



Clinical Challenges: HIV and the Opioid Epidemic

Infection often leads to chronic pain, and thus to risk for painkillers, overuse and abuse

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One of the consequences of the ongoing opioid epidemic has been that certain subgroups of the U.S. population -- particularly rural communities -- are at an increased risk of HIV transmission.

In a viewpoint published in *JAMA* last year, Andrea M. Lerner, MD, and Anthony S. Fauci, MD, both of the National Institute of Allergy and Infectious Diseases, wrote that "this public health crisis is fueling a growing epidemic of people injecting opioids, especially in rural communities as individuals with opioid use disorder shift from taking prescribed oral opioids to injecting prescribed or illicit opioids."

But what is the epidemic's impact on people already living with HIV?

One of the defining features of HIV infection is chronic pain. A systematic review published in the *Journal of the International Aids Society* confirmed that pain is "one of the most commonly reported symptoms in people living with HIV/AIDS" with a prevalence ranging from 54% to 83%. That review found that the reported pain was of moderate-to-severe intensity and can occur in multiple sites.

"There are many reasons why people with HIV have a larger burden of chronic pain than others," Chinazo Cunningham, MD, MS, of Albert Einstein College of Medicine in New York City, told *MedPage Today*. "Some of these reasons are due to the HIV itself, side effects of older HIV medications that patients may have taken, co-occurring conditions like depression and substance use disorders that are more common in patients with HIV than others, and aging."

Also, according to an article in *Practical Pain Management*, 30% to 60% of patients with HIV will develop HIV sensory neuropathy, with the cause of that neuropathy being multifactorial.

In a review in *Topics in Antiviral Medicine*, Cunningham pointed out that research has shown that patients with HIV are more likely to be prescribed opioids to manage pain than patients without HIV, and that HIV-infected patients receive higher doses of opioids and are more likely to have substance use disorder and mental illness.

"Thus, risk of opioid misuse is elevated in the HIV-infected population," she wrote.

"Addiction can impact HIV in many ways," Cunningham told *MedPage Today*. "Decades of research show that people with addiction are less likely to access care, take HIV medications, be engaged in care, and have optimal HIV outcomes. However, we also know that people who receive treatment for their addiction have better outcomes for their HIV. We have little data about how prescribed opioids (for pain) may impact HIV care."

There have been efforts to provide guidance for managing these patients. In 2016, the CDC published a Guideline for Prescribing Opioids for Chronic Pain (CDCG) which, while not specific to HIV, included guidelines for prescribing opioids for non-cancer chronic pain.

The following year the Infectious Diseases Society of America issued clinical practice guidelines for management of chronic pain in patients living with HIV, which included recommendations on treating HIV-infected patients with opioid analgesics.

In a 2019 paper in *Contemporary Clinical Trials Communications*, Jessica Robinson-Papp, of Icahn School of Medicine at Mount Sinai in New York City, and colleagues observed that these guidelines have yet to be translated into easily implementable interventions. In addition, "there is also a lack of strong evidence that adhering to these recommendations improves patient outcomes such as amount of opioid use and pain levels."

Trials are underway with interventions that accord with the guidelines and seek to improve care for HIV patients on long-term opioid therapy. TEACH, for example, is testing a collaborative care intervention designed to increase guideline-concordant care for these patients.

Robinson-Papp and colleagues developed TOWER (TOWard Safer Opioid Prescribing), which they described as an intervention "designed to support HIV primary care providers in CDCG-adherent opioid prescribing practices with patients with HIV who are already prescribed opioids for chronic pain." The idea behind TOWER is to develop and test an algorithm based on the

CDCG guidelines that incorporates communication and implementation strategies tailored to the HIV primary care setting.

Their study testing the intervention is scheduled to be completed in 2020.

Cunningham said that, when considering how to manage HIV-infected patients, it is critical to think about people with addiction differently than people who are prescribed opioids without addiction.

"The medical issues are fundamentally different – addiction versus pain management," she explained. "The specific problem determines the kind of care we provide. For example, those with addiction should receive addiction treatment [whereas] those prescribed opioids without addiction should have a multi-modal comprehensive pain management approach. The main challenges in caring for people with HIV and addiction include helping them to remain engaged in their care and to take their medications."

According to Cunningham, treating opioid addiction with buprenorphine or methadone is a very effective way of not only treating the addiction, but also improving HIV care. For example, in her review in *Topics in Antiviral Medicine*, Cunningham noted that the BHIVES (Buprenorphine HIV Evaluation and Support) initiative demonstrates that buprenorphine "integrates well into HIV treatment." In BHIVES, researchers found that among HIV-infected participants with opioid dependence who were eligible for buprenorphine treatment, those who took buprenorphine/naloxone for a longer duration (at least three of four quarters during a given year) were more likely to initiate antiretroviral therapy and achieve viral suppression than those patients who took buprenorphine/naloxone for a shorter time.

"For those prescribed opioids for pain, treatment approaches should be consistent with safe opioid prescribing," Cunningham added. "This includes providing the lowest opioid dose possible with additional efforts to address pain, conducting urine drug tests, using treatment agreements, and other steps."