Obesity, Nutrition, and HIV in the Clinical Setting

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HIV-positive status no longer equates with emaciation. In fact, if anything, patients are more likely to be over- than under-weight, and this can affect the success of their treatments. Here, some guidance for clinicians on how to address the issue.

The traditional image of those with HIV and AIDS is of an emaciated, skeletal person wracked with nausea and diarrhea. But that image is at least 20 years out of date. Today, with extended lifespans thanks to highly active antiretroviral therapy (ART), people with HIV and AIDS, like most Americans, are far more likely to be overweight than underweight.

One study of 681 people with HIV/AIDS found that almost half (44%) were overweight or obese when they started treatment. Within six months, 53% were overweight or obese, and by two years 56% were in that category.¹

“The findings that almost half of patients were overweight or obese at ART initiation, and 1 in 5 patients moved to a deleterious BMI category within 2 years of ART initiation are alarming. ART therapy provides only a modest contribution to weight gain in patients. Obesity represents a highly prevalent condition in patients with HIV infection and an important target for intervention.”¹

Registered dietician Amanda Proscia, who works at the Center for AIDS Research and Treatment at North Shore Healthcare System in New York, sees those numbers in real life every day. “People are living longer today with the new ART, so, like the regular public, they choose foods that aren’t so healthy,” she said.

That’s particularly dangerous for people with HIV, who already have an increased risk of cardiovascular disease (CVD) and diabetes.²-⁵ In addition, recent studies find that ART treatment is less effective in obese patients as well as underweight patients, and that obese patients have higher levels of circulating inflammatory proteins.⁶,⁷

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Although there appears to be some effect of CD4 count and protease inhibitors on weight gain, it doesn’t come close to explaining the rise in obesity.¹ But diet does.

“When I talk to patients, they admit that they don’t eat breakfast, they eat a huge lunch with a lot of meat and cheese, and they overeat at night,” Proscia said.

For this reason, as well as to strengthen patients’ immune systems and reduce their risk of metabolic diseases, Proscia spends much of her time counseling patients on the basics of good nutrition. It’s not complicated, she says: lean protein like fish, lots of beans, vegetables and fruit, low-fat dairy, and whole grains.
Yet studies find that HIV-infected adults consume more overall fat and saturated fat than recommended, and less fiber, and that low fiber intake is associated with a higher incidence of lipodystrophy. A low-fiber diet, one author wrote, suggests a “lack of dietary quality, as whole grains, fruits and vegetables, nuts and seeds are major sources of fiber.” Other work finds that people with HIV may be deficient in micronutrients such as vitamin E and magnesium, and have diets high in sodium.

Meanwhile, a diet high in calcium and fruits and vegetables appear protective against hypertension in HIV-infected individuals, as it is among people without HIV.

Unfortunately, physicians rarely counsel patients on lifestyle issues like nutrition and weight management despite studies that find doctors carry a lot of weight (no pun intended) when it comes to changing patient behavior.

However, as a review in American Family Physician noted, clinicians face several barriers to nutritional counseling. These include a lack of time, financial disincentives, competing agendas, a perception that nutritional counseling is not effective, lack of knowledge about nutrition, lack of training and expertise in lifestyle modification techniques, and uncertainty about changing guidelines.

In addition, insurance may not cover referrals to nutritionists, or clinicians may not have access to registered dieticians. Also patients who already face numerous medical appointments and who experience social and economic barriers to health care may not want to or be able to add another appointment to their schedule.

All of which makes point-of-care counseling important. Techniques such as making a specific appointment for nutritional counseling, using motivational interviewing, and assessing an individual patient’s readiness to change, as well as incorporating nurse practitioners, physician assistants, and group appointments into educational approaches, may help.

Physicians can screen for dietary imbalances with the Food Frequency Screening Questionnaire or a 24-hour recall form (have patients complete them in the waiting room). They should also ask patients about “hidden” calories, such as specialty coffees, cream in coffee, and butter on bread. Use open-ended questions, however, such as “Do you put anything in your coffee?”

This is advice physicians themselves may want to follow. Studies find that patients are more likely to listen to a doctor who follows a healthy lifestyle.

REFERENCES


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