CLASSIFYING CHILDREN LIVING WITH HIV/AIDS

Three important steps

Calling child patients “Known RVD’s” does them, and you as their healthcare provider, a disservice. Euphemisms may be OK if they are not misleading or inaccurate.

Use this guideline to help you categorise child patients properly, so that you can look after each child properly and appropriately, by devising a comprehensive HIV care plan.

Step 1: Decide which euphemism you or your ward/department and your patients are comfortable with

- Most people still prefer to use euphemisms both in the clinical record and when speaking aloud about the patient in front of other patients or other healthworkers. If your patient or others do not know what the euphemism means, they will soon pick it up
- Never use a misleading euphemism. “RVD” means retroviral DISEASE, which means AIDS. This is clearly inaccurate for many patients in the paediatric population
- Ask yourself why you are using a euphemism, and whether or not your euphemism does the child/family any good
- If you are seriously concerned about confidentiality (and you should be), speak to/about your patient in a confidential place

Step 2: Obtain a laboratory categorisation

Document HIV test results in the patient’s clinical record. The “HIV Testing and Staging Sheet” is the best place to record this.

“HIV +ve” implies an HIV test, but you need to interpret the test and result for each patient.

Not Infected
Any antibody test (rapid, or ELISA) or antigen (p24 or PCR) test result is negative. Document clearly which test was done

Remember, in end-stage disease antibody levels wane, and the antibody test can become negative
Remember, p24 sensitivity is only 30%, so there are many false negatives

Exposed
- Mother has a positive serology test (rapid with ELISA confirmation) in pregnancy, or later
- Antibody: The child has a positive serology test (rapid with ELISA confirmation) under 18 months of age

Infected
- Antibody: rapid positive (with ELISA confirmation) over 18 months of age
- Antigen: PCR positive at any age (but usually not recommended until at least 6 weeks, as it may take time for the viral load reach PCR-detectable levels)

Other
- Other possible laboratory categories include “no result/result awaited”, “not tested” e.t.c.

Step 3: Determine which Clinical Stage the child has reached

This is a very important part because staging assists with developing the appropriate care plan for each child

The appropriate care plan involves both general measures (see guidelines on Inpatient and Ambulatory Care), and Antiretroviral Therapy (see KZN Paediatric ARV Site Manual and Step by Step Guide).

The current staging is overleaf. Use the HIV Testing and Staging Sheet for each patient and document the date when you stage the child.
### Revised WHO Clinical Staging of HIV/AIDS for Infants and Children

#### Stage I
- Asymptomatic
- Persistent generalized lymphadenopathy

#### Stage II
- Hepatosplenomegaly
- Papular pruritic eruptions
- Seborrhoic dermatitis
- Extensive human papilloma virus infection
- Extensive molluscum contagiosum
- Fungal nail infections
- Recurrent oral ulcerations
- Lineal gingival erythema (LGE)
- Angular cheilitis
- Parotid enlargement
- Herpes zoster
- Recurrent or chronic RTIs (otitis media, otorrhoea, sinusitis)

#### Stage III
- Moderate unexplained malnutrition not adequately responding to standard therapy
- Unexplained persistent diarrhoea (14 days or more)
- Unexplained persistent fever (intermittent or constant, for longer than 1 month)
- Oral candidiasis (outside neonatal period)
- Oral hairy leukoplakia
- Acute necrotizing ulcerative gingivitis / periodontitis
- Pulmonary TB
- Tuberculous lymphadenopathy (axillary, cervical or inguinal)
- Severe recurrent presumed bacterial pneumonia
- Unexplained anaemia (<8gm/dl) &/or neutropenia (<500/mm³) &/or thrombocytopenia (<50 000/mm³) for > 1/12
- Chronic HIV-associated lung disease including bronchiectasis
- Symptomatic lymphoid interstitial pneumonitis (LIP)

#### Stage IV
- Unexplained severe wasting or severe malnutrition not adequately responding to standard therapy
- Pneumocystis pneumonia
- Recurrent severe presumed bacterial infection (eg empyema, pyomyositis, bone/joint inf, meningitis, but excluding pneumonia)
- Chronic herpes simplex infection (orolabial or cutaneous of more than 1 month’s duration)
- Extrapulmonary TB
- Kaposi’s sarcoma
- Oesophageal candidiasis
- CNS toxoplasmosis (outside the neonatal period)
- HIV encephalopathy
- CMV infection (retinitis or infection of organs other than liver, spleen or lymph nodes; onset at age of ≥ 1 month)
- Extrapulmonary cryptococcosis including meningitis
- Any disseminated endemic mycosis (e.g. extrapulmonary histoplasmosis, coccidiomycosis, penicilliosis)
- Cryptosporidiosis
- Isosporiasis
- Disseminated non-tuberculous mycobacterial infection
- Candida of trachea, bronchi or lungs
- Visceral herpes simplex infection
- Acquired HIV-associated rectal fistula
- Cerebral or B cell non-Hodgkin’s lymphoma
- Progressive multifocal leukoencephalopathy (PML)
- HIV-associated cardiomyopathy or HIV-associated nephropathy