HIV testing above the age of 50 – Old challenges and unmet needs

The EATG runs the Ageing with HIV - A Lifecycle Approach project about growing up and growing old with HIV. The project started in December 2015 and lasts for 30 months. Three distinct stages of the project look at the biomedical, mental and psychosocial consequences of living with HIV over the age of 50, in childhood, and finally in adolescence and early adulthood.

Following two well-attended webinars, the first conference “New Challenges and Unmet Needs of People Living With HIV/AIDS Aged 50+” was organised in Berlin between 31 March and 3 April 2016. More than 70 participants, scientists, medical professionals, regulators and patient experts came together for an intensive meeting of three and a half days. Thirty-seven presentations and two comprehensive panel discussions explored the implications of living with HIV over the age of 50 including epidemiology, testing, co-morbidities, co-infections, stigma and other social matters, polypharmacy and other pharmacological challenges, mental health, specific groups, quality of life, palliative and end-of-life care. A key recognition behind this project is that while there is plenty of work done in order to prevent new HIV infections, we should also consider those who live and have been living with HIV for several decades, while the entire cohort of PLHIV is ageing.

One of the key topics and focal points was HIV testing in the age bracket of 50+. Epidemiological data from the European Centre for Disease Control and Prevention, presented by Lara Tavoschi, show that the rate of people living with HIV (PLHIV) over the age of 50 years is already over 20% of the total population of PLHIV, while there is a constant increase in the proportion of this age group among new diagnoses. The mode of transmission is mainly sexual contact (MSM and heterosexual) and injecting drug use, while the rate of 50+ patients amongs the newly diagnosed grew steadily between 1990 and 2014, reaching more than 17% by 2014.

There was a lot of discussion around the social collaterals that act as barriers to testing in the 50+ age bracket. Talking about sex is generally a taboo in society, but the sexual life of older people is often simply erased. There is a general assumption in society, including the medical profession, that older people don't have sex, or if they do, then they have heterosexual sex. These assumptions lead to a false assessment of risks and plenty of missed diganoses. The same applies to drug use. It seems that there are no sufficient testing strategies or, in fact, awareness that older people can be, and actually are, at risk of contracting HIV. Also, ageing and old age are stigmatising phenomena in contemporary society. This, combined with the stigma associated with HIV, creates an additional barrier to testing in this population.

Tavoschi presented three studies about HIV testing in the 50+ age group. All of these (Ellman et al., Massari et al., Camoni et al.) confirm that there is not only ana alarmingly small number of tests performed with older people, but these patients usually present late with low CD4 counts and complex AIDS related illnesses (more than 70% of late presenters in one sample in the USA).

One recommendation made by Tavoschi and then discussed extensively by the conference participants was the concept of indicator condition guided testing. This approach is about getting medical specialists who normally do not conduct HIV testing to offer HIV tests to individual patients who attend health care settings with certain medical conditions – the so-called indicator conditions. These are conditions that might be indicative of undetected HIV

and include for example sexually transmitted diseases, hepatitis B or C and mononucleosis-like illness. A study by Raben et al. found in 2015 that indicator condition (IC) guided testing is not routinely applied across Europe although it is contained in the testing guidelines. They say: "Applying the observed rates of testing HIV+ within individual ICs and regions to all persons presenting with an IC suggested that 105 diagnoses were potentially missed. Testing rates in well-established HIV ICs remained low across Europe, despite high prevalence rates, reflecting missed opportunities for earlier HIV diagnosis and care. Significant numbers may have had an opportunity for HIV diagnosis if all persons included in IC audits had been tested."

In summary, Tavoschi described four categories of barriers to testing in the 50+ age group: Patient level factors include low HIV related knowledge, fears and misconceptions, wrong self-assessment of risk, and a misattribution of symptoms to other causes, for example ageing. Provider level factors include discomfort in exploring older patients' sexual or drug using behaviour; lack of specific training, and also the misattribution of symptoms to ageing by health care providers. Institutional level factors include the lack and unawareness of specific guidelines for HIV testing in older adults. Societal level factors include stigma and ageism. Older adults are not seen as at risk for HIV; older adults are seen as asexual; targeting HIV prevention to older adults seems to be futile if the same messaging is used as for younger age groups.

In another presentation, Michael Meulbroek representing the community based voluntary testing and counselling site “Checkpoint Barcelona”, confirmed that while the number of 50+ age clients who come for a HIV test remains low, they are usually men (MSM) and present at a late stage in their infection. Early testing and diagnosis would be even more important for the more advanced age groups, as the immune system takes longer to recover, and the earlier treatment is initiated, the better the health related outcomes.

In conclusion there was consensus across the participants of the conference that new HIV diagnoses among people aged 50 and older have been increasing over the past decade in the European Union and the EEA region. Older adults newly diagnosed with HIV in the EU area are more likely to be men, nationals (i.e. not migrants) and late presenters. New HIV diagnoses are increasing also among older women as opposed to younger age groups. Older people are less likely to be offered an HIV test, which creates missed opportunities in testing. There is a large need for tailored interventions and testing approaches to increase coverage and uptake of HIV tests in the 50+ age-group, and closer cooperation with the community is needed in order to be able to reach out more effectively to these groups and close this persistent gap in testing.