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HIV NURSING

CARING FOR PEOPLE AFFECTED BY HIV

Ageing

Editorial

Features

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Aims and Scope

HIV Nursing has been developed as a forum for those at the forefront of caring for people affected by HIV. The journal is supported by a highly respected Editorial Board drawn from a wide range of nursing specialties. This is further strengthened by an Advisory Panel who will be making regular contributions to the journal.

HIV Nursing is intended to provide a medium for communication on issues relating to HIV care, which will be run by the care professionals for those involved in the day-to-day matters affecting the lives of patients.

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The changing face

Juliet Bennet

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I suspect that it isn't news to you that the population of the UK is ageing; aren't we all? We all recognise the signs... your back goes out more than you do, you find yourself recording daytime TV programmes and waking up feeling like it's the morning after, when you haven't been anywhere the night before!

Seriously, however, over the last 25 years the percentage of the UK population aged 65 and over has increased from 15% in 1983 to 16% in 2008, in real terms an increase of 1.5 million in this age group. Over the same period the percentage of the population aged 16 and under has decreased from 21% to 19% (Office of National Statistics, www.statistics.gov.uk) and the trend is projected to continue. Therefore, in all areas of healthcare service provision, including the field of HIV, we have increasing numbers of older people on our caseloads.

The articles in this issue raise some interesting points for HIV nursing in the coming decade. Several of the challenges that older people with HIV face are identified; but we must also remember that there may be benefits to being older with any chronic disease. This group may, for example, have learned skills for coping, have more insight into their own strengths and limits, and a sense of accomplishment at having achieved some of their goals in life. Older people may also be more likely to value and look after their health and be less likely to take risks, they are perhaps better able to accept limitations brought about by ill health and be willing to pass on their knowledge and advice to younger people.

Users of health services have increasingly greater expectations of, and a more discriminating and demanding approach to their rights, as consumers of healthcare. As healthcare professionals, we are increasingly recognising and acknowledging that people with HIV infection often have the most comprehensive expertise in dealing with their condition, and our older patients, may have even more to teach us. We must draw upon this as a resource and learn from that expertise. There is clearly a need for more research into the quality of life experienced by older people and how best to promote autonomy; and for both responsive and proactive service developments, to meet the needs of this ever-increasing cohort.

I hope this issue gives you some food for thought. As always, NHIVNA would love to hear about how you are responding, both within your organisation and on a personal professional level to this emerging challenge. Please do use the NHIVNA website (www.nhivna.org) to share your experience with other members.

Ageing, policy and practice: an overview

Julie McGarry

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Introduction

The UK has an ageing population and this is mirrored globally. Recent survey data indicates that in the UK approximately 9.7 million people are aged 65 years or over [1]. Moreover, as Tullett and Neno [2] highlight, by 2030 radical changes within the population structure overall will have taken place due to significant advances in care and technology. Compared with today, as life expectancy increases, the number of people aged 85 years and over will have doubled, leading to a much greater proportion of older people within the population as a whole. Tullett and Neno [2] further emphasise that as these changes take place, effective strategies for successful ageing 'must be realised' at both a policy and practice level. Health and social care professionals will also need to develop the requisite skills and knowledge in order to 'enhance the quality' of care delivery.

Historically, within the context of health and social care, a number of commentators have highlighted the particular situation of older people with regard to explicit care encounters and have shown the often disempowering nature of care interactions between nurses and older people [3,4]. The direct impact of ageist practice for the individual has been described in terms of disempowerment [5], fragmentation and lack of resources [6], routinisation [4] and objectification [7].

Lately, however, there have been significant changes in policy developments that specifically target older people and which aim to address the core deficits in care delivery and management. Whereas previously the voices of older people in the development of services have been described as 'only faintly heard' [8], these overdue contemporary policy changes have specifically acknowledged, at least at a documentary stage through 'stakeholder' involvement, the rights of older people within care and service provision overall [6].

Contemporary policy developments: the National Service Framework for Older People

As a result of the sustained deficits in the quality of care experienced by older people [9], the National Service Framework (NSF) for Older People [6] was launched. It has been described as 'a comprehensive strategy that seeks to ensure fair, high quality, integrated health and social care services for older people' [10].

The National Service Framework initiative was launched in 1998 as part of a 'package to drive up the quality of service to patients' [11]. The NSF for Older People is one of a series of National Service Framework policy documents that covers a range of areas of service provision and care. The NSFs have been defined as 'long term strategies for improving specific facets of care, within clearly set time frames' [12]. All of the NSFs, including the NSF for Older People, include defined targets for particular areas of service improvement and health promotion. Moreover, while each NSF has a specific focus, it has also been recognised that there is the capacity for 'crossover' or integration between the NSFs. For example, mental healthcare provision, forms one of the core standards of the NSF for Older People, and should also be considered by professionals within the context of the NSF for Mental Health in terms of equity of access and quality of care indicators.

The cornerstones of the NSF for Older People are a commitment to promoting healthy ageing, the eradication of ageist practice and the provision of universal care and services regardless of age. The NSF is founded on the key principles of equity, dignity, respect and individuality [6]. These principles are not new: a number of commentators have highlighted the centrality of dignity and respect in the care of older people [13,14]. Although the concepts described in the NSF for Older People are not revolutionary, it is the first key national policy to provide specific guidance for the development of universal health and social care provision, based around the perceived particular needs of older people.

Within the NSF for Older People there is a clear stress on the development of primary care services, support and the promotion of independence for particular client groups and service users and, where appropriate, their carers. However, one of the main challenges that has resulted from the reorganisation of services in light of this developing policy is the greater emphasis on the provision of integrated services between health and social care, and more particularly on the role of nursing, in the overall provision of care for older people within the home [15].

