9° WORKSHOP NAZIONALE CISAI

PREVENZIONE E GESTIONE DELLE CO-MORBIDITÀ ASSOCIATE ALL'INFEZIONE DA HIV

Comorbilità psicopatologica in corso di HIV: la necessità di un approccio integrato di trattamento

Caterina Viganò

FONDAZIONE ASIA

CISAI
Coordinamento
Italiano
Studio
Allergie e
Infezione da HIV

BARI | 21-22 MARZO 2019
CENTRO CONGRESSI PALACE HOTEL BARI

UNIVERSITÀ DEGLI STUDI DI MILANO

Ospedale Luigi Sacco
POLO UNIVERSITARIO
Sistema Socio Sanitario
Regione Lombardia
ASST Fatebenefratelli Sacco

HIV

- Comorbilità con patologie psichiatriche
  - Disturbi psichiatrici indotti

- Trattamenti

- Difficoltà di aderenza ai trattamenti

comorbilità ?

- **Infezione HIV primaria** e successivi sintomi psichici/ disturbi psichiatrici
  - Effetto diagnosi?
- Disturbi psichiatrici indotti da trattamenti per HIV
- **Disturbi psichiatrici primari** e aumento del rischio di contrarre HIV
  - **HIV odds 2.57 > che nella popolazione generale**

Bauer-Staeb C et al , Lancet Psychiatry 2017

Disturbi psichiatrici e rischio di infezione HIV

Linee guida dello European Centre for Disease Prevention and Control (Ecdc)

Comportamenti a rischio

- contatti sessuali non protetti
- consumatori di sostanze d'abuso per via iniettiva

Comportamenti a rischio sostenuti da:

Dis/regolazione emotiva (instabilità affettiva)

Personalità con elevata impulsività

Condizioni che abbassano la capacità di critica

Disturbi dell'umore

- Dist. Depressivi
- **Dist. Bipolari *fasi maniacali e comportamenti a rischio**

Ansia e PTSD

Disturbi del controllo degli impulsi

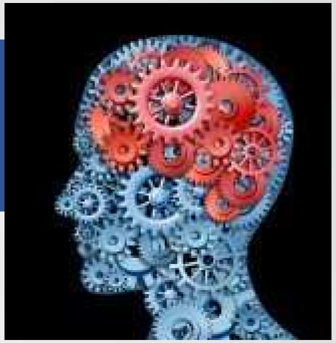
Uso di sostanze (non solo iniettive!)

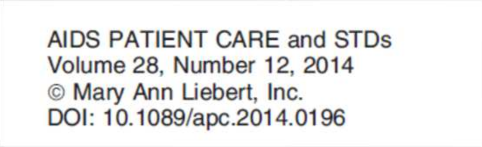
Disturbi di personalità cluster B

9° WORKSHOP NAZIONALE CISAI

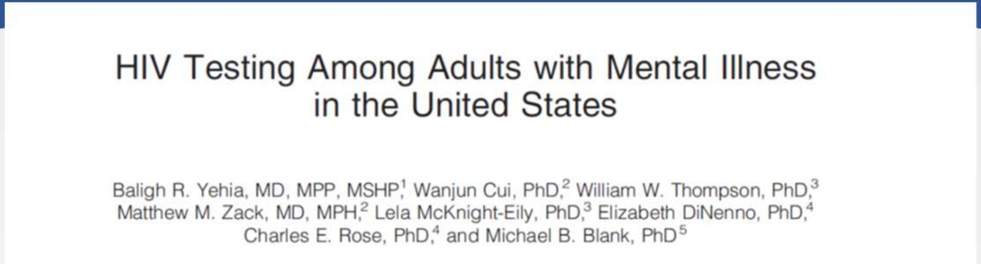
PREVENZIONE E GESTIONE DELLE CO-MORBIDITÀ ASSOCIATE ALL'INFEZIONE DA HIV

Disturbi psichiatrici e rischio di infezione HIV





AIDS PATIENT CARE and STDs
Volume 28, Number 12, 2014
© Mary Ann Liebert, Inc.
DOI: 10.1089/apc.2014.0196



HIV Testing Among Adults with Mental Illness in the United States

Baligh R. Yehia, MD, MPP, MSHP,[1] Wanjun Cui, PhD,[2] William W. Thompson, PhD,[3] Matthew M. Zack, MD, MPH,[2] Lela McKnight-Eily, PhD,[3] Elizabeth DiNenno, PhD,[4] Charles E. Rose, PhD,[4] and Michael B. Blank, PhD[5]

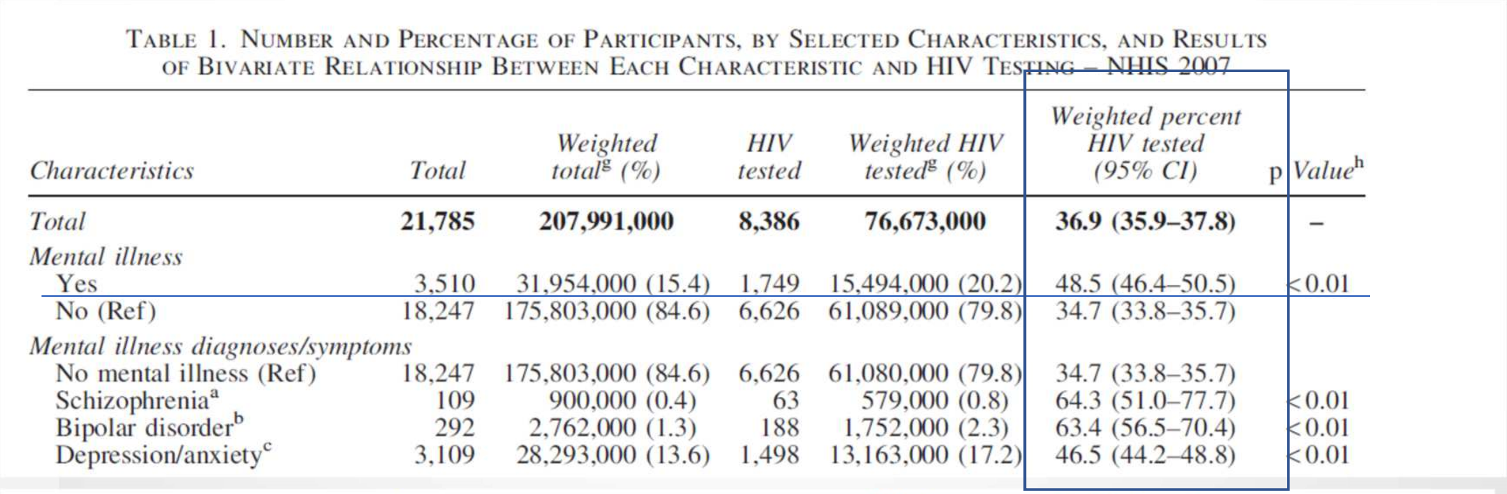


TABLE 1. NUMBER AND PERCENTAGE OF PARTICIPANTS, BY SELECTED CHARACTERISTICS, AND RESULTS OF BIVARIATE RELATIONSHIP BETWEEN EACH CHARACTERISTIC AND HIV TESTING – NHIS 2007

Characteristics	*Total*	*Weighted total*[g] *(%)*	*HIV tested*	*Weighted HIV tested*[g] *(%)*	*Weighted percent HIV tested (95% CI)*	p *Value*[h]
Total	**21,785**	**207,991,000**	**8,386**	**76,673,000**	**36.9 (35.9–37.8)**	–
Mental illness						
Yes	3,510	31,954,000 (15.4)	1,749	15,494,000 (20.2)	48.5 (46.4–50.5)	<0.01
No (Ref)	18,247	175,803,000 (84.6)	6,626	61,089,000 (79.8)	34.7 (33.8–35.7)	
Mental illness diagnoses/symptoms						
No mental illness (Ref)	18,247	175,803,000 (84.6)	6,626	61,080,000 (79.8)	34.7 (33.8–35.7)	
Schizophrenia[a]	109	900,000 (0.4)	63	579,000 (0.8)	64.3 (51.0–77.7)	<0.01
Bipolar disorder[b]	292	2,762,000 (1.3)	188	1,752,000 (2.3)	63.4 (56.5–70.4)	<0.01
Depression/anxiety[c]	3,109	28,293,000 (13.6)	1,498	13,163,000 (17.2)	46.5 (44.2–48.8)	<0.01

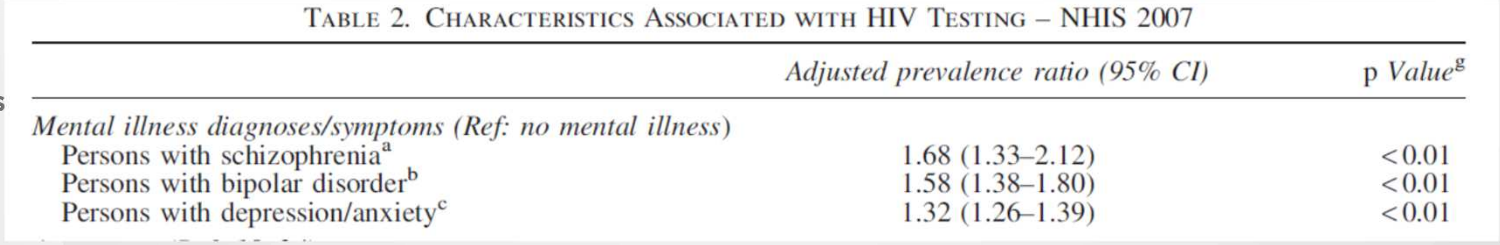


TABLE 2. CHARACTERISTICS ASSOCIATED WITH HIV TESTING – NHIS 2007

	Adjusted prevalence ratio (95% CI)	p *Value*[g]
Mental illness diagnoses/symptoms (Ref: no mental illness)		
Persons with schizophrenia[a]	1.68 (1.33–2.12)	<0.01
Persons with bipolar disorder[b]	1.58 (1.38–1.80)	<0.01
Persons with depression/anxiety[c]	1.32 (1.26–1.39)	<0.01

