

Letters to the Editor

Enhanced Screening for People Living With HIV Infection

To the Editor: I appreciated the excellent review of osteoporosis by Dr. Harris and colleagues.¹ HIV continues to be managed as a chronic disease, mainly within primary care.² Family physicians should recognize that people living with HIV infection are at increased risk of osteoporosis and require enhanced screening.³

The relationship between HIV infection and low bone mineral density (BMD) is multifactorial and includes lower average body weight, increased rate of tobacco use, altered bone metabolism, and systemic inflammation.³ Additionally, certain antiretroviral medications (i.e., tenofovir disoproxil fumarate [Viread] and some boosted protease inhibitors) directly predispose patients to an increased loss of BMD.⁴

The HIV Medicine Association of the Infectious Diseases Society of America provides enhanced osteoporosis screening recommendations.⁵ They recommend that all women who are postmenopausal and all men 50 years and older be screened with dual energy x-ray absorptiometry. They also recommend that all men with HIV who are between 40 and 49 years of age and women with HIV who are premenopausal and at least 40 years of age should be assessed with the Fracture Risk Assessment Tool (FRAX), with many experts recommending checking the “secondary osteoporosis” box. Dual energy x-ray absorptiometry should be performed if the 10-year risk of major osteoporotic fractures is greater than 10%. People living with HIV infection who have other risk factors for fragility fractures (e.g., chronic glucocorticoid use) should be screened earlier.

Osteoporosis management in people living with HIV infection is similar to that in other patients and includes dietary changes, weight-bearing exercise, and consideration of bisphosphonates. Optimizing the patient’s antiretroviral medications to avoid worsening BMD loss is also important.⁵ Supplementation with calcium and vitamin D should be considered; however, clinicians should be reminded that calcium supplements have a drug-drug interaction with the

integrase strand transfer inhibitors dolutegravir (Tivicay) and bictegravir.

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In Reply: Thank you for highlighting the importance of early screening in this higher-risk patient population. HIV infection is a recognized risk factor for the development of osteoporosis and is associated with a higher risk of fracture. As with other patient populations, use of the FRAX score to assess fracture risk has not been validated in patients with HIV. Evidence shows that FRAX does not identify many patients with HIV infection who have low BMD, even when the “secondary osteoporosis” box is selected.¹ Therefore, clinicians should consider all risk factors when determining the need for dual energy x-ray absorptiometry. Clinical management of osteoporosis is similar to that of other populations with osteoporosis.² First-line treatment options, including zoledronic acid (Reclast) and denosumab, have shown similar effectiveness in improving BMD in men with osteoporosis.³ Future research on optimal screening and fracture prevention strategies is important because the prevalence of osteoporosis in people living with HIV continues to grow.

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