Neurocognitive Symptoms in PLWH

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Objectives

• What do people worry about?

• What do their partners worry about?

• What’s the ‘truth’?
He took hold of his wife’s head
Tried to lift it off, to put it on
Screening Principles

• Wilson and Jungner

  – the condition should be an important health problem

  – there should be an accepted treatment

  – there should be a suitable test

  – the natural history of the condition should be understood

Issues

• Symptoms don’t always predict NCI

• Tests aren’t very good

• Natural history not understood

• No clear intervention that helps
Natural History

- A large proportion of HAND does not appear to have major impact on everyday function
  - falling into ANI in Frascati criteria

- May be a risk of deterioration and some reports show risk of subsequent impairment with mild NC disorder (MND) inpatients with ANI at baseline

- Link with depression may affect ‘progression’
  - thus change from ANI to MND can be mood congruent

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Challenges

• Norms
  – old
  – don’t reflect our population

• Circularity of screening research
  – populations
  – mood
Widespread implementation of screening for HIV associated neurocognitive disorders is premature, on the basis of available evidence.
Symptoms

• Important because they guide clinical decisions around investigation and treatment
  - but often they do not identify patients at risk of neurological disease

• Even if symptoms are only weakly correlated with cognitive impairment they are often highly important to the patient

• Other reasons may affect the validity of self reported scales
  - psychiatric problems
  - excessive substance use
  - other reversible cause affecting daily functioning

• May perceive a decline in function that’s not present, because of depression or anxiety

• May be worried or hypervigilant about symptoms

• May state decline in function as they thing the clinician or researcher wants to hear it

• May be secondary gain by reporting it

• Measuring instruments may lack validity and fail to measure what they purport to

Symptoms

• Subcortical vs. cortical

• Motor vs. memory

• Self vs. others
Symptoms

• Life, drugs, alcohol

• HIV, treated or otherwise

• Something else.....
Symptoms

• Mood

• Personality change

• Multitasking

• Remembering things
Symptoms

• Mood
  – cause or symptom?

• Personality change

• Multitasking

• Remembering things
What Symptoms?

• General cognitive symptoms may be the main driver of patients coming to the attention of clinicians:
  – memory
  – concentration
  – reasoning
  – attention

• Patients’ own causal attributions of functional decline (cognitive or physical) are inconsistent with objective neuropsychological assessments of function

Evidence

• CIPHER Group

• 5 European countries

• Determine factors associated with self-reported decline in ADL and cognitive impairment symptoms

• Computerised as well as pen and paper tests
  – cognitive function in five domains
  – psychosocial factors
  – clinical parameters

Evidence

• 448 completed the assessments (approx 46y, 84% male, 87% white)

• 96 (21.4%) reported decline in ADLs and attributed this to cognitive difficulties

• Declining ADLs and increased frequency of cognitive symptoms were both associated with worse cognitive performance on testing

Evidence

• A number of factors were found to be associated with self reported decline in ADLs:
  – speed/reaction time
  – attention/working memory

• Several other factors were also associated with a decline in ADLs:
  – ability to afford basic needs most of the time or some of the time
  – depressive symptoms
  – anxiety symptoms
  – longer time since HIV diagnosis (median time 10 years)
Evidence

- A number of factors were found to be associated with self reported decline in ADLs:
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  - depressive sx
  - anxiety sx
  - longer time since HIV diagnosis (median time 10 years)

- Participants in London were more likely to report a decline in everyday function due to cognitive problems than those in any of the other 3 sites (p=0.0042)
Evidence

• In longitudinal studies of HIV associated cognitive impairment:
  – other factors driving self reported decline could mimic progressive decline in the absence of true cognitive change

• Work
  – 50% reported problems in CHARTER
  – 10% of functionally unimpaired patients had difficulties with work in CIPHER report
Recommendations

• Awareness
  – health care professional and patient

• Approaches to screening

• Brief intervention and education

• Practical support

• Referral pathways
Guidelines for Integrated Care in HIV

• PLWH should be given the opportunity to discuss their psychological wellbeing *with the professionals providing their health and social care*

• All PLWH *should be assessed* for the appropriate level of psychological support to meet their needs

• PLWH should be provided with access to care according to a *stepped care model*

http://www.bhiva.org/documents/Publications/Standards_for_psychological_support_for_adults_living_with_HIV.pdf
Specialist intervention
- Psychiatric diagnosis
- Neuropsychological assessment
- Assessment and formulation of complex psychological problems
- Assessment for cognitive impairment
- Assessment of risk of harm to self and others

Counselling and psychological therapies
- Assessment and formulation of psychological problems
- Identification of psychiatric problems
- Screening for cognitive impairment
- Assessment of risk of harm to self and others

Enhanced support
- Screening for psychological distress
- Screening for cognitive difficulties
- Assessment of risk of harm

Information and support
- Understanding the psychological needs of PLWH
- Recognising overt distress
- Understanding risks

http://www.bhiva.org/documents/Publications/Standards_for_psychological_support_for_adults_living_with_HIV.pdf
Summary

• What do people worry about?

• What do their partners worry about?

• What’s the ‘truth’?
Screening
Screening

HELLO

HOW ARE YOU

TODAY?

www.jhcoy.com
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Question everything
THANK YOU!

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