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HIV ECHO: PREP FOR OLDER ADULTS?

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[video transcript]

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I'm going to talk now about PrEP for older adults. And we're using the objectives for this presentation really kind of discussed the clinical considerations for PrEP and older adults review some best practices and describe some of the best barriers and facilitators. So I thought actually start off with a quick polling question for all of you. So please feel free to answer this question, what percentage of your patients on PrEP are 50 years or older? More than 20% 10 to 19%? One to 9%? For I have no patients who are older than 50. Okay, so it looks like about a third, don't have anybody over 50. And it looks like a small hand of the small handful of you about a percent have folks over 50. Alright, so here, let's jump in. And let's talk about this important topic. So when we think about new diagnosis in the US, right, we know that overall, we've made significant improvements in terms of new infections over the last several years, primarily due to the availability of better testing and also better treatment, but also with biomedical prevention strategies like PrEP or Pre-Exposure Prophylaxis. And if we look at new infections, we know the majority of new infections are occurring in younger individuals, those under 30. Right that we know. However, if you look at the data, there are still individuals about 16 or 17% of new diagnosis in the US are occurring in people 50 years or older. So we need to remember not to forget this specific population. And if we look at the population over 50, we still see in terms of demographics in terms of modes of transmission, it mirrors much like the broader population as a whole. So we still know that among older adults, MSM remains one of the primary modes of transmission. And in terms of women heterosexual contact, is the primary mode of transmission for women with newly acquired HIV over 50 years of age. How are we doing in New York City, one of the leading states in terms of ending the epidemic, we've seen some nice declines overall, just as we have in the US. But still in New York City, you can see here that we still have had new infections occur. But the overall trend is quite favorable in terms of the last 20 years or so we're seeing a nice decline. So we're definitely on the right track. In terms of New York state as a whole, this is data from the New York State, and the academic dashboard. And the exciting thing you can see here in the blue, is this is statewide, the number of prescriptions for people over 50 have increased over the last six years or so. Not at the same rate, but you can still see sort of an upward trend would be PrEP used in those over 60s. So again, this is probably reflective of many issues. But the good news here is that at least people in the 50 to 59 range, or getting or at least some percentage of people are accessing using PrEP. Now I know most people on this call are quite familiar with the different PrEP options. But just to refresh your memory, we do have three current FDA approved options for PrEP. There are two oral and one injectable option. Two of the oral options now basically contain them the same regimen, one contains tenofovir disoproxil fumarate, or TDF, which is

sort of the original version of Pre-Exposure Prophylaxis. The other oral option is a variation of that that contains to not have your elephant in mind, which has a little bit better renal profile. And then of course, there's the newly approved injectable option of Cabotegravir, which is an integrase inhibitor. Now they all have risks and benefits associated with them according to sort of their pharmacokinetic properties and some of their other side effects. So we know that with TDF FTC, there are some real parameters there. So not to be used or initiated and people with a creative clearance, less than 60. We know some of the impact of tenofovir disoproxil fumarate or TDF. We can see some changes in renal function and changes in bone mineral density. Cholesterol levels a little bit lower with TDF versus the TAF where there may be some and evidence of increased cholesterol as well as some weight gain issues associated with the tap version. So here, when we think about older adults, these are things that we have to take into consideration, right. So if somebody has potential renal dysfunction, or concurrent diabetic nephropathy or some other condition that may affect their kidneys that renal function is, is a huge component of that. The other thing would be somebody who has other CVD risk factors. So if if they already have issues with hypercholesterolemia, medications that may enhance their cholesterol level, that's something to consider to consider as part of the decision making are some of the options that we have to think about, that may not be the same, or say somebody in their early 20s or 30s. The one of the benefits of the injectable option, right, there are no issues in terms of the renal issues. But there are potentially issues because of an being an integrates class of medications, we see some changes in weight, that could be an issue and somebody's already maybe pre diabetic, hypertensive, etc. Those are some of the things we think about risk factors to mitigate. Those conditions are things that would kind of go again into the decision making. And really, when we think about older adults, the issue of comorbidities is really sort of the thing that plays a big role, right? So we think about these younger adults as well. But in older adults, because of the increased number of comorbidities, it plays a bigger role in terms of medication management in terms of monitoring patients in terms of thinking about unintended, unintended consequences of selecting one regimen over the other. The other thing that I think is important to think about when we think about older adults is the issue of polypharmacy. And that is something where, you know, we don't necessarily think so much about again in younger individuals. But when we think about older adults, and we think about potentials for drug drug interaction, the potential for non adherence because of polypharmacy things, such as maybe an adjective option could be a better option for some people who are struggling with issues of polypharmacy. So again, you know, there's no right or wrong answer. When you're selecting a regimen, you just have to kind of think about all of these issues together, which I think is an important concept when considering PrEP and older adults. Now one of the things that I think is interesting if you look at data, so we have really great data on the efficacy of PrEP. But if we look at well, who in the population was included in the you know, these pivotal trials. This table here provides just a summary of the sort of registration or pivotal trials showing the efficacy and benefit of prepping different populations. So this includes the

apex trial, the Discover trial showing CAB FTC vs. TDF, including the HPTN O eight three to O eight four trials looking at Cabotegravir as an option. If you look at the patient population and the age information on the right, you can see that there is actually very limited data on PrEP use in older adults, were they included necessarily in the study population. So in the Iprex trial, 11% of people were over the age of 40. In the IPERGAY trial 10% were over the age of 50. And the Cabotegravir trials are only month 0.3%, who are over the age of 60. And then in the HPTN O eight four trial, which is the trial of Cabotegravir in cisgender women, the upper age limit was 45. So again, when we think about is their data, I would say it's probably very limited or it is very limited. It's in terms of the stuff that we've had in terms of investigational trials, looking at the overall efficacy.

