Disclosure of Financial Interests

The presenter does not have any financial interests or relationships to disclose.

The presenter will not discuss any off-label use or investigation product during the presentation.
Learning Objectives

At the completion attendees should be able to:

• Explain the importance of the Gynecologic visit.

• Identify the most common gynecological problems for women living with HIV.

• Describe the recommendations for screening of cervical, breast, ovarian and colon cancer.

• Recognize specific needs and interventions in the gynecological care for women living with HIV
AZ is a 22 y/o, female, Para 2. Newly diagnosed with HIV infection, CD4: 250 and VL:158,700. Patient came for gynecological exam, complaining of genital irritation and discharge.

What we can do for AZ?
GYNECOLOGIC VISIT – CASE 1

A. Pap smear and STI’s screening
B. Evaluation and treatment of gynecological infections
C. Contraception / Family Planning
D. A, B and C
E. Comprehensive gynecological visit
GYNECOLOGIC VISIT – CASE 1

- Pap smear
- STI’s screening
- Evaluation and treatment of gynecological infections
- Contraception / Family Planning
- HPV vaccine
- Partner:
  - Testing
  - Disclosure
  - PrEP
- Counseling
- Prevention of abuse
Gynecological Visit

- Screening for malignancies:
  - Cervical
  - Anal
  - Breast
  - Colon
  - Ovarian

- STI’s testing and treatment
- Common Gyn problems
- Menstrual Problems
- Menopause
- Pre-conceptional care
- Contraception
GYNECOLOGICAL VISIT

- Partner testing and Disclosure
- Screening for Osteoporosis
- Screening depression
- Tobacco, alcohol and drug use
- Adherence
- Counseling
- Referral
Common Gyn Problems in HIV+ Woman

- High risk HPV infection
- Cervical / Anal / Rectal dysplasia
- Increase risk of invasive cervical cancer
- More incidence and extensive genital herpes
- Herpes outbreak more difficult to treat
- Recurrent genital warts
- Menstrual problems

HIV and Women's Health - AIDS.gov
Human Papilloma Virus (HPV)
HUMAN PAPILOMA VIRUS

HPV

Compared to women who are not HIV infected, women with HIV have:

- Higher prevalence and incidence of HPV ¹
- Higher HPV VL ²
- Longer persistence of HPV infection ³
- Higher likelihood of infection with multiple HPV subtypes ², ⁴, ⁵
- Greater prevalence of oncogenic subtypes ⁶

¹ Int J STD AIDS 2003;14:417; J Infect Dis 2001;184:682
² American J Obstet Gynecol 2002;186:21
³ American J Epidemiol 2000;151:1148;
⁵ Br J Cancer 2007;96(9):1480; Arch Virol 2007;152:75
⁶ Acta Cytol 2009;53:10
HPV

- HPV test: alone or cotesting
- HPV can cause cancer in cervix, anus, bladder, throat
- HPV vaccine
  - 9 to 26 years old
  - Types:
    - Bivalent: 16, 18
    - Quadrivalent: 6, 11, 16, 18
    - 9-valent: 6, 11, 16, 18, 31, 33, 45, 52, 58
  - 3-dose series over a 6 months period
BY is a 25 y/o, female, Para 1, with history of perinatal HIV infection and abnormal pap smears x 3: ASCUS and LSIL

Do you recommend the HPV vaccine for BY?
A. Yes. The HPV vaccine protects her against cervical cancer although she had abnormal pap smear before.

B. No. She already has HPV infection and the vaccine doesn’t make any difference preventing cervical cancer.

C. Yes. But not sure if HPV vaccine will be effective preventing cervical cancer.

D. No. The HPV vaccine could be dangerous because she already has the HPV infection.
* After the woman received the complete series of the HPV vaccine, it is recommended that she:

A. Does not need to do pap smear because she is protected.

B. Needs to do pap smear but no as often as recommended because she received the HPV vaccine.

C. Should be screened according to the same guidelines as women who have not been vaccinated.
HPV Vaccine

• Women who have received the HPV vaccine should be screened according to the same guidelines as women who have not been vaccinated.

