It is aging and not antiretroviral therapy that is the strongest risk factor for chronic pain in HIV-positive population?

CURRENT STATUS: UNDER REVIEW

Marcin Kowalski
Polish Medical Air Rescue, Clinical Governance Department Warsaw, Poland

Andrzej Horban
Department of Adults' Infectious Diseases, Medical Faculty, Medical University of Warsaw

Witold Rongies
Department of Rehabilitation, Medical Faculty, Medical University of Warsaw

Bartosz Slomka
central teaching hospital in Warsaw, Poland

Corresponding Author
ORCiD: https://orcid.org/0000-0003-4389-7201

Karen Shahnazaryan
Department of Rehabilitation, Medical Faculty, Medical University of Warsaw

DOI:
10.21203/rs.2.15543/v1

SUBJECT AREAS
Infectious Diseases

KEYWORDS
HIV, AIDS, pain, opioids, antiretroviral treatment
Abstract
Background Chronic pain in HIV-positive patients is a serious health problem that limits patients’ normal functioning both somatically and psychologically. The current state of knowledge on the topic is insufficient, with the underlying causes of this pain unexplained.

Methods During their routine visit patients were asked to fill in a general information form and the Alcohol Use Disorders Identification Test Consumption (AUDIT-C) form. All patients reporting any pain were additionally asked to fill in the Brief Pain Inventory (BPI) form and were subject to a brief examination performed by a physician who afterwards completed a Douleur Neuropathique en 4 Questions form (DN4). Logistic regression models were used to identify factors associated with chronic pain occurrence.

Results A total of 196 HIV-positive subjects, 96 (48.9% of the study group) of subjects reporting pain within the week prior to enrollment. The reported pain was mostly (75%) limited to a single area of the body (most commonly to the lower limbs). Pain duration was reported to be >6 months previous to study enrollment by 57 subjects (59.4% of those reporting pain). Most subjects were undergoing combination antiretroviral therapy (cART).

Conclusions The prevalence of chronic pain in the studied population of HIV-positive Polish patients was high in comparison with other HIV-positive and HIV-negative patient populations. The most prominent risk factor for chronic pain in the study group was age, which poses an important clinical and epidemiological problem due to the aging of the HIV-positive population. It is imperative to develop cooperation protocols for specialist HIV treatment clinics, pain treatment clinics, and rehabilitation units.

Background
As a result of introducing combination antiretroviral therapy (cART) for HIV-1-positive patients their survival has been improved to the level of that in the general population [1,2]. One of the effects of this phenomenon is the increased prevalence and early onset of the so-called lifestyle diseases (particularly cardiovascular disease, chronic kidney disease, type 2 diabetes mellitus, and cancer) in HIV-positive individuals [3–6]. At the same time, we are observing accelerated aging in HIV-positive people, which is associated mainly with increased immune activation, impaired regulatory functions, as well as direct effects of HIV replication on tissues and organs. One important question that has not
been answered yet is whether or not osteoarthritis is more common and/or occurs at a younger age in this population in comparison with the general population. If so, this may have a significant impact on the overall benefit of cART [7, 8, 9]. Accelerated aging and early onset of selected lifestyle diseases in HIV-1-positive adults result in an increasing prevalence of pain (of various nature) in this population. It is chronic pain that constitutes a particularly big challenge for the primary healthcare team, as it is believed to detrimentally affect the patients’ personality, their mental balance, and their ability to perform their social and professional roles [10,11].

Such pain no longer serves as a warning sign, thus losing its biological purpose and becoming, in itself, a disease. Experiencing a chronic pain has a negative impact on all aspects of the patient’s life, to the extent that everything else becomes irrelevant to the sufferer. Such pain is often accompanied by powerful emotions, such as anxiety, despair, anger, and helplessness. It is these emotions, combined with a pain that commands the patient’s attention, that make the experience even harder to bear. Not uncommonly, the situation is made worse by problems at work due to an inability to perform the required tasks, which leads either to financial problems or experiencing the lack of professional fulfillment [12,13]. Therefore, the purpose of this study was to determine the prevalence of chronic pain in the HIV-positive population remaining under continuous specialist care, as well as the underlying causative factors of such pain.