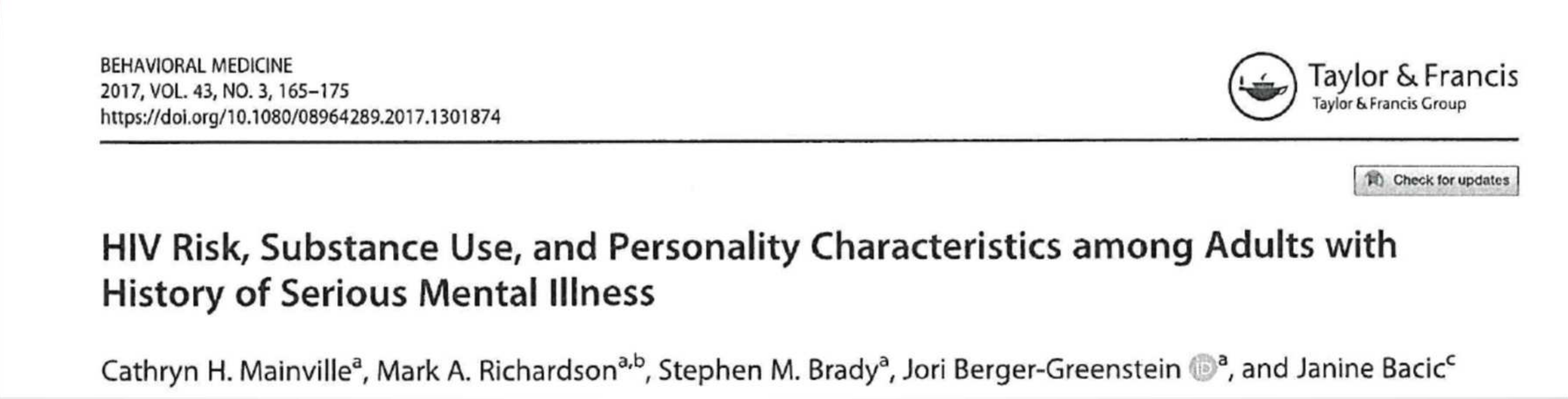
A volte i pazienti con disturbi maggiori sono anche quelli piu testati rispetto alla popolazione senza malattia mentale

FONDAZIONE AS

CISAI
Coordinamento Italiano Studio Allergie e Infezione da HIV

BARI | 21-22 MARZO 2019
CENTRO CONGRESSI PALACE HOTEL BARI

Disturbi psichiatrici e rischio di infezione HIV



BEHAVIORAL MEDICINE
2017, VOL. 43, NO. 3, 165–175
https://doi.org/10.1080/08964289.2017.1301874

Taylor & Francis
Taylor & Francis Group

Check for updates

HIV Risk, Substance Use, and Personality Characteristics among Adults with History of Serious Mental Illness

Cathryn H. Mainville[a], Mark A. Richardson[a,b], Stephen M. Brady[a], Jori Berger-Greenstein [a], and Janine Bacic[c]

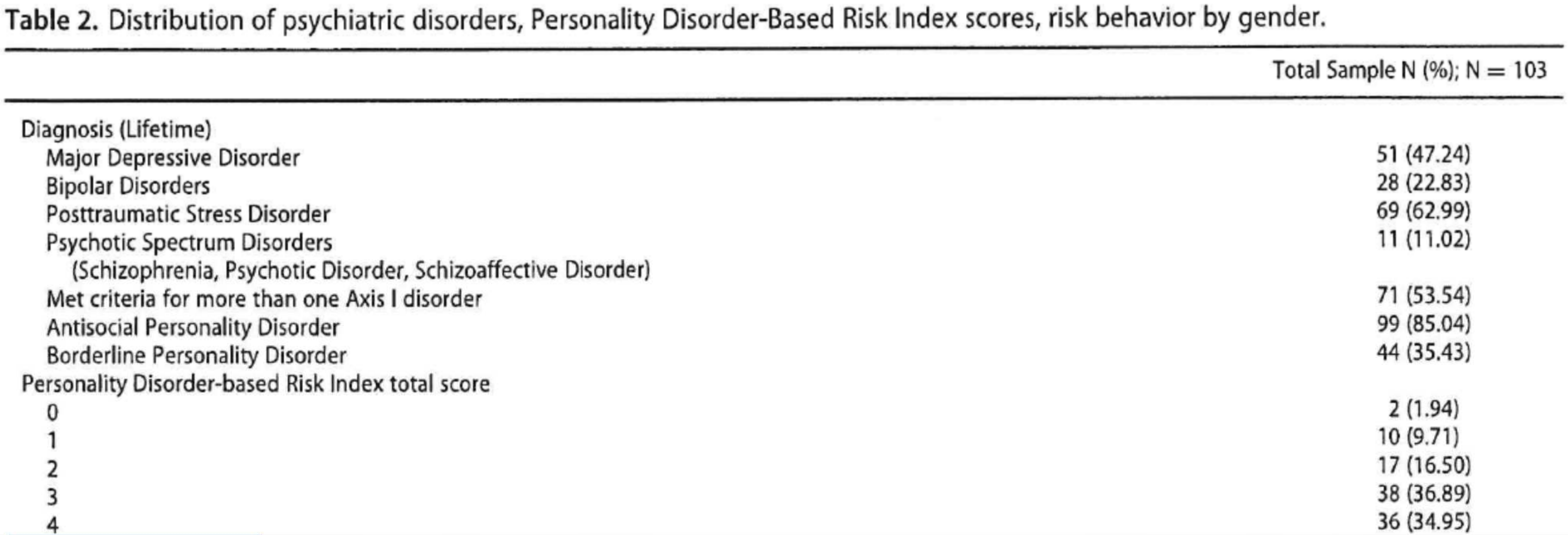
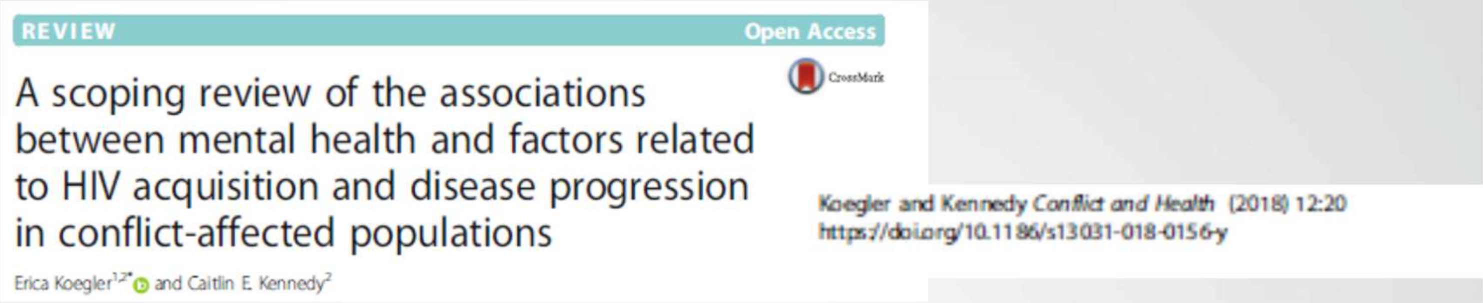


Table 2. Distribution of psychiatric disorders, Personality Disorder-Based Risk Index scores, risk behavior by gender.

	Total Sample N (%); N = 103
Diagnosis (Lifetime)	
Major Depressive Disorder	51 (47.24)
Bipolar Disorders	28 (22.83)
Posttraumatic Stress Disorder	69 (62.99)
Psychotic Spectrum Disorders (Schizophrenia, Psychotic Disorder, Schizoaffective Disorder)	11 (11.02)
Met criteria for more than one Axis I disorder	71 (53.54)
Antisocial Personality Disorder	99 (85.04)
Borderline Personality Disorder	44 (35.43)
Personality Disorder-based Risk Index total score	
0	2 (1.94)
1	10 (9.71)
2	17 (16.50)
3	38 (36.89)
4	36 (34.95)

