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CLINICAL PEARL
Routine HIV Testing in Older Adults
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In 2006, the Centers for Disease Control and Prevention (CDC) released revised guidelines for HIV testing in health care settings [1]. These guidelines, endorsing routine HIV screening in primary care settings, are aligned with long-established public health principles of timely diagnosis and control of communicable diseases [2]. Routine screening in primary care settings integrates HIV testing with the laboratory tests that are conducted as part of annual physician examinations, including blood glucose, cholesterol, and electrolytes. Despite the release of the CDC recommendations several years ago, nationwide implementation has been sluggish, particularly among older adults who are not perceived to be at risk for HIV [3, 4]. Consequently, over the last few years, the CDC has reported an increase in new HIV diagnoses in persons over 50 years of age, with more than 15 percent of all new diagnoses falling in this age group [3]. The emerging HIV epidemic among older adults warrants urgent clinical and public health attention.

Clinical Case Scenario
In 2009, a 66-year-old widow was referred for infectious diseases consultation by a primary care physician. The patient was newly diagnosed with HIV, and her CD4 count was less than 200. She had AIDS. Despite being in the physician's care for hypertension and diabetes for over 10 years, she had never been tested for HIV, nor had her physician considered her to be at risk for it. The diagnosis was a coincidental discovery during her hospitalization for persistent diarrhea. Upon presentation for HIV care and treatment, she asked several questions about her new diagnosis that suggested she had little knowledge about HIV infection or how it was transmitted. Furthermore, she reported 10 years of celibacy and was bewildered by the diagnosis. She asked why, in all of her interactions with health care professionals over the years, none had ever discussed HIV.

Lessons Learned from Missed Opportunities
Unfortunately, scenarios like this are increasingly common and warrant the attention of health care professionals for several reasons. First, many physicians do not consider older adults to be at risk for HIV infection. As a result, many older persons are diagnosed late in the disease. Meanwhile, data show that many older persons have sexual risk factors for HIV. A study conducted in 2004 to assess the prevalence of sexual behavior among older adults found that 73 percent of persons aged 57-64 reported having engaged in sexual activity during the previous year. Among those aged 65-74, 53 percent reported having engaged in sexual activity, as did 26 percent

of those aged 75 to 85 [5]. Therefore, HIV testing and prevention counseling should be offered to older adults just as it is to younger patients.

Second, opportunities for diagnosing HIV in older adults may be missed due to misinterpretation of signs and symptoms that are common among the aging. The HIV status of the patient in the case scenario was identified during a workup for diarrhea. Many older adults present with signs of normal aging such as fatigue, mental confusion, and weight loss—symptoms that may also signal HIV infection. Failing to consider HIV in the differential diagnosis for aging patients leads to increased HIV morbidity and mortality, particularly since many older patients already suffer from preexisting conditions like diabetes, heart disease, and renal insufficiency. The delay in diagnosis and treatment of HIV in older adults has led to poorer outcomes, including lower baseline CD4 counts, decreased time to onset of AIDS, and increased mortality from AIDS-related illness [6, 7].

Third, data show that health professionals are often uncomfortable discussing a patient's sexual history, discomfort that is likely to be exacerbated in older patients and that can lead to missed opportunities for diagnosis. In a sexuality study among persons over 50 years of age, only 38 and 22 percent of men and women, respectively, reported having a physician-initiated conversation about sexuality [8].

Anecdotally, medical students have reported a lack of clinical instruction on how to approach taking a sexual history. Although the subject may be somewhat uncomfortable, particularly when the clinician is younger and the patient is older, the sexual history is essential to good medical care and can provide important clues about a patient's risk for HIV infection. To avoid patient discomfort and awkwardness when obtaining a sexual history, physicians should consider inserting the sexual history seamlessly between nonsensitive sections of the social history such as inquiries about employment and pets or recent travel. Finding a comfortable style for obtaining a sexual history is the most critical element to eliciting such sensitive information and is necessary for identifying older patients who can benefit from additional screening and prevention messages.

Finally, as illustrated in the case scenario, HIV literacy is low among older adults, and health care professionals should serve as an HIV information resource. A study assessing HIV prevention among older adults revealed that HIV knowledge and condom usage were inadequate in that group [9, 10]. Given these knowledge gaps, older adults are unlikely to utilize condoms during sexual activity or purposefully seek HIV testing.

Avoiding Missed Diagnoses in Older Adults

Given the need for early identification of HIV infection among older patients, it is imperative that physicians and other health care professionals adopt routine HIV screening as a standard of care. As outlined by CDC, routine screening can accomplish several goals:

Elimination of HIV-testing stigma. If testing is adopted as the standard of care, older patients will not feel stigmatized by it.

Avoidance of missed opportunities for identifying HIV infection in early disease stage. Routine screening will eliminate physician guesswork in deciding when HIV testing is warranted.

Reducing the U.S. AIDS burden. Earlier identification and linkage to care leads to earlier treatment and avoidance of AIDS.

Implementation of routine HIV screening in the health care setting is often perceived as difficult, cumbersome, and challenging, but it can be straightforward and logistically feasible. Two concrete suggestions for implementing routine screening are adding HIV consent to the general informed consent form and, after telling the patient, adding an HIV ELISA to the panel of routine tests conducted for general care. Strategies like this can help eliminate missed HIV diagnoses in older persons.

Conclusion

Implementation of the revised CDC HIV-testing guidelines in adults is imperative to improve early identification and reduction of HIV morbidity in older adults. Although older adults may have low HIV literacy and may not perceive themselves to be at risk for HIV infection, health care professionals must exercise the clinical leadership required to diagnose HIV infection early and to educate older adults about their risk for HIV infection. Through early diagnosis and education, it is possible to reduce substantially the burden of AIDS in older adults and possibly even to eliminate AIDS diagnoses among older adults altogether.

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