Contemporary policy developments: the NSF for Long-term Conditions

Tullett and Neno [2] have drawn a direct comparison between the identified aims of the NSF for Older People and the NSF for Long-term Conditions [16] in terms of the need for knowledge and skill development among professionals, for example the centrality of integrated working practices and person-centred care. However, they further argue that these two major contemporary policies, although exhibiting commonalities in terms of core philosophies, have, to date, largely been treated as separate entities. In the UK, however, it has been estimated that 15.4 million people have a long-term condition and of these 60% are aged 60 years or over [17], showing that there is a clear correlation between long-term conditions and ageing. There is, therefore, a need to consider the way in which the NSF for Long-term Conditions not only echoes but also has the capacity to reinforce and set the direction of the quality of care agenda for older people.

The overarching concept of the NSF for Long-term Conditions is that health and social care agencies work collaboratively with people with long-term conditions to deliver services. Three key areas form the core mandate: improving quality of life; supporting people to manage their own conditions; and enabling people to live independently. While this NSF has a clear bias towards neurological conditions, it is also acknowledged that its guidance applies to anyone living with a long-term condition.

In a similar vein to the NSF for Older People, the NSF for Long-term Conditions places the individual at the centre of care and focuses on a series of specific quality requirements. These include: prompt diagnosis and treatment; the development of person-centred services, including integrated care delivery between health and social care services; timely rehabilitation and promotion of independence; palliative care; and support for family and carers. It may be argued, therefore, that the underpinning core philosophies of care provision and the realignment of organisational boundaries are also central for older people, particularly within the context of successful ageing [15]. However, from the particular perspective of older people, a major challenge in the translation of philosophies and ideals into practice and individual experiences of care lies in realigning structures of care management as well as confronting care professionals' perceptions of older people in terms of 'homogenous attitudes', long-term conditions and notions of disability [2]. Despite espousing notions of person-centred care within contemporary care ideologies and policy, there is clear evidence that there are still barriers to achieving this in practice situations from both service design and care delivery perspectives [18].

Conclusion

Changing demography and increasing longevity, alongside shifting patterns of ill-health and disability, suggest that older people will become an increasingly significant proportion of healthcare service users [19]. The preceding discussion has highlighted the particular position of older people in terms of care provision generally, and in light of the developing policy and care delivery surrounding long-term conditions. Also highlighted, is the obvious need at both a policy and provision level for clear health and social care strategies that incorporate integrated service planning and care delivery, facilitate person-centred care approaches and are cognisant of the particular needs of older people. Finally, it has been suggested [2] that consideration of the similarities and differences between policy and models of care delivery for older people and the management of long-term conditions has the potential to foster 'creativity of service redesign' as a way forward in the future.

References

1. Age Concern. Older people in the United Kingdom: key facts and statistics 2008. London, Age Concern, 2008.
2. Tullett M, Neno R. Approaches to long-term conditions management and care for older people: similarities or differences? *Journal of Nursing Management*, 2008, **16**, 167–172.
3. McCormack, B. *Negotiating Partnerships with Older People: A Person Centred Approach*. Aldershot, Ashgate, 2001.
4. Davies S, Ellis L, Laker S. Promoting autonomy and independence for older people within nursing practice: an observational study. *Journal of Clinical Nursing*, 2000, **9**, 127–136.
5. Tonuma M, Winbolt M. From rituals to reason: creating an environment that allows nurses to nurse. *International Journal of Nursing Practice*, 2000, **6**, 214–218.
6. Department of Health. The National Service Framework for Older People. London, HMSO, 2001. Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066 (last accessed 12 March 2010).
7. Kitwood T. *Dementia Reconsidered: the Person Comes First*. Buckingham: Open University Press, 1997.
8. Glendinning C, Coleman A, Rummery K. Partnerships, performance and primary care: developing integrated services for older people in England. *Ageing and Society*, 2002, **22**, 185–208.
9. Philp I. Developing a National Service Framework for Older People. *Journal of Epidemiology and Community Health*, 2002, **56**, 841–842.
10. Ford P, Wild D. National Service Framework for Older People. *Primary Health Care*, 2001, **11**, 33–35.
11. Department of Health, Local Authority Social Services Letter: National Service Frameworks. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Localauthoritysocialservicesletters/AllLASSLs/DH_4004840 (last accessed 24 March 2010)
12. Bernard S, Aspinal F, Gridley K, Parker G. Integrated policy making in England for adults with long-term neurological conditions (LTNCs): some preliminary findings from a scoping study. *International Journal of Integrated Care*, 2008, **8**, 1–8.
13. Castledine G. Nursing elderly people with dignity and respect. *British Journal of Nursing*, 1996, **5**, 191.

14. Arblaster G, Brooks D, Hudson R, Petty M. Terminally ill patients' expectations of nurses. *Australian Journal of Advanced Nursing*, 1990, **7**, 34–43.
15. Department of Health. Our Health, Our Care, Our Say: a new direction for community services. London, HMSO, 2006. Available at www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/DH_065882 (last accessed 12 March 2010).
16. Department of Health. The National Service Framework for Long-term Conditions. London, HMSO, 2005. Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4105361 (last accessed 12 March 2010).
17. Berzins K, Reilly S, Abell J, Hughes J, Challis D. UK self-care support initiatives for older patients with long-term conditions: a review. *Chronic Illness*, 2009, **5**, 56–72.
18. Nolan M, Lundh U, Grant G, Keady J. *Partnerships in Family Care: Understating the Caregiving Family*. Buckingham, Open University Press, 2003.
19. Office for National Statistics. Population Trends (PT 131) London, Office for National Statistics, 2008. Available at www.statistics.gov.uk/statbase/product.asp?vlnk=6303 (last accessed 12 March 2010).