1 Cervical Cancer Screening and Prevention. ACOG Practice Bulletin Number 157, January 2016
Anal and Cervical HPV Infection in HIV+ Women & HIV- Women

SCREENING FOR CERVICAL CANCER
Most cases of cervical cancer were never screened or were screened inadequately.

In the setting of HIV infection:
- 30 - 60% of Pap smears exhibit cytologic abnormalities
- 15 - 40% have evidence of dysplasia
- These abnormal rates are 10 - 11 times greater than those observed among women who are not HIV infected
- Cytologic abnormalities are associated with HPV and the degree of immunosuppression.
- Abnormal paps and histologically documented dysplasia have been associate with declining CD4 cells and higher HIV RNA levels

J Natl Cancer Inst Monogr 1998;23:43
Screening for Cervical Cancer in HIV+ Women

Start Screening:

• At age of initiation of sexual activity regardless of mode of HIV transmission

• No later than 21 y/o

• Women newly diagnosed with HIV should be screened at time of diagnosis

_Cervical Cancer Screening and Prevention. ACOG Practice Bulletin Number 157, January 2016_
How Often to Screen with Negative Cytology?

**Women <30**
- Initial Pap (-)
- 2nd Annual Pap (-)
- 3rd Annual Pap (-)
- Repeat Pap every 3 yrs

**Women 30+**
- Initial Pap (-)
- 2nd Annual (-) Pap
- 3rd Annual (-) Pap
- Repeat Pap in 3 yrs
- Re-test In 3 yrs.

---

Cervical Cancer Screening and Prevention. ACOG Practice Bulletin Number 157, January 2016
How Often to Screen Co-testing and/or Positive Cytology?

- **(-) Pap**
  - HPV (-): Repeat co-testing in 3 yrs
  - HPV (+): Repeat co-testing in 1 yr

- **ASCUS Pap**
  - HPV (-): Repeat Pap in 6-12 mo
  - HPV (+): Refer for Colposcopy

- **≥ LGSIL Pap**
  - Refer for Colposcopy

*Cervical Cancer Screening and Prevention. ACOG Practice Bulletin Number 157, January 2016*
Screening for Cervical Cancer in HIV+ Women

Stop Screening:

- Screening should continue through a woman’s lifetime.
- No stopping @ 65 y/o

Cervical Cancer Screening and Prevention. ACOG Practice Bulletin Number 157, January 2016
SCREENING FOR ANAL CANCER
Anal Cancer Risk Factors

• High-risk HPV infection
• Multiple sex partners
• Anal warts
• Smoking
• HIV infection

ANAL CANCER SCREENING

Protocol for Anal Cancer Screening

- Patient Receives Anal Cancer Screening Counseling
  - Declines Anal Pap
    - Re-offer at next gynecological exam
  - Accepts Anal Pap
    - Receives education
      - Anal Pap Smear done
        - Normal
          - Repeat in 1 yr.
        - ASC-US
          - Repeat in 6 months; if ≥ ASC-US
        - ASC-H, L/HSIL
          - High Resolution Anoscopy

University of Miami. Department of Obstetrics and Gynecology. Division of Research and Special Projects.
MENSTRUAL PROBLEMS
MENSTRUAL PROBLEMS

- Menstrual disorders are reported by 20%–30% of HIV+ women. 1
- HIV+ women are more likely to have amenorrhea, oligomenorrhea, and irregular periods. 2
- Taking antiretroviral therapy (ART) and/or having suppressed HIV RNA levels may reduce the prevalence or incidence of menstrual disorders. 3
- Analysis of data collected at 6-month intervals from women in the WIHS prospective cohort indicated no difference in the prevalence or incidence of menstrual disorders by HIV serostatus; however, amenorrhea and oligomenorrhea were less likely, in women with CD4+ cell counts >200 cells/mm3. Both effective ART and higher CD4+ cell counts were associated with lower rates of incident menstrual abnormalities. 4

