BREACH
BELGIAN RESEARCH AIDS&HIV CONSORTIUM

13th BREACH Symposium – Palais des Académies, Brussels
Thursday November 27th, 2025

EACS
European
AIDS
Clinical
Society

Clinical Update: Screening Comorbidities in PLHIV (EACS v13.0, ECDC-EACS)

13th BREACH Symposium, Thursday 27th November 2025, Palais des Académies, Brussels, Belgium

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Conflict of Interest: JKR

- **Honoraria for lectures and/or consultancies from Abbvie, BerlinCure, Boehringer, Gilead, Janssen, MSD, and ViiV.**

- **Research grants from Dt. Leberstiftung, DFG, DZIF, Gilead, Hectorstiftung, NEAT ID.**

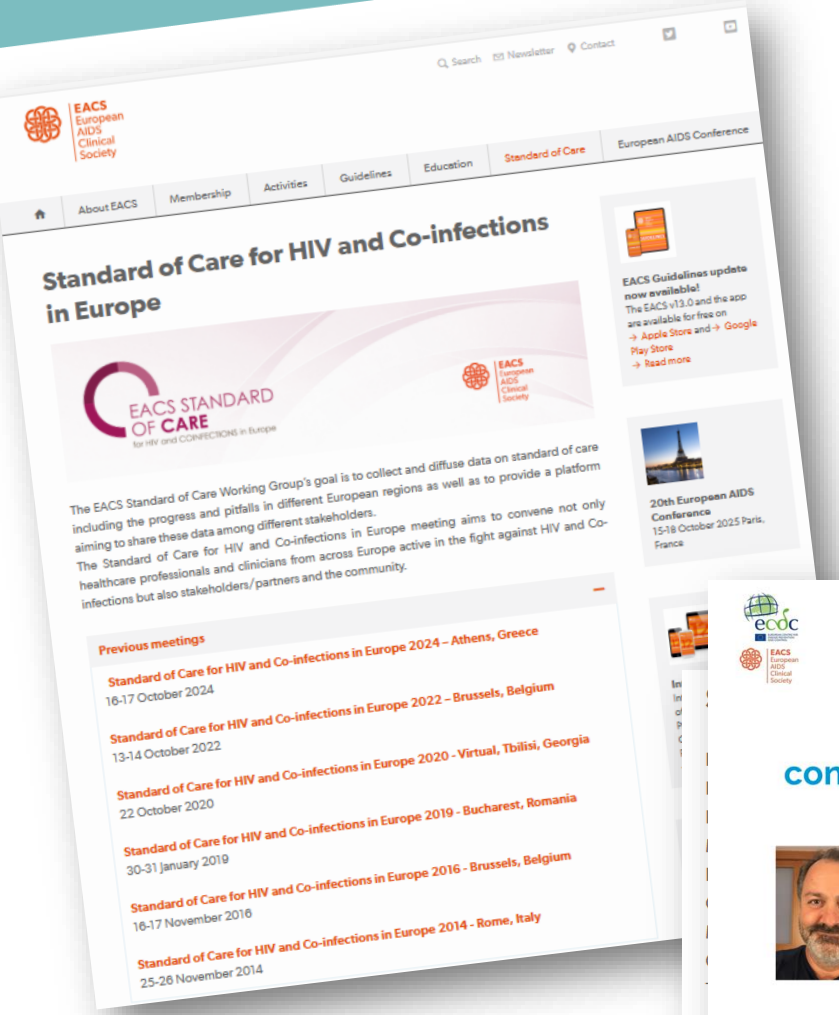
What are standards of HIV care?

- HIV standards of care refer to the set of **guidelines** and **best practices** for the prevention, diagnosis, treatment, and management of individuals living with HIV

- The standards are based on current **scientific evidence**, **clinical research**, and/or **expert consensus** to provide optimal care and improve health outcomes for people at risk for or living with HIV

- Standards **translate existing guidelines** into **measurable policies and practices** that can be **monitored** and/or **audited**

Source: ECDC/EACS standards of HIV prevention and care. https://www.ecdc.europa.eu/en/infectious-disease-topics/hiv-infection-and-aids/prevention-and-treatment/ecdceacs-standards-hiv



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Clinical Stand

B iving with HIV 2018

Introduc

The Standard HIV
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The new Stan s,
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There are eig expect
to receive. Eac mes.
Three new sectio HIV
across the life course.