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HIV: the coming of age. An overview of nursing older people with HIV

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Introduction

HIV tends to be seen as a disease affecting young people, in part because of the mistaken assumption that it is only the young who are sexually active. However, the evidence is overwhelming: the face of HIV is ageing. Antiretroviral drugs have been available for almost two decades and HIV-positive people are living longer. Many of those who were diagnosed earlier in the epidemic are now entering older age and the numbers of people accessing HIV care aged 55 and over has increased markedly. In 2007, Health Protection Agency statistics revealed that 7.6% of those accessing HIV care in the UK were aged 55 and over [1]. As expected, this year's data [2] show that this percentage is on the rise.

Ageing with HIV isn't simply an issue for those who have been living with the virus for some time. The numbers of new HIV diagnoses made in the over-50s is also rising [3]. And the situation in the UK appears to reflect an international trend. In the US, the term 'greying and growing' is used to describe the HIV-positive community: 11% of those accessing HIV care in the US are over 50 and it is the fastest growing group of HIV-positive people.

This ageing HIV-positive cohort has significant implications for nursing practice in both HIV and non-HIV settings. Whilst caring for the older HIV-positive patient will undoubtedly be one of the next big challenges for healthcare, it has, until recently, been a somewhat neglected area with minimal research available, particularly in the UK. However, the message from current research is clear. This is a heterogeneous group with a complex and often unique set of physical, psychological and social needs that will demand informed and insightful attention. As nurses, regardless of the setting, we will need to be aware of the key issues affecting this group in order to provide the kind of high-quality care expected [4,5].

Methods

This article is based on the results of both a scoping literature search and a narrative literature review. A search of the Cochrane Library database established that no other review on this topic existed.

In order to maintain the nursing focus, the British Nursing Index (BNI) and the Cumulative Index of Nursing and Allied Health Literature (CINAHL) were searched, accessed via EBSCOHost. To ensure currency, only articles published from 2000 onwards are included. For further discussion of research methods please contact the author.

Definitions

Before beginning any discussion regarding older people with HIV it is important to define older age. Definitions of exactly who is 'older' are the subject of some debate and different organisations have different markers for what constitutes older age [6]. The United Nations and World Health Organization define older age as 60 whilst the Health Protection Agency defines it as 55 [1]. However, the Centers for Disease Control (CDC) in the US specifically defines older, in the context of HIV infection, as 50. The majority of the literature reviewed in this article is from the US, and for ease, this definition will be used unless otherwise stated.

Findings

Survival rates, delayed diagnosis and misconceptions of risk

One of the most striking issues highlighted by this review is that older people have reduced rates of survival after being diagnosed with HIV despite the fact that they have good virological and immunological responses to antiretroviral therapy [7,8]. HPA statistics reinforce this, showing that those aged 55 and over have a crude mortality rate almost three times higher than all other groups infected with HIV in the UK [1]. Whilst this may in part be due to an age-related immune deterioration that exacerbates HIV disease progression, it is also true that older people are more likely to be diagnosed later than their younger counterparts [7–13]. They are also more likely to have had a delay in their diagnosis and, as a group, have an increased rate of symptomatic HIV at initial diagnosis or within the first year after diagnosis [7,8,12].

The reasons for delayed diagnosis need examination. HIV has been stereotyped as a disease of the young and from which older people are not at risk [13]. This stereotype is pervasive; health professionals appear to make this assumption, as do older people themselves. Older people are often assumed to be either sexually inactive or only active within monogamous heterosexual relationships, when in fact quite the opposite may be true. The isolation associated with ageing may increase older people's risk behaviours such as drug use and the use of casual sex workers [12]. Data from sexual behaviour studies show that older people are less aware of risk factors, more likely to have unprotected sex and less likely to have had a recent HIV test [8,12]. Older women dispensing with condoms may also be at increased risk of infection due to changes in the vaginal mucosa in ageing [12].

Misconceptions about older people's behaviour mean they are almost completely excluded from health promotion messages regarding risk, prevention and testing [8,12]. Sexual health strategies for reducing STIs and HIV in the UK are certainly a reflection of such exclusion. The Department of Health's blueprint for sexual health services contains almost no mention of STI and HIV prevention in older age groups [14].

Nurses in all settings are in a prime position to address such significant oversight, and can take the opportunity to explore sexual histories and provide education on potential risks and strategies for STI/HIV prevention. However, those outside HIV and GUM settings often express concern about discussing sexual health. Research does show that older people are rarely affronted in the context of promoting health, and health professionals should not be deterred from broaching these issues, particularly when so much is potentially at stake [10,12,15]. Supporting less-experienced colleagues in training sessions and also in more informal ways, such as signposting them to the Chief Medical Officers' (2008) guidelines that encourage HIV testing in general medical settings, is key in terms of increasing uptake of testing and normalising testing outside specialist HIV/GUM clinics.

The result of assuming that older people aren't at risk from HIV can be catastrophic. Cloud *et al.* [8] show increased rates of delayed or missed symptomatic HIV diagnoses, particularly of PCP, in those over 60. Increasing health professionals' awareness that HIV infects people across the lifespan is fundamental. Nurses working in GUM/HIV settings can play an important part in providing support for nursing colleagues caring for older patients in non-HIV settings, encouraging them to play a primary role in assessing HIV risk, carrying out HIV testing and facilitating a smooth transition to specialist HIV care where necessary. It is also important to address the main issues experienced by older people with HIV.

Comorbidity

'Well, I am not going to die of AIDS' [17]. This older patient's observation about ageing with HIV suggests that comorbidities in older patients are now the most significant cause for concern.

There is an overlapping interplay between HIV disease, normal ageing and the long-term effects of antiretroviral therapy. Researchers suggest this relationship is unclear and needs further research [6,9]. However, it is clear that older people with HIV are at increased risk of comorbidity [9,13,17,18]. Data show that they have increased rates of hypertension, diabetes, hypercholesterolaemia, osteoporosis, malignancy, renal and hepatic insufficiency, pain, dementia, increased cognitive complaints and reduced immunity possibly due to a reduction in thymic function [10,19].