4 J Womens Health 2006;15(5):591.)
MENOPAUSE
MENOPAUSE AND HIV

- Defined retrospectively as cessation of menstrual periods for one year, not associated with other causes
- Perimenopause is the transition period around menopause
- Average age in US: 51 y/o (45-54)
- Early menopause increase cardiovascular and fracture risk
- Some studies suggest HIV as a risk factor for early menopause
- HIV+ women are living longer
- More women now with HIV are over 40 y/o
- Older women are also newly diagnosed
- In 2013 between the adults that were diagnosed with HIV
  - 18% were between 45 - 54 y/o
  - 10% were 55 y/o or older
HIV+ women report more severe hot flashes and greater interference of the vasomotor symptoms with daily activities.

Before treatment of vasomotor symptoms, consider if the woman is candidate for hormonal replacement therapy and drug interactions with cART (CYP450 pathway) and other medications. ¹

The additive effects of menopause, HIV infection, and HAART on changes involving bone, lipid, and glucose metabolism need further investigation. ²

Assess menopause symptoms, risk for osteoporosis (FRAX), vitamin D level, bone density.

After initiation of ARV, HIV+ women experience substantial declines in bone mineral density (BMD). ¹

Largest losses seen in patients who initiate a Tenofovir (TDF). ¹

DXA scans recommended at 65 y/o or young postmenopausal if one or more risk factors

Counseling:
Ca+Vit D
Regular weight bearing exercise
Smoking cessation
Decrease alcohol intake

SEXUALLY TRANSMITTED INFECTIONS
SEXUALLY TRANSMITTED INFECTIONS (STI’s)

- More risk for Herpes and Condyloma
- Same Guidelines for STI’s treatment in HIV + and HIV- women
- May need adjustments in treatment for herpes infection

Herpes among HIV+ Population

Various studies have shown the prevalence of HSV-2 among people infected by HIV to be 50%-90%* vs. 20-70% in the general US adult population**

**American Sexual Health Organization website, August 2016.
SEXUALLY TRANSMITTED INFECTIONS

• Gonorrhea and Chlamydia
  No differences between HIV infected and uninfected women in prevalence, clinical presentations, diagnosis, or treatment

• Syphilis
  May have abnormal serologic test
  Atypical manifestations maybe seen
  More probability to have multiple ulcers
  CDC recommends annual screening

• Trichomoniasis
  Possible higher risk of PID?
COMMON GYN INFECTIONS
COMMON GYNECOLOGICAL INFECTIONS

- Bacterial Vaginosis
- Vulvovaginal Candidiasis (VVC)

- Some studies indicate that Candida vaginitis, even if more frequent in HIV infected women, is clinically similar to that experienced in HIV-negative women and does not appear to be of increased clinical severity.

- VVC in HIV-positive women can be treated by conventional methods including the use of maintenance suppressive antifungal therapy and most importantly RVVC in women is not in itself a sentinel of HIV infection.

- Ongoing concerns include vaginal acquisition of non-albicans Candida species and the development of antimycotic drug resistance in C. albicans vaginal isolates.

CONTRACEPTION
High rates of unplanned pregnancy among HIV+ women
CX is a 19 y/o, female, Para 0, diagnosed with HIV 2 years ago, with CD4: 980 and VL: 2014. Medical History significant only for HIV.

