Review Articles

HIV-Associated Venous Thromboembolism

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Abstract: HIV infection has been recognized as a prothrombotic condition and this association has now been proven by a large number of studies with a reported VTE frequency among HIV-infected patients ranging from 0.19% to 7.63%/year. HIV infection is associated with a two to tenfold increased risk of venous thrombosis in comparison with a general population of the same age. Some risk factors demonstrated a strongest association with VTE such as, low CD4+ cell count especially in the presence of clinical AIDS, protein S deficiency, and protein C deficiency. Whereas other risk factors are still controversial like protease inhibitor therapy, presence of active opportunistic infections and presence of antiphospholipid antibodies, including anticardiolipin antibodies and lupus anticoagulant. Physicians caring for HIV positive patients should be able to recognize and treat not only the well-known opportunistic infections and malignancies associated with this chronic disease, but also be alert to the less well-known complications such as thromboses. Pulmonary embolism should be included in the differential diagnosis when patients with HIV/AIDS have unexplained dyspnea or hypoxemia. In younger individuals with VTE, especially men, without other identifiable risk factors for VTE, HIV should be considered. Because interactions between warfarin and antiretrovirals is possible, health care providers should also be alert to the potential of dangerously high or low INRs when they are giving anticoagulants to patients with HIV infection who are undergoing antiretroviral therapy.

Introduction: Human immunodeficiency virus (HIV) infection results from one of two similar retroviruses (HIV-1 and HIV-2) that destroy CD4+ lymphocytes and impair cell-mediated immunity, affecting multiple organ systems. HIV manifestation ranges from asymptomatic carriage to the acquired immune deficiency syndrome (AIDS), which is defined by serious opportunistic infections or cancers. In 2009, there were worldwide an estimated 33.3 million (31.4 million–35.3 million) of adults and children living with HIV, 2.6 million [2.3 million–2.8 million] people became newly infected with HIV, and 1.8 million (1.6–2.1 million) are the AIDS-related death among adults and children. Treatment with highly active antiretroviral therapy (HAART) has successfully prolonged the life expectancy of HIV-infected patients.
and infection with the human immunodeficiency virus is increasingly becoming a chronic disease in the developed world. Improved survival has been followed by an increased and anticipated prevalence of non-AIDS related conditions, in particular cardiovascular disease is now a leading cause of morbidity and mortality among HIV-infected people.

**Epidemiology:** Venous thromboembolism (VTE) is a common, serious disease with an estimated incidence rate in the general population of 1 per 1000 person-years of observation. Prevention and treatment of VTE are gaining attention because of an increase in frequency, cost, and risk factors. Furthermore VTE is a potentially preventable disease and it is of utmost importance to identify individuals in high-risk populations who may benefit from primary thromboprophylaxis. HIV infection has been recognized as a prothrombotic condition and this association has now been proven by a large number of studies. In fact many epidemiological studies reported on the occurrence of VTE among HIV-infected patients with a frequency ranging from 0.19 to 7.63 %/year. These studies (Table 1) estimates that the overall increase of the risk of VTE in HIV-infected patients was 2-10-fold higher than expected in general population. However many trials were limited by small sample size and a lack of a population based comparison control, and mainly were conducted in the pre-HAART era. Few studies were conducted in the more recent HAART era. Of interest recently Rasmussen found that the 5-year risk of VTE was 8.0% in injecting drug users (IDU) HIV-infected patients, 1.5% in non-IDU HIV-infected patients and 0.3% in the population comparison cohort.

Although HIV-infected patients are at increased risk for venous thromboembolism little work has been done on defining the exact mechanisms by which this phenomenon occurs, and still less has been done on evaluating the role thromboprophylaxis in HIV-infected individuals. Notably the 2008 American College of Chest Physicians (ACCP) guidelines on antithrombotic and thrombolytic therapy are silent on this subject. Furthermore there are some important concerns about the therapy of HIV-related thromboses. The aim of this review is to provide an overview about the venous thromboembolism in HIV-infected individuals, trying to cover pathogenesis, prophylaxis and treatment issues.