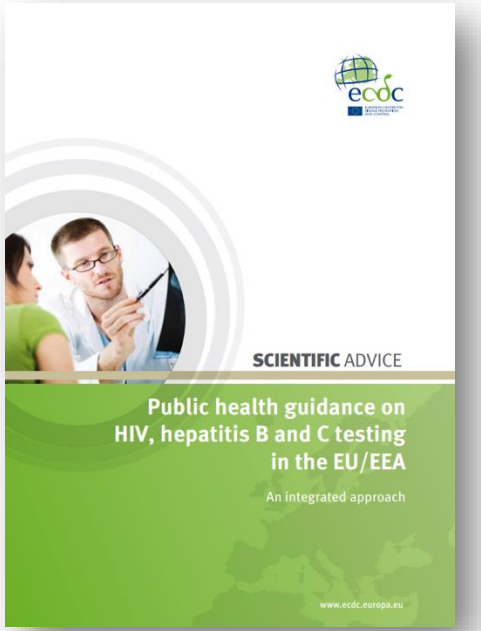
Following the recent launch of the 2018 BHIVA Standards of Care for People living with HIV, it became

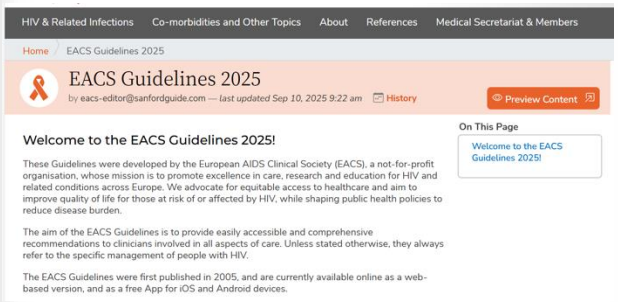
8 quality standards:

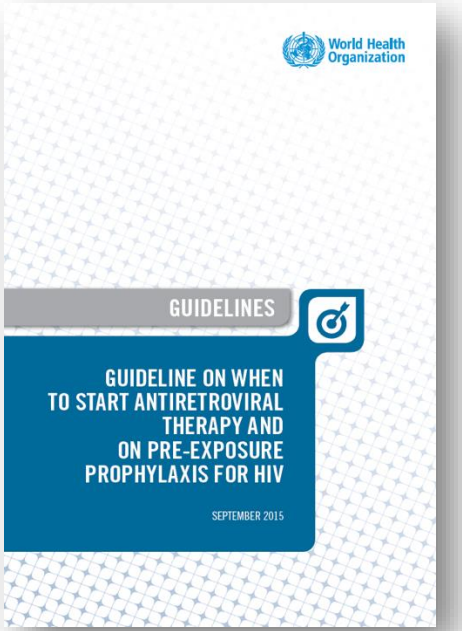
Covering the care that any adult living with HIV in the UK should expect to receive

Each standard presents:

- **a rationale**
- **quality statements**
- **measurable and auditable outcomes**







Large differences in delivery of HIV prevention, treatment and care exist across the WHO European region

EACS European AIDS Clinical Society

Inequities in prevention, testing and clinical outcomes

The belief is that developing standards of care will help:

1. Reduce the inequities in the delivery of HIV prevention, testing and care services across Europe
2. Improve the quality of the HIV services provided
3. Improve the quality of life for people living with HIV

Should ECDC get involved in the development of European standards of HIV care?

- Scoping project and expert meeting (2019)
- Development of a European Standard of (SoC) for PLHIV covering the Eur would be of added value
- The SoC shou proceed in a step-wise man
- The SoC should include auditable and measurable indicators
- Regular audits to measure SoC implementation

COVID-19 halted progress

ECDC tender on European Standards of HIV Care

Main objectives:

1. To define standards of HIV care along the care continuum pathway and related quality statements and measurable and auditable outcomes

2. To develop a tool which can be used to audit the implementation of defined standards (national, clinical and community level)

Contract number: ECDC-2022-021 ECDC NORMAL

2019

EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL

FRAMEWORK CONTRACT FOR SERVICES

FRAMEWORK CONTRACT NUMBER — **ECDC-2022-021**

The European Centre for Disease Prevention and Control ("the Centre" or ('the contracting authority'), represented for the purposes of signing this framework contract by Karl Ekdahl, Head of unit Disease Programmes,

on the one part and

European AIDS Clinical Society
No Profit
0458322624
56, Rue des Colonies,
1000, Brussels
Belgium
BE0458322624

4 year contract

('the contractor'), represented for the purposes of the signature of this framework contract by Verluyten Joelle, Executive Secretary,

on the other part,

Audience for the standards of HIV care

EACS European AIDS Clinical Society

chip Centre of Excellence for Health, Immunity and Infections

ecdc

EACS European AIDS Clinical Society

Clinic staff: responsible for the provision and delivery of HIV related services, using self-auditing as a means for quality improvement