Il ruolo del trauma

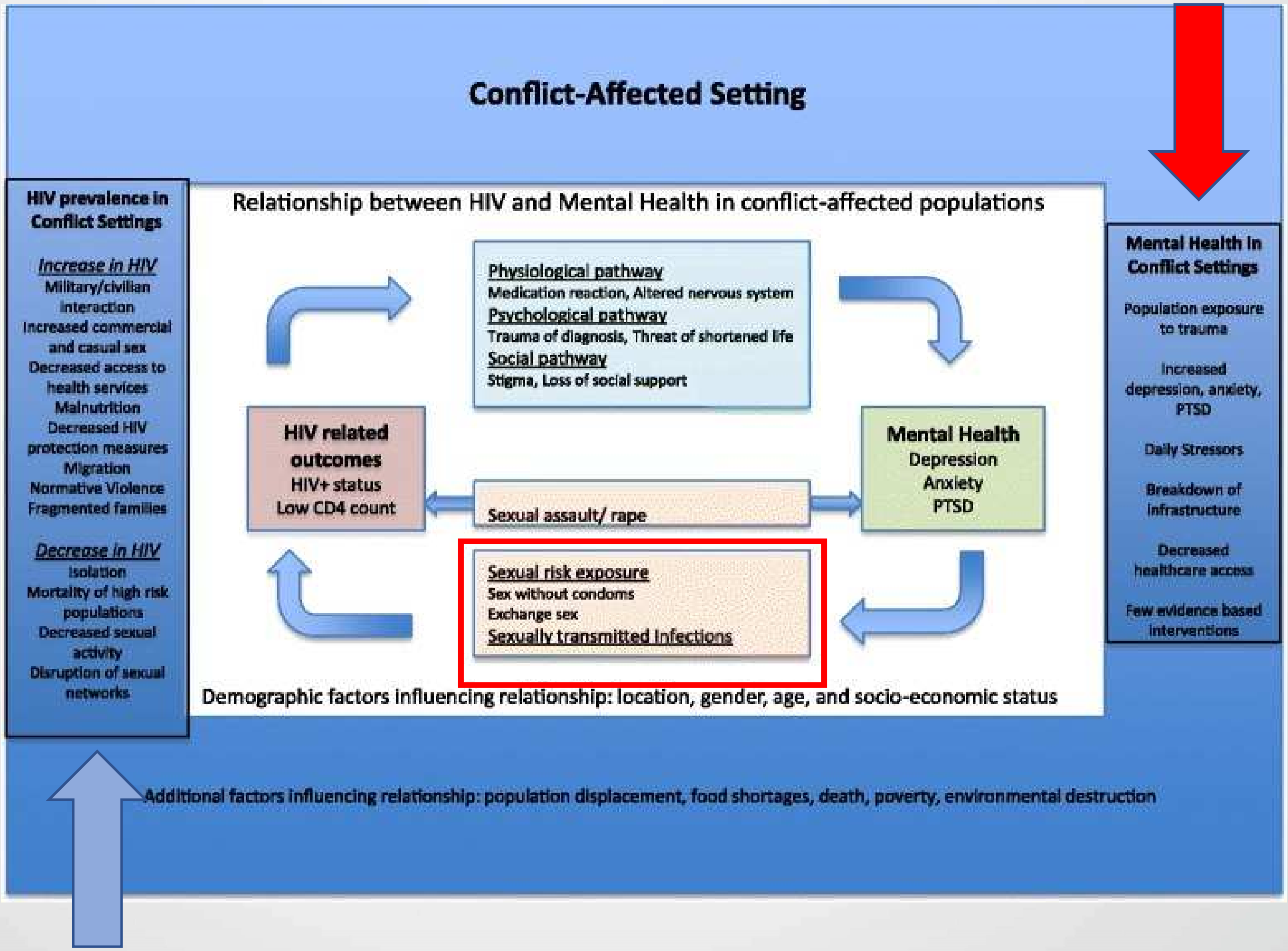


REVIEW Open Access

A scoping review of the associations between mental health and factors related to HIV acquisition and disease progression in conflict-affected populations

Erica Koegler[1,2*] and Caitlin E. Kennedy[2]

Koegler and Kennedy *Conflict and Health* (2018) 12:20
https://doi.org/10.1186/s13031-018-0156-y



Conflict-Affected Setting

HIV prevalence in Conflict Settings

Increase in HIV
Military/civilian interaction
Increased commercial and casual sex
Decreased access to health services
Malnutrition
Decreased HIV protection measures
Migration
Normative Violence
Fragmented families

Decrease in HIV
Isolation
Mortality of high risk populations
Decreased sexual activity
Disruption of sexual networks

Relationship between HIV and Mental Health in conflict-affected populations

Physiological pathway
Medication reaction, Altered nervous system
Psychological pathway
Trauma of diagnosis, Threat of shortened life
Social pathway
Stigma, Loss of social support

HIV related outcomes
HIV+ status
Low CD4 count

Sexual assault/ rape

Mental Health
Depression
Anxiety
PTSD

Sexual risk exposure
Sex without condoms
Exchange sex
Sexually transmitted Infections

Demographic factors influencing relationship: location, gender, age, and socio-economic status

Mental Health in Conflict Settings

Population exposure to trauma

Increased depression, anxiety, PTSD

Daily Stressors

Breakdown of infrastructure

Decreased healthcare access

Few evidence based interventions

Additional factors influencing relationship: population displacement, food shortages, death, poverty, environmental destruction

FONDAZIONE ASIA

CISAI
Coordinamento Italiano Studio Allergie e Infezione da HIV

HIV - Test
Type of specimen
HIV Infection
Screening test
CPV 380
CPX 070
Confirmatory
CPX 025

Infezione primaria da HIV

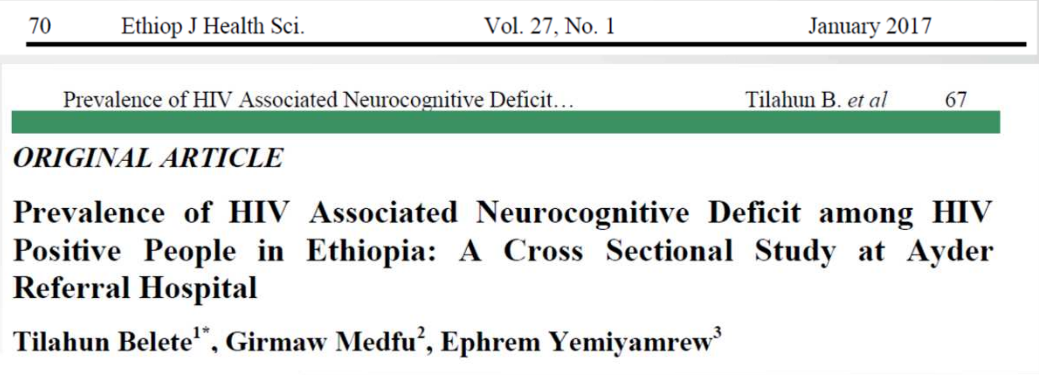
Comorbilità con disturbi psichiatrici:

- Depressione: 4-22%
- AIDS mania: 4-8%
- Disturbo da uso di sostanze: 28%
- Disturbo da uso di alcol: 14%

Prevalenza infezione:

- Mondo: 33 milioni
- Italia: 94 mila

Dubé B, J, Psychiatry Neurosci, 2005
Tucker JS, Am J Med, 2003
WHO, AIDS epidemic update, 2004
Istituto Superiore della Sanità, 2013



70 Ethiop J Health Sci. Vol. 27, No. 1 January 2017

Prevalence of HIV Associated Neurocognitive Deficit… Tilahun B. *et al* 67

ORIGINAL ARTICLE

Prevalence of HIV Associated Neurocognitive Deficit among HIV Positive People in Ethiopia: A Cross Sectional Study at Ayder Referral Hospital

Tilahun Belete[1*], Girmaw Medfu[2], Ephrem Yemiyamrew[3]

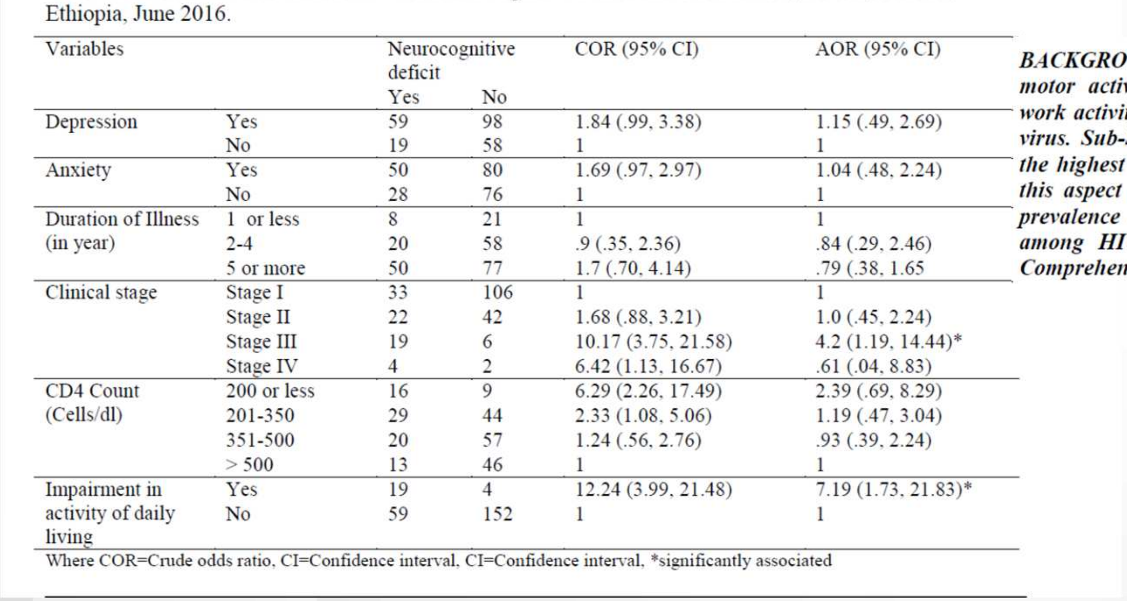
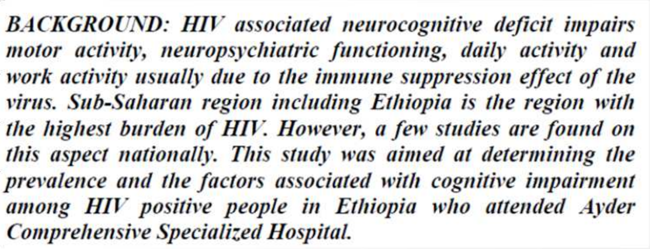


Table 3: Multivariate association between neuro cognitive deficit and other factors, ACSH, Mekelle, Ethiopia, June 2016.

