time, or it was like a complete shock. So, it's very easy for me to say, "Hey, it's

easy to take a pill every day." For some, it's really not. So, that's why I really try to get a sense of, like, what is their understanding of the disease and how do they view themselves overall during a visit?

Paul: This is fairly granular, but I wonder, how do you document in the record, sort of who knows about the diagnosis, who can be disclosed to? I feel like I don't know about you all, but I've been involved in teams where there's been catastrophic disclosure of diagnoses to family members who didn't know or that kind of thing. So, is there a way to safely share that information, so that you're protecting the patient the way they need to be protected?

Jonathan: Yeah, I try to keep it in my note. I think I try to forward with every part of my note, part of the HIV initial history, so that if anyone's pulling up the chart. I also try to use stickies if we can. So, my previous medical records, you can actually put it. So, it comes up as a pop up that you can make sure that they're not aware of the diagnosis. Our medical record here has that option too. I just assume that no one knows and you shouldn't assume that anyone does. I think also when you're seeing patients in the hospitalized setting, you just assume that someone in the room does not know actually because I've had similar instances where they were accidentally disclosed in front of people that didn't know.

Matt: Thank you for not mentioning the medical record by name. We bleep that on the show.

Paul: [laughs]

Matt: Actually, a past guest complained to Paul and I, because we bleeped them, because they said the medical record name so many times that their colleagues were like, "Why are you swearing so much on Curbsiders?" And he's like, "I wasn't swearing. I was saying the name of a medical record."

Paul: Yeah. Listen, until they sponsor us-

Matt: Anyway, yeah.

Paul: -they're not getting free press from us.

Matt: All right. Paul, should we move on with the case?

Paul: We should probably move on the case. All right. So, Mr. Jones, in terms of getting your excellent history, he tells you that he was diagnosed with HIV three years ago. He states that his viral load is undetectable. He believes his CD4 count was "pretty good" at last check approximately six months ago. He is without any other medical issues other than occasional seasonal allergies. He states that his parents are in good health. He reports occasional alcohol use, smokes cannabis daily, and denies other substance use. He is sexually active with two male partners and engages in receptive and penetrative anal and oral sex endorsing routine barrier protection. He reports a prior history of chlamydia infection about nine months ago and then again two years prior to that. Works as a graphic designer currently and lives alone. We'll get into some of the social history and some of the management stuff, but I did want to give a space to at least talk about your initial physical examination if this diagnosis changes anything that you would do or if it's just your routine bread and butter.

Jonathan: Sure. I think a lot of its visualization, actually, just looking at the patient if they seem anxious overall that gives me some kind of things to look for. Also, the things I'm looking for during my history, even though it's part of the physical, I always do a full review of symptoms because it gears me if there're issues with adherence. Things I'm looking for really is if there's been any weight loss, any night sweats, any fevers, have they noticed any

lymphadenopathy overall, because it might gear to me on what I'm going to focus on my necessarily exam as well. And then thinking about the sexual history, actually, which I'll talk about in a little bit. But I think one of the big things is if they're having any active symptoms, because, again, one of the big things I try to do on the exam is make sure that we're not missing anything on the diagnosis.

Then for the physical exam, really, just like I tell the residents, it's really just head to toe. But a couple of things for me to keep an eye on is if there's weight loss, if the patient looks cachectic. I think other things, if there's visual field deficits, the rooms have ophthalmoscopes, we can use them. Reminding them that they're there other than paperweights. I do a good full skin exam, lymphadenopathy. And then, depending on patient preference and reading the room unless there's an active symptom that's concerning for me for an STD, I also make sure that I try to do a sexual health exam as well, but that might also be determined by patient comfort.

Matt: You mentioned looking for cachexia and everything, but one thing that I guess not as aware of, like, people with screening for metabolic syndrome or just like weight gain on medications, can you speak to that a little bit? That wasn't really on my radar.

Jonathan: Totally. So, also part of my exam is looking through the vitals and then also looking for anything that's suggestive of metabolic syndrome. So, why is that? Because I think patients had mentioned that there has been weight gain with certain HIV medications. I think a lot of times back in my day as a trainee, and as a student and as a fellow, we used to always mention that HIV is this catabolic state, "You're undetectable, you lose fat deposits, you're on medications that's why you're gaining weight." Although, since there's been newer treatment options, which is awesome in the sense that they're easier to take, has less reportable side effects, they suppress the virus really well, we're learning a lot about our patients on these new medications. I think there's been a lot of association with weight gain as well.