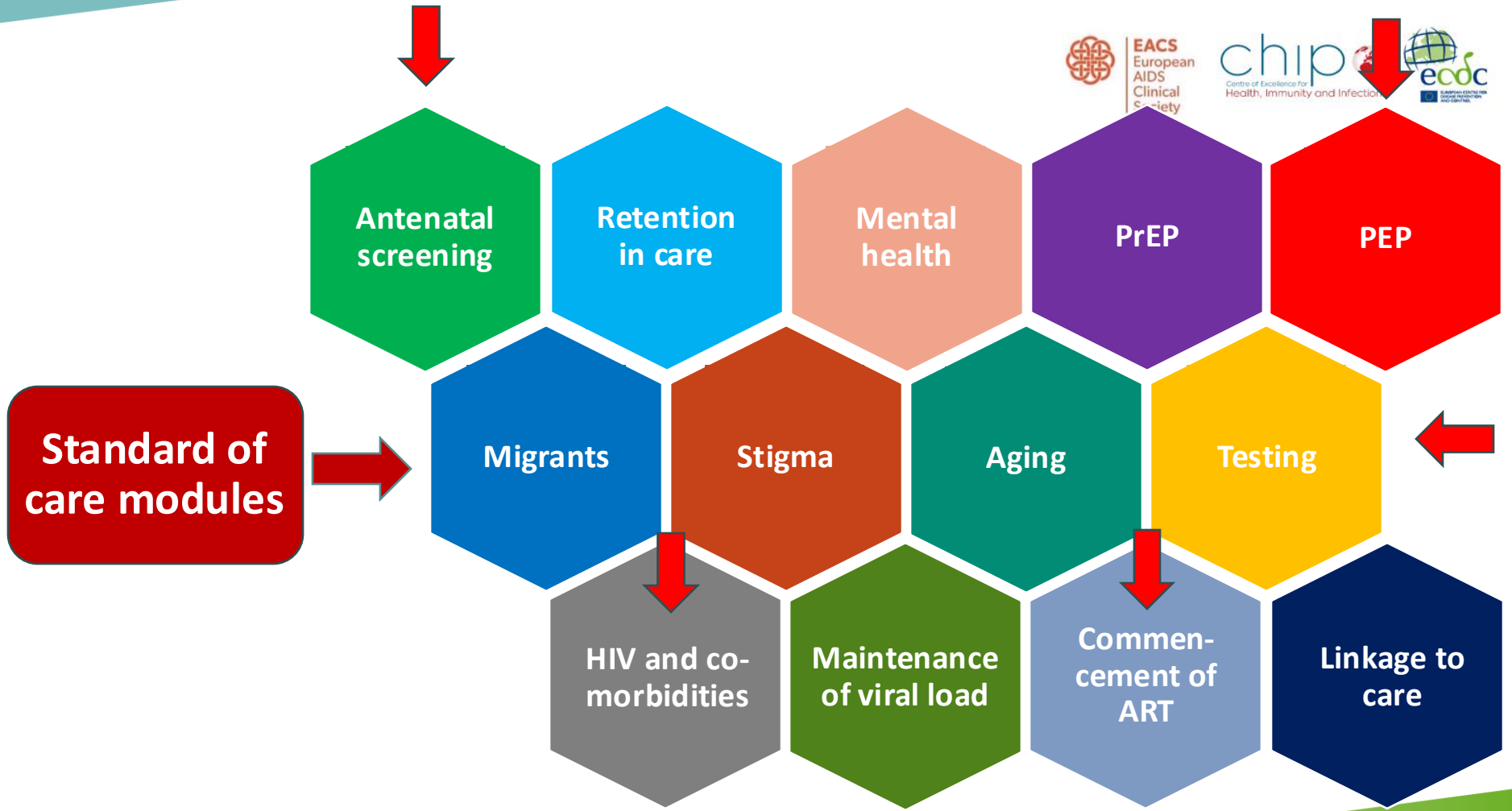
EATG European AIDS Treatment Group

PLHIV or people at risk of acquiring HIV: who should expect certain standards when seeking HIV prevention and care

ecdc

Policy and public health staff: who have responsibility for policy and guidance development and for commissioning or funding of HIV-related services

Source: ECDC/EACS standards of HIV prevention and care. https://www.ecdc.europa.eu/en/infectious-disease-topics/hiv-infection-and-aids/prevention-and-treatment/ecdceacs-standards-hiv


Standard of care modules
Antenatal screening
Retention in care
Mental health
PrEP
PEP
Migrants
Stigma
Aging
Testing
HIV and co-morbidities
Maintenance of viral load
Commen-cement of ART
Linkage to care

Key elements of the project

Annual workshops at EACS conferences

ECDC advisory group meetings

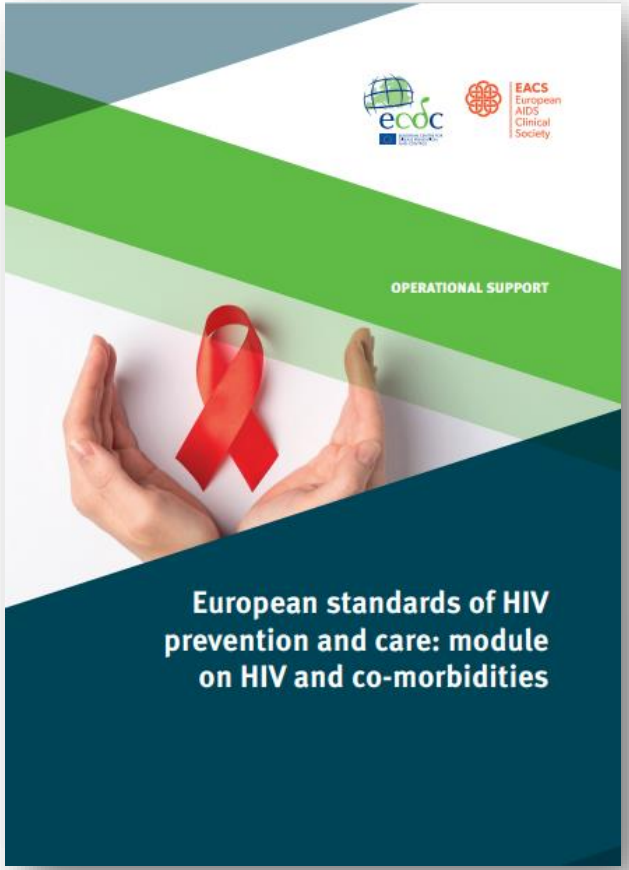
Standard of care modules

Support implementation of standards
(country support tender)