Patients And Methods
The inclusion criteria for this study were the age of 18 years or older and a documented HIV-1 infection, as well as a written informed consent. Any mental condition, diagnosed based on the available clinical data (history-taking or the available medical records), was an exclusion criterion. Chronic pain was defined as pain lasting a minimum of 6 months. The data on the subject’s sex, age, route of HIV infection, age at the time of registration at a specialist clinic for HIV/AIDS-positive patients, laboratory test results (CD4+ cell count, HIV viral load), duration of specialist care (in years), and history of antiretroviral therapy (ART) (yes or no) were obtained from the clinic’s electronic database (table 1). The patients who consented to take part in the study were asked to fill in a general information form and the Alcohol Use Disorders Identification Test Consumption (AUDIT-C)
form. All patients reporting any pain were additionally asked to fill in the Brief Pain Inventory (BPI) form and were subject to a brief examination performed by a physician who afterwards completed a DN4 Douleur Neuropathique en 4 Questions (DN4) form.

The general information form contained questions on the history of any pain over the previous week, mean duration, date of onset, frequency, and any help by physicians other than an infectious disease specialist (particularly those specializing in pain therapy) in dealing with the pain. Subsequent questions addressed the use of any psychoactive drugs or other drugs that could affect the perception of pain, as well as cART adherence (including the frequency of missing a dose).

The other questionnaire used in this stage of the study was AUDIT-C, which helps detect alcohol misuse and is an abridged, modified version of the AUDIT assessment tool [14,15,16,17]. The AUDIT-C questionnaire contains three questions about alcohol consumption within the past year. The first question asks the respondent how often they have a drink and provides five answer choices: never; 1 monthly or less; 2–4 times a month; 2–3 times a week; 4 or more times a week. These answers are scored from 0 to 4, respectively. The second question is about the number of units of alcohol (“standard drinks”) consumed on a typical day when drinking, with the following answer choices: None, I do not drink; 1 or 2; 3 or 4; 5 or 6; 7 to 9; 10 or more. The scores are as follows: 0 for the first two answers and from 1 to 4 for the subsequent answers, respectively. The last question asks the respondent how often they have more than six units of alcohol (“standard drinks”) on one occasion. The answer choices are: never; less than monthly; monthly; weekly; daily or almost daily (with scores from 0 to 4, respectively). A “standard drink” is a unit of alcohol defined as 12 oz. (approximately 330 mL) of beer (5% of ethanol), a 5-oz. (approximately 140 mL) glass of wine (12%), or 1.5 oz. (40 mL) of liquor (40%), each of which is equivalent to approximately 10 grams of pure ethanol. A total score of 4 or more for men and 3 or more for women was considered indicative of hazardous, excessive and unhealthy alcohol consumption or alcoholism.

The subjects who reported pain in the initial questionnaires went on to complete the BPI - Short Form [18]. Some of the questions in this 9-item questionnaire are about the intensity of pain felt at the moment and within the previous 24 hours, quantified in an 11-point numerical rating scale, ranging
from 0 to 10, where 0 indicates no pain and 10 – the worst pain imaginable. In addition, all respondents were asked to mark the approximate location of their pain on a diagram of the human body. The questionnaire also asks about treatments or medications used for the pain and asks the respondent to rate the effectiveness of these treatments or medications on a scale from 0% to 100% (in 10% increments), where 0% indicates no relief and 100% – complete pain relief. The questionnaire also assesses the extent to which the pain interferes with selected aspects of everyday life (normal work, general activity, mood, walking ability, relations with other people, sleep, and enjoyment of life) with the answer choices ranging from zero (no interference) to 10 (complete interference).

**Statistical analyses**

In order to compare the study groups the Chi-squared and Kruskal-Wallis tests were used in statistical analysis. The potential prognostic factors for the study endpoint were identified via uni- and multivariate logistic regression analyses. All statistical analyses were conducted with the use of SAS version 9.3 (SAS Institute, Cary, NC).

**Results**

A total of 196 subjects aged from 34.6 to 49.1 years (mean age 42.4 years; median 41.1 years) were qualified to take part in this study. Men constituted 82.6% of the study population, with 41 subjects (20.9%) having contracted HIV through heterosexual contact, 90 (45.9%) through homosexual contact, and 37 (18.9%) through the use of intravenous drugs. The subjects who had contracted HIV in a different way constituted 4.1%, and those who contracted the infection via an unknown route constituted 10.2% of the study population. All patients included in the study had been under specialist care at the HIV Outpatient Clinic of the Hospital for Infectious Disease in Warsaw, Poland at the time of enrollment. The individual subjects were included in the study in the order they presented at their infectious disease specialist’s office. Table 1 shows detailed subject characteristics.

Experiencing pain in the week prior to study inclusion was reported by 96 subjects (48.9% of the study group). The mean duration of pain was characterized as “several seconds” by 3 subjects (3.1%), “several minutes” by 28 subjects (28.9%), “several hours” by 51 subjects (52.6%), whereas “continuous pain” was reported by 13 subjects (13.4%). Out of the subjects reporting pain, 57
(59.4%) identified the onset of symptoms as over 6 months before study enrollment (Fig. 1).