When we look at that, it's also not necessarily equal actually. So, I remember reading something where about one in six patients within the next two years will gain 10% of their body weight actually starting on antiretrovirals. When you split that even more, the weight gain is even higher in African-Americans, especially African-American women. So, nearly 20% of patients. Some of these studies, I think the one I remember is the advanced trial noticed that there was weight gain about up to 6.4 kilos. So, is it part of the medications? It could be. I think some of the newer formulations, when we used to use a lot of tenofovir disoproxil, we advanced to tenofovir alafenamide.

We're noticing that there is some weight gain and there might be even more concurrent weight gain with some of the integrase inhibitors. So, when we're thinking of dolutegravir or bictegravir. So, it's something to think of console. As exam wise, it's important to keep an eye on that because there is going to be some weight gain and I think preparing patients for that, if you want to talk about adherence is important.

Paul: What do you do in terms of mitigation strategies for that? This is not the episode for initiation of therapy, but I guess, if you were at that point, is it just an anticipatory guidance? How do you talk to that with patients?

Jonathan: I think I've changed my focus on a couple of things. I think, one, I really think about talking about diet and nutrition very early on. And then again, it's really not just that. It's really checking if there's access to healthy food. So, I think if there's an issue with that with patients, I might tie that in with my case manager or local resources to focus on that. I think three, try to really form and talk about physical activity. When I talk about physical

activity, that's another sneaky way I find out safety of the neighborhood because there are some neighborhoods where it's not super safe to go exercise outside.

It also has made me rethink sometimes med switches. So, a lot of times, the thought process is a newer medication comes out, super great, less side effects. But if my patient haven't had issues to change them, sometimes, it's conversations now that I initiate, "Hey, there's this new option, but let's sit down if this is the right option for you." So, I've been rethinking some of the initiations and switches overall. Or, if I do switch, mentioning that this may be something that note that we will know actually.

Matt: I've had some patients recently tell me that they started doing YouTube workouts, because Peloton all those things are expensive, unattainable for a lot of patients, but there're free workouts on YouTube and things and same thing. Patients are like, "My neighborhood is too dangerous, so I don't walk around" or during the pandemic, people weren't comfortable going outside, so now they're doing that. I did want to ask you switch-- is it okay to talk about labs now, Paul? Are we moving into the initial labs or we have something else? I would save my question.

Paul: Well, I guess, while we're here in metabolic land, I guess, or any other considerations. I know that I hear some rumblings about screening and diagnosing diabetes and choosing labs for that, and timing of the initiation of ART and that kind of stuff. Is there anything that might be a little bit more nuanced that we need here? But from a primary care standpoint, is there anything that we should know about specifically between HIV as treatments and diabetes?

Jonathan: Yeah, I think the one thing that's really interesting and I'm happy to have patients that are living longer lives. I'm happy for the day they're cured and I lose my job. I tell them I'll cry tears of joys with that. But there is a risk for cardiovascular disease about two times higher in patients living with HIV, even being undetectable and higher CD4 counts. So, I think as we look back at that, there's some big focus points for [unintelligible [00:21:31] syndrome. I think one of the things is really being aggressive to screen for diabetes. I think also making sure that lipid profiles that we're not just checking them, we're actually treating them. So, as we're thinking about things, I have many patients who are super well controlled for the HIV, their diabetes needs a little bit of help actually.

I think one of the big things as I focus on that is highlighting that. That's probably just as important or even more important for mortality overall than necessarily just treating your HIV. So, I think I tend to do a lot more screening. Then as I'm thinking about my antiretrovirals, as we talk about switches, it's important to think of what medication interactions there might be. I think one of the big things is making sure that if a patient needs to be on a statin medication to really think about that. You can't just go by the ASCVD risk factor in our patients who are living with HIV, because we're not actually part of the calculation. We know there's a risk, so as I discuss with my patients why I'm doing stuff.

