Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents

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HIV-Infected Adolescents and Young Adults (Last updated January 10, 2011; last reviewed January 10, 2011)

Older children and adolescents now make up the largest percentage of HIV-infected children cared for at pediatric HIV clinics in the United States. The Centers for Disease Control and Prevention (CDC) estimates that 15% of the 35,314 new HIV diagnoses reported among the 33 states that participated in confidential, name-based HIV infection reporting in 2006 were among youth 13–24 years of age.[1] Recent trends in HIV prevalence reveal that the disproportionate burden of HIV/AIDS among racial minorities is even greater among youth 13–19 years of age than among young adults 20–24 years of age.[2] Furthermore, trends for all HIV/AIDS diagnoses in 33 states from 2001 to 2006 decreased for all transmission categories except among men who have sex with men (MSM). Notably, among all black MSM, the largest increase in HIV/AIDS diagnoses occurred among youth 13–24 years of age.[3] HIV-infected adolescents represent a heterogeneous group in terms of sociodemographics, mode of HIV infection, sexual and substance abuse history, clinical and immunologic status, psychosocial development, and readiness to adhere to medications. Many of these factors may influence decisions concerning when to start antiretroviral therapy (ART) and what antiretroviral (ARV) medications should be used.

Most adolescents who acquire HIV are infected through high-risk behaviors. Many of them are recently infected and unaware of their HIV infection status. Thus, many are in an early stage of HIV infection, which makes them ideal candidates for early interventions, such as prevention counseling, linkage, and engagement to care. A recent study among HIV-infected adolescents and young adults presenting for care identified primary genotypic resistance mutations to ARV medications in up to 18% of the evaluable sample of recently infected youth, as determined by the detuned antibody testing assay strategy that defined recent infection as occurring within 180 days of testing.[4] This transmission dynamic reflects that a substantial proportion of youth's sexual partners are likely older and may be more ART experienced; thus, awareness of the importance of baseline resistance testing among recently infected youth naive to ART is imperative.

A limited but increasing number of HIV-infected adolescents are long-term survivors of HIV infection acquired perinatally or in infancy through blood products. Such adolescents are usually heavily ART experienced and may have a unique clinical course that differs from that of adolescents infected later in life.[5] If these heavily ART-experienced adolescents harbor resistant virus, optimal ARV regimens should be based on the same guiding principles as for heavily ART-experienced adults. (See Virologic and Immunogic Failure.)

Adolescents are developmentally at a difficult crossroad. Their needs for autonomy and independence and their evolving decisional capacity intersect and compete with concrete thinking processes, risk-taking behaviors, preoccupation with self-image, and the need to "fit in" with their peers. This makes it challenging to attract and sustain adolescents' focus on maintaining their health, particularly for those with chronic illnesses. These challenges are not specific to any particular transmission mode or stage of disease. Thus, irrespective of disease duration or mode of HIV transmission, every effort must be made to engage them in care so they can improve and maintain their health for the long term.

Antiretroviral Therapy Considerations in Adolescents

Adult guidelines for ART are usually appropriate for postpubertal adolescents, because the clinical course of HIV-infected adolescents who were infected sexually or through injection drug use during adolescence is more similar to that of adults than to that of children. Adult guidelines can also be useful for postpubertal youth who were perinatally infected because these patients often have treatment challenges associated with the use of long-term ART that mirror those of ART-experienced adults, such as extensive resistance, complex regimens, and adverse drug effects.

Dosage of medications for HIV infection and opportunistic infections should be prescribed according to Tanner staging of puberty and not solely on the basis of age.[6-7] Adolescents in early puberty (i.e., Tanner

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Stages I and II) should be administered doses on pediatric schedules, whereas those in late puberty (i.e., Tanner Stage V) should follow adult dosing schedules. However, Tanner stage and age are not necessarily directly predictive of drug pharmacokinetics. Because puberty may be delayed in children who were infected with HIV perinatally,[8] continued use of pediatric doses in puberty-delayed adolescents can result in medication doses that are higher than the usual adult doses. Because data are not available to predict optimal medication doses for each ARV medication for this group of children, issues such as toxicity, pill or liquid volume burden, adherence, and virologic and immunologic parameters should be considered in determining when to transition from pediatric to adult doses. Youth who are in their growth spurt period (i.e., Tanner Stage III in females and Tanner Stage IV in males) and following adult or pediatric dosing guidelines and adolescents who have transitioned from pediatric to adult doses should be closely monitored for medication efficacy and toxicity. Therapeutic drug monitoring can be considered in selected circumstances to help guide therapy decisions in this context. Pharmacokinetic studies of drugs in youth are needed to better define appropriate dosing. For a more detailed discussion, see Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection.[9]

Adherence Concerns in Adolescents

HIV-infected adolescents are especially vulnerable to specific adherence problems based on their psychosocial and cognitive developmental trajectory. Comprehensive systems of care are required to serve both the medical and psychosocial needs of HIV-infected adolescents, who are frequently inexperienced with health care systems and who lack health insurance. Many HIV-infected adolescents face challenges in adhering to medical regimens for reasons that include:

- denial and fear of their HIV infection;
- misinformation;
- distrust of the medical establishment;
- fear and lack of belief in the effectiveness of medications;
- low self-esteem;
- unstructured and chaotic lifestyles;
- mood disorders and other mental illness;
- lack of familial and social support;
- absence of or inconsistent access to care or health insurance; and
- incumbent risk of inadvertent parental disclosure of the youth's HIV infection status if parental health insurance is used.