Clearly an HIV diagnosis in an older patient should not obscure assessment of other health problems. As nurses, we will need to play a key role in assessment for other health complaints. We are well placed to assess and monitor cardiovascular health, reporting and facilitating management of issues such as hypertension and angina. We can also play a significant part in health promotion for such patients: assessing lifestyle issues such as exercise, dietary intake, smoking, alcohol and recreational drug use, providing support and referring on to specialist services such as dietitians, smoking cessation services and community-run programmes such as the YMCA's Positive Health. From a neurocognitive perspective, we may be the first people to whom patients disclose changes in their cognitive function. Reports in changing ability to

think or concentrate may need further investigation, and should not be dismissed as normal ageing [18].

Polypharmacy

Increased rates of comorbidities can lead to increased rates of polypharmacy. One study shows that 81% of HIV-positive people over 55 were taking non-HIV-related medication as well as their antiretroviral therapy [20]. Polypharmacy increases older patients' risks of drug interactions [9–11]. Problems can be further exacerbated by the hepatic and renal insufficiencies more common in older patients. These can lead to increased rates of antiretroviral-related toxicities, interactions between antiretroviral drugs as well as between antiretroviral therapy and other medicines [10].

As nurses play a central role in patients' medicine management, we will need to have increased awareness of the potential for drug interactions, hypersensitivity reactions and side-effects in our older patients and work in partnership with the patient's medical team and pharmacists to address these. In addition, we will often be the team members who inform patients of the potential for such interactions and encourage the reporting of any concerns they have. Ultimately, any nursing intervention that addresses the problems that older patients may experience when taking antiretroviral therapy along with other medications will assist them to maintain the strict levels of adherence needed with antiretroviral regimens.

Social support

There is a significant volume of research assessing the impact of reduced social support on older people ageing with HIV. Social support is recognised as a crucial buffer against the stress caused when adjusting to living with a life-threatening or chronic illness [11].

Even without an HIV diagnosis older people are at an increased risk of isolation. They are more likely to have low income, to live alone, to experience chronic or debilitating ill-health and to lack other means of social support [20]. The unique stigma of HIV is likely to further compound this risk of isolation [22]. Older people with HIV have reduced social networks and thus reduced social support [9,11,16,23].

The reasons for this are varied. Older people may disclose to fewer people for fear of stigma and rejection [9,16]. They may experience ageism when accessing more youth-orientated community-run HIV services [12]. They may also experience HIV-related exclusion when accessing non-HIV senior groups [24]. The resulting isolation can lead to a significantly increased risk of depression, reduced physical health and therefore to a premature reliance on formal care networks [11].

HIV-positive older people are also likely to have seen their social networks decline due to the death of their partner, friends and family [17]. These losses may be a result of HIV. For some older HIV-positive people, such as men who have sex with men (MSM), some of the usual points of access to social support, such as the gay 'scene', no longer appear available to them precisely because they are older. Anecdotal evidence based on discussion with older HIV-positive MSM in a busy London clinic certainly supports this. They report that the experience of isolation can be compounded by inner-city gay scenes that appear fixated on youth and may not provide for, or encourage, the presence of older MSM. However, whilst this was not a theme found in the literature analysed, it does seem pertinent and may highlight a need for further research.

The role nurses play in assessing the level of social support for their older HIV-positive patients is vital. We can enable discussions around disclosure and assess access to social support. Although there are currently very few organisations in the UK that specifically support older people with HIV, this is beginning to be addressed. THT recently launched a project reviewing the needs of older HIV-positive people [25]. In the meantime targeted referrals to local support groups may be welcomed.

Depression

Emphasising the positives to being older with HIV is important. The literature presents a picture that is somewhat bleak, particularly with regard to the incidence of depression in this group. Life experience may, however, equip older patients to cope better with both their diagnosis and any associated health problems. Some research suggests they feel less 'cheated' of life than those diagnosed younger [6]. None the less, older people ageing with HIV have been shown to be at significant risk of depression [23,24,26–29]. Assessing for depression no doubt already forms a key part of our patient assessment and we will need to continue to be vigilant, referring where necessary to services such as clinical psychology for therapies such as cognitive behavioural therapy and encouraging the ongoing use of these coping strategies [27]. A focus of research in the US is the concept of hardiness. Hardiness includes characteristics such as control, commitment and challenge and has been found to help with managing the negative impacts of HIV and supporting an attitude that enables successful ageing with the virus. Vance *et al.* [28] encourage nurses to assess these characteristics and to support their development through the referral to behavioural therapies.

Future research

The impact of ageing with HIV is an area that has been neglected in research, particularly in the UK. Older people's needs are typically marginalised

within wider society and it could be argued that this will have a negative effect on the health outcomes of older people with HIV. Current literature demands further research to combat this, in particular calling for research to enable a clearer understanding of the impact of HIV on an ageing immune system [10], the provision of guidelines for monitoring older HIV-positive people's health to ensure consistency of care [8,12], and further research into their specific psychological and social needs and how best to support these [28]. Nurses clearly have a role to play here. Furthermore, the growth of this group has added a new dimension to nursing care. Providing 'frontline' care means that nurses are best positioned to highlight issues that had previously gone unrecognised in this emerging group. Publishing their insights can only help nurses to advocate for their older HIV-positive patients, providing awareness into how best to provide truly holistic care for these patients. Such material can only improve the health outcomes for this cohort.

Conclusion

Caring for those ageing with HIV is likely to become a leading challenge for both HIV services and health services generally. Nurses in all settings will need to play a primary role in meeting this challenge. Increased awareness of the key issues affecting this group will be fundamental to ensure that older people receive the care they need. Insightful, non-judgemental assessment of older patients' risks of HIV infection can help to reduce late diagnoses; timely health promotion interventions can reduce incidences of comorbidities later; vigilant assessment of physical, social and psychological health will mean earlier intervention and management when needed. Increased awareness of the issues that affect older people ageing with HIV is fundamental to supporting them to age as successfully as possible.