I think one of the big things for my patients is I feel a lot of times overall, both non-HIV, more meds. I'm always pushing meds, right? They want less meds, but I try to really focus that, "Hey, if you have a heart attack, there's going to be about three or four meds I'm going to add on to your med list that probably won't go off." I think that's if you have a minor heart attack with no dysfunction after.

So, for us, for mostly taking off the patients for boosters, for cholesterol medications, if we can, some of the protease inhibitors can cause dyslipidemia, the newer ones not as much, but compared to the integrase inhibitors, they tend to be pretty lipid neutral. But my dosing for the statins can be contraindication. I have to start with a lower dose and make sure that

they're not having any side effects. The statins we tend to use is rosuvastatin or atorvastatin overall.

For diabetes management, some of the longer acting integrase inhibitors actually do interact with metformin, so the dosing should probably be a little bit lower. So, thinking about dolutegravir and bictegravir, but I think one of the big things is just making sure that as a provider, we're doing just as updated care for HIV for their primary care. So, if they really are indicated to get a GLP-1 for diabetes really thinking about that, if they need the statin, really thinking about that overall. So, I tend to be pretty aggressive on that. And same thing for blood pressure control.

Paul: Do you have any preferred resources for the statin interactions or do you just know if these off the top of your head at this point?

Jonathan: I always double check.

Paul: Great. Thank you. [crosstalk]

Jonathan: I think I always double check. There're a couple of great resources. I think University of Washington has this self-study module for HIV and also HIV in primary care. It's free. It's amazing. They also have one for Hep C. UCSF also has one where I think they're just revamping the website because it's been off for about a year, and it's called the Knowledge Link, and it's great, because it's all topics necessarily all towards there. Those are my go-to ones. Then I know I'm digressing a little bit, but I think as I talk about my patients is really focus on smoking because there's a much higher prevalence of smoking in patients living with HIV.

I describe it as a couple of years ago, our journal, Clinical Infectious Disease, had an article on smoking, and smoking conversations to have with patients, reviewing their treatments for patients. Pretty much a primary care article in an Infectious Disease journal. I think it just shows that the prevalence of smoking is much, much higher.

Matt: Yeah. The quit line in the state of Pennsylvania is great. They give five free coaching sessions, and they'll send patients patches, and then either gum or lozenges for free. So, it's a fantastic resource. I think it's a national resource. I think if you call, you actually get a person too. So, I would recommend people just even call it yourself just to see what experience the patient's got. I've done it and it is very helpful. I wanted to note the Liverpool calculator, isn't that the one that all the ID docs-- I think it's been mentioned on the show before. I think they have one for Hep C, for HIV, and for the COVID medications and things.

Jonathan: Yeah, and thank you for bringing that back up, because that one's also a very helpful source. I've used it a lot during COVID, especially just a med check for the Paxlovid interaction.

Matt: Yeah. All right, Paul, where to next?

Paul: Well, it's Valentine's Day.

Matt: [laughs]

Paul: We should probably-- [crosstalk]

Matt: Oh, it is Valentine's Day. Happy Valentine's Day.

Paul: Yeah, thanks to you too, buddy. Let's talk about because I do want to make space for this too about the conversations about transmissibility in relation to, say, viral load and CD4

counts. What's the current thinking, the current counseling? I just want to make sure that we talk about the U=U before we move past it into the other screenings.

Jonathan: Yeah. So, I think this was big when this came out with CDC. I think there were many studies that were already super suggestive of this. There was a study which I can't remember at all. I think it was HPTN 052. You might quote me on that one.

Paul: [laughs]

Jonathan: I should know that one. But I think overall I was looking at serodiscordant couples. What they noticed in serodiscordant couple, one living with HIV, one without is that as long as the patient was undetectable, actually did not contract-- was unable to transmit HIV. There've been several iterations of it from different parts. There's the partner studies and the partner 2 studies that looked at more diversified patient populations and same thing. So, when we're looking at patients at MSM or gay or bisexual, they were able to extrapolate as well that U=U. So, really thinking about treatment is not just treatment, it's also preventive. So, that's why I think a lot of our treatment options are really focusing on starting medications very early on. It's crazy. Like 10 years ago, I would wait till there was a defining illness.

Paul: We were just talking about this, yeah.