Audits

Scientific manuscripts

Assess implementation of standards
(Dublin monitoring)



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Source: ECDC/EACS: https://www.ecdc.europa.eu/en/news-events/new-guidance-ecdc-and-eacs-aims-raise-standards-hiv-care-focusing-lifelong-health

Building blocks for HIV and Co-morbidities Standard of Care

Prevention and management of cardiovascular disease

General screening for chronic diseases

Cancer screening

Ageing in people living with HIV

Mental health

Lifestyle interventions

Monitoring and Evaluation

Background

- 18.7% of new HIV diagnoses occur in people aged over 50 years
- In Western and Central Europe, the proportion of people living with HIV aged 55 years and older will increase from 34% in 2020 to 47% in 2030.
- With increasing life expectancy, people living with HIV face a growing burden of non-communicable diseases (NCDs), including cardiovascular disease (CVD), diabetes, cancers, chronic renal, liver, and pulmonary diseases, as well as mental and neurocognitive disorders. In the general population, the age-standardised mortality rate from
- After 10 years of follow-up, PWH have nearly twice the risk of developing an NCD (42.2% vs. 23.9% in the non-HIV cohort.
- By 2030, it is projected that up to 84% of people living with HIV will have at least one NCD, with 28% experiencing three or more.

What are standards of care for HIV?

Each standard is based on the following structure:

- Brief description of the rationale for the standard;
- Quality statements describing best practice based on current guidelines, evidence, and expert opinion;
- Related, measurable and auditable outcome indicators used to assess the quality and effectiveness of the services;
- Numeric values for defined targets.

The standards are person-centred in their approach with a specific focus on being equitable, non-discriminatory, relevant, appropriate, and accessible for people at risk of or living with HIV.

What do the Comorbidity standards look like?

Quality statements, indicators, and targets

The standards of care for HIV and co-morbidities is divided into topics under which quality statements and indicators have been developed. The topics are listed below followed by the quality statements describing best practice and the minimum service and care that a person at risk of or living with HIV should expect to be able to access relative to HIV risk or status and across the life-course.

Topics

- Prevention and management of cardiovascular disease;
- Cancer screening;
- Mental health;
- General screening for chronic diseases;
- Ageing in people living with HIV;
- Lifestyle interventions;
- Monitoring and evaluation.

For each of the quality statements listed above, indicators and targets have been developed to support their monitoring.

A detailed overview of quality statements, indicators, numerator, denominator, targets, and data source can be found in Annex 2.

Note: The indicators in this module focus on ongoing monitoring and disease management of people in routine HIV care. For the baseline visit assessments, please refer to the 'Commencement of ART' Standard of care module.

Source: ECDC/EACS standards of HIV prevention and care. In development.

Table 1. Quality statements, indicators, and targets for topic 1 'Prevention and management of CVD'

Quality statement 1.1 People living with HIV should be screened for CVD and have their modifiable risk factors managed	
Indicator **1.1.1 Percentage of people aged ≥ 40 years accessing HIV care who have their 10-year CVD risk estimated annually.**	**Target** **90%**
Indicator 1.1.2 Percentage of people aged ≥ 40 years screened for diabetes (blood glucose or HB1Ac) within the last 15 months**	**Target** 90%
Quality statement 1.2 In people living with HIV where elevated cardiovascular risk was identified, an appropriate intervention should be offered	
Indicator 1.2.1 Percentage of people aged ≥ 40 years with a 10-year CVD risk estimate ≥ 5% who were offered a statin or referred/advised to attend routine provider of statin within the last 5 years	**Target** **80%**
Indicator 1.2.2 Percentage of people aged ≥ 40 years with a 10-year CVD risk estimate ≥ 5% who were offered referrals to relevant experts (i.e., endocrinologists, dieticians, etc.) within the last 5 years depending on confounding uncontrolled risk factors***	**Target** 90%

Indicators highlighted in bold have been selected for prioritisation to maximise acceptability and feasibility of adoption and reporting against the standards.
***Diabetes is listed here as a risk factor for CVD events.*
****Confounding risk factors: diabetes, arterial hypertension, BMI>30, smoking.*

Cancer Screening

Table 2. Quality statements, indicators, and targets for topic 2 'cancer screening'