**Risk Factors for Thromboembolism in HIV-Infected Patients:** VTE is a multicausal disease and most commonly is the result of more than one “Hit”. The probability of developing venous thromboses would depend on type and number of risk factors involved (Figure 1). Many established factors are known to increase the risk of VTE in general population. Furthermore several specific factors are thought to be associated with VTE in patients with HIV. For convenience we grouped them in three categories: those regarding the host, mainly defining a hypercoagulable state and endothelial dysfunctions, those regarding the HIV diseases state, and those regarding the therapy whether HAART or other.

| Author       | Years studied | Population Size | VTE Incidence       |
|--------------|---------------|-----------------|---------------------|
| Jenkins      | 1991          | 243             | 3.29 %              |
| Laing        | 1996          | 728             | 0.96 %              |
| Howling      | 1999          | 3792            | 1.07 %              |
| George       | 1999          | 650             | 0.19-1.07 %         |
| Sullivan     | 2000          | 42935           | 0.26 %              |
| Saber        | 2001          | 4752            | 0.95 %              |
| Safi         | 2001          | 131             | 7.63 %              |
| Copur        | 2002          | 362             | 2.76 %              |
| Fulz         | 2004          | 13549.514       | 2.0% - 1.6%         |
| Ahonkhai     | 1989-2004     | 160             | 0.54 %              |
| Malek        | 1996-2004     | 6944            | 0.52                |
| Crum-Cianflone | 1996-2007  | 465             | 3.7%                |
| Rasmussen    | 1995-2007     | 4333            | 8.0%-1.5%; norm pop 0.3% |

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**Host Risk Factors:**

**Age:** In the developed world advancing age is a well known risk for thrombosis in general population. The incidence of venous thromboembolism increase dramatically as the population ages, from 0.001% a year in childhood to nearly 1% a year in the elderly. Because most HIV infected people are relatively young, their risk of DVT should be expected to be lower than the overall incidence. Conversely many studies reported that HIV-infected patients had a median age of 40 at time of venous thromboembolism that is 20 years younger than the median age of non infected patients. Furthermore patients younger than 50 years with HIV had a significantly higher incidence rate of VTE/year compared with age-matched healthy controls. HIV-infected patient are in fact older than their chronological age and they...
experience the so-called “Premature Aging”. In this immunological ageing the immune system has persistent defects even after years of treatment mediated viral suppression. Many are similar to those seen in normal ageing, but they occur at an earlier age than normal. Persistent abnormalities include low CD4:CD8 ratio, low naïve:memory cell ratio, expansion of CD28− effector T cells, reduced T cell repertoire, and reduced responsiveness to vaccines. Most of these abnormalities are seen only in patients who start treatment in late stage disease (CD4 nadir <200 cells).

The heightened risk for premature aging is also the result of residual immunodeficiency and inflammation.

**Intravenous Drug Use:** The intravenous use of recreational drugs is associated with considerable morbidity, a significant proportion of which may be from the drug itself. Intravenous drug use has been recently identified as an important cause of community-acquired VTE in young adults. In a recent elegant paper Rasmussen first show the impact of intravenous drug use on risk Of VTE in HIV-infected patients. This study found that the risk of VTE was nearly 15 times higher in IDU HIV-infected patients that in non IDU HIV-infected patients.

**Hypercoagulable State: Protein S Deficiency:** It is currently accepted that protein S (PS) deficiency is a significant contributor to the pro-coagulant nature of HIV infection. In fact protein S deficiency is the most consistently observed coagulation abnormality observed in HIV-infected patients, with a reported prevalence ranging from a 27% to a 76%, with a 12% of those patients having a venous thromboembolism. PS deficiency in HIV-positive patients is probably multi-factorial and the frequency of this alteration/deficiency has led to an extensive pursuit of potential mechanism. Type III PS deficiency is the most common abnormality found and characterized by a normal total protein S level with a decrease in both free protein S and functional protein S activity. Decreased synthesis by the endothelial cells, hepatocytes and megakaryocytes injured in HIV infection has been proposed. A positive correlation between antibodies to PS and low levels of circulating free antigen has also been noted in symptomatic HIV-infected patients. Other authors suggested that tumor necrosis-factor-alpha (TNF-α) can lower the levels of active protein S down-regulating the protein S
flagellins, are translocated through the damaged gut in reported.

