

Psychiatric Implications of HIV/ HCV Coinfection

POSITION STATEMENT

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Background

Patients at risk for or infected with HIV are also at risk for infection with Hepatitis B, and/or C, and sometimes Hepatitis A depending on sexual practices. Psychiatric patients, in particular, may not have had adequate assessment of their hepatitis exposure status. Studies show that people with severe mental illness have higher rates of Hepatitis C virus (HCV) compared to the general population.¹

Approximately one quarter of people infected with HIV in the United States are also infected with HCV,² the most common route being injection drug use. Independent of HIV, HCV becomes chronic in 80-85% of infected individuals. Of those, 20-25% will develop serious chronic liver disease. In fact, HCV is the most common reason for liver transplants in the U.S. Most chronically infected people, however, usually remain asymptomatic for many years before being diagnosed with HCV.

HIV often complicates the course of HCV by increasing the prevalence and hastening the development of liver disease and failure. The effects of HCV coinfection on HIV disease progression are less certain. Some studies have suggested that HCV infection is associated with more rapid progression to AIDS or death. However, while the subject remains controversial, it is possible that HCV has detrimental effects on the liver's ability to process medications used to treat HIV and its associated medical consequences. Among the problems that follow is the potentially increased toxicity of the antiretrovirals.

In advanced HCV disease, increasing ammonia levels often lead to CNS impairment, potentially affecting treatment adherence, and making the diagnosis of cognitive impairment due to HIV more problematic. HCV appears to replicate in the brain and its viral load can be measured in the cerebrospinal fluid, thereby causing cognitive impairment independent of HIV infection. Thus, there may be an increased likelihood of Minor Cognitive Motor Disorder (MCMD) and HIV-associated Dementia (HAD) in the setting of HCV co-infection (see statement on the *Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments*). Patients may, therefore, present with cognitive impairment due to MCMD and/or hepatic encephalopathy.

Treatment is not recommended, or necessary, for all people with HCV infection. With information currently available, early treatment seems justified only in patients with data suggesting unfavorable outcome as established by liver biopsy. Treatment of people with HCV alone using a combination of pegylated interferon α 2b and ribavirin may clear the virus in 30-50% of patients thus decreasing morbidity and liver failure. These rates of improvement may be lower in patients co-infected with HIV, perhaps in part related to decreased HCV treatment adherence, but nonetheless may significantly improve the patient's prognosis. When deciding to initiate HCV treatment with HIV/HCV coinfecting individuals is important to consider carefully issues related to treatment readiness (e.g., motivation, behavior, substance use) in order to maximize treatment adherence to both HIV and HCV treatment regimens.

Pegylated interferon α 2B treatment of HCV has significant neuropsychiatric side effects, most importantly severe depression and suicidal thinking and behaviors. In addition, fatigue, insomnia, anxiety, and impaired neurocognitive function have also been observed. Ribavirin also has problems associated with toxicity, predominantly anemia (which may also increase fatigue), depression, and cognitive dysfunction. Hepatologists and other medical providers, recognizing these potential effects, may be concerned about initiating treatment for HCV in people with significant histories of depression and other mental illnesses. However, based on clinical experience, and published research, the high incidence of depressive symptoms on HCV treatment suggests prophylaxis with antidepressants may prove to be beneficial in all patients.

Pre-existing mental illness, including severe depression and other mood disorders, are not necessarily contraindications to HCV treatment. Psychiatrists can support HCV treatment initiation by enhancing treatment readiness and enlisting other supportive resources (e.g., family support, psychotherapy, support groups). Psychiatrists can also participate after treatment initiation in supporting adherence and treatment response monitoring.

Recommendations:

1. Psychiatrists should stay current in their medical knowledge of the psychiatric and neuropsychiatric manifestations of HIV and HCV disease and the complications of their treatments.
2. Patients should be treated for current mood disorders prior to initiating HCV treatment. Patients with a past history of mood disorders may benefit from prophylaxis with psychotropic medications.
3. Psychiatrists have a responsibility to advocate for necessary access to HCV treatment for their infected patients. In addition, psychiatrists should be involved in closely monitoring changes in neuropsychiatric functioning, such as mood, behavior and cognition.
4. Psychiatrists are encouraged to collaborate with hepatologists, infectious disease physicians and other primary care providers for the HIV/HCV infected.
5. Because of the increased hepatotoxicity in the HCV co-infected patient, psychiatrists should actively monitor the potential for drug – drug interactions and overlapping toxicities of treatments for HCV, HIV and psychiatric disorders. In addition, attention should be paid to the potential for the interaction of substances of abuse with HIV/HCV antiretroviral treatment and psychiatric medications.
6. Patients infected with HIV should be screened for Hepatitis A, B, and C and vaccinated against A & B where immunity is not present to these infections.

¹ Rosenberg SD, Goodman LA, et al. *Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness*. American Journal of Public Health, Vol 91, Issue 1 31-37, 2001

² Center for Disease Control. *Frequently Asked Questions and Answers About Coinfection with HIV and Hepatitis C Virus*. National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention, August 2001