**Location of chronic pain (n=57)**

The part of the body most commonly reported to be affected by chronic pain were the lower limbs (24 subjects; 42.1%), followed by the upper limbs (15 subjects; 26.3%), back and lumbosacral region (13 subjects; 22.8%), head (11 subjects; 19.3%), abdomen (8 subjects; 14.0%), chest (4 subjects; 7.0%), and other regions (3 subjects; 5.3%). Generalized pain was reported by 3 subjects (4.3%). Forty-three subjects (75.4%) reported pain limited to a single region of the body, 12 subjects (21%) reported pain limited to two regions, and 2 subjects (3.5%) reported pain limited to 4 regions.

**Pain intensity scored in a Numerical Rating Scale**

The subjects who declared chronic pain (n=57) rated pain intensity in a numerical rating scale (NRS). According to the established standard for this scale, the score of 1–4 points indicated mild pain, 5–6 points indicated moderate pain, and 7–10 points indicated severe pain. Assessed over the period of the previous 24 hours, the intensity of pain was rated as mild, moderate, or severe by 19 (33.3%), 24 (42.1%), and 14 (24.6%) subjects, respectively, when assessing their pain at its worst; by 47 (82.5%), 7 (12.3%), and 3 (4.2%) subjects, respectively, when assessing their pain at its least; and by 44 (77.2%), 7 (12.3%), and 6 (10.5%) subjects, respectively, when assessing their pain on the average. At the time of completing the questionnaire, 48 subjects (85.7%) rated their pain as mild, 4 subjects (7.1%) – as moderate, and 4 subjects (7.1%) – as severe (Fig. 2).

**Comparison of patient characteristics between the chronic pain group (n=57) and no chronic pain group (n=139).**

Both study groups were statistically comparable with respect to sex (22.8% of women in the chronic pain group vs. 15.1% in the no chronic pain group; p=0.216), the presence of anti-HCV antibodies (28.0% vs. 17.3%, respectively; p=0.214), total HBcAb titers (24.6% vs. 24.5%; p=0.962), positive
Venereal Disease Research Laboratory (VDRL) test (14.0% vs. 15.8%; p=0.509), hazardous alcohol consumption (19.3% vs. 16.5%; p=0.679), the use of psychoactive drugs over the evaluated period (8.8% vs. 5.5%; p=0.519).

The median lymphocyte counts at the time when the subjects started to receive specialist care and at the study inclusion were also comparable between the two groups. In the group of those reporting pain, the median CD4+ cell count at the time when they started receiving specialist care was 348 cells/mcL (vs. 350 cells/mcL in the no-pain group; p=0.761), with 25% of the pain-reporting subjects having CD4+ counts lower than 189 cells/mcL (vs. <196 cells/mcL in the no-pain group). The most recent (prior to study inclusion) median CD4+ cell counts were higher at 516 cells/mcL and 563 cells/mcL, respectively (p=0.256).

At study inclusion, 184 subjects were receiving ART (55 in the pain group and 127 in the no pain group). The two groups were comparable in terms of ART rates (98.2% vs. 92.1%, respectively; p=0.185) and initial viral suppression (98.2% vs. 99.2%; p=0.517). Poor cART adherence (based on an initial questionnaire) was reported by 38.2% of subjects with chronic pain and by 30% of those without chronic pain (p=0.306).

The two groups differed significantly in terms of age at study inclusion (with the median age of 45.3 years in the pain group vs. 39.6 years in the no pain group; p=0.0002); median duration of specialist care (10.8 years vs. 4.9 years, respectively; p=0.0008), median nadir CD4+ cell counts (168 cells/mcL vs. 253 cells/mcL), median duration of ART (8.5 years vs. 3.4 years; p=0.0046), viral rebound after complete suppression (5.1% vs. 38.3%; p=0.018), as well as previous treatment with zidovudine (44.6% vs. 30.5%; p=0.063) and ‘D’ drugs (33.9% vs. 11%; p=0.0004).

