

This educational event is supported by



GILEAD



MSD



Acute Presentations of HIV: Looking at all sides of the story

Grace Newbold, Manchester Foundation Trust

James Macdonald, North Manchester General Hospital

Acute Presentations of HIV: Looking at all sides of the story

James Macdonald, North Manchester General Hospital MFT

Grace Newbold, North Manchester General Hospital MFT

Conflict of Interest Declaration

In relation to this presentation, we both declare that we have
no conflict of interest

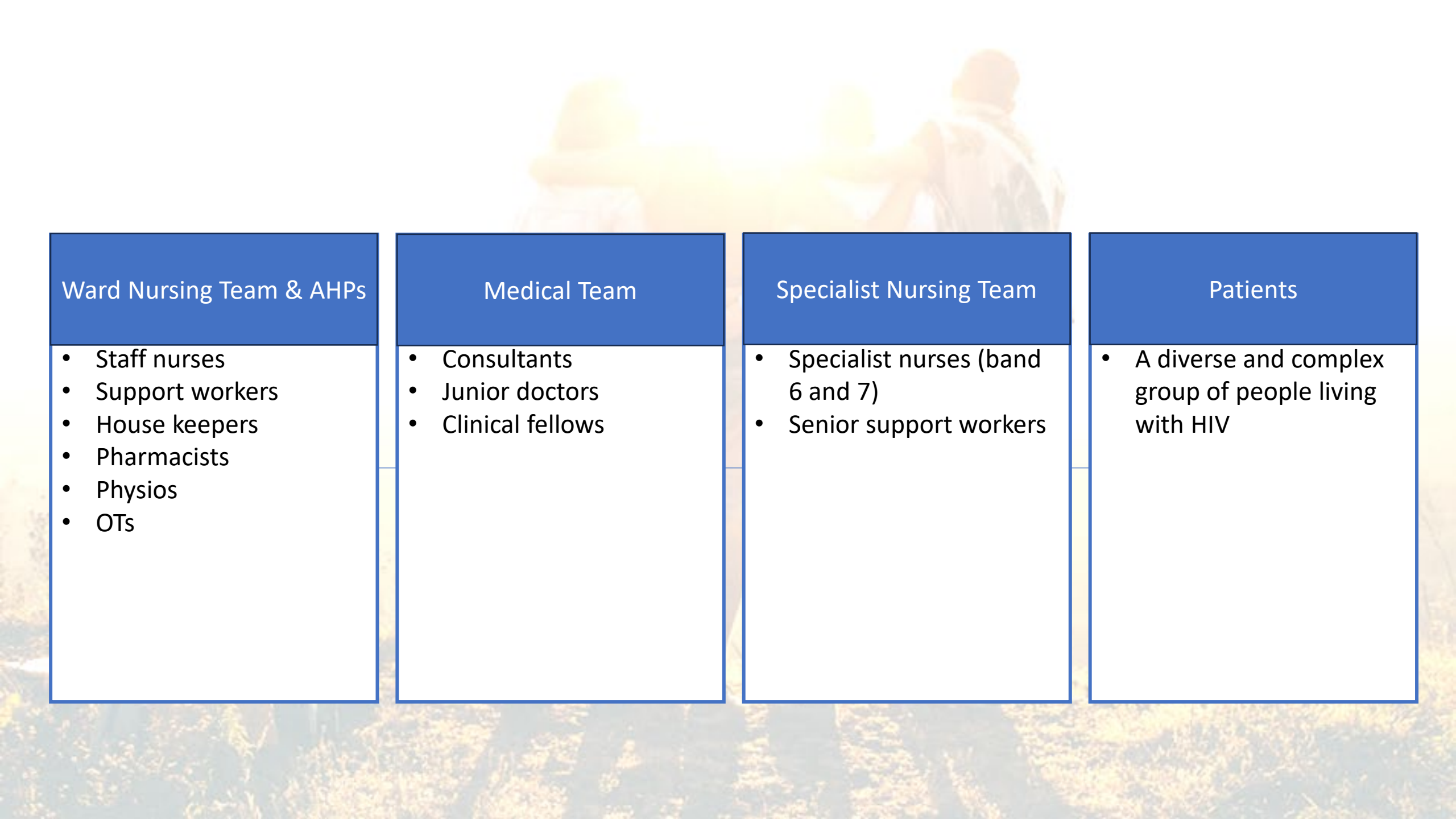


Speakers are required by the Federation of the Royal Colleges of Physicians to disclose conflicts of interest at the beginning of their presentation, with sufficient time for the information to be read by the audience. They should disclose financial relationships with manufacturers of any commercial product and/or providers of commercial services used on or produced for patients relating to the 36 months prior to the event. These include speaker fees, research grants, fees for other educational activities such as training of health professionals and consultation fees. Where a speaker owns shares or stocks directly in a company producing products or services for healthcare this should also be declared. Finally, other conflicts of interest including expert functions in health care or healthcare guidance processes should be declared (e.g. if the professional is a member of a health board). The Federation considers it good practice to also make speakers' disclosures available in digital format(s) relating to the educational event.