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But you know, what are some of the real world experiences so this is a trial or this is a report actually taken out really trial from the Veterans cohort. And they looked at PEP use in older adults, and here they use the cutoff of 45 as being sort of an older person or people in the upper upper age limits here. So if you look, it was actually a very small percentage. So although the range of ages went from 45 to 70, there were only The 18 individuals that met this criteria in terms of their PrEP population, and the majority of them were being all. And if you look, just in terms of the indication, again, most were MSM. But the good thing out of this trial or this report, this is just a small report, again, from the Veterans Administration that there is no significant difference in GFR, between baseline and the follow up for folks who were started on to fftc. So that's the sort of more promising news there. Now, this is data, which probably many of you have already seen before, looking at TAF FTC versus TDF FTC. And I'm just really summarizing some of the key points here of the other real differences or subliminal benefits, if you will, between top FTC, intact FTC has less impact, statistically significant differences in terms of creativity and, and GFR changes. And there was a recent meta analysis looking at the risk of experiencing clinically significant declines in credit clearances, less than 60 With TDF FTC. And you can see here from their report that the majority or the highest incidence really occurred in people 50 years or older. So that's just something to note, and I don't think that's news to people. But this is just sort of a summary indicating that, you know, age is a factor of experiencing something of decline there. So, you know, what are the current guidelines and according to the see the new or revised CDC guidelines, they do recommend assessing creatinine clearance at initiation and again, at least every six months in persons who are whose baseline GFR is less than nine. What about bone mineral density effects? Again, we know that the effect or impact if not the beer can cause changes in bone mineral density, in terms of the clinical significance, or what do we see in terms of clinical outcomes? Really, although there are changes in bone mineral density, there were no differences in fragility factors. And I think that's the important thing when we're thinking about, you know, why we're worried about changes, or osteopenia or osteoporosis is the fact that people, older adults may have a fall, or fragility

fracture, which can lead to other complications, including more others significant morbidity and mortality. And so, the good news was that no significant differences in features in fractures between the TAF versus TDF What about bone mineral density and DEXA scan. So this again, according to the CDC guidelines for 2021 DEXA scans not recommended before initiation of PrEP, but for people who have a history of fragility fracture or risk for osteoporosis, they should be referred for consultation. So that's just something to consider when you're looking are considering PEP in somebody who's an older adult. And just in terms of risk factors for osteopenia or osteoporosis. This is just a table here show you some of the key risk factors that you might see including things such as long term corticosteroid use Vitamin D deficiency. Other concurrent conditions like diabetes, lupus, hyperparathyroidism, but also we see osteopenia and osteoporosis occurring most commonly in most postmenopausal women. I'll talk a little bit more about that as well. What about some of the metabolic changes? I've alluded to this earlier. And this again, probably is not new for you for many of you on this call, but just to share with you or summarize again for you that the changes in lipid values. We see some lipid increases, especially again, total cholesterol triglycerides with tap FTC versus TDF FTC. And so what are their limits? For monitoring guidelines they do recommend people who are prescribed F TAF should be monitored with their levels of cholesterol levels and triglycerides at least annually. Statin should be prescribed if indicated. What about TDF FTC and postmenopausal women? So remember, I showed you sort of some of the earlier data about the limitations of older adults and specifically, if we look at cisgender women, very few in registrational trials. But there was one small study that looked at postmenopausal women. And this they looked at or tried to measure active metabolites of TDF in postmenopausal X plant in tissue and vaginal tissue, and they found that there was greater than nine fold lower concentrations of TDF in postmenopausal tissue as plants compared to pre menopausal or younger. So, that's something to think about in terms of, you know, what is the right option in terms of PrEP? Mayor, because we also know that tapping DC not necessarily indicated or at this time, at least, for individuals at risk for vaginal sex. So considerations there in terms of risk manifests, I talked about polypharmacy as as a significant issue when we think about older adults. And again, these are some of the reasons why we're concerned about them in terms of non adherence, there are some things that polypharmacy is associated with decreased quality of life, and also increase mortality. So we want to be very conscious of that. So what are some of the options with dealing with polypharmacy? Well, Cabotegravir, we know is an injectable option. So there's no new need for kettles there. So that can be a potential plus for Cabotegravir arm. But what are some of the side effects and how do those compare to the other existing options, this is just data. We're comparing the from the HP tn o a three and a weight four trials, compared to the comparator arm, which was the TDF FTC here. And we know that the main difference between or the main side effect that was reported, compared to the TDF arm was really the localized injection site reactions that we see here. But also just in terms of weight gain, you can see waking in both the OIT three and a week four trials was significant compared to the comparator

arms, and also just changes in cholesterol, a little bit increases in cholesterol, versus the TDF FTC are there.