Quality statement 2.1 All people living with HIV should receive cancer screening in line with EACS Guidelines	
Indicator **2.1.1 Percentage of women and people with a cervix aged >18 years who have been screened for cervical cancer at least once in the last three years following EACS Guidelines**	**Target** **80%**
Indicator **2.1.2 Percentage of men who have sex with men who have received anal cancer screening within the last two years following EACS Guidelines**	**Target** **90%**
Indicator 2.1.3 Percentage of people aged 50-75 years who are not terminally ill and have a life expectancy > 10 years who have been at least once referred for colon cancer screening or been called up by national screening programmes	**Target** 90%
Indicator **2.1.4 Percentage of people with liver cirrhosis who have been screened for hepatocellular carcinoma using ultrasound**	**Target** **90%**
Indicator **2.1.5 Percentage of people aged 50-80 years with at least a 20 pack-year smoking history*, and are either current smokers or former smokers who have stopped smoking within the past 15 years, who have been screened for lung cancer**	**Target** **90%**
Indicator 2.1.6 Percentage of men and people with a prostate aged > 50 years who are not terminally ill and have a life expectancy > 10 years who have been screened for prostate cancer at least once	**Target** 90%
Indicator 2.1.7 Percentage of women and trans men aged 50-74 years who have received mammography-based breast cancer screening within the last five years	**Target** 90%

**A 20 pack-year smoking history indicates a cumulative exposure to tobacco equivalent to smoking one pack of cigarettes (20 cigarettes) per day for 20 years, or any combination that multiplies to 20 (e.g. two packs a day for 10 years).*

Cancer

No quality statement 2.2 All people living with HIV should receive cancer preventive vaccination as recommended by EACS	
Indicator **2.2.1 Percentage of people aged < 45 years who received at least one dose of HPV vaccination following EACS guidelines**	**Target** **90%**

Quality statement 2.3 People living with HIV who are diagnosed with cancer should have timely access to specialised oncologists, and should be managed jointly by HIV physicians and oncologists	
Indicator 2.3.1 Number of services with documented, agreed-upon referral pathways for people who are newly diagnosed with cancer	**Target** 95%
2.3.2 Percentage of people with a new cancer diagnosis who have a documented medicines review checking for potential drug-drug interactions (DDI) between ART and proposed chemotherapy drugs, by a competent clinician (e.g. pharmacologist/pharmacist, experienced HIV physician) or using the Liverpool HIV Interaction website	**Target** 97%

Indicators highlighted in bold have been selected for prioritisation to maximise acceptability and feasibility of adoption and reporting against the standards.

Mental Health

Table 3. **Quality statements, indicators, and targets for topic 3 'mental health'**

Quality statement 3.1 All people living with HIV should be screened for mental health problems and quality of life	
Indicator **3.1.1 Percentage of people who are assessed for QoL within 15 months of last visit using a recognised and validated assessment tool****	**Target** **80%**
Indicator **3.1.2 Percentage of people screened for depression and anxiety within 15 months of HIV diagnosis using recognised and validated screening tools*** **e.g. Patient Health Questionnaire (PHQ) for depression [32], Generalised Anxiety Disorder (GAD) for anxiety [33] or other validated questionnaires. Diagnostic questions proposed in the EACS Guidelines may also be used*	**Target** **80%**
Indicator 3.1.3 Percentage of people living with HIV screened for sleep disorders within 15 months of last visit, preferably using insomnia-specific screening questions or a validated tool (e.g. Insomnia Severity Index ISI-3 [34] **	**Target** 80%

Quality statement 3.2 People living with HIV with mental health problems should have accessible, documented referral pathways for further management of their condition, to ensure timely access to mental health care	
Indicator **3.2.1 Percentage of people with mental health problems with documented referral or access to mental health care service**	**Target** **80%**

General Screening for Chronic Diseases

Table 4. **Quality statements, indicators, and targets for topic 4 'general screening for chronic diseases'**

Quality statement	
4.1 All people living with HIV should be offered regular organ-specific screening for chronic diseases	
Indicator	**Target**
4.1.1 Percentage of people with renal profile (including at least creatinine and proteinuria) measured within the last 12 months**	**90%**
Indicator	**Target**
4.1.2 Percentage of people who have liver profile assessment (AST and/or ALT) measured within the last 12 months**	**90%**
Indicator	**Target**
4.1.3 Percentage of smokers/ex-smokers with documented screening for respiratory symptoms (shortness of breath, cough, sputum, re-occurring lung infections) within the last 24 months	90%
Indicator	**Target**
4.1.4 Percentage of people older than 40 years of age with risk factors for osteoporosis (including smoking, alcohol use, metabolic syndrome, and frailty-related factors) with a calculated FRAX[1] score within the last 24 months	90%
Indicator	**Target**
4.1.5 Percentage of people at increased risk of fracture who had vitamin D checked within the last 15 months (Assessment based on clinical evaluation, screening questionnaires, or biomarker evidence as defined in Annex 2)	90%
Quality statement	
4.2 If abnormalities in organ function have been detected, patients should be fully assessed for the underlying cause and appropriately managed and monitored, including specialist referral when indicated	
Indicator	**Target**
4.2.1 Percentage of people with chronic kidney disease monitored by repeat renal profile test and/or UPCR/UACR at least once in the last 15 months**	**95%**
Indicator	**Target**
4.2.2 Percentage of people with elevated liver transaminases who had received non-invasive fibrosis assessment through biomarkers, fibroscan or imaging within the last 15 months**	**90%**
Indicator	**Target**
4.2.3 Percentage of people with organ impairment with documented referral to specialised care	90%

