Avoid unnecessary CD4 tests.

A CD4 count is not required in conjunction with every viral load test. Viral load testing is a better indicator of a patient’s response to therapy. CD4 monitoring is not necessary for patients who have stable viral suppression. For the first two years after treatment initiation, the CD4 count should be monitored every three to six months. After two years, if the viral load is undetectable, the CD4 count should be measured yearly if it is 300–500 cells/mm³. If it is consistently above >500 cells/mm³ then further monitoring is optional.

Don’t order complex lymphocyte panels when ordering CD4 counts.

Order only CD4 counts and percentages rather than ordering other lymphocyte panels. For example, CD8 testing, including the CD4/CD8 ratio, adds cost without providing useful information. More complex lymphocyte panels are unnecessary and increase costs even more.

Avoid quarterly viral load testing of patients who have durable viral suppression, unless clinically indicated.

Viral load testing should be conducted before initiation of treatment, two to eight weeks after initiation or modification of therapy, and then every three to four months to confirm continuous viral suppression. In clinically stable patients who have durable virological suppression for more than two years, clinicians may extend the interval to six months.²

Don’t routinely order testing for glucose-6-phosphate dehydrogenase (G6PD) deficiency for patients who are not predisposed due to race/ethnicity.

G6PD deficiency testing is recommended upon entry into care or before starting therapy with an oxidant drug only in HIV-infected patients who are predisposed to this genetic disorder that can cause hemolytic anemia. G6PD most frequently occurs in populations of African, Asian and Mediterranean descent and is most likely to affect HIV-infected patients with one of these racial or ethnic backgrounds.

Don’t routinely test for CMV IgG in HIV-infected patients who have a high likelihood of being infected with CMV.

Cytomegalovirus (CMV) IgG testing is recommended only in patients who are at lower risk for CMV to detect latent CMV infection. CMV IgG testing is not necessary in patients at higher risk for CMV, including men who have sex with men and injection drug users, because they can be assumed to be CMV positive. Testing for CMV antibody in low-risk populations is recommended to foster patient counseling in avoidance of CMV infection through practicing safe sex and to avoid transfusion except with CMV-negative blood products. Patients at lower risk for CMV infection, e.g., patients who are heterosexual and have not injected drugs, should be tested for latent CMV infection with an anti-CMV IgG upon initiation of care.

¹ These recommendations do not supersede grant reporting requirements.
² Note: Some patients may still require a face to face visit every three to four months to make certain that other comorbid conditions are stable, and to assess if there are other social changes that might have surfaced which could impact HIV medication adherence. Multidisciplinary practices can consider interim visits with other non-prescribing practitioner team members to support treatment adherence.

These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician.
How This List Was Created

An expert work group composed of four members of HIVMA’s Board of Directors directed the development of HIVMA’s Choosing Wisely® list of “Five Things Physicians and Patients Should Question.” The work group was provided with the ABIM Foundation guidelines on recommendation development, and identified a preliminary list of inappropriate and overused clinical practices. A list of five items was drafted and then vetted by the full HIVMA Board of Directors to develop a finalized list of consensus recommendations.

HIVMA’s disclosure and conflict of interest policy can be found at www.hivma.org

Sources


About the ABIM Foundation

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice.

To learn more about the ABIM Foundation, visit www.abimfoundation.org.

About the HIV Medicine Association

The HIV Medicine Association (HIVMA) is an organization of nearly 5,000 medical professionals who practice HIV medicine. Housed within the Infectious Diseases Society of America (IDSA), HIVMA represents the interests of HIV health care providers and researchers and their patients by promoting quality in HIV care and by advocating for policies that ensure a comprehensive and humane response to the HIV/AIDS pandemic informed by science and social justice.

HIVMA is pleased to partner with the Choosing Wisely® campaign to raise awareness of inappropriate, wasteful clinical actions that harm patients and lead to wasteful health costs. Consistent with the mission of Choosing Wisely®, HIVMA is committed to evidence-based medicine and continually develops and updates clinical practice guidelines that inform the use of high-quality, truly necessary medicine.

For more information on HIV medical specialists and HIVMA, please visit the HIVMA website, www.hivma.org.

For more information or to see other lists of Things Physicians and Patients Should Question, visit www.choosingwisely.org.