Variables		Neurocognitive deficit		COR (95% CI)	AOR (95% CI)
		Yes	No		
Depression	Yes	59	98	1.84 (.99, 3.38)	1.15 (.49, 2.69)
	No	19	58	1	1
Anxiety	Yes	50	80	1.69 (.97, 2.97)	1.04 (.48, 2.24)
	No	28	76	1	1
Duration of Illness (in year)	1 or less	8	21	1	1
	2-4	20	58	.9 (.35, 2.36)	.84 (.29, 2.46)
	5 or more	50	77	1.7 (.70, 4.14)	.79 (.38, 1.65
Clinical stage	Stage I	33	106	1	1
	Stage II	22	42	1.68 (.88, 3.21)	1.0 (.45, 2.24)
	Stage III	19	6	10.17 (3.75, 21.58)	4.2 (1.19, 14.44)*
	Stage IV	4	2	6.42 (1.13, 16.67)	.61 (.04, 8.83)
CD4 Count (Cells/dl)	200 or less	16	9	6.29 (2.26, 17.49)	2.39 (.69, 8.29)
	201-350	29	44	2.33 (1.08, 5.06)	1.19 (.47, 3.04)
	351-500	20	57	1.24 (.56, 2.76)	.93 (.39, 2.24)
	> 500	13	46	1	1
Impairment in activity of daily living	Yes	19	4	12.24 (3.99, 21.48)	7.19 (1.73, 21.83)*
	No	59	152	1	1

Where COR=Crude odds ratio, CI=Confidence interval, CI=Confidence interval, *significantly associated



BACKGROUND: *HIV associated neurocognitive deficit impairs motor activity, neuropsychiatric functioning, daily activity and work activity usually due to the immune suppression effect of the virus. Sub-Saharan region including Ethiopia is the region with the highest burden of HIV. However, a few studies are found on this aspect nationally. This study was aimed at determining the prevalence and the factors associated with cognitive impairment among HIV positive people in Ethiopia who attended Ayder Comprehensive Specialized Hospital.*

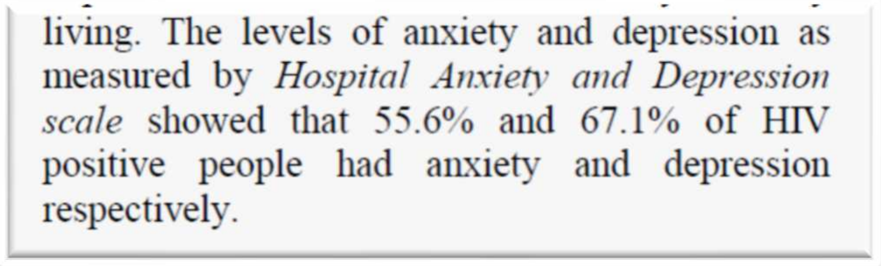
Depressione

Mania

Psicosi

Disturbi cognitivi

Demenza



living. The levels of anxiety and depression as measured by *Hospital Anxiety and Depression scale* showed that 55.6% and 67.1% of HIV positive people had anxiety and depression respectively.

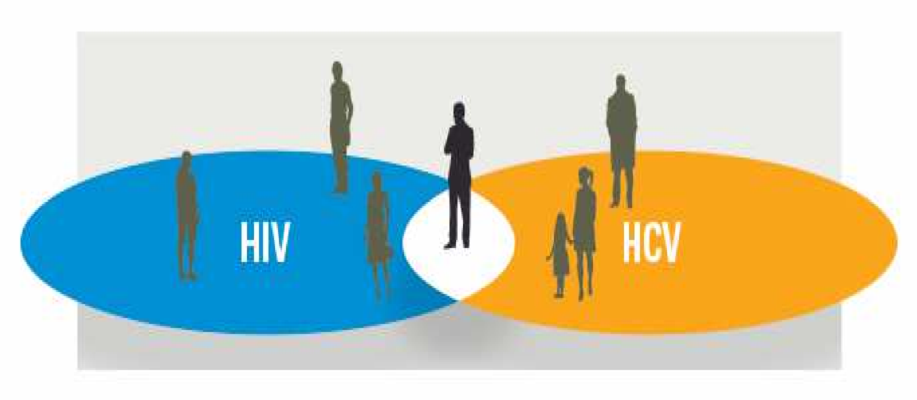
Co-infezione HIV-HCV

Disturbi psichiatrici:

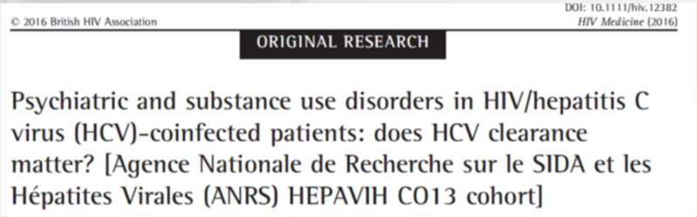
- Disturbo depressivo maggiore: 26%
- **Disturbo d'ansia generalizzata: 20%**
- Disturbo da uso di sostanze: 18%
- Disturbo da uso di alcol: 14%

Prevalenza infezione:

- Mondo: 4,5 milioni
- Italia: 33 mila



Michel L, HIV Medicine, 2016
Lega Italiana Lotta AIDS, 2010



© 2016 British HIV Association
DOI: 10.1111/hiv.12382
HIV Medicine (2016)

ORIGINAL RESEARCH

Psychiatric and substance use disorders in HIV/hepatitis C virus (HCV)-coinfected patients: does HCV clearance matter? [Agence Nationale de Recherche sur le SIDA et les Hépatites Virales (ANRS) HEPAVIH CO13 cohort]

Lo studio delle variabili sociodemografiche e di malattia associate al disturbo d'ansia non mostra **significatività se non per la copresenza di HCV**

La maggiore comparsa di depressione si correla alla presenza precedente di disturbi psichici

Nei pazienti non in trattamento:
Stigma
Uso di sostanze

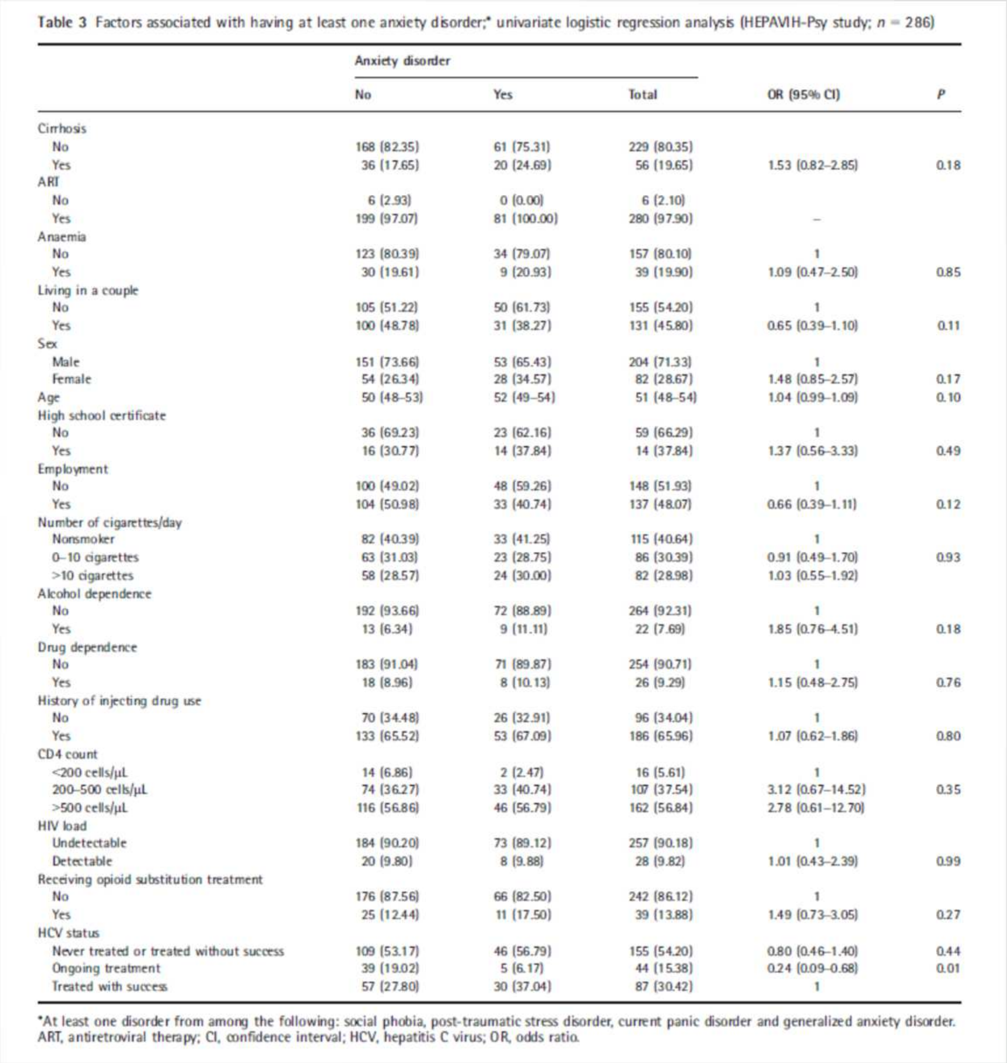


Table 3 Factors associated with having at least one anxiety disorder;* univariate logistic regression analysis (HEPAVIH-Psy study; $n = 286$)