**Indicators highlighted in bold have been selected for prioritisation to maximise acceptability and feasibility of adoption and reporting against the standards.*
***Measured as occurring at least once within a 15-month time period; 12 months plus a three-month window allowing for variation in clinic attendance.*

Ageing in people with HIV

Table 5. **Quality statements, indicators, and targets for topic 5 'ageing in people living with HIV'**

Quality statement 5.1 In older people living with HIV (aged 50 years or older) timely screening for ageing-related conditions should be considered and adequately supported to help maintain health	
Indicator **5.1.1 Percentage of people over 50 years of age experiencing weakness, slowing, decreased energy, lower activity, or unintended weight loss screened for frailty using validated tools*** **e.g. gait speed measurement, Short Physical Performance Battery (SPPB), Clinical Frailty Scale (CFS) and FRAIL Scale (FS)*	**Target** **70%**
Indicator **5.1.2 Percentage of people with cognitive symptoms/complaints and no known cause with documented neurocognitive assessment**	**Target** **80%**
Indicator **5.1.3 Percentage of people living with HIV over 50 years of age with annual medication review for possible DDI**	**Target** **90%**
Indicator **5.1.4 Percentage of HIV clinics offering linkage/direction to social support for ageing people or having agreed documented pathways to social support services**	**Target** **70%**

Indicators highlighted in bold have been selected for prioritisation to maximise acceptability and feasibility of adoption and reporting against the standards.

Lifestyle intervention

Table 6. **Quality statements, indicators, and targets for topic 6 'lifestyle interventions'**

Quality statement 6.1 All people living with HIV should be screened for modifiable risk factors and informed about effective lifestyle intervention to reduce the risk of co-morbidities	
Indicator **6.1.1 Percentage of people who have a documented smoking status within the last 15 months****	**Target** **80%**
Indicator **6.1.2 Percentage of current smokers provided with smoking cessation advice**	**Target** **90%**
Indicator **6.1.3 Percentage of people with documentation of (history of) recreational drugs and alcohol use within the last 15 months* including men who have sex with men under the influence of recreational drugs (sometimes referred to as 'chemsex') ***	**Target** **80%**
Indicator 6.1.4 Percentage of people who have been asked about their level of physical activity at least once within the last 15 months	**Target** 60% (85% minimum in the aging group of older than 50 years old)

**Indicators highlighted in bold have been selected for prioritisation to maximise acceptability and feasibility of adoption and reporting against the standards.*
***Measured as occurring at least once within a 15-month time period; 12 months plus a three-month window allowing for variation in clinic attendance.*

Monitoring and Evaluation

Table 7. Quality statements, indicators, and targets for topic 7 'monitoring and evaluation'

Quality statement	
7.1 Every country should develop a standardised protocol that will assure the highest possible quality of care for people living with HIV, care that is coordinated across levels and providers throughout the life-course, together with ways of measuring and auditing performance.	
Indicator	**Target**
7.1 Percentage of countries with adopted national protocol or guidelines for HIV and co-morbidity management or alternatively adopt relevant regional or global guidelines if a national one is not yet available	90%

**Indicators highlighted in bold have been selected for prioritisation in order to maximise acceptability and feasibility of adoption and reporting against the standards.*

Where do we want to be by 2030?

- We want to have **consensus standards of HIV care** across the European region
- We want to **support implementation** of standards of HIV care across the European region
- Support **increased uptake of regular practice of self-audit** to promote quality improvement on HIV care in the European region
- We want to **raise the standards** of HIV care and ***reduce*** **the observed inequities** in the standards of care in the European region
- **Support** European **countries** reach the Sustainable Development Goals

Different sources/tools to get data :

- National level data sources
- Dublin Declaration monitoring data
- Questionnaire to national HIV focal points
- Review of national strategies, guidelines or policies
- Audit (service level)

HCC screening among PWH with chronic HBV

Group	Eligible (n)*	Screened (n)	Screened % (95% CI)
With cirrhosis	123	81	66 (57–74)
Without cirrhosis but ≥1 criterion**	1,019	242	24 (21–27)
• Age > 45 years	896	218	24 (22–27)
• HDV coinfection (HDV-RNA +)	27	10	37 (19–58)
• Asian/African origin	230	60	26 (21–32)
• Caucasian ethnicity with PAGE-B ≥10	664	169	25 (22–29)
Total meeting criteria for HCC screening	1,142	323	28 (26–31)

**14 patients with prior HCC were excluded from the analysis.*

***Individuals without cirrhosis could fulfill more than one eligibility criterion for HCC screening.*

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METHODS

- Data analysis of 523 patients who presented to the infectious disease outpatient clinic at the University Hospital Bonn in the 3rd quarter of 2023
- Data sources: paper progress notes in personalized records, medical reports, and laboratory findings in the hospital information system ORBIS, Hiob's database
- Data collection and analysis using Excel
- Classification and quantification of cardiovascular risk using SCORE2 and SCORE2-OP