What birth control method is better recommended for CX?
CONTRACEPTIVE METHODS

- LARC
  - IUD’s
    - Non-Hormonal
    - Hormonal
  - Implants
  - Permanent

- OCP
  - CHC
  - POP

- Injectables (DMPA)

- Ring

- Patch

- Others
## 2016 U.S. Medical Eligibility Criteria for Contraceptive Use for HIV

<table>
<thead>
<tr>
<th>Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 No restriction</td>
<td>No restriction (method can be used)</td>
</tr>
<tr>
<td>2</td>
<td>Advantages generally outweigh theoretical or proven risks</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risks usually outweigh the advantages</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk (method not to be used)</td>
</tr>
</tbody>
</table>

MMWR / July 29, 2016 / Vol. 65 / No. 4
# 2016 U.S. Medical Eligibility Criteria for Contraceptive Use for HIV

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>a) High risk for HIV</td>
<td>2</td>
<td>2</td>
<td>1*</td>
<td>1*</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HIV</td>
<td>b) HIV infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>i) Clinically well receiving ARV therapy</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii) Not clinically well or not receiving ARV therapy†</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If on treatment, see Drug Interactions

---

*CDC*  
*MMWR / July 29, 2016 / Vol. 65 / No. 4*
<table>
<thead>
<tr>
<th>Drug Interactions: ARVs and Hormonal Birth Control and/or IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NRTIs</strong></td>
</tr>
<tr>
<td><strong>Abacavir (ABC)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>Zidovudine (AZT)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>Emtricitabine (FTC)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>NNRTIs</strong></td>
</tr>
<tr>
<td><strong>Etravirine (ETR)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>Nevirapine (NVP)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>Rilpivirine (RRV)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>Norvir-boosted PIs</strong></td>
</tr>
<tr>
<td><strong>Darunavir (DRV)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>Lopinavir (LPV)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>PIs without Norvir</strong></td>
</tr>
<tr>
<td><strong>Atazanavir (ATV)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>Fosamprenavir (FPV)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>Integrase Inhibitors</strong></td>
</tr>
<tr>
<td><strong>Raltegravir (RAL)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>Dolutegravir (DTG)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
<tr>
<td><strong>Elvitegravir (EVG)</strong></td>
</tr>
<tr>
<td>1 / 2</td>
</tr>
</tbody>
</table>
DW is a 35 y/o, female, Para 6, diagnosed with HIV 10 years ago, with severe immunosuppression, smoking cigarettes.

What birth control method is better recommended for DW?
CONTRACEPTIVE METHODS

- **LARC**
  - IUD’s
    - Non-Hormonal
    - Hormonal
  - Implants
  - Permanent

- **OCP**
  - CHC
  - POP

- **Injectables (DMPA)**

- **Ring**

- **Patch**

- **Others**
Contraceptives

Barriers to Obtaining IUDs & Implants

• Lack of Insurance coverage
• Fear of painful insertion
• Fear of serious side effects (TV ads for by med malpractice law firms)
• Need for additional appointment or referral to different office/provider
• Ambivalence about desire for pregnancy vs delaying
• Competing day to day priorities
PRECONCEPTIONAL CARE
EN is 36 y/o, female, Para 4, diagnosed with HIV 10 years ago, who missed some of the appointments with her PCP / HIV specialist because she didn’t have transportation and no child care. Taking cART, but was off medications for 2 weeks due to problems with her medical insurance. She has a new partner since 2 months ago, they have been having unprotected sex, she wants to have a child with him.

BP 145/93
BMI 45
CD4: 350
VL: 4,598
H / H: 10 / 30.8
Plt: 80
HbA1C: 8.5
RPR: 1:8
Drinks alcohol socially
Is EM’s current health state ideal for pregnancy?

A. Yes. She has minor problems that can be fixed during pregnancy

B. Yes. She is stable and taking her medications.

C. Yes. She is 36 y/o, can’t wait more.

D. No. It is recommended to work on some health issues before trying conception.
PRECONCEPTIONAL CARE

- Viral load undetectable
- Optimize T-cells
- cART
- Partner HIV status
- Safe sex practices
- Immunizations
- Tobacco, alcohol and drug use
- Intimate Partner Violence
- Disclosure
- Mental Health Issues
- Healthy lifestyles
- Body Mass Index
- Nutrition
- Exercise
- Co-morbidities
SCREENING FOR BREAST CANCER
## SCREENING FOR BREAST CANCER USING FILM MAMMOGRAPHY
### CLINICAL SUMMARY OF 2009
#### U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION*