Jonathan: When I was a resident, I think the SMART trial came out. So, it was like CD4 count of 500, really talking about the rapid initiation and really bringing down that viral load as quick as often. There's a lot of stuff from UCSF also looking at bringing down that viral load very quickly with same day initiation. You just got to remember there're some patients that you may want to do that too. There might be others that you want to be careful on, actually.

Matt: Yeah, this is something I do on the show from time to time. So, tell me if I'm wrong, I might be wrong, feel free to shoot this down.

Paul: He's going to be wrong, by the way.

Matt: Yeah. [chuckles] We should just check the CD4 count. That's still most important. We should just check it every month or so for just the entire time the person has HIV. What's the current thinking on that? Am I up to date?

Jonathan: So, we'll check a CD4 count, initially, as baseline when we're thinking of treatment naive mostly to give us an idea of if there're issues with us to think about for opportunistic infections prophylaxis. The absolute number is what my patients are so on and remember, but to me, just as important as the CD4 counts the percent, because the absolute number can change. Someone can be ill, hospitalized with a pneumonia, come in with a colitis, that absolute number can come down. But the percent tends to be less variable for how often we check it. So, I usually will check it within three to six months in the initial part as patients who've been undetectable for greater than two years I've sometimes just switched to once yearly actually. It also is patient driven. There are some patients that really that is super important to them to know. So, I think that's something I keep into my thought as well.

Matt: Probably, it depends on when they were diagnosed too, right?

Jonathan: Yeah.

Matt: Yeah. We had talked years ago with Michael Saag and he was just like, "Yeah, viral load is what's important now suppressing that. Once someone's viral load suppressed and

their CD4 is greater than 500 and stable for years." Checking it has minimal value at that point if they're staying on their meds.

Jonathan: I would agree with that. I think some reporting that some funding comes from different states for our Ryan Wright program still are on.

Matt: They still want that.

Jonathan: They still want that.

Matt: [crosstalk] Interesting.

Jonathan: But I think I agree with that. To me, the bigger thing is making sure that the viral load. That's what I'm going to be checking more often, especially I want to make sure that's dropping within a log actually. With the introduction in integrase inhibitors, it does. Where I get worried is if it's not, and that's when you got to start thinking about, "Hey, were there barriers for errands? Is there some underlying resistance that I might see" and that's where I might focus on.

One thing I forgot to mention, even as I'm having this discussion with this patient too, is taking a really good sexual history, because one of the big things I want to make sure is that, if their patient partners get offered prep or discussions about HIV prep. I know these guys done talks on HIV prep. I won't focus so much on that, and then also take a really good sexual history as well.

Matt: Yeah.

Paul: So, I would like to hear what your sexual history sounds before we get there and before we leave this slide. Is there a recommended duration of time for someone to be undetectable before you can say with confidence, "Okay, U=U." Is there guidance, recommendation age for that? Is one lab sufficient? What's the timing about that?

Jonathan: So, back what I always remember when I'm talking about family planning, I would like to make sure that they're undetectable for at least six months. But I think honestly, the data suggests that if they're been undetectable with viral loads less than being detectable, it reduces the chance.

Paul: Perfect. Okay. And I know that you wanted to talk about your sexual health history. This feels like the right time.

Jonathan: So, I would say that the greatest thing I've ever had, honestly, was working with a young patient population, because they really broke me down in the sense of terms, lingo, everything.

Paul: [laughs]

Jonathan: I still learn so much from them. It's a joy taking care of them. There's actually an insert from the CDC and it's really thinking about the five Ps. Now I don't always remember all the Ps, but it's still good.

Paul: [laughs]

Jonathan: So, I think one is looking at practice. So, what is their practice? I always start off with like, "I have no assumptions. Just tell me what preference of partners do you have trans, female, bi? Overall, how do you practice, top, bottom, vers?" Usually, I preface this by this is important for me to think about for testing. So, I usually will preface that from that. Sometimes I'll even ask them, have they been tested in that modality before overall? I think

the next thing I get to is number of partners within the last three to six months. So, again, it gives me an idea of how often to do STD screening, making sure that that's offered. And then also thinking about HIV prep, if there're also partners that they're necessarily having that might be interested in that as well.

I think also prior history. So, again, knowing if they had previous histories of STDs, mostly to make sure that they get tested more frequently, and then also to make sure that they're getting tested correctly. A lot of times I see the primary care providers, amazing. They'll do a good job of screening. They forget to check syphilis. So, a lot of times, I'll see the urine and the swab, but I won't see the RPR actually. So, there're higher rates of syphilis as expected.

