

HIV Nutrition Update

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- **Comprehensive Care Center— Nashville, TN**

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Nutrition Forum

Nutritional Services For People Living With HIV

Question: How has the provision of nutritional services changed since the beginning of the AIDS pandemic?

Answer: Sharon Ann Meyer <sharon@hivresources.com>, AS, AA, DTR, Certified HIV Counselor and President of HIV ReSources, Inc., responds: Nutritional management of HIV infection has become increasingly complex since the introduction of highly-active antiretroviral therapy (HAART). During the last few years, the reported incidence of HIV infection (as opposed to the mandatory reporting of AIDS cases) began to rise as a result of newly passed laws in many states. The following information provides an

account of the shifting nutritional concerns for people living with HIV.

[Editor's Note: This information is mainly based on the experience and knowledge of nutritional services in the area of Fort Lauderdale, Florida. Clinicians who reviewed this article and live in Arizona, California, North Dakota and Texas did not note the provision of nutritional services until around 1990. Future projections are based purely on speculation taking into account changes that have occurred over the past 20 years. It is vital to note that both nutrition professionals and people living with HIV can influence change by getting active in local and national politics.]

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The provision of nutritional care has changed greatly over the past few years. In the early years of the AIDS epidemic, survival after diagnosis was very

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CHANGES IN NUTRITIONAL SERVICES FOR PEOPLE LIVING WITH HIV

	1980-1990	1991-2000	2001- 2010
Interest In Nutritional Status	<p>Little was known about problems impacting nutritional status. The majority of AIDS patients had little interest in their nutritional condition. In the early 1980s, health care professionals caring for hospitalized AIDS patients rarely considered their nutritional care. More time was spent considering feeding options. Access to information on nutrition and HIV/AIDS was very limited and many HIV-positive people based their treatment decisions purely on speculation. Extremely limited nutritional services were offered to people with AIDS after Congress passed the first Ryan White Care Act in 1990 <http://hab.hrsa.gov/history.htm>. A very limited number of nutrition professionals began to focus on the care of people living with HIV and AIDS. Few HIV-positive patients, however, received advice on how to deal with the various aspects that affected their nutritional status other than food and water safety issues.</p>	<p>Problems impacting nutritional status were defined. More people living with HIV became interested in learning about nutrition and HIV. As the decade progressed, more clinicians began to recognize the value of providing early nutritional services to HIV-positive people. The advent of protease inhibitors and other medications used to delay the progression of HIV dramatically changed the way HIV infection was treated <http://www.medscape.com/hiv-aidshome>. New concerns were associated with the use of these medications. We learned that nutritional therapies can be effective in the nutritional repletion of malnourished people living with HIV. Access to the World Wide Web increased the amount of nutrition information available to the general population. Some HIV-positive people began to base treatment decisions on Internet information without knowing if the information was reliable. Reauthorization of the Ryan White Care Act helped more HIV-positive people receive nutritional services <http://www.thebody.com/aac/may2096.html>.</p>	<p>Information on the need for nutritional services will continue to grow <http://www.hivresources.com/National.htm> as more nutrition professionals report positive outcomes <http://www.gwu.edu/~chsrp/cihcn/> and raise awareness of the importance of nutrition in HIV care. More HIV-positive people will also strive to improve their nutritional status as they learn about the benefits of nutritional services. Access to the World Wide Web will increase sources of reliable nutrition information due to increased pressure from government regulators and groups such as the Health Information Technology Institute of Mitretek Systems, Inc. <http://hitiweb.mitretek.org/docs/criteria.html>. Some health care professionals will correspond with their patients through the Internet. Around 2009, Medicare <http://www.kff.org/content/2001/1622>, Medicaid <http://www.aidsinfonyc.org/medicaid.html>, and Medical Nutrition Therapy (MNT) <http://www.infoweb.org/library/nutrition/mntla/sld001.htm> is likely to be accessed more by HIV-positive people living with heart disease and diabetes allowing more people to obtain nutritional guidance. The use of 'natural remedies' will also increase.</p>