<table>
<thead>
<tr>
<th>Population</th>
<th>Women Aged 40−49 Years</th>
<th>Women Aged 50−74 Years</th>
<th>Women Aged ≥75 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation</strong></td>
<td>Individualize decision to begin biennial screening according to the patient’s context and values.</td>
<td>Screen every 2 years.</td>
<td>No recommendation.</td>
</tr>
<tr>
<td></td>
<td>Grade: C</td>
<td>Grade: B</td>
<td>Grade: I (insufficient evidence)</td>
</tr>
</tbody>
</table>

SCREENING FOR BREAST CANCER USING METHODS OTHER THAN FILM MAMMOGRAPHY CLINICAL SUMMARY OF 2009 U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION*

<table>
<thead>
<tr>
<th>Population</th>
<th>Women Aged ≥40 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Method</td>
<td>Digital Mammography</td>
</tr>
<tr>
<td></td>
<td>Magnetic Resonance Imaging (MRI)</td>
</tr>
<tr>
<td></td>
<td>Clinical Breast Examination (CBE)</td>
</tr>
<tr>
<td></td>
<td>Breast Self-Examination (BSE)</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Grade: I (insufficient evidence)</td>
</tr>
<tr>
<td></td>
<td>Grade: D</td>
</tr>
</tbody>
</table>

SCREENING FOR OVARIAN CANCER
USPSTF recommends against screening for ovarian cancer in women

• This recommendation applies to asymptomatic women

• NOT included in this recommendation IF:
  - Signs of ovarian cancer
  - History for breast, uterine or colorectal cancer
  - Close relative with ovarian cancer
  - Genetic mutations: BRCA1, BRCA2 genes, or one associated with Lynch syndrome

• Rectovaginal pelvic exam, transvaginal ultrasound, CA-125 blood test

SCREENING FOR COLON CANCER
SCREENING COLON CANCER

• Starting at age 50, anybody at average risk for developing colorectal cancer should use one of the screening tests below:

  • Tests that find polyps and cancer
    Flexible sigmoidoscopy every 5 years*
    Colonoscopy every 10 years
    Double-contrast barium enema every 5 years*
    CT colonography (virtual colonoscopy) every 5 years*

  • Tests that mainly find cancer
    Guaiac-based fecal occult blood test (gFOBT) every year*,**, Fecal immunochemical test (FIT) every year*,**
    Stool DNA test every 3 years*

• *Colonoscopy should be done if test results are positive.
• **Highly sensitive versions of these tests should be used with the take-home multiple sample method. A gFOBT or FIT done during a digital rectal exam in the doctor’s office is not enough for screening.
TESTING
Diagnosed People Living with HIV (PLWH) in Florida, Including Selected Stages of Continuum of Care, 2014

In Florida, 83% of those diagnosed with HIV in 2014 had documented HIV-related care within 3 months of diagnosis.

The CDC estimates that 12.4% of PLWH in Florida are undiagnosed.

http://www.floridahealth.gov/_documents/HIV/_images/continuum-x.svg
TESTING

- Patient
- Partner
- Engage in treatment
- PrEP
SERODISCORDANT COUPLES
SERODISCORDANT COUPLES

- The HIV-infected partner should be receiving combination antiretroviral therapy and demonstrate sustained suppression of plasma viral load below the limits of detection (AI).

- Preconception administration of antiretroviral pre-exposure prophylaxis for HIV-uninfected partners may reduce the risk of sexual transmission (CIII).

- For Discordant Couples with HIV-Infected Women, the safest conception option is artificial insemination, including the option of self-insemination with a partner’s sperm during the peri-ovulatory period (AIII).