Introduction

- Who are we and where have we come from?
- What have we seen?
- What are we doing to help?



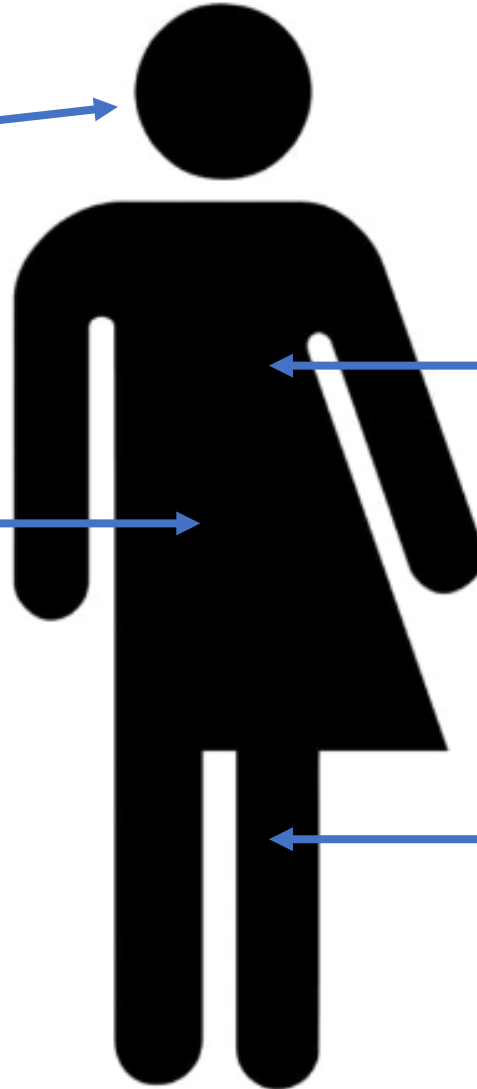
The background of the slide features a soft-focus photograph of several people standing in a field. In the foreground, the backs of two individuals are visible as they look towards a group of people further away. The scene is bathed in warm, golden light, suggesting a sunset or sunrise. The overall composition is peaceful and evokes a sense of community and shared experience.

Ward Nursing Team & AHPs	Medical Team	Specialist Nursing Team	Patients
<ul style="list-style-type: none">• Staff nurses• Support workers• House keepers• Pharmacists• Physios• OTs	<ul style="list-style-type: none">• Consultants• Junior doctors• Clinical fellows	<ul style="list-style-type: none">• Specialist nurses (band 6 and 7)• Senior support workers	<ul style="list-style-type: none">• A diverse and complex group of people living with HIV

The past 6 months

- Progressive multifocal leukoencephalopathy
- TB meningitis
- Toxoplasmosis
- Poor mental health

- Seroconversion illness
- Weight loss
- Candidiasis



- Pneumocystis pneumonia
- Tuberculosis

- Kaposi's sarcoma

Patient One – New diagnosis of primary HIV

- JP is a 41 year old male, MSM, long term open relationship
- Presented with diarrhoea, vomiting, reduced intake, hypertension, tachycardia
- Had been on prep
- Treatment plan – start antiretrovirals, baseline bloods, CNS input, intravenous fluids

Management and experiences

- Medical team – symptom control and management
- Ward nurses and AHPs – mixed experiences, capacity for time, sensitive diagnosis so struggle to engage
- Patient - Surprised by inpatient admission and how long it took to confirm. Found hospital isolating, but staff supportive
- Specialist Nurse – Although patient was well educated, curious about how to safely return to usual sexual activity and work guidance. Information given and signposted to support services.

Patient Two – Late diagnosis of HIV

- 50 year old heterosexual male
- Admitted through A&E with productive cough 10+ days, weight loss and shortness of breath when mobilising
- CPAP/high flow, ICU review, BBV screen
- Unclear on last HIV screen, not informed family, no obvious “risk” factors identified, 6 years+ last partner

Management and experiences

- Medical team – Prompting the HIV test, management of acute illness and liaison with escalation team
- Ward nurses and AHPs - Building relationships with patients. Although struggle during the day, night shift able to build rapport.
- Patient - Conscious about judgements how they may have acquired HIV, did not fit into any “high risk” groups, felt like this was questioned frequently.
- Specialist Nurse - trying to rationalise to the patient to not focus on stereotypes, explaining we see a wide range of patients with different lifestyles, genders, sexualities. Also supported with him navigating telling his family and why his diagnosis might have been missed

