AGING WITH HIV

Managing Multimorbidity and Frailty

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The graying of the epidemic

Antiretroviral therapy turned HIV into a chronic disease — and the population living with it is now an aging one.

~42%

of people with diagnosed HIV in the U.S. are 55 or older

~50%

are aged 50 and over — roughly half the epidemic

50–54

is now the single largest age group of people with HIV

Source: CDC / NIH — HIV and Older People; HIV Surveillance, 2022–2023

The comorbidity cascade

The conditions that now dominate the visit are largely the same ones internists manage in any older adult — only sooner, and more of them at once.

Cardiovascular

Earlier coronary disease, hypertension, atrial fibrillation

Bone

Osteopenia, osteoporosis, fragility fracture risk

Renal

Reduced clearance — a key driver of drug dosing

Metabolic

Type 2 diabetes, neuropathy, dyslipidemia

Neurocognitive

Cerebrovascular disease, impairment, neuropathy

Pulmonary

COPD and bronchiectasis, often smoking-related

Polypharmacy

Polypharmacy ≥ 5 non-ART medications

Hyper-polypharmacy ≥ 10

Prevalence climbs steeply with age — exceeding 50% of people with HIV over 50, and reported as high as ~65% past age 60. **Older patients also face more drug–drug interactions and potentially inappropriate medications.**

Polypharmacy independently raises geriatric risk

2.1×
recurrent falls with polypharmacy

3.5×
recurrent falls with hyper-polypharmacy

1.8×
odds of slow gait speed

Associations persist after adjusting for comorbidity burden.

Sources: Kosana et al., Clin Infect Dis 2024 (ACTG A5322 / HAILO) · Courlet et al., Open Forum Infect Dis 2019 (Swiss HIV Cohort)

TWO CASES FROM OUR CLINIC

Same lesson, two angles

All names, dates, and identifying details have been removed.

CASE 1

Virologically controlled, clinically complex

69-year-old man

HIV — well controlled

- Viral load undetectable (<20 copies/mL)
- CD4 ~770; single-tablet regimen
- Adherent, doing well on therapy

"HIV is the easy part." His morbidity is almost entirely non-HIV.

Active problem list

- Type 2 diabetes w/ neuropathy
- COPD + bronchiectasis
- Osteoporosis
- CIDP
- Prior stroke (CVA)
- Atrial fibrillation — s/p ablation
- Glaucoma
- Major depression

One HIV pill — plus ~25 more

Antiretroviral

Bictegravir/FTC/TAF — daily

Pain

Morphine sulfate ER 30 mg — q12h
Oxycodone 30 mg — q6h PRN
Gabapentin ~900 mg/day
Cyclobenzaprine 10 mg — HS PRN
Acetaminophen 325 mg — PRN
Ibuprofen 800 mg — daily PRN

Seizure

Levetiracetam 500 mg — BID

Cardiac & anticoagulation

Metoprolol succinate ER 25 mg — daily
Apixaban 5 mg — BID
Lisinopril 2.5 mg — daily
Atorvastatin 10 mg — daily

Diabetes

Metformin 1000 mg — BID
Dapagliflozin 10 mg — daily

Psychiatry

Citalopram 40 mg — daily
Aripiprazole 15 mg — daily

Sleep

Eszopiclone 2 mg — HS

Bone & endocrine

Teriparatide — SC daily
Testosterone cypionate — 0.5 mL IM weekly

Pulmonary

Fluticasone/vilanterol 100/25 — daily

Ophthalmic

Latanoprostene bunod — 1 drop OU nightly

Supplements & rescue

Vitamin D 50,000 IU — weekly
Zinc 220 mg — daily
Vitamin C 500 mg — daily
Naloxone nasal — PRN

CASE 1

A single difficult year

None of it driven by HIV — a frailty cascade set off by surgery, immobility, and opioids.

Major lumbar spine surgery

Hardware placed; the start of a long downhill course.

Post-op pneumonia + pulmonary edema

Prolonged hospitalization, then inpatient rehab.

Aspiration while on opioids

Choked, then a witnessed cardiac arrest in transit.