References

1. HPA. Testing Times – HIV and other Sexually Transmitted Infections in the United Kingdom: 2007. London, Health Protection Agency, 2007. Available at: www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203084355941 (last accessed 15 March 2010).
2. HPA. HIV in the United Kingdom: 2009 Report. London, Health Protection Agency, 2009. Available at: www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1259151891866 (last accessed 15 March 2010).
3. HPA. United Kingdom New HIV Diagnoses to end of December 2009. Available at www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1237970242135 (last accessed 15 March 2010).
4. Department of Health. The NHS Plan: a plan for investment, a plan for reform. Cm 4818-1. London, HMSO, 2000. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960 (last accessed 15 March 2010).
5. Nursing and Midwifery Council. The Code: standards of conduct, performance and ethics for nurses and midwives. London, Nursing and Midwifery Council. Available at: www.nmc-uk.org/aDisplayDocument.aspx?documentID=5982 (last accessed 15 March 2010).
6. Bernard EJ. HIV and aging: is growing older with HIV all bad news? *HIV Treatment Update*, 2008, **174**, 4–7.
7. Navarro G, Nogueras MM, Segura F. HIV-1 infected patients older than 50 years: PISCIS cohort study. *Journal of Infection*, 2008, **57**, 64–71.
8. Cloud GC, Browne R, Salooja N, McLean KA. Newly diagnosed HIV infection in an octogenarian: the elderly are not 'immune'. *Age and Ageing*, 2003, **32**, 353–354.
9. Aging and AIDS: special series on older patients. Experts offer this advice for improving care for older HIV patients. *AIDS Alert*, 2007, **22**, 28–31.
10. Gebo KA. HIV and aging: implications for patient management. *Drugs and Aging*, 2006, **23**, 897–913.
11. Nokes KM, Holzemer WL, Corless IB *et al*. Health-related quality of life in persons younger and older than 50 who are living with HIV/AIDS. *Research on Aging*, 2000, **22**, 290–310.
12. Lieberman R. HIV in older Americans: an epidemiological perspective. *Journal of Midwifery and Women's Health*, 2000, **45**, 176–182.
13. Ress B. HIV disease and aging: the hidden epidemic. *Critical Care Nurse*, 2003, **23**, 38–44.
14. UK Collaborative Group for HIV and STI Surveillance. A Complex Picture. HIV and other Sexually Transmitted Infections in the United Kingdom: 2006. London: Health Protection Agency, 2006. Available at: http://194.74.226.162/web/HPAwebFile/HPAweb_C/1194947365435 (last accessed 15 March 2010).
15. Gott M. Sexual health and the new ageing. *Age and Ageing*, 2006, **35**, 106–107.
16. Chief Medical Officer. Improving the detection and diagnosis of HIV in non-HIV specialties including primary care. Letter dated 13 September 2007. Department of Health.
17. Emlet CA. 'You're awfully old to have this disease'. Experiences of stigma and ageism in adults 50 years and older living with HIV/AIDS. *Gerontologist*, 2006, **46**, 781–790.
18. Vance DE, Struzick T, Burrage J Jr. Suicidal ideation, hardiness and successful aging with HIV: Considerations for nursing. *Journal of Gerontological Nursing*, 2009, **35**, 27–33.
19. Vance DE, Burrage J. Promoting successful cognitive aging in adults with HIV: strategies for intervention. *Journal of Gerontological Nursing*, 2006, **32**, 34–41.
20. Porter K, Babiker A, Bhaskaran K *et al*.; the Cascade Collaboration. Determinants of survival following HIV-1 seroconversion after the introduction of HAART. *Lancet*, 2003, **362**, 1267–1274.
21. Heath H, Schofield I. *Nursing Older People: Healthy Ageing*. London, Harcourt, 1999.
22. NAM. HIV, *Stigma and You*. London, NAM, 2006.
23. Shippy R, Karpiak S. Perceptions of support among older adults with HIV. *Research on Aging*, 2005, **27**, 290–298.
24. Shippy R, Karpiak S. Aging with HIV: fragile social networks. *Aging and Mental Health*, 2005, **9**, 246–254.
25. THT (2009) 50Plus: Exploring the needs of people 50 plus with HIV. London, THT, 2009. Available at: www.tht.org.uk/howyoucanhelpus/surveys/content (last accessed 15 March 2010).
26. Kahana E, Kahana B. Successful aging among people with HIV/AIDS. *Journal of Clinical Epidemiology*, 2001, **54**, S53–S56.
27. Vance DE, Burrage J Jr, Couch A, Raper J. Promoting successful aging with HIV through hardiness: implications for nursing practice and research. *Journal of Gerontological Nursing*, 2008, **34**, 22–31.
28. Vance DE. Spirituality of living and aging with HIV: a pilot study. *Journal of Religion, Spirituality and Aging*, 2006, **19**, 57–74.
29. Vance DE, Childs G, Moneyham L, McKie-Bell P. Successful aging with HIV: a brief overview for nursing. *Journal of Gerontological Nursing*, 2009, **35**, 19–25.

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The times they are a-changing HIV and ageing: a new frontier

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I recently had a discussion with a colleague from a rural UK hospital who told me about a phone call he had received from another physician in his hospital regarding a patient under his care who was acutely unwell with miliary tuberculosis, brain abscesses and 'bizarre dark patches' to his torso. My colleague asked whether the patient had had an HIV test, to which he received the reply: 'No, it was not thought that the patient had any risk factors …' The patient was 61 years old. An HIV antibody test was subsequently performed and the result was positive. The patient had a CD4 cell count of 18 cells/mm^3 and biopsy revealed that the patches on his torso were due to Kaposi's sarcoma; he continued to deny any known risk factors. While this article is not specifically about testing older individuals for HIV, there is no doubt that HIV infection can, and does, present in the ageing population and needs to be a serious consideration in patients presenting with an apparent infectious disease. In 2008, one-third of men who have sex with men (MSM) accessing HIV care in the UK were aged 45 years or older. This is due both to an increase in new diagnoses in older MSM and effective therapies reducing mortality [1]. It is expected that by 2015, 50% of all North American HIV patients will be over the age of 50 [2].