Protein C Deficiency: The relationship between protein C deficiency and VTE in HIV infection is not as clear as that of protein S deficiency, with a prevalence ranging from 0 to 14%. However in one study a high prevalence of protein C deficiency was found in HIV patients who had VTE without other noted risk factors for venous thromboembolism. The mechanism of PC deficiency in HIV infected persons is multi-factorial, including altered synthesis and metabolism as well as low-grade disseminated intravascular coagulation (DIC) with consumptive coagulopathy.

Antithrombin Deficiency: There is no direct evidence of HIV infection leading to Antithrombin deficiency. Acquired AT deficiency frequently occurs in the course of HIV disease as a consequence of associated conditions that cause decreased protein synthesis (liver diseases eg HCV coinfections and malnutrition), protein-losing nephropathies or enteropathies, consumptive states (malignancy, DIC, surgery). Nevertheless cases of AT deficiency in HIV patients who experienced thrombotic events have been reported.

Antiphospholipid And Lupus Anticoagulant Antibodies: The antiphospholipid syndrome (APS) is an autoimmune disease associated to the appearance of two main circulating auto-antibodies, anticardiolipin antibodies (ACA) and lupus anticoagulant (LA). The frequency of APS in the general population is 2-4%, and is clearly linked to increased risk of venous and arterial thrombosis. ACA have been reported in HIV-infected patients with a prevalence ranging from 7% to 94%. However there are both reports of no association and positive association between having positive ACA and VTE in HIV+ patients.

Homocysteine: Mild to moderate Hyperhomocysteinemia (HHcy) is relatively common in HIV-infected individuals, especially those using cART, with a prevalence ranging from 11 to 29%. Prospective cohort studies and an interventional trial in general population have estimated the increase in the risk of recurrence associated with raised homocysteine concentrations to be about 1 to 5-fold. However, because vitamin supplementation (which reduces homocysteine concentrations) does not affect rate of recurrence, a causal relation between hyperhomocysteinemia and venous thrombosis remain uncertain. HHcy is frequently present in HIV-patients without causing clinical manifestation suggesting that it may not be sufficient alone causing VTEs. However HHcy may add an additional risk among patients with other risk factors for venous clots.

Endothelial Dysfunction: Many studies showed a strong association between endothelial cells abnormalities and VTE in general population. Under normal conditions endothelial cells exert a vasodilatory, antiplatelet and local fibrinolytic tone that prevents platelet adhesion, leukocyte attachment, as well as blood coagulation. A non-thrombogenic endothelial surface is maintained through a number of mechanisms, including the production of thrombomodulin (TM) (an activator of anticoagulant protein C), the expression of heparan and dermatan sulphate (which accelerate the thrombin-inhibitory activity of antithrombin III and of heparin cofactor II), the constitutive expression of tissue factor pathway inhibitor (TFPI)(an inhibitor of tissue factor), and the local production of tissue plasminogen activator (tPA) and urokinase-type plasminogen activator (uPA), that are the main

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Various and vWF creates alterations in the coagulation cascade. However, no paper has shown a direct correlation between leukocytes and upregulation of tissue factor expression. Generation of prothrombotic microparticles from hypercoagulable environment by inducing the synthesis of prostacyclin (PGI2) and of nitric oxide (NO).[60] In the context of VTE, a dysfunctional venous endothelium may express increased amounts of P-selectin, von Willebrand factor (vWF), tissue factor (TF), plasminogen activator inhibitor-1 (PAI-1), and factor V, all of which may promote blood clotting and participate in the development of a thrombus.[61] It is now well established that the endothelium could be activated directly by HIV virus. In fact, multiple studies reported the role of HIV in causing endothelial dysfunction.[62,63]

**P-Selectin**: In a recent study, P-selectin was found in HIV-infected patients to be independently and most strongly associated with venous thrombosis.[64] Stored in endothelial cells and platelet granules, P-selectin interacts with its receptor to promote a hypercoagulable environment by inducing the generation of prothrombotic microparticles from leukocytes and upregulation of tissue factor expression on monocytes.[65] Prospective studies in HIV-uninfected participants with malignancies have demonstrated that P-selectin is significantly elevated in patients with an impending or acute VTE. Furthermore, P-selectin has been shown to have comparable diagnostic value to D-dimer in patients with confirmed DVTs.[66]