Patient 3 – Defaulted from HIV care

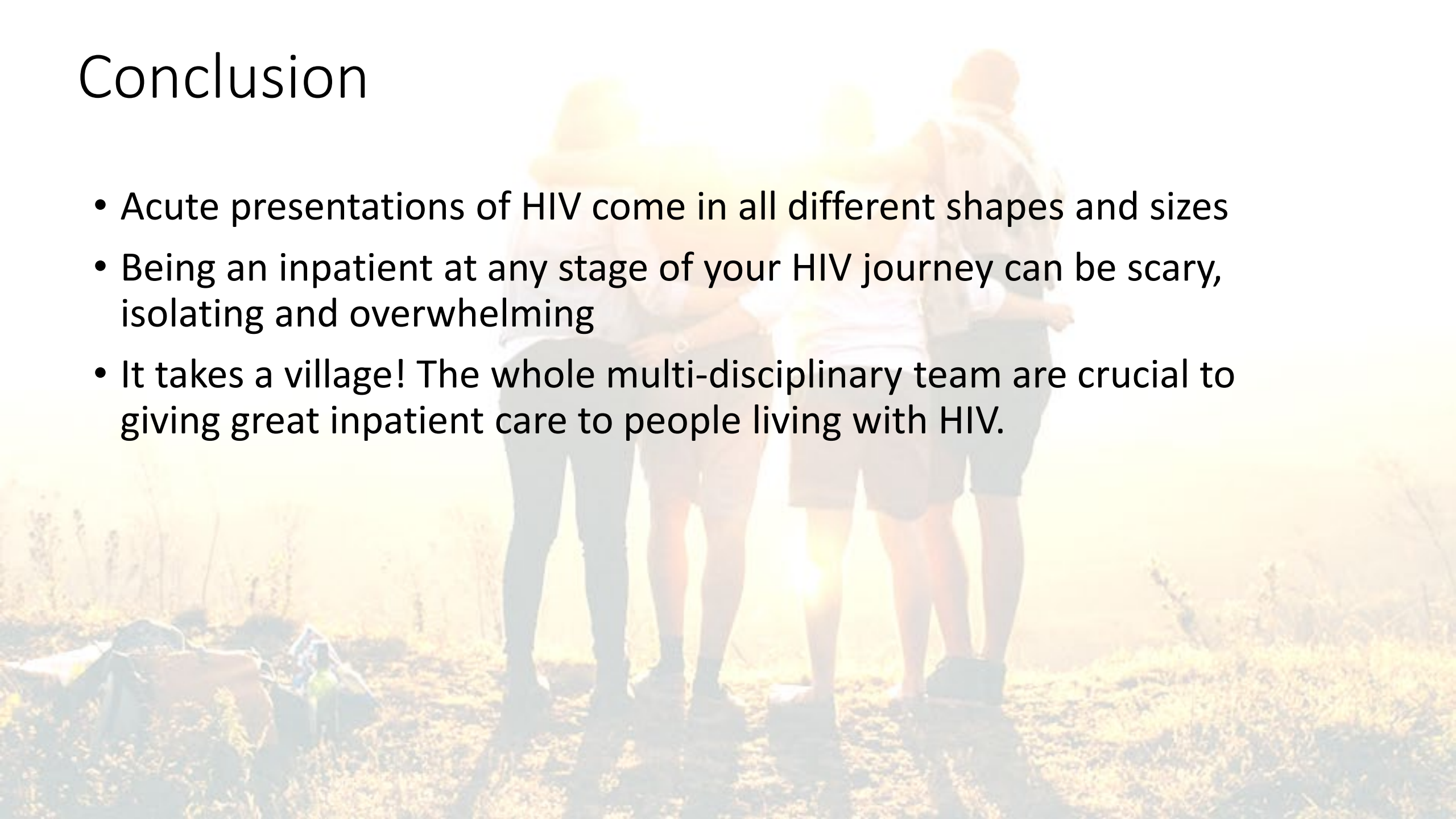
- 40 year old Zimbabwean woman
- Diagnosed with HIV during pregnancy in 2006
- Mixed experience with concordance to ART
- Partially re-engaged with HIV care in January 2023
- Admitted from a respiratory clinic appointment late December 2024 with widespread Kaposi's sarcoma, lower respiratory tract infection, extensive oesophageal candidiasis and CD4 count of 60
- She had very poor psychical reserve and was declared “not for resuscitation”

Management and experiences

- Medics – Management of acute presentation and liaison with oncology, advocating for the patient and their care
- Ward nurses and AHPs – Support with patient care, nutritional support, 24 hour emotional support and reassurance
- Patient – This was an incredibly scary time. The hospital rooms felt isolating. Lots of uncertainty around next steps
- Specialist Nurses – familiar faces who had to have very difficult conversations around advanced care planning and navigate family dynamics
- Education and exploration of the barriers to engagement and care planning once there was a treatment plan

Conclusion

- Acute presentations of HIV come in all different shapes and sizes
- Being an inpatient at any stage of your HIV journey can be scary, isolating and overwhelming
- It takes a village! The whole multi-disciplinary team are crucial to giving great inpatient care to people living with HIV.



Thank you for your time!

What questions do you have?