It is indeed interesting to comment on what exactly we mean by the 'ageing patient'. The clinical specialty of geriatrics generally refers to the care of patients above the age of 70 or 75; however, in the field of HIV, as also discussed in Hazel Ridgers' article in this issue, the term 'ageing' has been used in relation to patients who are over the age of 50. The real concern, however, is not that the HIV-infected population is getting older but that for any given age, HIV-infected persons are at increased risk of age-associated complications [3].

Many of the issues that are pertinent in the care of patients ageing with HIV are issues that have been the case in the care of the elderly for many years. They include polypharmacy, medical comorbidities, cognitive dysfunction, cardiovascular disease, bone disorders, malignancies, kidney and hepatic disease; although in HIV-infected individuals it appears that these conditions are occurring earlier. This article discusses specifically cognitive dysfunction, bone disease, cardiovascular disease, malignancy and psychosocial issues, and highlights some of the current recommendations for the management of patients over the age of 50.

Cognitive dysfunction

There have been a myriad complex acronyms for neurocognitive dysfunction disorders over the years, but these all generally now come under the umbrella of HAND, HIV-associated neurocognitive disorders. These range from asymptomatic neurocognitive impairment (ANI) to HIV-associated mild neurocognitive disorder (MND) to HIV-associated dementia (HAD). Since the advent of highly active antiretroviral therapy (HAART), the incidence of HIV dementia has dropped by 50% [4]. The milder forms of HAND are characterised by mild difficulties in concentration, attention and memory but with unremarkable neurological examination [5]. Patients often complain of being easily distracted, losing their train of thought and poor concentration. As with all the other issues discussed here, is ageing, HIV or antiretroviral therapy to blame? Or indeed, could excessive alcohol or recreational drug abuse be playing a part? In a US study of a sample of HIV-infected individuals accessing primary care, 11% reported drinking at 'hazardous' levels in the previous 4 weeks [6]. Co-infection with hepatitis C and its treatment can also cause cognitive impairment in HIV-infected individuals [7]. No single laboratory test can diagnose HAND; however, all patients who complain of any of the above problems should undergo simple neuropsychometric testing. The International HIV Dementia Scale (IHDS) has been validated to detect mild to severe neurocognitive impairment in HIV-infected patients and is recommended by the European AIDS Clinical Society (EACS) [8].

If this test is abnormal, onward referral to psychologists for full neuropsychometric testing is indicated. Further investigations may include neuroimaging studies and cerebrospinal fluid (CSF) analysis.

Bone disorders

Certain lifestyle and hormonal factors, which increase the risk of disordered bone metabolism, are prevalent in HIV-infected patients. These include physical inactivity, suboptimal intake of calcium and vitamin D, cigarette smoking, alcohol and opiate use, depression, and low testosterone levels. Antiretroviral therapy itself may be associated with decreased bone mineral density (BMD) and there has been discussion for several years of the contribution of NRTIs, in particular tenofovir.

Osteopenia (60% prevalence) and osteoporosis (10–15% prevalence) are becoming more common metabolic complications as the HIV-infected population continues to live longer [8]. At the recent Conference on Retroviruses and Opportunistic Infections (CROI), a US study was presented that found that HIV infection conferred an independent but 'modest' risk of fragility fractures in the hip and spine [9]. However, the researcher also recommended that 'all people at risk' should be encouraged to start appropriate protective measures such as weight-bearing exercise, vitamin D supplementation and smoking cessation. It was clarified that those 'at risk' should include patients with any known risk factor, including HIV disease. Currently, there is no standard regarding who has BMD scans and vitamin D levels checked in the UK. In the over 50s clinic at the Chelsea and Westminster Hospital, all patients who attend the clinic have a BMD scan and vitamin D level checked. If the vitamin D level is low, serum calcium, phosphate, alkaline phosphatase and parathyroid hormone (PTH) levels should be checked. If classic risk factors are cited without a BMD scan, a FRAX score should be performed to assess risk score or need for a BMD scan (www.shef.ac.uk/FRAX).

Cardiovascular disease

Whether HIV is an independent risk factor for CVD or the increased risk is solely due to ART remains controversial. However, it is well known that infection and inflammatory disease are associated with increased atherosclerosis and HIV is an infection that is accompanied by inflammation. It is also well known that specific PIs have an affect on lipid metabolism and NRTIs can affect mitochondrial function. When this is combined with the fact that changes in body composition have been noted with several antiretroviral drugs, it seems clear that HIV-infected patients may be at greater risk of cardiovascular disease than the general population [10]. The DAD study group has reported that 1-in-10 deaths is from a cardiovascular disease-related event [11]. It is crucial that cardiovascular risk factors are assessed on a regular basis. These include smoking, high blood pressure, raised blood cholesterol and glucose, and more recently have been found to include cocaine and injection drug use. Smoking cessation should be a priority in the management of HIV-infected individuals and many clinics are now providing local smoking cessation services. Blood pressure should be checked at every visit, as should fasting lipids and blood glucose. EACS recommends using the Framingham equation to assess 10-year CVD risk (http://cvrisk.mvm.ed.ac.uk/calculator/calc.asp?framingham), however, many clinics use the Joint British Societies' calculator www.patient.co.uk/doctor/Primary-Cardiovascular-Risk-Calculator.htm), which is based on the Framingham study. Obviously these are considerations for all HIV-infected individuals, but especially close monitoring is required in the over-50s population.