	Anxiety disorder				
	No	Yes	Total	OR (95% CI)	*P*
Cirrhosis					
No	168 (82.35)	61 (75.31)	229 (80.35)		
Yes	36 (17.65)	20 (24.69)	56 (19.65)	1.53 (0.82–2.85)	0.18
ART					
No	6 (2.93)	0 (0.00)	6 (2.10)		
Yes	199 (97.07)	81 (100.00)	280 (97.90)	–	
Anaemia					
No	123 (80.39)	34 (79.07)	157 (80.10)	1	
Yes	30 (19.61)	9 (20.93)	39 (19.90)	1.09 (0.47–2.50)	0.85
Living in a couple					
No	105 (51.22)	50 (61.73)	155 (54.20)	1	
Yes	100 (48.78)	31 (38.27)	131 (45.80)	0.65 (0.39–1.10)	0.11
Sex					
Male	151 (73.66)	53 (65.43)	204 (71.33)	1	
Female	54 (26.34)	28 (34.57)	82 (28.67)	1.48 (0.85–2.57)	0.17
Age	50 (48–53)	52 (49–54)	51 (48–54)	1.04 (0.99–1.09)	0.10
High school certificate					
No	36 (69.23)	23 (62.16)	59 (66.29)	1	
Yes	16 (30.77)	14 (37.84)	14 (37.84)	1.37 (0.56–3.33)	0.49
Employment					
No	100 (49.02)	48 (59.26)	148 (51.93)	1	
Yes	104 (50.98)	33 (40.74)	137 (48.07)	0.66 (0.39–1.11)	0.12
Number of cigarettes/day					
Nonsmoker	82 (40.39)	33 (41.25)	115 (40.64)	1	
0–10 cigarettes	63 (31.03)	23 (28.75)	86 (30.39)	0.91 (0.49–1.70)	0.93
>10 cigarettes	58 (28.57)	24 (30.00)	82 (28.98)	1.03 (0.55–1.92)	
Alcohol dependence					
No	192 (93.66)	72 (88.89)	264 (92.31)	1	
Yes	13 (6.34)	9 (11.11)	22 (7.69)	1.85 (0.76–4.51)	0.18
Drug dependence					
No	183 (91.04)	71 (89.87)	254 (90.71)	1	
Yes	18 (8.96)	8 (10.13)	26 (9.29)	1.15 (0.48–2.75)	0.76
History of injecting drug use					
No	70 (34.48)	26 (32.91)	96 (34.04)	1	
Yes	133 (65.52)	53 (67.09)	186 (65.96)	1.07 (0.62–1.86)	0.80
CD4 count					
<200 cells/μL	14 (6.86)	2 (2.47)	16 (5.61)	1	
200–500 cells/μL	74 (36.27)	33 (40.74)	107 (37.54)	3.12 (0.67–14.52)	0.35
>500 cells/μL	116 (56.86)	46 (56.79)	162 (56.84)	2.78 (0.61–12.70)	
HIV load					
Undetectable	184 (90.20)	73 (89.12)	257 (90.18)	1	
Detectable	20 (9.80)	8 (9.88)	28 (9.82)	1.01 (0.43–2.39)	0.99
Receiving opioid substitution treatment					
No	176 (87.56)	66 (82.50)	242 (86.12)	1	
Yes	25 (12.44)	11 (17.50)	39 (13.88)	1.49 (0.73–3.05)	0.27
HCV status					
Never treated or treated without success	109 (53.17)	46 (56.79)	155 (54.20)	0.80 (0.46–1.40)	0.44
Ongoing treatment	39 (19.02)	5 (6.17)	44 (15.38)	0.24 (0.09–0.68)	0.01
Treated with success	57 (27.80)	30 (37.04)	87 (30.42)	1	

*At least one disorder from among the following: social phobia, post-traumatic stress disorder, current panic disorder and generalized anxiety disorder.
ART, antiretroviral therapy; CI, confidence interval; HCV, hepatitis C virus; OR, odds ratio.

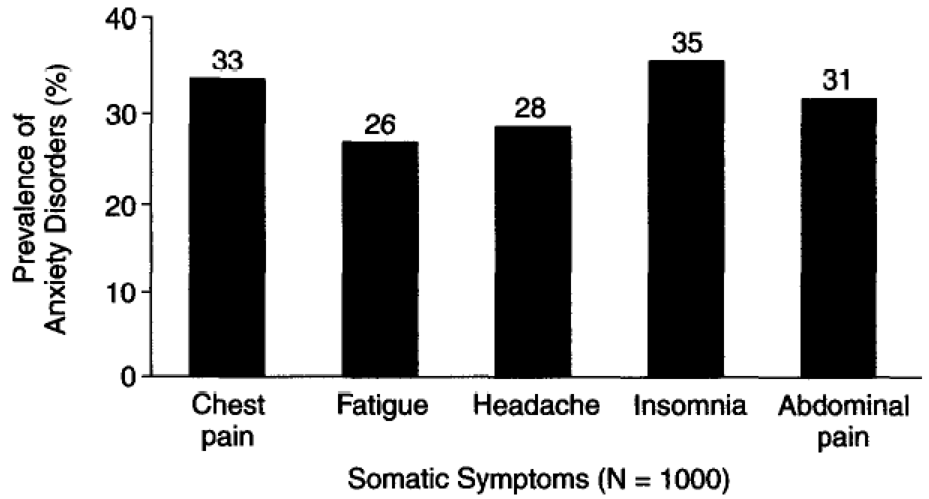
ELSEVIER

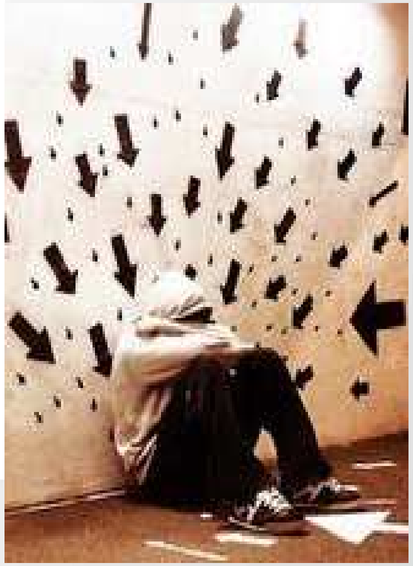
Anxiety Disorders

Brandish EK, Baldwin DS. / Medicine, 40 (11): 599-606; 2012.

MEDICINE

Somatic symptoms as potential markers for anxiety disorders. Data were collected from patients presenting at 4 primary care clinics.





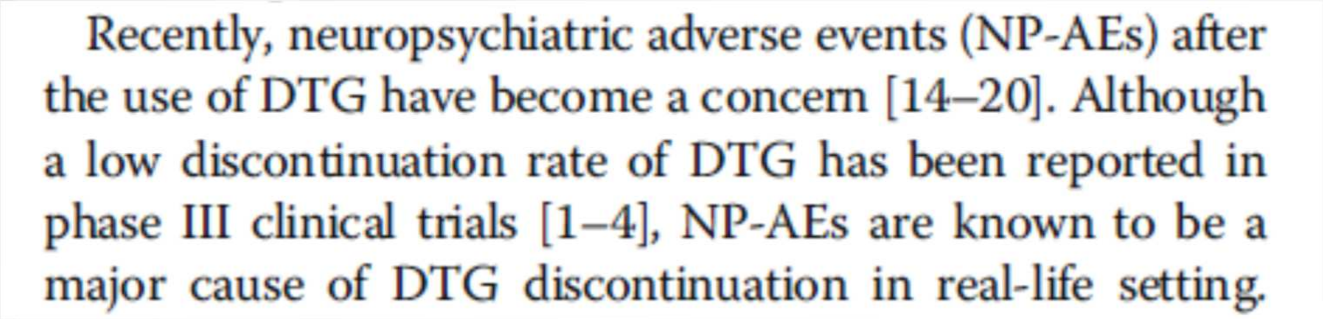
Disturbi psichiatrici indotti da HIV

Alterazioni organiche / assunzioni di farmaci

- Mania secondaria
  - 1,2% nei **sieropositivi**
  - 4,8% nei **soggetti con AIDS**.

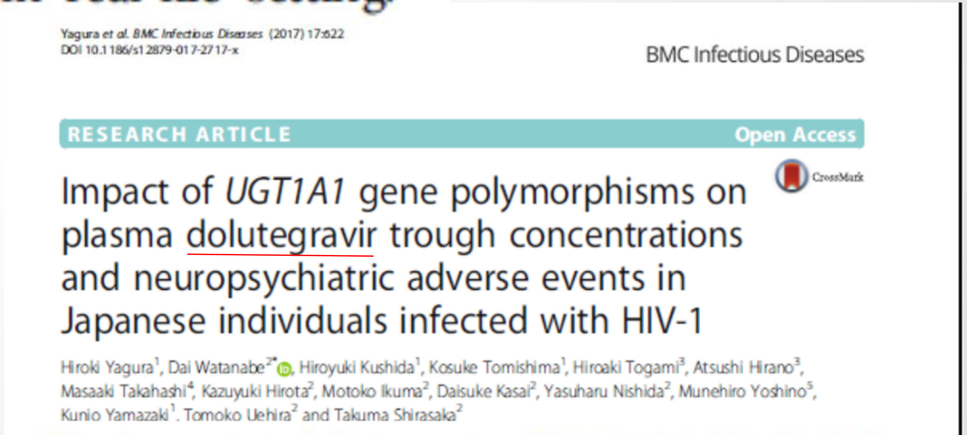
  deve perdurare per almeno una settimana ed è caratterizzato per la presenza di umore elevato o irritabilità e da almeno due dei seguenti sintomi: iperattività, logorrea, grandiosità, insonnia, distraibilità e alterato giudizio.
- Psicosi funzionali
  - Sintomatologia produttiva (deliri, allucinazioni, disorganizzazione)
  - collegate all'azione diretta del virus a livello del SNC *(diminuite in era HAART).*
- Delirium e la Demenza (complicazione tardive della malattia).

Effetti psichiatrici indotti dalle attuali terapie


Recently, neuropsychiatric adverse events (NP-AEs) after the use of DTG have become a concern [14–20]. Although a low discontinuation rate of DTG has been reported in phase III clinical trials [1–4], NP-AEs are known to be a major cause of DTG discontinuation in real-life setting.

Insonnia e altri disturbi del sonno. Un numero più ridotto di pazienti ha lamentato depressione e difficoltà cognitive.

Soggetti a rischio >
donne, i pazienti più anziani
dolutegravir in combinazione con l'abacavir.

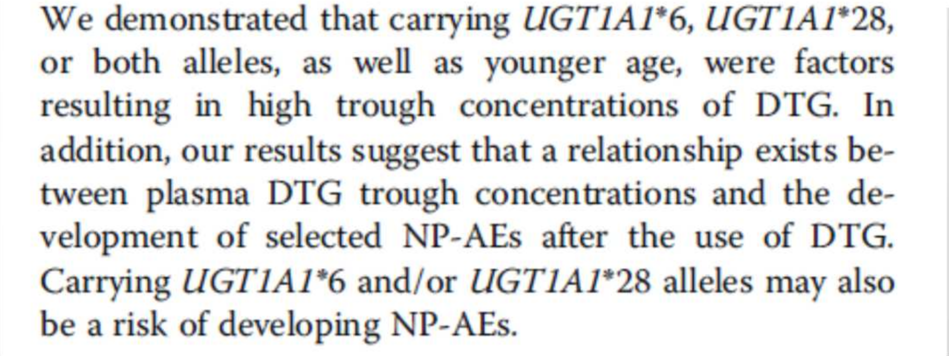

Yagura *et al. BMC Infectious Diseases* (2017) 17:622
DOI 10.1186/s12879-017-2717-x

BMC Infectious Diseases

RESEARCH ARTICLE Open Access

Impact of *UGT1A1* gene polymorphisms on plasma dolutegravir trough concentrations and neuropsychiatric adverse events in Japanese individuals infected with HIV-1

Hiroki Yagura[1], Dai Watanabe[2*], Hiroyuki Kushida[1], Kosuke Tomishima[1], Hiroaki Togami[3], Atsushi Hirano[3], Masaaki Takahashi[4], Kazuyuki Hirota[2], Motoko Ikuma[2], Daisuke Kasai[2], Yasuharu Nishida[2], Munehiro Yoshino[5], Kunio Yamazaki[1]. Tomoko Uehira[2] and Takuma Shirasaka[2]


We demonstrated that carrying *UGT1A1**6, *UGT1A1**28, or both alleles, as well as younger age, were factors resulting in high trough concentrations of DTG. In addition, our results suggest that a relationship exists between plasma DTG trough concentrations and the development of selected NP-AEs after the use of DTG. Carrying *UGT1A1**6 and/or *UGT1A1**28 alleles may also be a risk of developing NP-AEs.

