

HIV and Aging in Canada: Diagnosis, treatment and care

Ensuring timely diagnosis and providing appropriate treatment, care and support to older Canadians living with HIV presents specific challenges.

Diagnosis


Older people are more likely than younger people to present late for HIV diagnosis and care.¹ One study showed that older patients were more likely than younger people to be given a diagnosis during hospitalization and more likely to have serious damage to their immune system at the time of HIV diagnosis.²

Older adults are less likely to be tested for HIV because they, and their health care providers, perceive that they are at lower risk of acquiring HIV; 70% of ‘baby boomers’ have never been tested for HIV.³ The assumption that older adults are not sexually active, often means that

Treatment

Early diagnosis of HIV is important no matter what your age; however, the older you are, the more critical early diagnosis becomes. This is because HIV progresses more quickly in older people.⁸ Both age and CD4 count (a measure of the strength of the immune system) at the time when treatment is started have a big impact on life expectancy. One large study found that people living with HIV and on antiretroviral therapies can live well into their 60s, even if they started therapy with severely depleted immune systems. Those who begin therapy with CD4 counts above 200 can expect to live into their 70s.⁹

Older people living with HIV are more likely to adhere to their drug regimen than younger populations.^{10,11} This leads to a better initial control of the virus in older individuals. In other words, they are more likely to achieve and maintain an undetectable viral load than younger people living with HIV. But, there may be a smaller CD4 increase (a measure of how well the immune system is recuperating from HIV infection) in comparison to younger



health care providers neither review the sexual histories of their older patients, nor do they provide education about safer sex practices,⁴ both of which they may do routinely with younger patients. Since physicians are less likely to discuss HIV/AIDS and related risk factors with older patients,⁵ they may be less likely to suspect and propose testing for HIV symptoms, delaying diagnosis. HIV/AIDS symptoms resemble those of other chronic illnesses which tend to develop in older adults.⁶ Older HIV-positive adults and their health care providers are therefore more likely to attribute HIV-related symptoms to other illnesses or to the normal aging process.⁷

people who are HIV-positive. Older HIV-positive people in general require two years to reach CD4 gains that younger populations see in one year.¹²

Treating HIV can be more complicated for older people. This is because people living with HIV/AIDS may be at a higher risk for specific types of illness and disease as they age, including decreased kidney function, osteoporosis and cancer.¹³ Taking several drugs at the same time can raise the risk of drug interactions, side effects and toxicities. Complementary and alternative medicines may also interact with treatment for HIV and other health problems. Health care providers and older Canadians living with HIV should carefully monitor all of these medications.¹⁴

The side effects of anti-HIV drugs don't appear to occur more often in people living with HIV as they get older, but they can be made worse by the side effects of other non-HIV medications. Additionally, decreases in kidney and liver function that come naturally with age, changes in hormone levels and metabolism, as well as weight loss associated with aging can all increase the chance of an adverse drug reaction.¹⁵

Published by:



In association with:



Canadian Working Group on HIV and Rehabilitation
Groupe de travail canadien sur le VIH et la réinsertion sociale



Funded in part by:



Updated: November 2013



Appropriate care for older Canadians living with HIV must take into account not only HIV-specific physiological and psychosocial effects, but also the effects of aging and the co-morbidities that are associated with it.

As HIV-positive Canadians get older and seek services outside HIV-specific care, they may find that services are not tailored to their needs, and they may experience greater stigma. For example, health care service providers that have traditionally cared for older Canadians (for example, home care workers, rehabilitation practitioners, gerontologists) may not be accustomed to working with people who are HIV-positive, gay, or who have a history of drug use. The need for this type of care may also occur somewhat earlier for Canadians living with HIV than others, presenting an additional challenge to the willingness and capacity of service providers to care for persons living with HIV.

It may be a challenge to meet the care needs of older Canadians living with HIV in this context. This may be especially true in smaller communities. The existence and access to appropriate services varies across the country. There may be a need to adapt existing services to meet the needs of older Canadians living with HIV, and to ensure additional training for a range of health care providers. The changing demographic profile of people living with HIV in Canada may also mean there is a need to adapt policies to increase access to appropriate services and supports by people aging with HIV in Canada. Income security, for example, is an important issue for people aging with HIV and other chronic illnesses who may experience alternating periods of illness and wellness that affect their ability to work to the age of retirement.¹⁶

In terms of acute care and palliative care, there may be two shifts to consider. First, as Canadians are living longer with HIV, a balance will need to be struck between the need for acute care and the need for end-of-life supports. Second, an increasing number of HIV-positive older Canadians might require care for non-HIV-related issues, in addition to HIV-related issues.

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