Malignancies

Non-AIDS-defining cancers have accounted for an increasing proportion of cancer cases reported in HIV-infected individuals since the advent of HAART. The incidences of Hodgkin's disease, anal cancer, lung cancer and cervical cancer have increased since the beginning of potent ART in 1998, although the incidences of Kaposi's sarcoma and central nervous system lymphoma have dropped. The incidences of prostate cancer, breast cancer and hepatoma have remained stable in the US [12]. Current EACS recommendations include the following.

- Mammography every 1–3 years for women between the ages of 50 and 70 years.
- Cervical smear tests every 1–3 years for sexually active women (British Association for Sexual Health and HIV (BASHH) guidelines state this should end at the age of 65 [13]).
- Digital rectal examination with or without anal smear every 1–3 years for homosexual men (BASHH and BHIVA guidelines state that the role of annual anal cytology and anoscopy is not yet proven; however, patients should be encouraged to report any lumps noticed in the anal canal and HIV clinicians need to increase their awareness and knowledge of anal intraepithelial neoplasia).
- Faecal occult blood test every 1–3 years for all patients between the ages of 50 and 75 years to screen for colorectal cancer. The benefit is, however, marginal.
- Digital rectal examination with and without prostate specific antigen (PSA) every 1–3 years in men over the age of 50 years. The benefit is controversial [8,13].

It is important to note that these recommendations are not currently standard practice in the UK but require serious consideration in the implementation of specialist clinics for the over 50s.

Psychosocial issues

Whether diagnosed with HIV at an older age or a long-term survivor of HIV, there is no doubt that there is a significant psychological burden of ageing with HIV. The term 'fragmented life narratives' has been used to refer to those who have lived longer than expected and have not made plans for the future. The Crusaid hardship fund reported a dramatic increase during 2009 of applications for financial assistance from patients over the age of 50 experiencing HIV-related poverty [14]. Other issues, such as difficulties with employment, changes in sexual desire and function, 'survivor guilt' and bereavement, are

regularly cited by patients over the age of 50. Further qualitative research is required to fully understand the psychosocial issues of ageing with HIV, but a discussion about support networks, employment and financial security, and depression screening should be part of clinical consultation with the over 50s.

Conclusion

There are innumerable unanswered questions surrounding ageing with HIV; however, there is an abundance of clinical and patient research currently in the pipeline that aims to answer a lot of these questions. Suffice to say, however, that management of this group of patients will remain challenging for the foreseeable future as the number of our patients who are over the age of 50 continues to increase. The future really does seem like a new frontier.

References

1. Health Protection Agency. MSM HIV data. 2009. Available at: www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203928687610#fig2 (last accessed 19 March 2010).
2. HIV over Fifty: Exploring the New Threat. Hearing before the Special Committee on Aging, United States Senate, *109th Congress, First Session*, 12 May 2005. Available at:http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_senate_hearings&docid=f:23758.wais (last accessed 18 March 2010).
3. Deeks SG. Perspective: immune dysfunction, inflammation, and accelerated aging in patients on antiretroviral therapy. *Topics in HIV Medicine*, 2009, **17**, 118–123.
4. Sacktor N, Lyles RH, Skolasky R *et al*. HIV associated neurologic disease incidence changes: Multicenter AIDS Cohort Study, 1990–1998. *Neurology*, 2001, **56**, 257–260.
5. Ances BM, Ellis RJ. Dementia and neurocognitive disorders due to HIV-1 infection. *Seminars in Neurology*, 2007, **27**, 86–92.
6. Chandler G, Josephs J, Fleishman JA *et al*. Alcohol use among HIV-infected persons in care: results of a multi-site survey. *HIV Medicine*, 2008, **9**, 196–202.
7. Clifford DB, Yang Y, Evans S. Neurologic consequences of hepatitis C and human immunodeficiency virus coinfection. *Journal for Neurovirology*, 2005, **11**(Suppl 3), 67–71.
8. European AIDS Clinical Society Guidelines 2009. Available at: www.europeanaidsclinicalsociety.org/Guidelines2009/G2_p50.htm (last accessed 18 March 2010).
9. Womack J, Goulet J, Gibert C *et al*. HIV-infection and fragility fracture risk among male veterans. *17th Conference on Retroviruses and Opportunistic Infections*, February 2010, San Francisco. Abstr. 129.
10. Grinspoon S. Diabetes mellitus, cardiovascular risk, and HIV disease. *Circulation*, 2009, **119**, 770–772.
11. Smith C, DAD Study Group. Association between modifiable and non-modifiable risk factors and specific causes of death in the HAART era: the Data Collection on Adverse Events of Anti-HIV Drugs Study. *16th Conference on Retroviruses and Opportunistic Infections*, February 2009, Montreal. Abstr. 145.
12. Patel P, Hanson DL, Sullivan PS. Incidence of types of cancer among HIV-infected persons compared with the general population in the United States 1992–2003. *Annals of Internal Medicine*, 2008, **148**, 728–736.
13. Fakoya A, Lamba H, Mackie N *et al*.; BHIVA, BASHH and FRSH. UK guidelines for the management of sexual and reproductive health of people living with HIV infection 2008. *HIV Medicine*, 2008, **9**, 681–720. Available at: www.bhiva.org/UKGuidelines2008.aspx (last accessed 18 March 2010).
14. Crusaid reports: Rise in 'older' generation experiencing HIV-related poverty. Positive Nation, 143. Available at: www.positivenation.co.uk/feature/article.php?article_id=217 (last accessed 18 March 2010).

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Needles and pins: Eastern Europe, drug use and HIV

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As the 18th International AIDS Conference (IAC) looms, a press release this month from the United Nations Information Service (UNIS) [1] confirms that the HIV epidemic in Eastern Europe will be under the spotlight at July's event. This reflects increasing international concern at the rapid spread of HIV in the region, one of the only areas in the world where HIV prevalence continues to rise, fuelled by poor support services for injecting drug users (IDUs). For countries so close to the (wealthy and progressive) European Union – or even already members – this is surely a problem that is soluble.