In selecting treatment regimens for adolescents, clinicians must balance the goal of prescribing a maximally potent ART regimen with realistic assessment of existing and potential support systems to facilitate adherence. Adolescents benefit from reminder systems (e.g., beepers, timers, and pill boxes) that are stylish and inconspicuous.[10] It is important to make medication adherence as user friendly and as little stigmatizing as possible for the older child or adolescent. The concrete thought processes of adolescents make it difficult for them to take medications when they are asymptomatic, particularly if the medications have side effects. Adherence to complex regimens is particularly challenging at a time of life when adolescents do not want to be different from their peers.[11-13] Directly observed therapy might be considered for selected HIV-infected adolescents such as those with mental illness.[14-18]

Difficult Adherence Problems

Because adolescence is characterized by rapid changes in physical maturation, cognitive processes, and life style, predicting long-term adherence in an adolescent can be very challenging. The ability of youth to adhere

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to therapy needs to be included as part of therapeutic decision making concerning the risks and benefits of starting treatment. Erratic adherence may result in the loss of future regimens because of the development of resistance mutations. Clinicians who care for HIV-infected adolescents frequently manage youth who, while needing therapy, pose significant concerns regarding their ability to adhere to therapy. In these cases, alternative considerations to initiation of therapy can be the following: (1) a short-term deferral of treatment until adherence is more likely or while adherence-related problems are aggressively addressed; (2) an adherence testing period in which a placebo (e.g., vitamin pill) is administered; and (3) the avoidance of any regimens with low genetic resistance barriers. Such decisions are ideally individualized to each patient and should be made carefully in context with the individual's clinical status. For a more detailed discussion on specific therapy and adherence issues for HIV-infected adolescents, see Guidelines for Use of Antiretroviral Agents in Pediatric HIV Infection.[9]

Special Considerations in Adolescents

Sexually transmitted infections (STIs), in particular human papilloma virus (HPV), should also be addressed in all adolescents. For a more detailed discussion on STIs, see the most recent CDC guidelines[19] and the pediatric opportunistic infection treatment guidelines on HPV among HIV-infected adolescents.[20] Family planning counseling, including a discussion of the risks of perinatal transmission of HIV and methods to reduce risks, should be provided to all youth. Providing gynecologic care for the HIV-infected female adolescent is especially important. Contraception, including the interaction of specific ARV drugs on hormonal contraceptives, and the potential for pregnancy also may alter choices of ART. As an example, efavirenz (EFV) should be used with caution in females of childbearing age and should only be prescribed after intensive counseling and education about the potential effects on the fetus, the need for close monitoring—including periodic pregnancy testing—and a commitment on the part of the teen to use effective contraception. For a more detailed discussion, see HIV-Infected Women and the Perinatal Guidelines.[21]

Transitioning Care

Given lifelong infection with HIV and the need for treatment through several stages of growth and development, HIV care programs and providers need flexibility to appropriately transition care for HIV-infected children, adolescents, and young adults. A successful transition requires an awareness of some fundamental differences between many adolescent and adult HIV care models. In most adolescent HIV clinics, care is more "teen-centered" and multidisciplinary, with primary care being highly integrated into HIV care. Teen services, such as sexual and reproductive health, substance abuse treatment, mental health, treatment education, and adherence counseling are all found in one clinic setting. In contrast, some adult HIV clinics may rely more on referral of the patient to separate subspecialty care settings, such as gynecology. Transitioning the care of an emerging young adult includes considerations of areas such as medical insurance, independence, autonomy, decisional capacity, confidentiality, and consent. Also, adult clinic settings tend to be larger and can easily intimidate younger, less motivated patients. As an additional complication to this transition, HIV-infected adolescents belong to two epidemiologically distinct subgroups: (1) those perinatally infected—who would likely have more disease burden history, complications, and chronicity; less functional autonomy; greater need for ART; and higher mortality risk; and (2) those more recently infected due to high-risk behaviors. Thus, these subgroups have unique biomedical and psychosocial considerations and needs.

To maximize the likelihood of a successful transition, facilitators to successful transitioning are best implemented early on. These include the following: (1) optimizing provider communication between adolescent and adult clinics; (2) addressing patient/family resistance caused by lack of information, stigma or disclosure concerns, and differences in practice styles; (3) preparing youth for life skills development, including counseling them on the appropriate use of a primary care provider and appointment management,

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the importance of prompt symptom recognition and reporting, and the importance of self-efficacy with medication management, insurance, and entitlements; (4) identifying an optimal clinic model for a given setting (i.e., simultaneous transition of mental health and/or case management versus a gradual phase-in); (5) implementing ongoing evaluation to measure the success of a selected model; (6) engaging in regular multidisciplinary case conferences between adult and adolescent care providers; (7) implementing interventions that may be associated with improved outcomes, such as support groups and mental health consultation; and (8) incorporating a family planning component into clinical care. Attention to these key areas will likely improve adherence to appointments and avert the potential for a youth to "fall through the cracks," as it is commonly referred to in adolescent medicine.

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