Figure 11.2 Clinical approach to patients with advanced disease

Advanced HIV: CD4 <200 or new WHO stage 3 or 4

Clinical approach to patients: all patients

If there are any danger signs, refer to hospital immediately:

- Respiratory rate >30
- Heart rate >120
- Systolic BP <90
- Temperature >39°C
- Moderate/severe dehydration
- Unable to walk unaided
- Saturation <90%
- Altered mental state: confusion, strange behaviour, reduced level of consciousness
- Any other neurological problem: new onset severe headache, seizures, paralysis, difficulty talking, cranial nerve problems, rapid deterioration in vision

While organising referral:

- Point of care investigations
- Urgent management, (e.g. IV fluids, oxygen)
- Start urgent treatment: (e.g. pneumocystis treatment, antibiotics, TB treatment). If delay in referral, see Figure 11.6.

If NO danger signs: History and examination looking for ART status, OIs and co-morbidities:

TB assessment

Patients with advanced HIV are at high risk for TB.

Disseminated TB frequently does not present with respiratory symptoms.

Past history: Any previous TB?

Currently history: On treatment now? Not improving on treatment?

Symptom screening today: Loss of weight, fever, night sweats, cough?

Examination: Pleural effusion, nodes, tender or distended abdomen, ascites, hepatomegaly?

History and examination

ART history:

Which regimens and when? Previous CD4 and VLs: Is treatment failure suspected?

Co-morbidities: Diabetes, hypertension, epilepsy, kidney or liver disease.

Hospitalised recently: Within past 3 months? Include reason.

Neurological conditions: All are danger signs – refer.

Respiratory conditions: If danger signs – refer.

Kaposi's sarcoma: Palate, skin.

CMV retinopathy in high risk areas.

Chronic diarrhoea.

Assess for **dehydration**.

Investigations for ALL patients

CD4:

- <200: do serum CrAg.
- <100: do TB LAM.
- 100–200: do TB LAM if TB symptoms.
- Collect sputum if productive cough.

Haemoglobin.

Urine dipstick: If proteinuria, do serum creatinine.

Routine viral load if not done within past 6 months.

Targeted viral load if not done within past 3 months, or if stage 4 condition, or last VL >1 000.

Malaria rapid test if endemic.

Hepatitis B if available and not yet done.

Management is now based on two key criteria:

1. Is the patient clinically STABLE or UNSTABLE?
2. Is the patient ART-naïve (or on ART for <6 months) or on ART >6 months?

Communication with hospital:

- Patients, apart from those with danger signs, may need referral – if appropriate investigation or management is not available at primary care, or if rapid decision-making for regimen switch for treatment failure is necessary at referral level.
- Establish a 'hotline' with hospital clinicians for clinical advice, case discussion, referral and back-referral – particularly when transfer is difficult.