The press release cites a recent study by Mathers *et al.* [2], comprising a systematic review of data describing national, regional and global coverage of HIV services for IDUs. In reading the article, what is striking is the huge variety in the level of services, not only between continents but also within regions. Globally, up to 21.2 million people use injection drugs, and estimates of HIV infection in this group range from 0.8 to 6.6 million [3]. As reported previously in *HIV Nursing* [4,5], Eastern Europe, with punitive legislation controlling drug use, inflexible Soviet-influenced public health systems, and geographical proximity to areas producing injectable drugs, is especially prone to this vector of HIV transmission.

Mathers *et al.* [2] confirm that, in comparing needle and syringe programmes, opioid substitution therapy and other drug treatment, access in parts of Eastern Europe is as low as 7% (Russia and Belarus). Ukraine achieves 39%, which is encouraging, though given this is the country with the highest prevalence of HIV in the European region (1.6% of the adult population [6]), a 'reach' of services for IDU equal to that of Lithuania (showing real progress) at 68%, should be the target.

One key problem that must be confronted is that IDUs face significant stigma and discrimination, not just from fellow citizens, but also from prejudices nested within the social system. Human Rights Watch reports that in the Russian Federation for example, the police regularly harass IDUs when they collect clean needles and syringes from drug stores [7]. Stigma increases the likelihood of recidivism amongst rehabilitating drug users [8], and in many countries, not just those in Eastern Europe, judicial systems remain insensitive to the context of IDU, preferring instead punishment, command and control [9]. For any policy aiming to improve support services for IDUs, careful and sensitive engagement is vital, not just from the perspective of public health, but also because of essential human rights. For UNAIDS Executive Director, Michel Sidibé, 'people using drugs have a right to access the best possible options for prevention, care and treatment' [1].

With the promised focus on HIV, and IDUs, at this year's IAC, it is to be hoped that the outcomes will be positive, and services radically improved in parts of Eastern Europe. Otherwise, large numbers of drug users remain at risk of HIV, in a region that includes five of the eight richest countries in the world.

References

1. United Nations Information Service, HIV/AIDS Epidemics in Eastern Europe under the Spotlight at Vienna AIDS Conference. Press release – online at: www.unis.unvienna.org/unis/pressrels/2010/unisinf356.html (last accessed 22 March 2010).
2. Mathers BM, Degenhardt L, Ali H *et al.*; 2009 Reference Group to the UN on HIV and Injecting Drug Use. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet*, 2010, **375**, 1014–1028.
3. Mathers BM, Degenhardt L, Phillips B *et al.*; 2007 Reference Group to the UN on HIV and Injecting Drug Use.Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *Lancet*, 2008, **372**, 1733–1745.
4. Hodgson I. European perspective: focus on Ukraine. HIV *Nursing*, 2009, **9**(3): 10.
5. McDonald D, I Hodgson. Training in palliative care for HIV and AIDS in Ukraine: the Mildmay Experience. *HIV Nursing*, 2009, **9**(4), 5–8.
6. UNAIDS. *AIDS Epidemic Update*. Geneva, UNAIDS, 2009.
7. Csete J. Lessons not learned: Human rights abuses and HIV/AIDS in the Russian Federation. New York: Human Rights Watch, 2004.
8. van Olphen J, Eliason MJ, Freudenberg N, Barnes M. Nowhere to go: how stigma limits the options of female drug users after release from jail. *Substance Abuse, Treatment and Prevention Policy*, 2009, **4**, 10.
9. Hodgson, I. The thin blue cage: police repression and enforced detention of drug users in four countries (report from the International Harm Reduction Conference, Bangkok, Thailand). 2008. Available at: http://healthdev.net/site/post.php?s=5254 (last accessed 22 March 2010).

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NHIVNA update

I hope this update finds you all well, having survived swine flu and one of the coldest winters on record! NHIVNA is looking forward to the year ahead and it will be a year of change which we hope you will be involved in. Amongst the Executive, several serving officers will be retiring and our Chair, Sheila Morris, will retire in June. If you would like to become an Executive Officer, look out for the email notifications or go online to the website (www.nhivna.org), where there will be regular updates as to how you can apply.

2010 will bring the usual packed NHIVNA programme, with three study days still to come and our 12th Annual Conference, this year to be held in Brighton on 29th and 30th June. Early-bird registration notifications have gone out, so don't miss the opportunity to save a little money!

The Study Day programme kicked off on 18th March in London, with Working in Partnerships, with good delegate attendance and extremely positive feedback. The next study day is on 12th May in Birmingham and will be a day designated to providing nurses with an HIV Update. Topics will include improving the uptake of testing, opportunistic infections, plus the latest HIV research and how the role of the HIV nurse continues to evolve and change to meet the needs of patients. The third study day will be on Sexual Health in London on 20th October and the year's programme will conclude in Edinburgh on 17th November, again looking at Working in Partnerships.

As always, NHIVNA would not be the organisation it is without your input. If you would be interested in assisting with any of the Study Days, speaking or writing on HIV nursing – or attending the conference – please contact any of us via the website or via our secretariat. Look forward to seeing you at an event soon!

Zoë Sheppard
NHIVNA Honorary Secretary

Call for Papers 2010

HIV Nursing welcomes all articles, editorial letters, case reports and other contributions which would be of interest to healthcare professionals working in the field of HIV.

If you have recently completed a dissertation for a degree, set up a project that has improved the service of care for your patients, or conducted some interesting research, let us know.

As professional nurses, one of the best ways to raise our profile is by demonstrating innovative work that improves the lives of patients, family, and staff within the domain of HIV care.
HIV Nursing aims to provide a forum for those at the forefront of caring for people affected by HIV and is intended to provide a medium of communication on issues relating to HIV care. Readers' contributions are highly valued.

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The themes for this year's issues include:

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