Then one other thing that might be a little bit different in my patient population is Hep C. So, there's been some data looking at sexual transmission, mostly in MSM. There've been thoughts that screen Hep C might want to have a discussion with patients to screen yearly actually. So, that might be something else in my practice. Making sure they're immune for Hep B is also a part of my practice. So, looking through all these is making sure that if we do have the swabs to do rectal and pharyngeal testing that should be included as well because we'll catch more cases that way.

Matt: Yeah. We did a STI episode years ago and I, again, was embarrassed to not know that. I was just like, "Oh, do the urine nucleic acid amplification test and I'm good to go?" And our guest is like, "No, you miss a ton if you do that." You have to ask them, "How are you having sex?" And then you have to do rectal swabs or pharyngeal swabs as you just said, as well, if that's happening. So, I think we can't say that enough, so that people remember to do that. What else, Paul?

Paul: I heard rumblings about doxycycline for STI prep. Can you talk me where are we at with that, how should we be thinking about that? Is that something that is commonly used?

Jonathan: Sure. When I was in Philadelphia, there was an arm of the IPERGAY) study that looked at doxycycline to look at reducing the cases of syphilis and chlamydia as the advent of HIV prep. Great in preventing HIV expectations that there've been higher cases of STD, especially in certain patient populations where there's just much, much higher cases overall. The thought process is that it's really thinking about post exposure prophylaxis, because what they're looking at is providing doxycycline, which is 200 milligrams within. You want to do it within 24 hours, but up to 72 hours after a condomless sexual activity.

What they notice is that it actually decreased syphilis cases and chlamydia cases. UCSF in their state health department, I thought, had just came out with a study because it was mentioned in the International AIDS Conference from last summer, actually looking at doxycycline. They were only looking at it for MSM. So, it's only really MSM. It's cismen or trans females to think about when we're talking about doxy PrEP, actually, although there's ongoing studies looking at it for cisfemales as well. But what they noticed was that reduced STDs, but up to 66%.

As a former before ID fellowship, I was an epidemiologist and I can tell you I've never done syphilis contact tracings, but I've done other contact tracings. It takes up a lot of time and resources to really find patient zero. So, when you're trying to find and track cases of syphilis, how much resources are spent thinking about conversations about doxy PEP might be something to actually talk about.

Matt: This is a daily doxy dose to prevent?

Jonathan: There're two different ways. So, most ways I've used it is mostly as post exposure prophylaxis. [crosstalk] So, 200 milligrams within the 72 hours, really try to put it 24 hours. There're other studies that are coming from Canada and Australia that are both looking at both PEP and doxy PrEP as well. So, there might be stuff coming about, because next week is our big retrovirus and opportunistic conference, which is a mouthful. So, we just call it CROI.

[laughter]

Jonathan: So, CROI. So, there might be some updates.

Matt: By the time this airs, we might have to update the show. You'll let us know if you need to update the show notes by the time this airs.

Jonathan: But the question comes on who to think about it. So, when I was in Philadelphia, I remember the Health Department meeting with us and just talking about how much resources they use for syphilis testing. There had been discussions and reflections on, should we be thinking about doxy PEP? So, it's a conversation that I've had for my patients. I think of any patients that had more than one or two STDs, actually within a year, especially if it was syphilis actually, so it's one of the big things that I have had discussions with. The controversy or the part did not know in that study, the most recent one was there was more resistance to gonorrhea. It reduced it, I think, by 50%, but there's increasing resistance [crosstalk]

Matt: Yeah, we don't want super gonorrhea to get any more prevalent than it.

Paul: [laughs]

Jonathan: But the caveat is that we don't really use tetracycline for gonorrhea treatment. But the question is, well, will it change the biome or resistance for other stuff that we use doxycycline for? Right. So, when we think about Staph infections and stuff like that. I think there's still a lot of data. So, CDC's inputs like, "Hey, it can be used off label, but they still need a lot of data."