**Miscellaneous Factors of Haemostasis**: Various markers of endothelial cell damage such as von Willebrand factor (vWF), soluble thrombomodulin (sTM), adhesion molecule E-selectin, tissue-type plasminogen activator (tPA), plasminogen activator inhibitor (PAI-1), fibronectin, angiotensin-converting enzyme (ACE), and endothelin have been shown to be increased in the course of HIV-1 infection.[67,68] HC II deficiency was significantly more pronounced in AIDS patients compared with HIV patients and possible reason for HC II deficiency could be the decreased synthesis, enhanced proteolysis or consumption.[69] However, no paper has shown a direct correlation between the low levels of HC II in HIV-positive patients and VTE. The secretion of tPA, (PAI-1), sTM, and vWF creates alterations in the coagulation cascade and could predispose to thrombosis.[66,67] Furthermore, HIV gp120 could induce tissue factor expression in vascular SMCs, which may have potential effects on the arterial wall thrombogenicity.[70] Anyway, a link between in vitro findings and clinical events in HIV patients is still lacking.

**Viral Risk Factors**

**CD4+ Cell Count**: The severity of the HIV infection appears to be of significance in association with VTE. In fact, several studies confirmed that there is a higher incidence of venous thrombosis in patients with low CD4 counts.[12,37,75,76] In particular, although the CD4 nadir and most recent CD4 count were both predictive in the univariate models, the strongest predictor in multivariate models was the CD4 cell count at the time of the VTE.[14,19,77,78] Although the frequency of VTE is higher in the presence of lower CD4 cell counts, there are reports of thrombosis occurring with CD4 cell counts as high as 800 cells/mm³, suggesting that the risk of thrombosis is not completely confined to patients with end-stage disease.[19] The correlation between CD4 count and the risk for the development of thromboses may be related to an increasing hypercoagulable state found with progressive immune suppression and HIV disease progression. Various studies have documented that the abnormalities in pro- and anticoagulant factors, and as described previously, worsens as the disease progresses, swinging the pendulum in favor of thrombosis.[53,79,80]

**Viral Load**: Another indicator of high disease burden of HIV infection is viral load, also known as HIV RNA level. Low CD4⁺ cell counts and high viral loads are predictive of progression of HIV and typically complement each other in the absence of treatment. One group of authors concluded that a higher viral load, and lower CD4⁺ cell count, was associated with a higher risk of thrombosis,[19] conversely others found no correlations.[14]

**Opportunistic Infection**: In spite of the efficacy of HAART, HIV-positive individuals are at the greatest risk for developing opportunistic infections depending on their immunologic status. So, the concomitant presence of advanced HIV disease and opportunistic infections appears to be an additional risk factor for Thrombosis.[8,13,14,76,79]

VTE is most commonly reported with Cytomegalovirus and *Pneumocystis jiroveci* pneumonia (PCP) and Mycobacterium avium-intracellulare. [79,80]

**Cytomegalovirus**: Cytomegalovirus active infection is a well-established cause of thrombosis and several case-studies described active cytomegalovirus infection in patient with VTE in general population.[81,86] Regarding HIV-infected patients active cytomegalovirus infection has decreased substantially, in current HAART era, to less than 6 cases/100 person-years.[87] In one study, it was associated with a procoagulant state independently of stage of HIV disease.[88] The reported frequency of VTE in the presence of cytomegalovirus in HIV-positive individuals is approximately 9.8%, with the majority of thrombosis associated with gastrointestinal-related disease.[12]
**Pneumocystis Jiroveci Pneumonia:** Many authors reported the presence of active PCP during a VTE in HIV-infected patients. VTE associated with PCP may be secondary to the hypercoagulable state in patients with AIDS. In fact *Pneumocystis jiroveci* pneumonia patients with HIV have been shown to have an high rate of concurrent antiphospholipid syndrome that may increase the risk for developing VTE. Venous thromboembolism, specifically pulmonary embolism, in this population may remain underdiagnosed because of similar signs and symptoms of presentation between pulmonary embolism and PCP.