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	1980-1990	1991-2000	2001- 2010
Nutrition Support	<p>The majority of AIDS patients had life-threatening conditions such as pneumocystis carinii pneumonia (PCP) <http://www.thebody.com/hivatis/glossary/a.html> and cytomegalovirus (CMV). Some hospitalized patients were offered costly total parenteral nutrition (TPN), or less often tube-feedings. As the decade progressed, the perceived risk of infection in an immunocompromised patient on TPN led to a decrease in its use. Patients began to voice their food preferences to try and increase food intake with favorite foods. Many received enteral formulas such as Ensure designed for weight gain.</p>	<p>In the early 1990s, many people with AIDS were hospitalized with secondary conditions such as wasting, lymphoma, Kaposi's Sarcoma (KS) and foodborne illnesses, which often required nutrition support. Some required a special meal pattern of frequent nutrient-dense meals to help them gain weight. Later in the decade HIV-positive patients were more apt to require specialized meal patterns that included specialized formulas such as Advera and dietary supplements. In 1998, patients began to receive meal-medication counseling to promote adherence to complicated HAART regimens. Also later in the decade, pharmaceutical companies began marketing anabolics and other hormone related medications to increase muscle mass and total body weight.</p>	<p>Fewer people living with HIV infection will be hospitalized but those that are will have worse complications than HIV-positive patients in the 1990s. More people living with HIV will use specialized dietary supplements such as multivitamins, probiotics, and complementary therapies such as meditation and acupuncture. As compared to the early epidemic years, wasting will not be as prominent. More HIV-positive patients will require food plans that will assist them in lowering cholesterol, triglyceride and blood sugar levels. HAART regimens will not be as complicated as in the 1990s.</p>

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limited. Nutritional services have become increasingly vital to people living with HIV for several reasons. First of all, energy and protein needs increase along with an increased need for micronutrients. Secondly, the use of medications to treat

HIV infection often cause adverse side effects such as nausea and lack of appetite that affect nutritional status. Protease inhibitor medications and HAART has lengthened the lives of HIV-challenged people dramatically. HAART has also dramatically increased the need for

nutritional services to help HIV-positive people deal with medication side effects. Many people are now experiencing adverse effects such as diabetes, heart disease, bone disorders and fat pattern changes.

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The tables here note seven areas within the realm of nutritional services and how the

provision of these services have changed over the past twenty years. It also speculates on how these aspects of

nutritional services may change over the next 10 years.

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	1980-1990	1991-2000	2001- 2010
Body Composition	AIDS patients frequently suffered from wasting syndrome, which occurred with disease progression. There were few anthropometry studies but some clinicians began to use anthropometry to measure changes in body composition. Height and weight measurements however, were not adequately taken or tracked on a regular basis. As the decade progressed, a few investigators began to research other body measurement techniques such as BIA (bioelectrical impedance analysis).	Measuring body composition by BIA became more accepted as the decade progressed and a few clinicians used it but access to this service was still very limited until the end of the decade. As the decade progressed, more clinicians performed BIA measurements to measure fat and fat-free tissues and track body fat so they could estimate lean and fat stores. Lack of training, equipment, time, and funding limited BIA assessment greatly. After the advent of HAART, fewer HIV-positive people experienced wasting but the phenomenon continued to occur despite HAART regimens. Clinicians began to detect a redistribution of body weight (lipodystrophy-muscle loss with fat gain).	Lipodystrophy will continue to occur but decrease in incidence as newer HAART regimens are developed. Clinicians in HIV/AIDS care will increase routine monitoring of body composition as measured by anthropometry, including height and weight along with waist and hip circumferences, and BIA. More nutrition professionals will base their treatment recommendations on the extent of body cell mass or fat wasting and hydration along with body compartment responses to therapy in follow-up monitoring. An increased emphasis will be placed on exercise activity.
Complementary Treatment Use	Many people with AIDS sought out alternative treatments hoping to find a cure. Little thought was given to the consequences of seeking out these unproven therapies. Thousands of dollars were spent on unapproved treatments < http://www.fda.gov/fdac/departs/196_irs.html > including urine therapy.	HIV-positive people continued to use complementary treatments. As the decade progressed, more people were considering the consequences of alternative therapies and avoiding those that could pose serious risks. Fewer HIV-positive people were foregoing conventional medical treatment for complementary therapies, as the value of HAART became widely known.	The use of vitamin and minerals, along with other dietary supplements will continue. Most people living with HIV will use at least one complementary treatment. More HIV-positive people will learn about and try to avoid detrimental interactions between food, prescribed medications, herbs, dietary supplements and recreational drugs.

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It is important to note that clinicians can influence the policy

initiatives of key audiences by educating the general public on the importance of

optimal nutritional status for people living with HIV/AIDS.