Matt: Well, I wanted to ask because we do want to leave time for audience questions. I know we have a lot of other stuff to test for. I did want to ask about anal cancer screening, because I think probably most primary care docs are less familiar with that and talking about doing digital rectal exams and anal Paps. Are you doing those in the office--? Who's doing those? Should primary cares be doing those if they're patients not seeing an HIV specialist yearly?

Jonathan: Sure. Yeah, I've been doing anal Pap screening. I did a lot of it before coming to Penn State, Hershey. The issue sometimes I worry is that the costs of the testing for patients prior. But I think a lot of things have swayed in the last couple of years. Last year at CROI, the anchor study gave out some preliminary results looking at anal cancer screening. So, I'm trying to remember what the anchor study stands for, but I think it's like anal cancer, high grade squamous intraepithelial lesions-- [crosstalk]

Matt: Oh, that's great. [crosstalk]

Paul: It's probably cardiology trial. That's not bad.

Jonathan: Yeah. But what they were looking at was they were screening patients over the age of 35. They had both men and women, trans female, trans males as well and they were looking through and seeing if a patient tested positive for a high-grade lesion, should they just take it out or should they just monitor it? The study actually closed early. It was between

15 different sites overall in the US, and just because there was clear benefit necessarily from it. So, it's something that I've been doing a lot more in my patient practice and having that discussion overall. I've caught a lot of high-grade lesions and after that really tying them for the endoscopy or colorectal to take a look to make sure if there're any suspicious lesions, and then after that, follow up with colorectal.

Matt: Any resources for people? I don't think I did not learn how to do that-- I know I did not learn how to do that in training. So, what resources are there for people if they have to learn how to do anal Pap testing?

Jonathan: Yeah, there's a wonderful iteration and stuff from some of the health departments overall. It sounds more difficult than it is. It's just a brush, actually, over on you're trying to get around the Z line and putting pressure as you go in, put pressure as you go in, and then just spin as you go out. You can google it. There're many different things in-- [crosstalk]

Matt: Yeah, and patients can't self-swab for that, like, they can rather-- [crosstalk]

Jonathan: That's one where we don't recommend necessarily self-swabbing. And then sometimes also thinking rectal exam, digital exam, just making sure you're not missing the lesion from the brush. So, those are things I've had discussions with my patients and recognize that, overall, they may not want to do that at the moment or I don't save it for the first visit. It might be stuff as we develop rapport.

Matt: Okay, great.

Paul: And along those lines, for cervical cancer screening, I know things are a little bit different for patients living with HIV. You don't have to go too, too granular, but any big differences between anything that you would do differently for someone who is living with HIV than someone who is not.

Jonathan: Yeah. So, I think if I remember correctly from the primary care guidelines, usually age 65, you would necessarily stop for cervical cancer screening in patients not living with HIV. And persons living with HIV, actually, it goes on past that. So, overall, also depends. We try to do it within the first time of diagnosis, but still go by the guidelines. So, nothing earlier than necessarily 21. Then, I always have to look at the flowchart overall to make sure that I remember, but that excellent chart up there that you're showing hides it.

Matt: Okay. So, Paul, I think we should leave a few minutes for audience questions. We have some time left, but what else do you definitely want to get to? I know we've got into a lot of the stuff on here already.

Paul: I think the things I want to hit for sure, any differences in vaccines, and then I think we should probably finish up with the futures, the injectable stuff, because I feel like that's an important conversation to have.

Matt: Great.

Paul: Any difference in terms of vaccine considerations for someone with the diagnosis of HIV?

Jonathan: Yeah, as I think about necessarily vaccines, making sure that they're definitely screened for Hep A and Hep B. So, making sure that they're Hep A and Hep B immune. Actually, again, for prevention as an STD, but also coinfection, there's worse liver with coinfection. Streptococcus pneumonia, so really thinking about Strep pneumo vaccinations, actually indicated there's higher rates. [crosstalk] Yeah, same thing. So, usually I start off

with the PCV15 and then 23. No, [Paul laughs] I got to look. Again, it's changed so much [crosstalk] recently.

Matt: Usually 23. Yeah.

Paul: Yeah.

Jonathan: Yeah. And then the other thing to think about, we will vaccinate every five years for meningococcal. And then even when I was looking at that ACIP guidelines thinking about recombinant zoster as well.