Mondi A et al. Journal of the International AID
http://onlinelibrary.wiley.com/doi/10.1002/jia2.

RESEARCH ARTI

Effectiveness of d
switch antiretrovir

Annalisa Mondi[1§], Alessandr
Francesca Ceccherini-Silberstein
Andrea Antinori[1], Antonella d'Ar

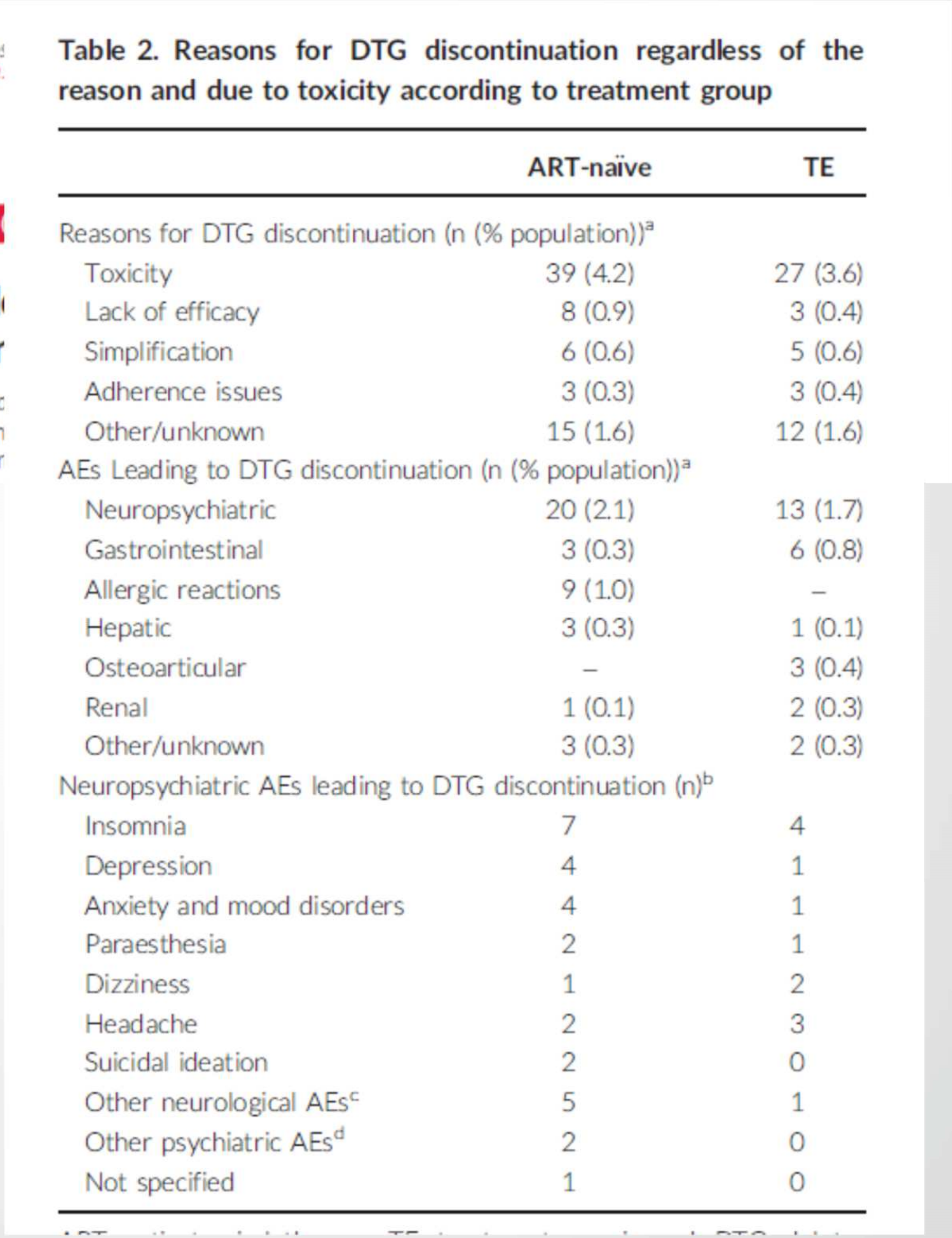


Table 2. Reasons for DTG discontinuation regardless of the reason and due to toxicity according to treatment group

	ART-naïve	TE
Reasons for DTG discontinuation (n (% population))[a]		
Toxicity	39 (4.2)	27 (3.6)
Lack of efficacy	8 (0.9)	3 (0.4)
Simplification	6 (0.6)	5 (0.6)
Adherence issues	3 (0.3)	3 (0.4)
Other/unknown	15 (1.6)	12 (1.6)
AEs Leading to DTG discontinuation (n (% population))[a]		
Neuropsychiatric	20 (2.1)	13 (1.7)
Gastrointestinal	3 (0.3)	6 (0.8)
Allergic reactions	9 (1.0)	–
Hepatic	3 (0.3)	1 (0.1)
Osteoarticular	–	3 (0.4)
Renal	1 (0.1)	2 (0.3)
Other/unknown	3 (0.3)	2 (0.3)
Neuropsychiatric AEs leading to DTG discontinuation (n)[b]		
Insomnia	7	4
Depression	4	1
Anxiety and mood disorders	4	1
Paraesthesia	2	1
Dizziness	1	2
Headache	2	3
Suicidal ideation	2	0
Other neurological AEs[c]	5	1
Other psychiatric AEs[d]	2	0
Not specified	1	0

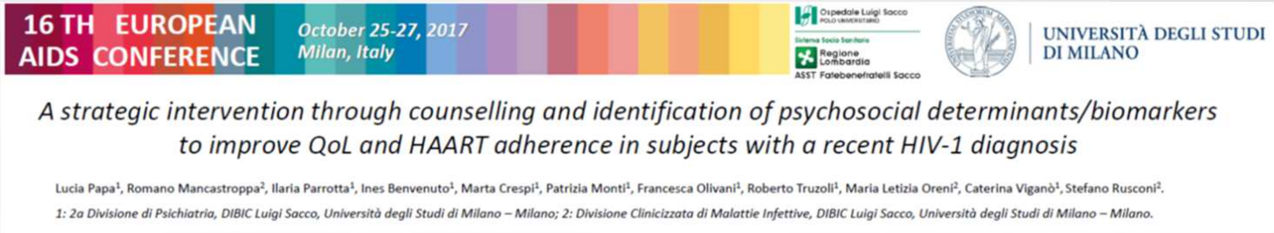
Studio multicentrico retrospettivo
1679 soggetti HIV+ di cui 932 ART
naive

Disturbi indotti : effetto diagnosi

Studio condotto su pazienti alla prima diagnosi prima di iniziare terapia

Nel corso del primo mese erano presenti sintomi psicopatologici

- 85% pazienti con sintomi depressivi (BDI test)
- 43 % sintomi ansiosi (STAI-Y)
- 71% con sintomi da stress (IES-R)
- Strategie di coping maladattive



16 TH EUROPEAN AIDS CONFERENCE October 25-27, 2017 Milan, Italy

Ospedale Luigi Sacco
Regione Lombardia
ASST Fatebenefratelli Sacco

UNIVERSITÀ DEGLI STUDI DI MILANO

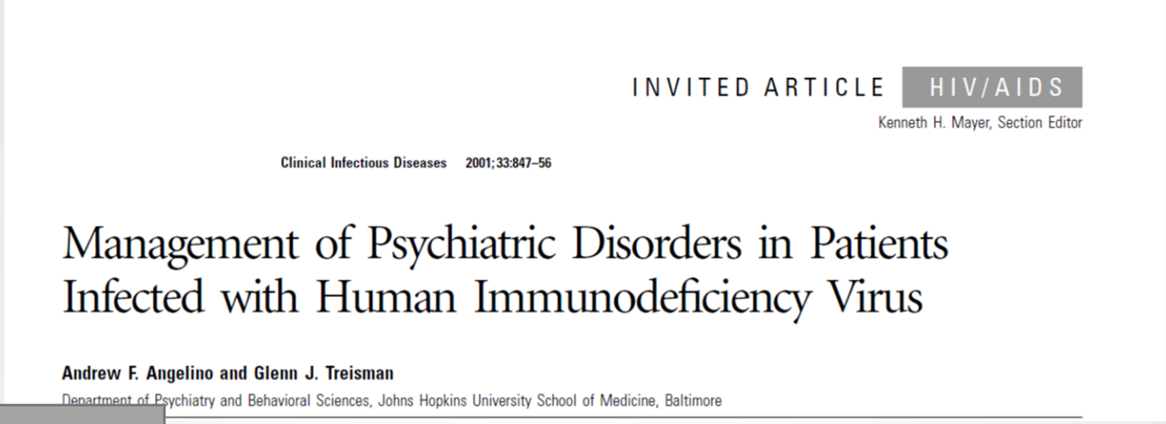
A strategic intervention through counselling and identification of psychosocial determinants/biomarkers to improve QoL and HAART adherence in subjects with a recent HIV-1 diagnosis

Lucia Papa[1], Romano Mancastroppa[2], Ilaria Parrotta[1], Ines Benvenuto[1], Marta Crespi[1], Patrizia Monti[1], Francesca Olivani[1], Roberto Truzoli[1], Maria Letizia Oreni[2], Caterina Viganò[1], Stefano Rusconi[2].