**Mycobacterium Tuberculosis and Intracellular mycobacterium Avium:** Mycobacterium-avium-intracellulare and Mycobacterium tuberculosis may induce antitrophoblastin antibodies and a hypercoagulable state. Although antitrophoblastin antibodies are found in these patients, a clear relationship with the appearance of thromboembolic complications was not demonstrated. Declining levels of antitrophoblastin antibodies seem to occur after the initiation of effective treatment of underlying infection. *Mycobacterium tuberculosis* is able to activate macrophages directly and induces them to produce cytokines, especially TNF-α, IL-1 and IL-6. TNF-α and IL-1 blocks the protein C anticoagulant pathway and can elicit tissue factor production on endothelium and monocytes. IL-6 can also stimulate new platelets formation which have increased sensitivity to thrombin activation and increased procoagulant activity. The prevalence of VTE in Tuberculosis patients is ranging from 0.6% to 3%, while the prevalence of VTE in patients with coexisting HIV and tuberculosis is unknown.

**HIV-associated Malignancy:** The risk of VTE in patients with cancer varies considerably between patients and even within an individual patient over time. Estimates ranging from 15 to 30 % have been reported. It is well-known how patients with no identifiable risk factors who develops DVT may have an underlying occult malignancy. People with HIV infection and AIDS have an elevated cancer risk. Compared with the general population, HIV-infected individuals have a 3640-fold increased risk of Kaposi sarcoma (KS), a 77-fold increased risk of non-Hodgkin lymphomas (NHL), and a six-fold increased risk of cervical cancer. These malignancies are AIDS-defining cancers, based on the Centers for Disease Control and Prevention (CDC) definition of AIDS. HIV-infected people also have an increased risk of a number of non-AIDS-defining cancers, including some associated with co-infections (eg, anal and oropharyngeal cancers associated with HPV infection, liver cancer associated with infection with hepatitis B and C viruses, and Hodgkin lymphoma associated with Epstein–Barr virus infection). Kaposi Sarcoma (KS) is the most common malignancy reported in literature associated with VTE in HIV-patients. Several reviews regarding thromboembolism in patients with KS in HIV-infected patients have reported an incidence of thrombosis ranging from 9.3% to 20%. The remaining malignancies were reported as single cases of primary CNS Lymphoma, B-cell non-Hodgkin lymphoma, Hodgkin disease, prostate cancer, anal cancer, colon cancer.

**Drugs Risk Factors:**

**HAART:** HAART and in particular the use of protease inhibitors (PI) have been associated with thrombotic events. PI are thought to interfere with hepatic metabolism, specifically cytochrome P450 metabolism, and regulation of thrombotic proteins. This may ultimately cause a prothrombotic state in HIV-infected individuals and therefore increase the risk of a thrombotic episode. Otherwise they may either downregulate the anticoagulant effect within the body or generate endothelial or platelet dysfunction. Consistent data exist connecting protease inhibitors with lipodystrophy, and HIV-positive individuals with metabolic disturbances may be at increased risk for developing an abnormal coagulation profile, such as increased fibrinogen, D-dimer, plasminogen activator inhibitor-1, or protein S deficiency. Despite limited data, protease inhibitors indinavir and saquinavir, have been associated with an increased risk of VTE in the HIV-positive population, however a recent publication could prove no such association, suggesting that the association between HAART and risk of thrombosis may arise from mutual associations with other risk factors, in particular advanced disease.

**Megestrol:** Megestrol acetate is a synthetic, orally active, progestational agent, used widely in the treatment of metastatic breast cancer. It has also been reported to stimulate appetite and weight gain in patients with AIDS-related anorexia and/or cachexia. In these groups of patients thromboembolic phenomena as adverse events potentially related to megestrol have been reported.

**Clinical Presentation:** Clinicians should be alert to unprovoked thrombosis as a possible complication of AIDS and consider this in the differential diagnosis of patients with HIV infection. It is possible that the incidence of thromboembolic disease in those patients have been underestimated either due to the clinical...
picture mimicking opportunistic infections (e.g., opportunistic pulmonary infection vs. PE) or not considering the less well-known complication such as venous thromboembolism. The clinical appearance and distribution of thrombosis reported in the literature is similar to non-HIV patients. Most commonly thromboses involve the popliteal and femoral veins followed by pulmonary emboli. In addition, abdominal involvement may occur as portal or splenic vein thromboses. HIV-infected persons may experience recurrences with an incidence of recurrence rate ranging from 8% to 15%. 

Pregnancy: Venous thromboembolism (VTE), in women during pregnancy and puerperium, has been described in literature with an incidence of approximately 1–2 in 1000 pregnancies. Women are five times more likely to develop VTE during pregnancy or puerperium compared to non-pregnant women. A recent study reported the annual incidence of VTE in HIV-positive women during puerperium of 313/1000 person-years (95% CI 65–915). According to this finding, HIV-positive pregnant women are 120-fold more likely to develop VTE than HIV-positive controls, whereas the risk is 157-fold higher compared to HIV-negative pregnant women.