- For Discordant Couples with HIV-Infected Men, the use of donor sperm from an HIV-uninfected man with artificial insemination is the safest option (AIII). Other options: sperm preparation techniques coupled with either intrauterine insemination or in vitro fertilization (AII).

http://aidsinfo.nih.gov/guidelines
PrEP
PrEP

- Pre-exposure prophylaxis (PrEP) is a way to help prevent HIV by taking a pill every day
  - Tenofovir and Emtricitabine – PrEP approved on July 2012
  - Better results when used consistently
  - Guidelines for PrEP use
  - F/U visits and HIV testing every three months
  - Evaluation of renal function
  - Assess pregnancy intent
  - Pregnancy test every three months
  - Appropriate counseling, safe sex practices

SUMMARY
• Gynecological visit is very important: screening, testing, diagnosis, treatment, prevention, education, immunization and referral.

• Women living with HIV have higher rates of genital and anal dysplasia and, therefore have different screening requirements from the general population.

• Start cervical screening at initiation of intercourse or age 21 (whichever comes first) and should continue through a woman’s lifetime.

• Refer all ASCUS, hr HPV detected and worse cervical paps for colposcopy.

• HIV+ women are living longer, more women are or will be in menopause.

• Herpes and genital condyloma are much more common in HIV infected women and often need to be treated more aggressively.

• Women with HIV can safely use any birth control method. Urge condoms.

• Providers need to ask about partners’ HIV status and encourage regular testing of patients and partners.

• Important to offer preconceptional care and PrEP

• Recommendations for screening of breast, ovarian and colon cancer are the same for HIV + and HIV - women
REFERENCES
REFERENCES

• Cervical Cancer Screening and Prevention. ACOG Practice Bulletin Number 157, January 2016


• http://www.floridahealth.gov/_documents/HIV/_images/continuum-x.svg

• HHS Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Updated April 8, 2015.


• Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2014 Clinical Practice Guideline

• www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/post-exposure-prophylaxis

• http://www.cdc.gov/hiv/resources/factsheets/index.htm
Thank You!

Questions?

NDiaz3@med.miami.edu
This Presentation and resources are made possible by AETC grant award U1OHA29295 from the HIV/AIDS Bureau of the Health Resources Services Administration (HRSA), U. S. Department of Health and Human Services (HHS).

The information presented is the consensus of HIV/AIDS specialists within the SEAETC and does not necessarily represent the official views of HRSA/HAB.

The AIDS Education and Training Center (AETC) Program is the training arm of the Ryan White HIV/AIDS Program. The AETC Program is a national network of leading HIV experts who provide locally based, tailored education, clinical consultation and technical assistance to healthcare professionals and healthcare organizations to integrate high quality, comprehensive care for those living with or affected by HIV.
The **South FL SE AIDS Education and Training Center**
within the University of Miami, Department of Medicine,
Division of Clinical Immunology, has over thirty faculty
members and staff dedicated to caring for patients with
HIV/AIDS and includes some of the world’s most renowned
researchers in infectious diseases. We have specialty clinics
in adult medicine, and obstetrics/gynecology that provide
state of the art clinical care for those individuals infected with
HIV and other STIs. HIV clinical care is provided by the UM
physicians for inpatient care at Jackson Memorial Hospital
(JMH) and University of Miami Hospital, and outpatient care
at numerous sites on the UM/JMH medical campus. UM HIV
faculty also provide off site care at Federally Qualified
Health Centers.
The South FL SE AETC includes the following counties: Polk, Hardee, Highlands, Indian River, Okeechobee, St. Lucie, Hernando, Pasco, Pinellas, Hillsborough, Manatee, Sarasota, DeSoto, Martin, Palm Beach, Broward, Miami-Dade, Monroe, Charlotte, Glades, Lee, Hendry and Collier.
The U.S. Department of Health and Human Services (DHHS) has released updated versions of its antiretroviral treatment guidelines for adults and adolescents, and for children with HIV. The new adult guidelines include revised recommendations for first-line antiretroviral therapy (ART) as well as management of treatment-experienced patients. The revised pediatric guidelines include a discussion of very early treatment for HIV-infected infants.