1: 2a Divisione di Psichiatria, DIBIC Luigi Sacco, Università degli Studi di Milano – Milano; 2: Divisione Clinicizzata di Malattie Infettive, DIBIC Luigi Sacco, Università degli Studi di Milano – Milano.

9° WORKSHOP NAZIONALE CISAI

**PREVENZIONE
E GESTIONE
DELLE CO-MORBIDITÀ
ASSOCIATE
ALL'INFEZIONE DA HIV**



INVITED ARTICLE HIV/AIDS
Kenneth H. Mayer, Section Editor

Clinical Infectious Diseases 2001;33:847–56

Management of Psychiatric Disorders in Patients Infected with Human Immunodeficiency Virus

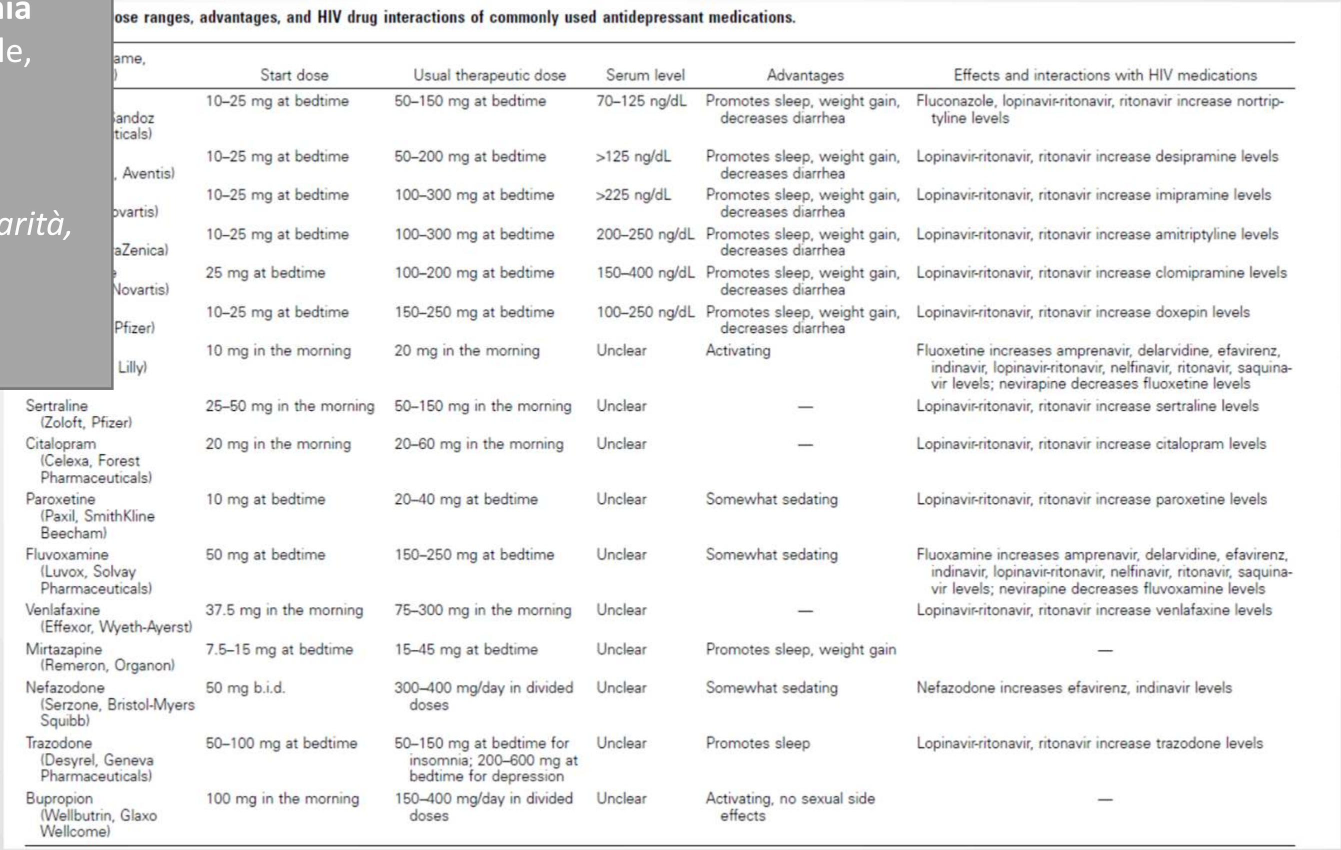
Andrew F. Angelino and Glenn J. Treisman
Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore

Quadri depressivi : SSRI /SNRI

Attenzione al viraggio in mania (studio anamnesi longitudinale, sintomi atipici)

Attenzione rischio suicidario *(fattori di rischio: età, famigliarità, genere, BDII + ansia)*

Attenzione a DUS !!!



ose ranges, advantages, and HIV drug interactions of commonly used antidepressant medications.

ame,)	Start dose	Usual therapeutic dose	Serum level	Advantages	Effects and interactions with HIV medications
andoz ticals)	10–25 mg at bedtime	50–150 mg at bedtime	70–125 ng/dL	Promotes sleep, weight gain, decreases diarrhea	Fluconazole, lopinavir-ritonavir, ritonavir increase nortriptyline levels
, Aventis)	10–25 mg at bedtime	50–200 mg at bedtime	>125 ng/dL	Promotes sleep, weight gain, decreases diarrhea	Lopinavir-ritonavir, ritonavir increase desipramine levels
ovartis)	10–25 mg at bedtime	100–300 mg at bedtime	>225 ng/dL	Promotes sleep, weight gain, decreases diarrhea	Lopinavir-ritonavir, ritonavir increase imipramine levels
aZenica)	10–25 mg at bedtime	100–300 mg at bedtime	200–250 ng/dL	Promotes sleep, weight gain, decreases diarrhea	Lopinavir-ritonavir, ritonavir increase amitriptyline levels
Novartis)	25 mg at bedtime	100–200 mg at bedtime	150–400 ng/dL	Promotes sleep, weight gain, decreases diarrhea	Lopinavir-ritonavir, ritonavir increase clomipramine levels
Pfizer)	10–25 mg at bedtime	150–250 mg at bedtime	100–250 ng/dL	Promotes sleep, weight gain, decreases diarrhea	Lopinavir-ritonavir, ritonavir increase doxepin levels
Lilly)	10 mg in the morning	20 mg in the morning	Unclear	Activating	Fluoxetine increases amprenavir, delarvidine, efavirenz, indinavir, lopinavir-ritonavir, nelfinavir, ritonavir, saquinavir levels; nevirapine decreases fluoxetine levels
Sertraline (Zoloft, Pfizer)	25–50 mg in the morning	50–150 mg in the morning	Unclear	—	Lopinavir-ritonavir, ritonavir increase sertraline levels
Citalopram (Celexa, Forest Pharmaceuticals)	20 mg in the morning	20–60 mg in the morning	Unclear	—	Lopinavir-ritonavir, ritonavir increase citalopram levels
Paroxetine (Paxil, SmithKline Beecham)	10 mg at bedtime	20–40 mg at bedtime	Unclear	Somewhat sedating	Lopinavir-ritonavir, ritonavir increase paroxetine levels
Fluvoxamine (Luvox, Solvay Pharmaceuticals)	50 mg at bedtime	150–250 mg at bedtime	Unclear	Somewhat sedating	Fluoxamine increases amprenavir, delarvidine, efavirenz, indinavir, lopinavir-ritonavir, nelfinavir, ritonavir, saquinavir levels; nevirapine decreases fluvoxamine levels
Venlafaxine (Effexor, Wyeth-Ayerst)	37.5 mg in the morning	75–300 mg in the morning	Unclear	—	Lopinavir-ritonavir, ritonavir increase venlafaxine levels
Mirtazapine (Remeron, Organon)	7.5–15 mg at bedtime	15–45 mg at bedtime	Unclear	Promotes sleep, weight gain	—
Nefazodone (Serzone, Bristol-Myers Squibb)	50 mg b.i.d.	300–400 mg/day in divided doses	Unclear	Somewhat sedating	Nefazodone increases efavirenz, indinavir levels
Trazodone (Desyrel, Geneva Pharmaceuticals)	50–100 mg at bedtime	50–150 mg at bedtime for insomnia; 200–600 mg at bedtime for depression	Unclear	Promotes sleep	Lopinavir-ritonavir, ritonavir increase trazodone levels
Bupropion (Wellbutrin, Glaxo Wellcome)	100 mg in the morning	150–400 mg/day in divided doses	Unclear	Activating, no sexual side effects	—

FONDAZIONE ASIA

CISAI
Coordinamento
Italiano
Studio
Allergie e
Infezione da HIV

BARI | 21-22 MARZO 2019
CENTRO CONGRESSI PALACE HOTEL BARI

Trattamenti integrati - Linee guida

	EPISODIO DEPRESSIVO		EPISODIO MANIACALE		TERAPIA DI MANTENIMENTO	
	1st	*2nd*	*1st*	*2nd*	*1st*	*2nd*
NICE 2014	**PSICOTERAPIA** **LIT** OLA+FLUO **QUET**	LAMO LAMO+LIT	**LIT** **OLA** ALO QUET RISP		**PSICOEDUCAZIONE** **LIT**	VAL OLA QUET
APA 2002	**LIT** LAMO LIT+SSRI		**LIT** VAL **OLA** LIT+AP		**LIT** VAL **PSICOEDUCAZIONE**	LAMO (OX-)CARB (AP)
CANMAT 2013	**LIT** LAMO **QUET** LIT+SSRI VAL+SSRI OLA+SSRI LIT+BUP	VAL LUR LIT+LAMO VAL+LAMO LUR+VAL LUR+LIT Agg. MOD	**LIT** VAL **OLA** RISP QUE ARI ASE PAL LIT+AP VAL+AP	(OX-)CARB ALO LIT+VAL **+ 3rd line**	**LIT** LAMO VAL OLA QUE RIS ARI LIT+AP VAL+AP	CAR PAL OLA+FLUO LIT+VAL LIT+OLA VAL+OLA LIT+CAR

