Clinical practice guidelines for HIV infection: progress towards making AIDS a primary care disease

SINCE THE RECOGNITION of the acquired immunodeficiency syndrome (AIDS) in 1981, more than 250 000 individuals have acquired AIDS and more than 170 000 have succumbed to it. An estimated million or more Americans are currently infected with human immunodeficiency virus (HIV) and 40 000 to 60 000 will become infected in 1994. Most infected individuals do not know they are infected and have not received appropriate counselling and medical care. The World Health Organization projects that by the year 2000, 30 to 40 million adults, adolescents, and children will be infected worldwide.

Who will care for all of these patients? To date, HIV has remained predominantly a specialty disease in this country, treated by infectious disease specialists, oncologists, and some general internists and pediatricians who have chosen to specialize in this area. For various reasons, many primary care physicians have not undertaken the care of HIV-infected patients. Surveys of primary care physicians in areas of both high and low HIV seroprevalence have disclosed that some simply do not wish to care for these individuals. Others feel ill-prepared[1,2] but would assume such care if adequate education and resources were available.

The former problem is not easily remediable. All physicians take the Hippocratic oath, which mandates care of all individuals in need, irrespective of their underlying illness. The latter problem, one of education and resource availability, has begun to be redressed. The clinical practice guidelines for the evaluation and management of HIV-infected individuals, released in January 1994 by the Agency for Health Care Policy and the US Public Health Service, represent an important contribution.[3] This report, written by an expert panel of physicians, nurses, dentists, physician-extenders, and consumers, is concise, relevant, and problem-oriented—ideal for the primary care physician. It focuses on key topics such as disclosure, counselling, evaluation and management of common clinical problems, and case management. Diagnostic and therapeutic algorithms are provided in the areas of initial diagnostic evaluation, antiretroviral therapy, *Pneumocystis carinii* prophylaxis, *Mycobacterium tuberculosis* infection, syphilis, gynecologic care, neurologic disease, and special issues related to pregnancy. It also contains useful information concerning drug dosages and adverse effects of commonly used medications.

This report will particularly help pediatricians in the care of infants born to HIV-infected women, and it complements other recent recommendations.[4–7] Since a diagnosis of neonatal HIV infection is difficult to establish in the first months of life, guidelines for the diagnostic evaluation of children are provided. These include a quick synopsis of the available diagnostic modalities, including HIV culture, polymerase chain reaction, and serologic testing with enzyme-linked immunoadsorbent assay (ELISA) and Western blot. Recommendations are provided regarding routine pediatric care, including routine immunizations and screening assessments for neurologic and cardiac disease.

The specialist's role in the care of HIV-infected patients will remain important in the coming decade. Primary care physicians, however, will need to assume increasing responsibility for their care, especially in those with early infection. This concise

compendium of clinically relevant information belongs on the shelf of every primary care physician's office. Copies may be obtained free of charge from the US Public Health Service and the Centers for Disease Control and Prevention by calling 1-800-342-AIDS.

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REFERENCES

1. **Lewis CE, Montgomery K.** Primary care physicians' refusal to care for patients infected with human immunodeficiency virus. West J Med 1992; **156:**36–38.
2. **Samuels ME, Shi L, Stoskopf CH, et al.** Incentives for physicians to treat HIV-seropositive patients: results of a statewide survey. South Med J 1993; **86:** 403–408.
3. **US Department of Health and Human Services.** Evaluation and management of early HIV infection: clinical practice guideline. AHCPR Publication No. 94-0572, January 1994.
4. Pediatric human immunodeficiency virus infection: a compendium of AAP guidelines. Elk Grove Village, Ill: American Academy of Pediatrics, 1994.
5. **Rank TH, Meyers A.** Role of the general pediatrician in the management of human immunodeficiency virus infection in children. Pediatr Rev 1993; **14:**371–379.
6. **Hauger SB, Nicholas WS, Caspe BW.** Guidelines for the care of children and adolescents with HIV infection. J Pediatr 1991; **119:**S1–S55.
7. **Working Group on Antiretroviral Therapy.** National Pediatric HIV Resource center: antiretroviral therapy and medical management of the human immunodeficiency virus-infected child. Pediatr Infect Dis J 1993; **12:**513–522.

Correction

In the *Highlights from Medical Grand Rounds* article, "Medical treatment of pituitary tumors," (*Cleveland Clinic Journal of Medicine*, March-April 1994) an error occurred in the discussion of acromegaly (page 100, column two). The sentence, "Growth hormone levels may not subside to normal until several years after surgery," should read as follows: "Growth hormone levels may not subside to normal until several years after radiation therapy."