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	1980-1990	1991-2000	2001- 2010
Nutrition Education	<p>In the early epidemic years, hospitalized patients did not see a dietitian. From 1985 to 1990, patients rarely received instructions on how to increase their food intake and avoid foodborne illness. Very few dietitians began to educate patients to help them avoid harmful alternative therapies and foodborne illness. Although the Centers for Disease Control (CDC) offered a video and booklet on foodborne illness, few people were aware of the educational tool. Some AIDS patients followed detrimental diets such as macrobiotics. Most nutrition professionals having the opportunity to see HIV-positive patients focused on getting them to eat frequent nutrient-dense meals without regard to fat content, in fact, often encouraging it.</p>	<p>Few patients received information on dealing with medication side-effects, food-borne illness and dietary supplements during the early 1990s. Nutrient-dense meals, often high in fat, were considered vital to avoid wasting. Post-HAART MNT in the late 1990s increasingly concentrated on the medical consequences of HAART therapy that impacted on nutritional status such as glucose abnormalities, hyperlipidemias, diabetes, heart disease and bone disorders. An increasing number of nation-wide and patient-targeted periodicals (mainly funded by pharmaceutical companies) included nutrition-related articles. As the decade progressed, nutrition education sometimes included information on the interaction of medications, herbs and dietary supplements, and the nutritional effects of complementary therapies. Evidence based counseling started to become an issue.</p>	<p>Nutrition education will continue to increase and help more people living with HIV or AIDS maintain optimal nutritional status and avoid unnecessary nutrient deficiency and secondary illness. People will learn how to avoid food and water-borne illness and lessen common body stresses such as alcohol and smoking. More consideration will be given to patient lifestyles and eating habits prior to choosing HAART regimens. Effective nutrition education will continue to help people deal with medication side effects such as diarrhea, nausea, anorexia, glucose abnormalities, hyperlipidemia, diabetes, heart disease and bone loss. Nutrition education will also help more HIV-positive people to prevent chronic disease and learn about the benefits and risks of exercise, dietary supplements and complementary treatments. Clinicians will increasingly focus nutrition education on cytochrome P450 liver enzymes and the interactions between prescribed medications, food, herbs, dietary supplements and recreational drugs.</p>

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services is vital.

Participating in local, state and national projects that involve the funding of nutritional

	1980-1990	1991-2000	2001- 2010
L a b o r a t o r y Parameters	Frequent abnormal liver function tests and blood lipid indices, especially low cholesterol occurred. Low albumin, sodium, potassium, calcium, serum vitamin levels, hemoglobin and hematocrit were seen as well, results of anemia, diarrhea and malabsorption.	A greater number of patients experienced abnormal liver enzymes and testosterone levels along with high blood lipid levels (cholesterol, triglycerides, etc.) and high glucose levels. Tests to measure bone density begin to occur.	The incidence of abnormal liver enzymes will continue, due in part to an increased frequency of hepatitis. High blood lipid levels (cholesterol, triglycerides, etc.) and glucose levels will also continue to be documented. More Dual-Energy X-Ray Absorptiometry (DEXA) and Cat Scan (CT) testing will help to determine body composition distribution and bone density.
Nutrition Screening	Nutrition screening began for hospitalized AIDS patients in a few states during the later part of this decade due to the efforts of a very limited number of nutrition professionals who focussed on HIV/AIDS care. Due to the stigma of AIDS, many patients were not admitted with an AIDS diagnosis making it difficult for clinicians to offer nutritional services to them.	Screening occurred more frequently for high-risk hospitalized AIDS patients. HIV-savvy nutrition professionals employed in hospitals and those affiliated with AIDS Service Organizations (ASOs) began to provide more regular nutrition screening for their patients as the decade progressed. More people living with HIV also received nutrition screening through county health care clinics, private infectious disease clinics and physicians and dietitians in private practice.	Nutrition professionals will increasingly provide nutrition screening to HIV-positive people through hospitals, county health care clinics, ASOs, private clinics and clinicians in private practice. Nutrition screening through the Ryan White Care Act and other government-funded services may be limited. More HIV-positive people seeking medical or food assistance will receive MNT, which includes nutrition screening. Rescreening of nutritional status may need to be addressed as a result of longer life expectancies and changes in metabolic function.



*Improving the quality of life for
HIV-challenged individuals
through effective nutritional services.*

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Editor's Corner

HIV Nutrition Update is a bimonthly newsletter of practical and timely nutrition resources. Features present peer-reviewed articles and practice-oriented reviews of essential information for the clinician working in HIV/AIDS care. Information is supplemented by news releases, conference proceedings, and expert recommendations.

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