INTRODUCTION

• Investigating the epidemiology of non-AIDS co-morbidities among persons in care is important to optimize clinical care and to plan health screening strategies.

• We evaluated number and types of non-AIDS comorbidities (NACMs) among HIV-infected persons who were followed for at least 5 years during 1/1/1997 to 6/30/2015 with ≥75% of time on ART and having ≥75% time on ART spent with HIV RNA levels <200 copies/mL.

METHODS

Study Population: HIV Outpatient Study (HOPS) patients at 8 U.S. HIV clinics, seen during 1/1/1997 to 6/30/2015, who were followed for a minimum of 5 years with ≥75% of observation time on ART and having ≥75% of time on ART with HIV RNA levels <200 copies/mL.

Statistical Methods: In stratified analysis (by age at last observation: 18-40, 41-50, 51-60, 61+ years), we calculated median years HIV+ (IQR) and median CD4 at ART initiation (IQR).

RESULTS

• Of 1,540 participants, there were 81% men, 26% non-Hispanic black, 55% with private insurance.

• Of 1,540 patients, there were 8% persons with injection drug use (IDU) history.

• Mean number of NACMs increased with advancing age category: 1.4, 2.2, 3.0, 3.9, respectively (Figure 1).

• Overall prevalence of each individual NACM increased with older age categories (P=0.001) except for HIV infection and psychiatric illness (Figure 2).

Significant differences (α=0.05) in mean number of NACMs were found by sociodemographic characteristics (Figure 3):

• Sex (women > men), race (black > non-black), 3 vs. 5 years of HIV transmission risk (IDU > heterosexual and MSM), 3 vs. 10 and 24.5 years, and insurance status (public > private, 3.6 vs. 2.1).

• These differences were especially apparent in older age groups (51-60 and > 61 years, 3.0 and 3.9 vs. 1.9 for 50 years of age), and were driven primarily by differences in specific NACMs: cancer and chronic kidney disease.

In the multivariable model, factors associated with higher number of NACMs were increasing age, IDU or heterosexual HIV transmission risk, public or self-pay/no healthcare insurance, BMI ≥ 30, and longer spent with HIV RNA levels <200 copies/mL.

Differences in NACM prevalence and type by age group, sex, race, HIV transmission risk, payer, body mass index (BMI), and years of ART exposure.

• Modeling performed using Poisson regression.

• NACMs included: cardiovascular disease, cancer, hypertension, diabetes, dyslipidemia, degenerative joint disease/fracture, chronic Hepatitis B (HBV) or Hepatitis C (HCV) infection, chronic kidney disease, anemia, and psychiatric illness.

• NACMs were assessed using abstracted data collected by routine medical record review: lab records, documented diagnoses, and medical record documentation.

• Participants with evidence of an NACM from at least one of the three data sources were classified as having a NACM, except persons with missing data or HIV RNA level <200 copies/mL.

• Study Population: HIV Outpatient Study (HOPS) patients at 8 U.S. HIV clinics, seen during 1/1/1997 to 6/30/2015 with ≥75% of observation time on ART and ≥75% of time on ART spent with HIV RNA levels <200 copies/mL (N=1,540).

Table 1: Characteristics of HOPS participants who were followed for at least 5 years during 1/1/1997 to 6/30/2015 with ≥75% of time on ART and ≥75% of time on ART spent with HIV RNA levels <200 copies/mL (N=1,540).