Matt: Yeah, I know they tried to simplify the pneumococcal guidelines, but I still think because there've been so many changes in quick succession and there're two new vaccines, the two new Prevnars. I feel it's still confused and people are still confused. Patients are like, "Didn't I already have two pneumonia vaccines?" So, anyway, I'm on your side. I'm on Team JJ for this one.

Paul: [laughs] I'm genuinely angry about the pneumococcal vaccinations, which is not great for my patients.

Matt: [laughs]

Jonathan: Well, I think there're still some tables that I have where I usually sit in my pod in clinic, and I'm like, "Yes, I'm still up to date on that one."

Matt: Yeah. All right, well, let's talk about-- I was excited. I think the first I heard about this was last year at probably ACP talking about the injectable medicine, both for prep and for just once every eight weeks injectable and they don't have to take a daily pill. Can you talk about this? Any barriers to this? Any downsides to this?

Jonathan: So, I think this has been really exciting. A lot of patients had been hearing rumblings for quite a while. As I mentioned to you, it's very easy for me to come and go, "Hey, take your medication every day." It's easy, but I have patients that it's a constant reminder of their diagnosis necessarily. I have patients that hide their pills or their transitional housing in between. So, not making sure that they don't want anyone to know that they necessarily have HIV. Then I have other patients that have just trouble taking pills.

So, when this came out, it was really awesome to really talk about different treatment options overall. One of the big things is it can't be used with Hep B. So, they have to be hepatitis B-- can't have chronic hepatitis B as we tend to use tenofovir a lot for Hep D infections. But I think it's been really revolutionary and really giving some of the autonomy back to the patient that they don't have to take a daily pill.

When they were looking at the studies, there's two actually. One, we're looking at it monthly, the other looked at higher dosing and providing the first shot, then the second shot, and then after that every two months. Patients did well. There was not as many breakthroughs overall from becoming detectable. So, I think it's a really effective tool in our toolbox. Couple of caveats to it is that it has to be done in a medical visit. So, because it's a gluteal injection, actually it has to be done. I always tell it's the commercial is awesome. I love the commercials. Commercials doesn't tell you that it's actually two shots.

[laughter]

Jonathan: Actually, as you're selling it with the patients overall.

Matt: Wait, two shots on the same day?

Jonathan: Yeah. So, one per gluteal cheek.

Paul: [laughs] [crosstalk] already used gluteal and then someone with cheek at the end. You start out medical and then just kind of-- [crosstalk]

Jonathan: This is how I talk about it with my patients. But I think one of the big things to really highlight overall from it is, from the patients I've had transition, they've absolutely loved it. I think one of the big things that really want to try to make sure is I need to have a way to find our patient. I think that's the hard part sometimes is you have to remember to come back to get that second shot. We have a little bit of a window or wiggle room, but the always concerning part is if you pass that window and the levels are starting to come down and we're promoting resistance, actually. So, I've been having my patients do it. We try to track it as best as we can, but I think sometimes that might be a barrier to think about as implementing, is really the patient follow-up and retention.

Then the other thing I mentioned is that injectable rilpivirine. So, I also do a lot of methadone. So, injectable rilpivirine can actually prolong QTc. So, one thing to remember is that if there's other QTc prolonging agents to make sure there's a baseline EKG and cabotegravir can actually interact with methadone, so it can actually lower the dose. So, it's something to think about when you're discussing if they're getting methadone with their site to make sure that they're monitoring for any withdrawal symptoms overall.

Paul: Logistically with these, do you do an oral run in period for tolerance? Are the oral medications first and then transition to the injections, or what does this look like? I know probably more than I need to know specifically-- [crosstalk]

Jonathan: No, no So, it's a great question. For some patients, if I haven't done an oral lead in, you don't necessarily have to do the orally. If you're doing a switch actually, and they're undetectable, they tolerate it well. For patients where I've had a lot of issue with medication side effects, I'll still do an oral lead in just to make sure that they're not having any side effects. So, I have had patients where we cycled through many different antiretrovirals overall, and that might be the time that I'll talk about it. The other thing is just remembering that they can't have an NRTI resistance. So, if they have resistance to rilpivirine, it's not an option. If there's a lot of integrase inhibitor resistance, it's not an option, but I think it's a good discussion to have with our patients overall. The exciting part of cabotegravir as well is thinking at it as an option for prep.

