Position Statement on Recognition and Management of HIV-Associated Neurocognitive Impairment and Disorders (HAND)

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Issue:
HIV-associated neurocognitive impairment and disorder (HAND) may develop in the HIV infected person at almost any point during the infectious process, although it remains most common in the latest stage of systemic disease -- AIDS.

POSITION:
1. Psychiatrists should be aware that HIV-infected individuals with neurocognitive impairment and HAND are protected by legislation. The Americans with Disabilities Act of 1990, which prohibits discrimination against individuals with disabilities, including those related to HIV infection and stipulates how disabled individuals must be accommodated in the work place.
2. Psychiatrists should refer patients for further assessment to confirm a HAND diagnosis in conjunction with a work-up by the primary care provider, whenever possible.
3. It is inappropriate solely to use HIV serostatus or a diagnosis of AIDS as an indicator of impaired personal, social, or occupational functioning and may lead to unwarranted restrictions on individuals who are infected. Standardized measures of cognition-related functional status should be used, whenever possible, to substantiate a diagnosis of HAND.
4. Psychiatrists should be aware of the neurocognitive manifestations of HIV infection and the importance of screening patients for and diagnosing the associated conditions of HAND.
5. Psychiatrists should participate in the treatment plan for and the prevention of HAND.

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The background information will not be posted to the APA website with the position statement.

Background Information:

There are three forms of HAND. HIV-associated dementia (HAD) is a disorder defined by moderate-to-severe neurocognitive impairment with a consonant level of associated decline in functional status. Mild neurocognitive disorder (MND) is defined by mild neurocognitive impairment and an associated mild decline in functional status. The condition of asymptomatic neurocognitive impairment (ANI) is defined by the presence of impairment less than that consistent with a diagnosis of dementia and with no associated decline in functional status. Each of the foregoing three HAND diagnoses requires proof that no other etiologies are sufficient to explain the impairment observed (1). While HAD predominated early in the epidemic, the most common conditions now are less severe (ANI and, less frequently, MND); however, the prevalence rate of these disorders as a group has remained high (approximately 50%) (2). It should be cautioned that signs and symptoms referable to the CNS can be associated with causes other than HIV infection itself, including a psychodynamic reaction to issues associated with being HIV-positive (or other life stressors), neuropsychiatric side effect of prescribed medications, comorbid conditions including psychiatric disorders (including alcohol and substance use disorder-associated intoxication and withdrawal), co-infection with hepatitis C virus (HCV), primary CNS infections, or CNS tumors.

References:

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2. Heaton RK, Clifford DB, Franklin DR, Jr., Woods SP, Ake C, Vaida F, et al. HIV-associated neurocognitive disorders persist in the era of potent antiretroviral therapy: CHARTER Study. Neurology. 2010;75(23):2087-96.

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