

Women With HIV May Have Higher Comorbidity Burden Than Men

Studies underline the need for better prevention and management of age-related health problems.

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Women living with HIV are more likely to have other age-related conditions that can affect their overall health and quality of life, according to study results published in [JAMA Network Open](#). What's more, another study found that the protective effect of female sex against heart disease was diminished for HIV-positive women.

More than half of people living with HIV in the United States are now ages 50 or older. Numerous studies have shown that HIV-positive people are more likely to develop various comorbidities—and to do so at younger ages—compared with their HIV-negative peers. But clinical guidance for comorbidity screening and prevention is lacking, according to the study authors.

Lauren Collins, MD, of Emory University School of Medicine in Atlanta, and colleagues assessed whether the burden of age-related comorbidities differs for women and men living with or at risk for HIV in the United States.

This cross-sectional analysis included data from 5,926 adults in the Multicenter AIDS Cohort Study (MACS) and the Women's Interagency HIV Study (WIHS) during the era of modern antiretroviral treatment. These cohort studies were designed to evaluate the natural history of HIV among gay and bisexual men and cisgender women, respectively. Participants were followed from 2008 (for the men) or 2009 (for the women) until March 2019, shortly before the two cohorts were merged to form the MACS/WIHS Combined Cohort Study.

The analysis included 2,316 HIV-positive women, 922 HIV-negative women, 1,452 HIV-positive men and 1,239 HIV-negative men. Looking at the participants living with HIV, the median age was 51 for women and 56 for men. Two thirds of the HIV-positive women were Black, 21% were Latina and 12% were white. For the men with HIV, the corresponding percentages were 30%, 16% and 52%.

Most participants were on antiretroviral therapy, and 81% of the women and 86% of the men had viral suppression. About 40% of the women and half of the men had been on treatment for 15 years or more, though 11% had started within the past five years. They were taking a variety of

regimens—about a third each on integrase inhibitors, protease inhibitors and NNRTIs—with no notable differences between women and men. The median current CD4 count was high, above 600, but about 30% had ever had a count below 200, the threshold for an AIDS diagnosis. Women with HIV were more likely to report current smoking (34% versus 25%) and current or former injection drug use (19% versus 16%).

The participants had semiannual study visits that involved physical examinations, collection of blood specimens and questionnaires about demographics, medical history, behaviors and self-reported medication use. The researchers evaluated 10 age-related non-AIDS comorbidities: hypertension (high blood pressure), dyslipidemia (abnormal blood fat levels), diabetes, cardiovascular disease, kidney disease, liver disease, lung disease, bone disease, psychiatric illness and non-AIDS cancers.

Overall, the unadjusted comorbidity burden was higher among women than men, with an average of 3.4 versus 3.2 conditions. Women were more likely than men to have bone problems (42% versus 19%), lung disease (38% versus 10%) or diabetes (24% versus 17%), but less likely to have hypertension (68% versus 75%), psychiatric illness (55% versus 58%), dyslipidemia (41% versus 64%), liver problems (34% versus 38%), kidney disease (14% versus 15%) or cancer (7% versus 12%). Both groups were equally likely to have cardiovascular disease (15% each).

The estimated mean difference in comorbidity burden among people with HIV was significantly greater for women versus men in every age group. However, among HIV-negative people, the difference between sexes varied by age. The findings were still statistically significant after adjusting for relevant cofactors.

“In this cross-sectional study, the overall burden of aging-related comorbidities was higher in women versus men, particularly among people with HIV, and the distribution of comorbidity prevalence differed by sex,” the study authors concluded. “Comorbidity screening and prevention strategies tailored by HIV serostatus and sex or gender may be needed.”

Another study, [published in AIDS](#), looked at the incidence of atherosclerotic cardiovascular disease (CVD) among women and men with and without HIV. In the general population, men are at higher risk for cardiovascular disease, the researchers noted as background. HIV-positive people have about double the risk of CVD compared with their HIV-negative peers.

Jenni Wise, PhD, RN, of the University of Alabama at Birmingham, and colleagues analyzed data from 17,118 women and 88,840 living men with HIV in the MarketScan database who had commercial health insurance between 2011 and 2019. They were matched with 68,472 women and 355,360 men without HIV according to age, sex and year of study enrollment. A limitation of the analysis is that more than 80% of participants were under age 55—a group at lower risk for heart disease—and people with public health coverage and uninsured people were not included.

The researchers analyzed new CVD events including myocardial infarction, stroke and lower-extremity peripheral artery disease.

Over an average follow-up period of about two years, women with HIV were less likely to experience CVD events compared with HIV-positive men (2.87 versus 3.61 per 1,000 person-years, respectively). But the advantage for women compared with men was substantially greater in the HIV-negative group (1.24 versus 2.57 events per 1,000 person years). After adjusting for other factors, HIV-positive women were about 30% less likely to have CVD events than HIV-positive men, while HIV-negative women were about half as likely as HIV-negative men.

“The protective advantage of female sex against [atherosclerotic CVD] observed in the general population is diminished among women with HIV,” the researchers concluded. “Earlier and more intensive treatment strategies are needed to reduce sex-based disparities.”

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