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RESULTS

Guidelines implementation lipid-lowering therapy

- 109 individuals fulfilled criteria for lipid-lowering therapy
  - ➢ **42,2%: No documented lipid-lowering therapy**

Target[vii] *		
	2ry prevention or very high risk[viii]	High risk [ix]
LDL-c**	< 1.4 (55)	< 1.8 (70)
non-HDL-c	< 2.2 (85)	< 2.6 (100)

Fig. 7: *Lipid targets for cardiovascular prevention (EACS – European AIDS Clinical Society, 2023)*

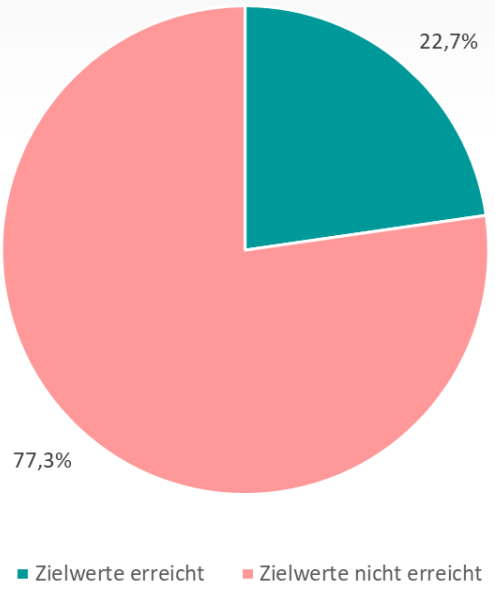

Abb. 8: *Distribution of patients on lipid-lowering medication due to known cardiovascular disease and/or a SCORE2/-OP ≥ 10%, with and without achieving target values*

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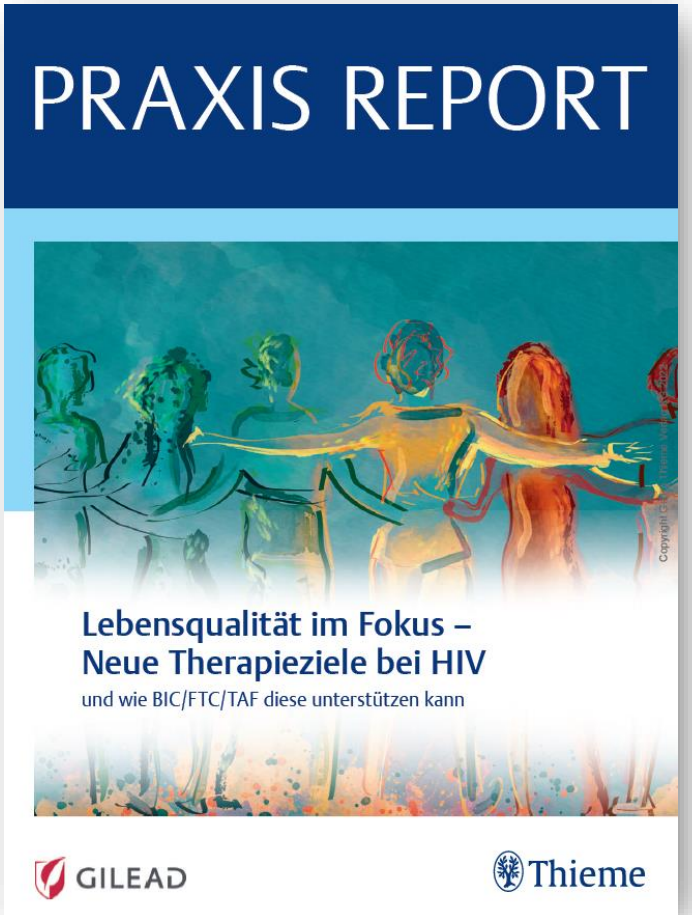
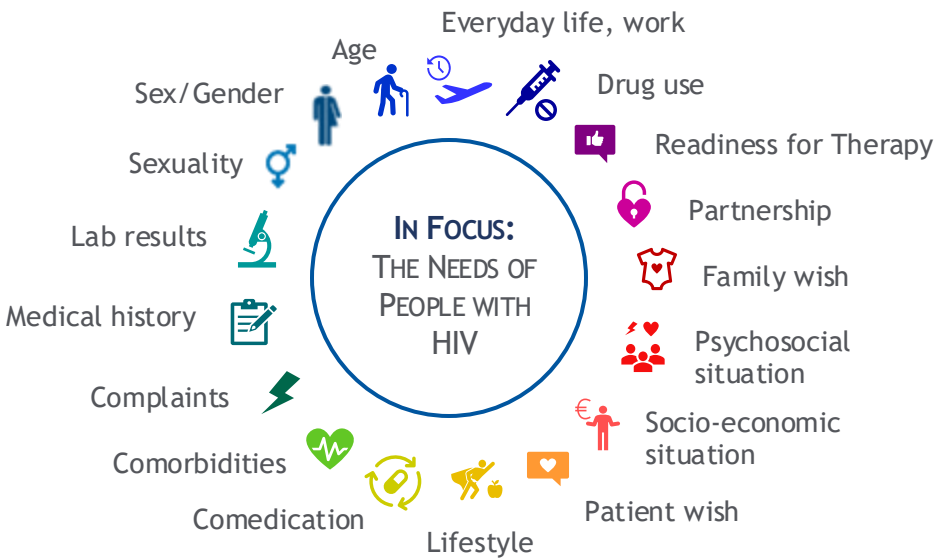