HIV / Disturbi psichiatrici e mancata aderenza ai trattamenti

Adesione ai trattamenti

OMS stima che adesione ai trattamenti nelle patologie croniche sia in media del 50% , con ricadute importanti su

- outcome di salute
- comparsa delle complicanze e delle resistenze ai trattamenti
- diffusione delle patologie infettive

Linee Guida Italiane dei farmaci antiretrovirali e sulla gestione diagnostico-clinica delle persone con infezione da HIV-1, 2015

Aderenza al trattamento: variabili associate

Paziente

Livello culturale basso

Livello sociale compromesso (abitare soli, disoccupazione)

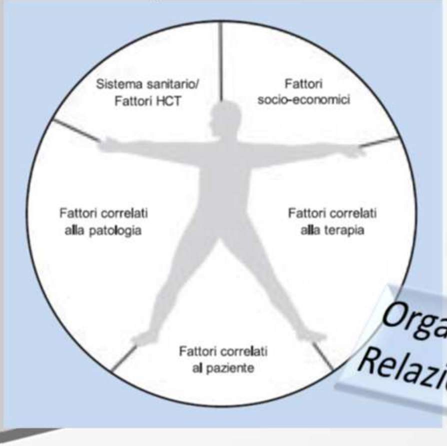
Età: peggiore in quella giovanile e nell'età over 65

Problematiche psicosociali (mancanza di supporto, stigma)

Patologie psichiatriche
Deficit neurocognitivi
Abuso di sostanze

Terapia

Tipologia di trattamento
Via e numero di somministrazioni
Effetti collaterali


Sistema sanitario/
Fattori HCT
Fattori
socio-economici
Fattori correlati
alla patologia
Fattori correlati
alla terapia
Fattori correlati
al paziente

Organizzazione sanitaria
Relazione interpersonale

CAUSE DI MANCATA ADERENZA ALLA TERAPIA
in pazienti sieropositivi HIV

- **Effetti collaterali**
- Mancanza di sintomatologia conclamata all'inizio della malattia — *Deschamps, AIDS Patient Care (2004).*
- **Comorbilità psichiatriche** — *Springer, AIDS behaviour(2012).*

DEPRESSIONE MAGGIORE	DISTURBO POST TRAUMATICO DA STRESS
• Fino al 45% degli individui sieropositivi[3]	• Fino al 74% degli individui sieropositivi[4]
• **Meno della metà dei pazienti sieropositivi con MDD ricevono una corretta diagnosi[1]**	• **La diagnosi di sieropositività è da considerarsi come evento traumatico che può innescare il disturbo.[4]**
• Può essere effetto collaterale di alcuni farmaci (Efavirenz) [2]	**DISTURBI D'ANSIA**
• L'utilizzo di SSRI migliora l'aderenza alla terapia ed i parametri immunologici[3]	• Fino al 38% degli individui sieropositivi[5]

1. *Asch, J Gen Intern Med. 2003*; 2. *Ickovics, JAMA 2001*; 3. *Himelhoch, J. Acquir. Immune Defic. Syndr 2004*; 4. *Sherr, Psychol. Health Med 2011*; 5. *Brogan, Curr. HIV/AIDS 2009*

Possibili interventi

Fattori legati alla patologia

Pazienti asintomatici vs sintomatici

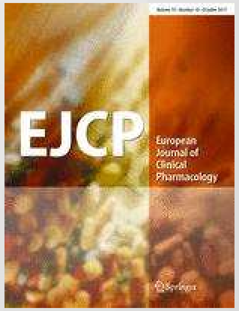
Carica virale e patologia

Buona informazione sulla malattia

Educazione all'uso di farmaci

Consulti medici di sostegno

Screening comorbilità (somatica, psichiatrica, abuso sostanze)


EJCP
European Journal of Clinical Pharmacology
Springer

Possibili interventi

- Fattori correlati alla terapia

Semplificazione regime terapeutico

Educazione all'uso dei farmaci

Valutazione e gestione effetti collaterali

Prescrizioni personalizzate

Trattamento farmacologico sintomi

Monitoraggio e rivalutazione continua della terapia

Possibili interventi

- Fattori correlati al paziente

Counseling/ psicoterapia

Interventi comportamentali e motivazionali

Interventi supportivi per migliorare il coping

Tecniche di «memo» (aiuti mnemonici telefonici, reminder)

Possibili interventi

- Fattori correlati al team di assistenza ed alla organizzazione sanitaria

Migliorare la comunicazione con i pazienti

Migliorare valutazione dell'adesione

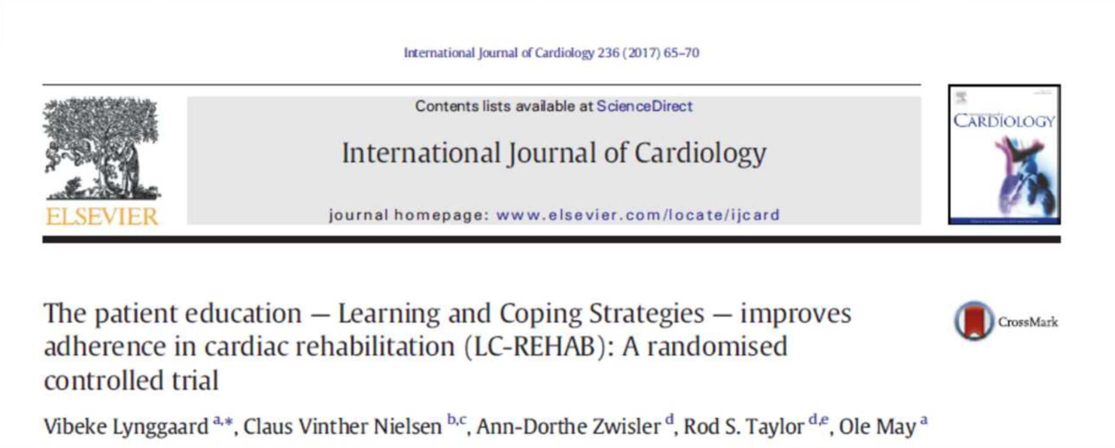
Promuovere una cultura anti stigma

Formazione continua agli operatori

1) **Specifica per disciplina**
2) **Training alla relazione di cura**
3) **gestione del burn out**

Quindi cosa fare? 1)

INTERVENTI DI INFORMAZIONE
E PSICOEDUCAZIONE



International Journal of Cardiology 236 (2017) 65–70

Contents lists available at ScienceDirect

International Journal of Cardiology

journal homepage: www.elsevier.com/locate/ijcard

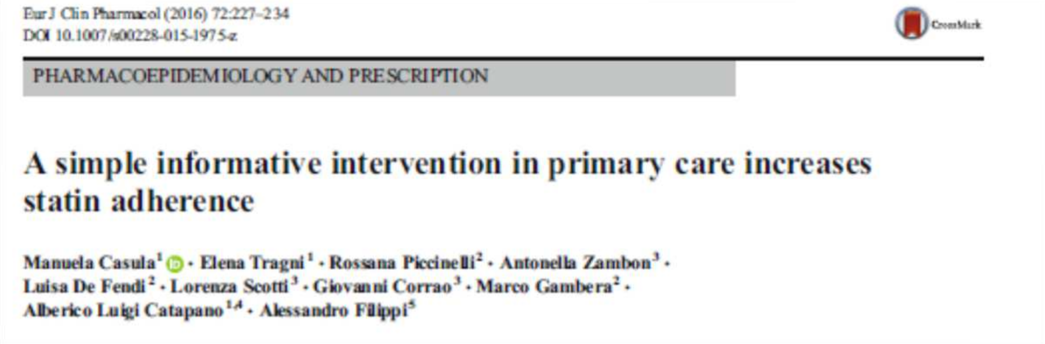
ELSEVIER

CARDIOLOGY

CrossMark

The patient education — Learning and Coping Strategies — improves adherence in cardiac rehabilitation (LC-REHAB): A randomised controlled trial

Vibeke Lynggaard [a,*], Claus Vinther Nielsen [b,c], Ann-Dorthe Zwisler [d], Rod S. Taylor [d,e], Ole May [a]



Eur J Clin Pharmacol (2016) 72:227–234
DOI 10.1007/s00228-015-1975-z

CrossMark

PHARMACOEPIDEMIOLOGY AND PRESCRIPTION

A simple informative intervention in primary care increases statin adherence

Manuela Casula[1] · Elena Tragni[1] · Rossana Piccinelli[2] · Antonella Zambon[3] · Luisa De Fendi[2] · Lorenza Scotti[3] · Giovanni Corrao[3] · Marco Gambera[2] · Alberico Luigi Catapano[1,4] · Alessandro Filippi[5]

Quindi cosa fare?

VALUTAZIONE DELLA COMORBILITÀ

1) eventuali sintomi ansiosi/depressivi che possono condizionare pensieri disfunzionali e quindi stili di coping disfunzionali **(test HADS)**

2) Collaborazione con **servizio psicologia /psichiatria**

3) Valutazione stili di coping (Brief Cope) e trattamento cognitivo comportamentale

Progettare interventi multidisciplinari !

Quindi cosa fare?

Interventi multidisciplinari

Collaborazione con MMG

Collaborazione con famiglia

WEB : risorsa o intralcio?

caterina.vigano@unimi.it

Luca Ferrara
Serena Borsani

Grazie
Thank You
Merci
Spasibo
Asante
Welalin
Vinaka
Salamat
Kia ora
Dankon
Kiitos
Multumesc
Arigato
obrigado
Dank Je
Matondo
Chokrane
Matur Nuwun
Mamana
Juspaxar
Nirringrazzjak
Terima Kasih
Mochchakkeram
shutterstock