

Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments POSITION STATEMENT

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APA Operations Manual.

*This statement was originally drafted by the 1997-1998 APA Commission on AIDS.**

BACKGROUND

Human Immunodeficiency Virus (HIV) invades the central nervous system (CNS) early in the course of infection and may result in decrements of cognitive, behavioral, and/or motor performance in a certain proportion of infected individuals. These decrements, however, when present, may or may not result in actual impairment in personal, social, and/or occupational functioning. It must be cautioned that the presumption of any change in neuropsychological or functional status based on HIV seropositive status alone is unwarranted. Neuropsychological testing may help to identify and track subtle abnormalities that are difficult to detect on routine mental status examination, with the caveat that abnormalities on testing may not translate into impaired daily functioning. Abnormalities may be present in uninfected as well as HIV-infected individuals and may result from many causes other than HIV infection.

The cognitive-motor disorders associated with HIV are Minor Cognitive-Motor Disorder (MCMD) and HIV-Associated Dementia (HAD)--formerly known as AIDS dementia complex (ADC). MCMD and HAD are diagnoses of exclusion. With the advent of highly active antiretroviral therapy (HAART) in late 1996 and its adoption as the standard of care, the incidence of cognitive-motor disorder associated with HIV decreased. Nonetheless, the prevalence of clinically relevant impairment statistically increases with stage of disease. Information concerning both the degree and prevalence of cognitive, behavioral, and motor impairments in otherwise asymptomatic HIV-infected individuals in the era of HAART remains inconclusive. It has been reported that individuals with early symptomatic HIV infection (non-AIDS) show a prevalence of MCMD of 14%, while individuals with late symptomatic HIV infection (AIDS) show a prevalence rate of MCMD of 24% in the era of HAART. HAD occurs with a cumulative prevalence of approximately 7 to 10 percent over the course of the late symptomatic stage and is an AIDS-defining condition. In addition to the clinical disorders of MCMD and HAD, sub-clinical cognitive-motor impairment also occurs and is typically detected only after use of an extensive neuropsychological test battery. Therefore, the overall prevalence of cognitive-motor impairment in those with AIDS would be expected to be greater than the total of approximately 31% to 34% implied by current studies of the prevalence of MCMD and HAD.

In addition to subclinical HIV-associated impairment, MCMD, and HAD, neuropsychological impairment may be due to other medical illnesses in the HIV infected. A broad differential diagnosis should always be considered, including secondary CNS disorders (such as opportunistic infections exemplified by CNS toxoplasmosis or cryptococcal meningitis), CNS tumor (e.g., CNS lymphoma), and metabolic and iatrogenic causes,

as well as premorbid or current psychiatric or substance use disorders. Because HIV-associated cognitive motor disorders are diagnoses of exclusion, other possible causes must be ruled out by a thorough neuropsychiatric workup (e.g., MRI of the head, lumbar puncture, serum chemistry panel, and reassessment of the prescribed medications and psychoactive substance use history for psychoneurotoxicity).

Clinical responsibility should also include clarifying the various levels of severity of cognitive-motor impairment for patients, their significant others, their employers, and those who provide health or mental health care. In addition, clinical responsibility includes providing or referring for appropriate treatment. Treatments shown to have some value for neuropsychological impairment include but are not limited to several antiretroviral medications, the psychostimulants, and investigational drugs, as well as cognitive rehabilitation techniques. Since neuropsychiatric symptoms may improve with treatment and may wax and wane over time, serial monitoring is recommended.

The psychiatrist, therefore, has an important role in 1) identifying symptoms of neuropsychological impairment; 2) making the diagnosis of clinical cognitive-motor disorders; 3) relating observed impairment to significant impairment in personal, social, and occupational functioning; and 4) coordinating, referring for, and/or providing treatment for clinical cognitive-motor disorders, as well as monitoring treatment response, in collaboration with medical providers.

SPECIFIC RECOMMENDATIONS

1. Psychiatrists should be aware of the neuropsychological manifestations of HIV and the importance of providing patients with or referring patients for further assessment and treatment when patients show signs of clinically significant neuropsychological impairment.

2. It is inappropriate solely to use HIV serostatus or a diagnosis of AIDS as an indicator of impaired personal, social, or occupational functioning.

3. Basing decisions about functional competence on HIV serostatus or neuropsychological testing alone, without observation and collateral information of performance in relevant personal, social, and occupational tasks, may lead to unwarranted restrictions on individuals who are infected.

4. Psychiatrists should be aware that HIV-infected individuals with neuropsychological deficits are protected by legislation. The Americans With Disabilities Act of 1990, which prohibits discrimination against individuals with disabilities, including those related to HIV, stipulates how disabled individuals must be accommodated in the workplace.

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