Management: The 2008 ACCP guidelines on antithrombotic and thrombolytic therapy do not mention HIV-infected patients. Nevertheless clinicians dealing with HIV must be aware that this high risk population needs particular attentions regarding antithrombotic prophylaxis and therapy looking at them in the same way as it would be for patients suffering from cancer. The management of proven VTE in HIV-infected patients should be the same as for the non-HIV patients, including long-term prophylaxis with low molecular weight heparin and warfarin for patients with recurrent thrombosis. Antiretroviral therapy and warfarin drug interaction: Because of an increased risk of thromboembolism in patients with HIV/AIDS and the increasing longevity of the HIV-infected population receiving effective antiretroviral therapy, more HIV-positive patients will be receiving in the future concomitant oral anticoagulant and antiretroviral therapy. The interaction between antiretroviral agents and other medications has been widely described. Interactions between warfarin and antiretrovirals is possible, given the influence of many antiretrovirals on CYP2C9, the enzyme responsible for the metabolism of the more active S-enantiomer of warfarin. Among the antiretrovirals, interactions involving non-nucleoside reverse transcriptase inhibitors (NNRTIs) and protease inhibitors (PIs) with warfarin are most likely to occur. Inhibition or induction of metabolism requiring warfarin dosage adjustment may be observed, depending on the specific antiretroviral drug. Among the NNRTIs, induction of warfarin metabolism is likely with nevirapine. Inhibition of warfarin metabolism may occur with efavirenz, delavirdine, or etravirine, but more evidence is needed to characterize the nature and onset of these interactions. Interactions involving ritonavir-boosted PIs are most frequent when warfarin is initiated in patients receiving concurrent efavirenz therapy. It seems prudent to base warfarin dosage adjustments on International Normalized Ratio (INR) response rather than empirically beginning with a lower warfarin dose. Similarly, INR response should be used to guide warfarin dosage requirements in patients on nevirapine, nelfinavir, lopinavir/ritonavir, or other ritonavir-boosted PIs rather than starting with higher baseline doses.

Health care providers should be alert to the potential for dangerously high or low INRs when they are giving anticoagulants to patients with HIV infection who are undergoing antiretroviral therapy. Perhaps alternative forms of anticoagulation, such as low-molecular-weight heparin (LMWH), should be considered in some cases in the HIV-infected population receiving antiretroviral therapy, given the absence of compliance in some HIV-affected subjects. LMWH should be a safer choice in those patients, always keeping in mind that HIV infection may be an independent risk factor for the development of heparin-induced thrombocytopenia (HIT). Lastly the timing of administration of warfarin and certain antiretroviral agents should be staggered.

Conclusions: Currently available epidemiological evidence suggests that chronic HIV infection is associated with a two to tenfold increased risk of venous thrombosis in comparison with a general population of the same age. Some risk factors demonstrated a strongest association with VTE such as like a diagnosis of AIDS, low CD4+ cell count especially in the presence of clinical AIDS, protein S deficiency, and protein C deficiency. Whereas other risk factors are still controversial like protease inhibitor therapy, presence of active opportunistic infections and presence of antiphospholipid antibodies, including anticardiolipin antibodies and lupus anticoagulant. With this understanding, appropriate prophylactic measures can be instituted, which may include universal VTE prophylaxis with oral anticoagulants or low-molecular weight heparin on hospitalization and for high-risk outpatients. Physicians caring for HIV positive patients should be able to recognize and treat not only the well-
known opportunistic infections and malignancies associated with this chronic disease, but also be alert to the less well-known complications such as thromboses. Pulmonary embolism should be included in the differential diagnosis when patients with HIV/AIDS have unexplained dyspnea or hypoxemia. In younger individuals with VTE, especially men, without other identifiable risk factors for VTE, HIV should be considered.

Finally new well-designed case control studies are needed to answer several open questions: Do traditional factors associated with increased VTE risk have the same impact in HIV patients? Does HAART contribute to VTE risk in HIV and How? Are traditional screening methods applicable in HIV? Are traditional VTE risk management strategies applicable in HIV?

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