References
HHS Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Updated April 8, 2015.
TRAINING OPPORTUNITIES

Preceptorships
An intensive clinical training program offered to healthcare providers in Florida who have an interest in learning more about the diagnosis and management of HIV/AIDS, opportunistic infections, and co-morbid conditions. Each preceptorship is structured to meet the unique needs of the individual participant based on his or her previous experience, geographic location, and time available. Experience 4 to 240 hours of clinical training at adult, pediatric, obstetric, and/or family practice clinics where care is provided to HIV-infected patients. All training provided is consistent with current guidelines from the Department of Health and Human Services or other nationally recognized guidelines when available.

Individual and/or Group Clinical Consultations
Individual and group clinical consultations are offered. Individual clinical case consultation is provided on the diagnosis, prevention, and treatment of HIV/AIDS and related conditions. These consultations take place by telephone, email or face-to-face meetings. Group clinical consultation with case-based discussions include information on pharmacology, clinical antiretroviral therapy updates, drug-drug interactions, and antiretroviral resistance.
Chart Reviews
The chart review program offers clinics that provide HIV/AIDS care an opportunity to assess adherence to current Department of Health and Human Services (DHHS) and other published guidelines utilized in the care and treatment of HIV-infected individuals. Using a team of specially-trained F/C AETC faculty, a review of selected patient charts is completed to identify the strengths of the healthcare team, as well as areas of opportunity for education and training to support quality improvement efforts.

Web-Based Education (Webinars)
We offer numerous web-based educational opportunities to increase the knowledge and skills of HIV healthcare providers. Our web-based educational opportunities cover a wide range of HIV-related topics. Trainings are provided both as live webinars or on-demand recorded webinars. Web-based education offers participants a way to stay up-to-date on current topics.

Telehealth Case Based Group Consultations
This model uses a live audio-video-based platform (Adobe Connect) to provide educational experiences through the creation of a learning network comprised of clinicians serving HIV/AIDS patients, novice to expert throughout our region.
National HIV/AIDS Clinicians’ Consultation Center
UCSF – San Francisco General Hospital

Warmline
National HIV/AIDS Telephone Consultation Service
Consultation on all aspects of HIV testing and clinical care
Monday - Friday
9 am – 8 pm EST
Voicemail 24 hours a day, 7 days a week

PEPline
National Clinicians’ Post-Exposure Prophylaxis Hotline
Recommendations on managing occupational exposures to HIV and hepatitis B & C
9 am - 2 am EST, 7 days a week

Perinatal HIV Hotline
National Perinatal HIV Consultation & Referral Service
Advice on testing and care of HIV-infected pregnant women and their infants
Referral to HIV specialists and regional resources
24 hours a day, 7 days a week

HRSA AIDS ETC Program & Community Based Programs, HIV/AIDS Bureau & Centers for Disease Control and Prevention (CDC)
www.nccc.ucsf.edu
Upcoming Events

Thursday, SEPTEMBER 15th
ART/HIV/HCV Telehealth Session
UM/NSU Faculty

Tuesday, SEPTEMBER 20th
Women and Clinical Trials (Haitian Creole)
Hancy Brignol, MSN, MHSA

Thursday, October 6th
Routine Testing in Healthcare Settings
Susanne Doblecki-Lewis, MD
Need Additional Information?

Contact the South FL SE AIDS Education and Training Center

Franklin Monjarrez, Program Manager:

fbm20@med.miami.edu

Tivisay Gonzalez, Program Coordinator:

tgonzalez1@med.miami.edu

or visit:

http://hivaidsinstitute.med.miami.edu/partners/se-aetc
Thank you!

We thank you for participating in today’s webinar and encourage you to stay on WebEx and fill out the Performance Evaluation after the call ends. This is a HRSA requirement that helps us ensure continued funding.