

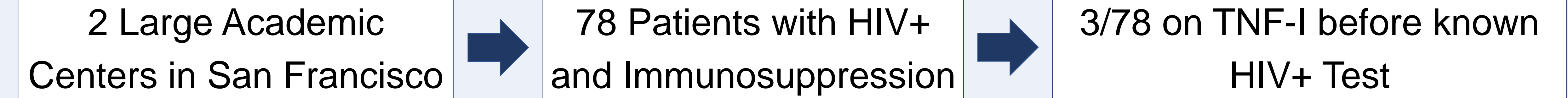
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BACKGROUND

- Both HIV infection and pharmacologic immunosuppression carry potential risks of infections, malignancies, and adverse clinical outcomes.
- Among patients with well-controlled HIV, limited data support the safety and effectiveness of using TNF-alpha inhibitors (TNF-I), such as infliximab and adalimumab, to treat chronic inflammatory conditions like rheumatoid arthritis, psoriasis, and inflammatory bowel disease.
- Little is known about patients with undiagnosed HIV infection who might be started on TNF-I.
- Several other countries recommend screening for risk factors for HIV acquisition and testing patients at high risk prior to starting TNF-I.
- No current guidelines exist in the U.S. for screening high-risk populations prior to TNF-I.

METHODS



CONCLUSIONS

- All 3 patients had well-known risk factors for HIV infection.
- Patients 1 and 3 had final diagnoses attributable to chronic HIV infection, without TNF-I indication.
- Patient 2 has poor symptom control despite excellent response to ART and may benefit from TNF-I.
- Screening for HIV infection and risk factors prior to the initiation of biologic therapy should be incorporated into clinical practice guidelines.

CASE SERIES

Patient Demographics	Risk Factor for HIV Acquisition	Immunosuppressant (Duration before HIV+ test)	Indication for Immunosuppression	HIV Status	CD4, HIV VL	Subsequent Events	Immunosuppression Course	Outcome
Patient 1: 53M Remote SUD		MTX (11 months) IFX (9 months) Leflunomide (4 months)	Rheumatoid Arthritis Symmetric peripheral arthritis, not controlled by MTX	Why tested: Flu-like symptoms (recurrent) Last negative test: 18 months prior	CD4 nadir: 859 VL: 6,000 → undetectable	<ul style="list-style-type: none"> • Recurrent shingles • Candidal infections • Gonococcal urethritis • Celiac disease 	Continued IFX+MTX 5 months after HIV+, stopped due to recurrent infections	Symptoms resolved with ART Unifying diagnosis = HIV arthropathy
Patient 2: 55F COPD, CKD		IFX (1 year) MTX (1 year)	Hidradenitis Suppurativa Inguinal, axillary LAD, on hibiclens washes	Why tested: 50-pound weight loss Last negative test: None	CD4 nadir: 87 VL: 276,000 → undetectable	<ul style="list-style-type: none"> • <i>C. difficile</i> colitis requiring ICU, 1 year later • Recurrent SSTI → surgical excision 	IFX/MTX stopped after HIV+ diagnosis	Symptoms inadequately controlled with local Kenalog injections
Patient 3: 32M Healthy		IFX (2 months) Prednisone (2 months)	Crohn's Disease Perianal abscesses, acute rectal inflammation	Why tested: Incident Kaposi Sarcoma (KS) Last negative test: None	CD4 nadir: 248 VL: 3,000 → undetectable	<ul style="list-style-type: none"> • Extensive visceral and cutaneous KS c/b IRIS <ul style="list-style-type: none"> • CMV colitis • Recurrent pericolic abscesses • Rectal stricture 	IFX stopped at HIV+, with slow wean of Prednisone limited by abd pain, bloody diarrhea	Symptoms improving with Doxorubicin No Crohn's Disease on follow-up endoscopy Unifying diagnosis = Cutaneous and visceral KS