17:26
But when we think about PrEP, and we think about, you know, prevention, I think this is a great ad that was out a few years ago. I know here in New York, this was one of the things that I think we need to remember, which is, age is not a condom, right? When we think about sex, and STIs and older adults, we know that in fact, STI is in older adults are increasing. So there's some data from the Centers for Disease Control that showed that STI is more than doubled in the past 10 years among individuals 65 years and older. Specifically, we've seen an increase in syphilis, as well as gonorrhea, shuffling over the course of 10 years. And if we know that Syphilis and Gonorrhea are indicators that people are having sex that is not protected or non barrier sex, we think of also that there could potentially be your risk for HIV. So again, we know that the risks is risk is there, so we just need to think about addressing them. But what are some of these barriers that come up in terms of prevention? Well, part of it, I think, is due to providers just not talking about sex with their patients. I'll talk a little bit more about that, um, misconceptions about risk older adults, even providers may not necessarily assume or think about risk of HIV in older adults, and or in their older adult patients. There are some issues of not associated with sex and HIV and STIs that also is permitted that still persist into older adulthood. Lack of knowledge people not knowing that this is an option that's available to them. There's concerns about cost insurance and also physical challenges in terms of just physical mobility and sex and, and different things that happen as you age that may change the way that you have sex or the type of sex that you're engaging in. This is a report from 2021 That looked at or they did a survey of older adults 65 to 80 over 1000 individuals responded to this and you know, are you currently sexually active or have you had recent sexual activity and more than half of the men and about a third of women use were sister other individuals in this were reporting sexual activity. Now the interesting thing was when we talk about sex, they said within this study that only about 17% of individuals talked about sex with their health care provider. And of those, the majority of them about 60% actually had to initiate the conversation that their providers did not initiate the conversation with them. So my challenge or my, you know, mantra here is, you know, don't be afraid to ask all your patients about their sexual activity, if you don't do so already. I'm sure most of you, if you're on this call, you're probably already doing it. But many of our colleagues who aren't doing HIV work or SGA work probably don't do this. And I think those are the people that we need to be champions of, and really model some of that behavior for others. One of the great things I think that New York did was they lifted or they modified the New York State HIV testing, law recommendation. So if you look at the USP STF guidelines, they say, individuals 15 to 65, they put an upper age limit on their guidelines should be screened for HIV, but New York took off the upper age limit. And I think that has really helped broaden the scope of thinking about when to test or who to test. So it

doesn't just stop at 65, that you this is a conversation that you can have ongoing? And I think, you know, really, the question is, how do you open that door? And how do you assess the risk, and everybody has their own way or style of doing this. And I really think, you know, my style that I use that I find is really helpful is just to incorporate sexual health questions as part of your general health history. And it can be anything from just a really broad, you know, open ended non judgmental question of, you know, tell me about sex. And I, that's usually kind of the question that I used to open the door, right. So tell me about sex. And I think it really allows the person to respond in a way that they feel most comfortable. And then once they open that door, they give me the okay, like, we're going to talk about sex now, then I can probe a little bit more and, and find my way into a discussion about that. So you can start off with, you know, what about sex and not having sex? And then I can go into? Well, you know, tell me a little bit more about why you're not having sex isn't? Is there a change in your libido? Are you having issues with erections? Or is it painful for you? Are there things that we can talk about? And that opens a whole other door? Right? Or it could be like, oh, yeah, I'm having sex. And then we go into the Okay, well, tell me about your partners. Tell me about how are you staying safe. So I think it's really how you open that door, and really finding the style that works best for you. The other thing, I think that plays a role in terms of older adults, and prevention and sex is just the effects of ageism. And some of the things of, you know, older adults, again, not having sex, people are concerned about so many different things isolation, depression, anxiety, performance, anxiety, fear of HIV and when we think about older adults now, right, 60s 60s 70s or 80s. Many of those individuals, probably and we're not probably or definitely have lived through the early HIV epidemic. And so there's a whole different lived experience around HIV insects and STI risk that's different than somebody in their 20s and 30s. And that's something also to counsel and address as you move forward. So what about PrEP and payment options, so most private insurance plans Medicare, Medicaid, should cover PrEP, and they're also assistance programs to help older adults may need assistance with that. So just a couple of take home points here. We're going to finish on time. I know I've been speaking most of this hour, but HIV infection remains an issue for older adults, clinicians should consider not only the comorbidities, but other psychosocial issues, when prescribing PrEP, and normalizing conversations about sexual health should be a part of routine care for older adults. And these are some resources that have made available here for you including the sage positive website and the GMHC hotline as well as if you're in the New York area. There's a program for mental health services for older adults that's LGBT affirming and it's called the spa program or services service program for older adults. And they're a great resource and So there you go Mark.

[End Transcript]