Traumatic intubation / re-intubation

Airway injury during emergency management.

Stage 3 sacral pressure injury

From immobility during the recovery period.

Residual stroke deficits

Facial droop, slurred speech, slow unsteady gait.

CASE 2

Falls in the age of polypharmacy

61-year-old man living with HIV — virologically suppressed on bictegravir/FTC/TAF. Recurrent falls: by his own count, roughly 25 in a single weekend, with blurry vision, confusion, and light-headedness during episodes. Background: prior small (lacunar) strokes with cognitive impairment.

Falls are multifactorial — and four medications stack the deck:

GLP-1 weight-loss injectable

~80 lb loss → possible hypoglycemia, hypotension, visual changes

Alpha-blocker (BPH)

Dose recently doubled → orthostatic hypotension

ARB antihypertensive

Now frankly hypotensive after major weight loss

Gabapentin 900 mg TID

Years of use → sedation and gait instability

Sixteen medications — four driving the falls

Antiretroviral

Bictegravir/FTC/TAF — daily

Neurology, cognition & mood

Donepezil 5 mg — HS

Lamotrigine 200 mg — daily

Duloxetine 60 mg — daily

Gabapentin 900 mg — TID

Urology (BPH)

Tamsulosin 0.8 mg — daily ↓ reducing to 0.4 mg

Dermatology

Dupilumab 300 mg — SC q2 weeks

Clindamycin 1% foam — topical PRN

Cardiometabolic

Aspirin 81 mg — daily

Rosuvastatin 20 mg — daily

Losartan 100 mg (½ tab) — daily ✕ stopping

Tirzepatide 12.5 mg — weekly ↓ reducing to 7.5 mg

Gastrointestinal

Omeprazole 40 mg — daily

Diclofenac 50 mg — BID PRN

Pulmonary

Budesonide/formoterol 160/4.5 — BID

Albuterol HFA — PRN

↓ reducing ✕ stopping — *addressed on the next slide*

Deprescribing as treatment

Before attributing the falls to “old age” or stroke alone, address what is modifiable — the medications, the blood pressure, the glucose.

Stop the ARB

Blood pressure now runs low without it

Reduce the GLP-1 dose

Monitor appetite and intake closely

Return alpha-blocker to baseline

Trade a little urinary relief for stability

Neurology work-up

Characterize lacunar disease and cognition

Sometimes the most important prescription is the one you stop.

Frailty — and how to catch it in the room

Frailty is reduced physiologic reserve — the inability to bounce back from a stressor. It appears earlier and more often in people with HIV, and it underlies both of today's cases.

Fried frailty phenotype

Five criteria — ~5–10 minutes:

- Unintentional weight loss
- Self-reported exhaustion
- Weakness (grip)
- Slow gait speed
- Low physical activity

≥ 3 = frail · 1–2 = pre-frail · 0 = robust

Quick tests you can do in the office

4-meter gait speed No equipment; < 1.0 m/s flags slow gait

Five-times chair rise Only a chair; sensitive, changes with treatment

Grip strength Hand dynamometer; weakness predicts mortality

Short Physical Performance Battery Chair + 4 m + stopwatch; ~5–10 min

Clinical Frailty Scale / FRAIL 9-point scale or quick waiting-room questionnaire

Source: Erlandson KM. Physical Function and Frailty in HIV. Top Antivir Med 2020;28(3):469–473

Clinical takeaways

Treat the whole patient Virologic success is not the same as clinical wellness. The hard work is now everything around the HIV.

Screen for geriatric syndromes Ask about falls and gait, check cognition, watch for frailty — proactively, not only when something breaks.

Reconcile medications every visit Count the non-ART drugs. Five is a flag; ten is a warning. Watch interactions and inappropriate prescribing.

Deprescribe deliberately Fewer drugs can mean fewer falls. Adjusting the regimen is an active intervention, not a last resort.

Coordinate the care Primary care, specialists, pharmacy, and navigation working together is what keeps complex patients safe.

Selected references

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Thank you

Questions & discussion