The provision of highly active antiretroviral therapy (HAART) has transformed HIV/AIDS from an acute/subacute disease to a controllable chronic disease. HIV-infected individuals now live longer and grow old. Furthermore, a number of older patients become infected later in life and are not aware of their HIV status. The prevalence of HIV infection in individuals older than 55 years is growing and HIV infection can no longer be thought of as a ‘young person’s disease’.

The US Centers for Disease Control and Prevention (CDC) considers individuals aged ≥ 55 years as a separate age group without determining further distinctions according to age.\(^1\) The age of 55 is considered high compared with the lower mean age of HIV-infected patients observed in the HIV pandemic.

There is a lack of age-specific data as well as treatment, interventions and prevention programmes in older individuals with regard to HIV infection in South Africa. These individuals are not routinely targeted for HIV testing, resulting in a late diagnosis of HIV infection when patients seek treatment for an HIV-related illness. The presentation of HIV-associated conditions can be nonspecific because the age-related co-morbid illnesses have similar symptoms, e.g. occult malignancy, myelodysplasia and Alzheimer’s disease.\(^2\) Diseases that may be an early sign of HIV infection, such as bacterial pneumonia and varicella-zoster virus reactivation, are common in the elderly.\(^3\) In addition, health carers may be reluctant to discuss matters of sexuality with older patients and are unlikely to request HIV screening.

Reasons for the increased HIV risk in the elderly include:

- Age-related changes in immune function contributing to an increased likelihood of seroconversion after sexual exposure and a shorter period of HIV clinical latency.
- Thinning of the vaginal mucosa due to oestrogen loss, rendering women more susceptible to tears during sexual activity and hence facilitating viral entry.
- Older individuals being more likely to receive blood transfusions for co-morbid illnesses.
- Studies indicating that the elderly do not perceive themselves as being at risk of HIV infection and hence have a low frequency of condom use.\(^2\)

A retrospective study of 43 cases in Singapore noted an increasing proportion of older individuals among HIV-seropositive patients (4.8% in 1991 to 16.7% in mid-1996).\(^6\) The mean age at presentation was 59.2 years (range 50 - 75 years). The majority (76.7%) were symptomatic at presentation. Pneumocystis jiroveci pneumonia and tuberculosis were the commonest AIDS-defining illnesses.

Studies before the HAART era have indicated that older individuals have a more severe disease course and a shorter survival.\(^6\) Pezzotti et al.\(^6\) showed a rapid progression to AIDS in patients > 35 years. This progression was independent of sex, CD4 count, and antiretroviral and prophylactic treatments. A physiological decline in immune competence associated with ageing, late diagnosis of HIV infection\(^7\) and presence of an underlying concurrent medical condition may contribute to more severe HIV disease.

Many antiretroviral and antimicrobial therapeutic trials exclude individuals with advanced age and/or concurrent end-organ disorders. Therefore, data with regard to response to antiretroviral therapy, safety of antiretroviral therapy and their associations, drug-drug interactions, short- and long-term toxicity, consequences of co-morbid illnesses or interactions with concomitant pharmacological regimens in the elderly\(^1\) are lacking.

The frequency of adverse events in older patients may be higher due to age-related impairment of renal and liver function and decreased albumin levels.\(^8\) Peripheral neuropathy, and bone marrow\(^2\) and liver toxicity may be more common in this age group. Co-morbid illnesses may require additional medical and psychological care that may further complicate HIV management.

Intergenerational support exchanges are common in South Africa. Older adults are often the caregivers of AIDS patients (children, grandchildren). This care extends to physical, financial and emotional support. A recent survey of households in South Africa revealed that two-thirds of caregivers were female, with almost one-quarter of them over 60 years.\(^9\) Preventive programmes and education for HIV infection are mainly focused on family values and monogamy and exclude older individuals who may be at risk of acquiring infection and may be the primary source of information for these households with regard to HIV prevention and testing.
More insight is needed into the risk factors, behavioural patterns, disease spectrum and treatment options other than HAART in older HIV-infected patients. Older persons contact health care workers more often than the general population for other illnesses – this may be used as an opportunity for HIV counselling.1

A high index of suspicion for suspected or undiagnosed HIV disease in an older person should be maintained. Three years after the start of the national antiretroviral drug treatment programme, a timely diagnosis of HIV infection is the key to starting adequate treatment, avoiding disease progression, and delaying opportunistic complications and a potentially severe disease course.1

References