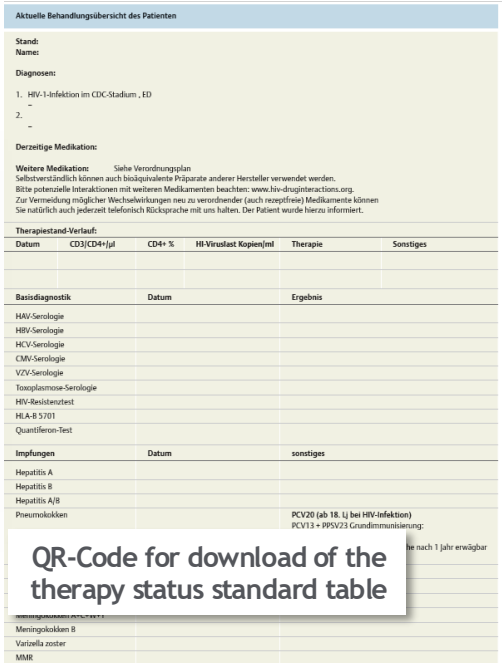
- Successful HIV therapy is more than achieving viral suppression
- At its best, it provides stigma-free, integrated care with other medical disciplines and services
- Living conditions of persons with HIV change continuously throughout life and should be a regular part of doctor-patient conversation with the goal of achieving the best possible quality of life at all times



Systematic long-term support for people with HIV

- **Goal:** holistic view of the patient's life situation
- Implementation in practice: "annual check-up" lasting at least 30 minutes, which is conducted during one of the usual 3–4 follow-up appointments per year.
- Therapy status table as a possible working basis for follow-up appointments and the annual check-up
- Questionnaires completed in everyday life before the doctor's visit can help identify potential complaints (for men, the "Aging Males Symptoms Score" is suitable here)

QR-Code for download of the therapy status standard table



Aktuelle Behandlungsübersicht des Patienten

Stand:
Name:

Diagnosen:

1. HIV-1-Infektion im CDC-Stadium , ED
2. –
–

Derzeitige Medikation:

Weitere Medikation: Siehe Verordnungsplan
Selbstverständlich können auch bioäquivalente Präparate anderer Hersteller verwendet werden.
Bitte potenzielle Interaktionen mit weiteren Medikamenten beachten: www.hiv-druginteractions.org.
Zur Vermeidung möglicher Wechselwirkungen neu zu verordnender (auch rezeptfreier) Medikamente können Sie natürlich auch jederzeit telefonisch Rücksprache mit uns halten. Der Patient wurde hierzu informiert.

Therapiestand-Verlauf:

Datum	CD3/CD4+/µl	CD4+ %	HI-Viruslast Kopien/ml	Therapie	Sonstiges

Basisdiagnostik	Datum	Ergebnis
HAV-Serologie		
HBV-Serologie		
HCV-Serologie		
CMV-Serologie		
VZV-Serologie		
Toxoplasmose-Serologie		
HIV-Resistenztest		
HLA-B 5701		
Quantiferon-Test		

Impfungen	Datum	sonstiges
Hepatitis A		
Hepatitis B		
Hepatitis A/B		
Pneumokokken		PCV20 (ab 18. Lj bei HIV-Infektion) PCV13 + PPSV23 Grundimmunisierung:
Meningokokken B		
Varizella zoster		
MMR		

Therapy status table (TST) as a tool for systematically structuring check-in examinations, here illustrated with an excerpt from the TST MSM (overview of treatment-relevant information of a patient, practical example Dr. Susanne Usadel, Freiburg). The TST MSM can be downloaded as a Word document for personal use via the QR code.

1. Rockstroh JK. Thieme Praxis Report, HIV-Therapieoptimierung für nachhaltigen Behandlungserfolg und optimale Lebensqualität, Juni 2024; 1-24 | 2. Heinemann LAJ, et al. The Aging Male 2001;4(1):14-22

Summary

- There is great variation in the quality of care across clinics and countries
- Consensus on standard of care does not cover the whole spectrum of HIV care, prevention and control
- Few surveyed countries have standards of care and levels of performance monitoring vary
- We want to raise the standards of HIV care and reduce the observed inequities in the standards of care in the European region
- Aging with HIV is associated with an increased risk for developing comorbidities
- Implementation of comorbidity management as well as cancer screening is a top priority in HIV-clinics
- Management of the aging individual with HIV needs to be adapted to the local/national service delivery pathways and benefits from multidisciplinary service approaches

Acknowledgements

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