Matt: Yeah. All right, well, I think we should probably take questions from the audience.

Paul: Sure.

Matt: We might probably only have time for maybe, like, one or so, but we'll just call on you and we'll repeat it for the people in the audience. So, does anybody have any questions? If not, that's okay. We're happy to just get some take-home points and get you all out of here, okay?

Paul: [laughs] Just a furious avoidance of eye contact is my favorite thing about medical education.

Matt: All right. We could end on time. Let's get some-take home points. We've talked about a lot today. We've done heroes work as always.

Paul: As always.

Matt: But if there was maybe a couple of things, one, two, three things you wanted the audience to remember, what would those be?

Jonathan: I think just making sure that we're balancing patient expectations and what they're looking for in primary care recognizing that barriers that they may have experienced, I think that's something to really think about as we work with our patient populations. The second thing that drives me crazy is the expectation that if patients are late, we just reschedule. We have no clue how our patients journey to come to our clinic or practice that day, and you don't know the competing factors that they're necessarily having. So, I think one of the big things is just being slightly flexible.

I think one of the big things is recognizing that when patient has questions that if you don't know the answer, just making sure that you can either refer or touch base with much smarter colleagues overall and not ignoring that. I bring that up because a lot of times we've always talked about patients mentioning, "Hey, I'm gaining weight, I'm gaining weight, I'm gaining weight." And then now there's a lot of data suggesting that, "Hey, it's true, you gained weight on your medication." So, I think listening to the patients overall.

[music]

Matt: We will be back with our lightning round. All right, JJ, these people know you, but maybe they don't have a time to talk to you about some of the more fun stuff. So, maybe give them a pick of the week. What are you enjoying these days and that you would recommend to them and to the audience at home listening to this after the fact?

Jonathan: So, I want to seem like I'm sophisticated. I probably might start off with an actual book I do love to read. I wish I could say something like memoirs or biographies or stuff, but it's usually sci-fi. So, I think right now I'm reading *The Wandering Earth*, which is really good. It's about moving this planet as our sun is dying. It's very depressing, but very good.

Paul: It sounds right up my alley, depression sci-fi is like my specific niche. So, I have to check it out.

Jonathan: Then realistically, probably playing video games is my stress reliever, mass effect, and I'm really enjoying that.

Matt: Okay. Is that available on Switch?

Jonathan: Not the moment.

Matt: Yeah, I probably won't check that out then because--

Paul: [laughs]

Matt: Yeah. PS5 is still hard to come by. Maybe, I don't know.

Paul: It's fine. This has been another episode of The Curbsiders bringing you a little knowledge food for your brain hole.

Matt: Yummy.

Paul: It could have been your chance to shine. You want to say, do you want yummy?

Matt: [laughs]

Jonathan: I'm okay.

Paul: In front of your colleagues, you could right here.

Jonathan: I'm okay.

Matt: [laughs]

Paul: Great. All right, missed opportunity, buddy. All right, get your show notes to *thecurbsiders.com*. While you're there, sign up for our mailing list to get our weekly show notes in your inbox, plus twice each month you'll get our Curbsiders Digest recapping the latest practice-changing articles, guidelines, and news in Internal Medicine.

Matt: And we're committed to high value practice changing knowledge. We'd also like your feedback. Please subscribe, rate, and review the show. You can find us on YouTube, Spotify, or Apple Podcasts. You can also email us at *askcurbsiders@gmail.com*. I wanted to give a special thanks to the great Dr. Paul Nelson Williams, America's primary care doctor.

Paul: [laughs]

Matt: And to Dr. Beth 'Garbs' Garbitelli for helping to write this episode. The Curbsiders technical production is done by the team at Pod Paste. Elizabeth Proto and Jen Watto run our social media and Stuart Brigham composed our theme music. With all that, until next time, I've been Dr. Matthew Frank Watto.

Paul: I do want to throw a quick thanks for Dr. Ellen Tedaldi, who actually is one of my legit heroes, who's at Temple right now, who actually looked over the script and gave me some ideas. So, I just want to say thank you to her and then also just ask for another round of applause for the great Dr. Nunez for this. I'm Paul William.

Jonathan: Thanks, guys.

[applause]

[Transcript provided by [SpeechDocs Podcast Transcription]]