

Viral Meningitis? Think Acute HIV Infection

BY BRUCE JANCIN

COLORADO SPRINGS — “When you’re running a Monospot test, when you’re thinking viral meningitis, you also should be thinking acute HIV,” according to Dr. Benjamin Young.

European studies conducted in health-care systems with comprehensive patient tracking indicate that two-thirds to three-quarters of all patients with acute HIV infection seek treatment because they feel ill. The acute illness before seroconversion typically lasts for about a month and consists of a nondistinctive rash, generalized lymphadenopathy, or viral meningitis.

Indeed, 25%-50% of those with acute HIV infection present with viral menin-



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DR. YOUNG

gitis. These are patients who are sick enough to get a lumbar puncture, which often shows lymphocytic pleocytosis. All too often, however, the patient is diagnosed as having an enteroviral meningitis and sent home on NSAIDs.

By definition, standard HIV antibody testing is negative in the setting of acute HIV infection. This is a diagnosis that requires suspicion and an HIV RNA PCR test, he observed. Deciding who warrants that test is difficult “Certainly the person who comes back because of the persistence of those symptoms gets my attention,” noted Dr. Young, an infectious disease specialist at the University of Colorado, Denver.

“These people with acute infection are the Typhoid Marys of HIV. Their plasma viral load is one or two logs higher than in chronic infection. They’re the ones most likely to transmit because they don’t know they’re at risk for transmission and their intrinsic biologic risk is probably 100 times greater than the average person in my HIV clinic who’s not on treatment. And they’re coming to us for a diagnosis and help,” he said.

The often-lengthy delay in diagnosis of HIV infection is reflected in the fact that 42% of HIV-positive individuals in Colorado develop AIDS within 12 months of being diagnosed with HIV.

“That means these patients have been out in the community for years prior to somebody making the diagnosis,” Dr. Young said.

To date, there has been poor implementation of the 3-year-old revised recommendations for HIV screening issued by the Centers for Disease Control and Prevention (MMWR Recomm. Rep. 2006; 55[RR-14]:1-17).

Those guidelines call for routine voluntary HIV screening for all people

aged 13-64 years. Testing is not based on assessment of patient risk, and no separate signed informed consent is recommended. Nor is the screening physician expected to provide counseling; it’s fine to refer for counseling. The intent of the guidelines is to make HIV screening a part of routine care in all settings, including primary care offices, emergency departments, inpatient hospital wards, correctional health facilities,

and substance abuse treatment centers.

“That means you,” Dr. Young stressed to his audience of family physicians.

The revised guidelines were developed partly in reaction to solid epidemiologic evidence that at least 25% of HIV-infected Americans remain undiagnosed. Making HIV screening a part of standard guideline-recommended health care should pick up many of those individuals, which in turn should theoretic-

cally reduce their risk of transmission.

He recommended coding the serologic test as “possible HIV exposure.”

“If someone is sexually active with a contact whose HIV status is unknown, that’s an HIV exposure until proven otherwise,” he explained. “I’ve never had any pushback from that. If I did I’d just point to the CDC guidelines, which are endorsed by a lot of the major medical professional organizations.” ■

Cardiac Risk Factors

Serving Size: 1 Adult Male
Servings Per Container: 1

Amount Per Serving	
Age	48
Weight	243
Total Cholesterol	259
LDL	169
HDL	47
Coronary Calcium Score	397
Body Mass Index	37
Waist Circumference	48
Blood Pressure	
Systolic	150
Diastolic	90
Fasting Blood Glucose	146


Ingredients for Coronary Artery Disease Risk:
Family History, Diabetes, Hypertension, Smoker, Occasional Chest Discomfort

Refer

Nuclear stress testing for reliable diagnostic and prognostic results^{1,2}

1. Klocke FJ, et al. *Circulation*. 2003;108:1404-1418.
2. Hachamovitch R, et al. *Circulation*. 1998;97:535-543.

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