The two groups also differed significantly in terms of the route of HIV infection. The chronic pain group was characterized by higher rates of individuals who contracted HIV through intravenous drug use (28.1% vs. 15.1%), heterosexual contact (21.0% vs. 14.8%), and in other ways (8.8% vs. 2.2%); whereas the no chronic pain group was characterized by higher rates of individuals who contracted HIV through homosexual contact (36.7% vs. 31.6%). The route of infection was characterized as unknown by comparable proportions of subjects from both groups.
Analysis of factors associated with chronic pain

Univariate logistic regression analysis

Logistic regression analysis was the statistical model used for analyzing the factors associated with the development of chronic pain. The following variables were assessed: sex; route of HIV infection; specialist care duration (years); age at study inclusion; the values of certain parameters at study inclusion, such as: body mass index (BMI), systolic and diastolic blood pressure, hemoglobin levels, C-reactive protein levels, immunological parameters (absolute CD4+ and CD8+ cell counts, CD4+ cell percentage), HIV RNA levels, anti-HCV antibodies, total anti-HBc antibodies, VDRL test result (positive, negative, inconclusive); previous ART; previous treatment with zidovudine (AZT) and/or a ‘D’ drug (ddl, ddC, d4T); ART duration (years); achieved undetectable viral load (<50 HIV RNA copies/mL following ART initiation) (yes or no); viral rebound (≥50 HIV RNA copies/mL) after complete suppression (yes or no); hazardous alcohol use. Moreover, the analyzed variables included the most recent (prior to study inclusion) levels of hemoglobin, C-reactive protein, and immunological parameters (CD4+ and CD8+ cell counts, CD4+ cell percentage).

Univariate analyses showed that the epidemiological factors associated with the development of chronic pain were: the route of HIV infection, age at study inclusion, and specialist care duration (in years). The chances of developing chronic pain increased by 36% with each 5-year increase in the age of subjects at study inclusion and by 8% with each 10-year increment in the duration of specialist care. Analysis of the routes of HIV infection yielded a statistically significant result when the intravenous drug use (IDU) route was adopted as reference, and the p-value for effect was 0.0307. Compared with the IDU subgroup, the subgroups infected through the heterosexual, homosexual, and unknown routes showed lower chances of developing chronic pain. However, statistical significance was demonstrated only while comparing the homosexual and IDU routes, with the subjects infected through homosexual contact showing a 67% lower risk of developing chronic pain in comparison with those infected through IDU. The subgroup that reported HIV infection through a different route showed significantly (over two-fold) higher risk of developing chronic pain in comparison with the IDU
subgroup. The individual p-values are presented in Tables 2 and 3.

Summing up, the univariate analysis variables that showed statistical significance (p<0.01) and were evaluated in multivariate analysis were: the route of HIV infection, specialist care duration (years), age at study inclusion, nadir CD4+ cell count, ART duration (years), detectable HIV RNA levels, and previous ART with AZT or ‘D’ drugs.

**Multivariate logistic regression analysis**

Ultimately, 184 subjects were analyzed with the multivariate regression model. Those subjects who were not receiving any ART at the time of inclusion into the study were excluded from this analysis due to the fact that various aspects of ART were to be analyzed in this model. A multivariate regression analysis of all the parameters that showed statistical significance in univariate regression models yielded only one parameter that was still statistically significant. It was age at study inclusion (Table 4). Odds ratio per 5-year increase in age was OR=1.28, with the 95% confidence interval of 1.06–1.55 (p=0.0089). This means that when comparing two individuals with the same baseline characteristics (i.e. sex, route of HIV infection, nadir CD4+ cell count, specialist care duration (years), ART duration (years), previous use of AZT and ‘D’ drugs, and ART adherence (based on the presence or absence of viral rebound following complete suppression), the 5 years older individual had a 28% higher chance of developing chronic pain. From an individual perspective, this result indicated that with each 5-year increase in the patient’s age the risk of developing chronic pain was higher by 28%.

**Discussion**

This study, conducted in a population of HIV-positive patients under the care of HIV Outpatient Clinic at the Hospital for Infectious Diseases, showed high rates of pain. One half of the patients in the study population reported pain at the moment of study inclusion, whereas one-third reported chronic pain.

A systematic review by Parker et al. regarding pain in HIV-positive patients showed the rates of chronic pain (defined as pain lasting more than 3 months) ranging from 54% to 83%. That review included 61 studies published between 1982 and 2012, and thus included also the studies conducted in treatment-naïve populations, populations undergoing potentially neurotoxic therapies, as well as
populations receiving low-toxicity cART [19]. In comparison, the proportion of chronic (>3 month long) pain reported by Robbins et al. in a 2011 study in a group of 254 HIV-positive patients in Thailand was 22% [20]. Another study (by Uebelacker et al.), based on the data collected in a group of 238 patients in the United States in the period 2012–2013, showed that chronic pain of over 6 months occurred in 53% of the study population [21]. Lawson’s study, conducted in a population of 1,050 patients in the United Kingdom in 2014, showed that as much as 50% of the study population reported pain lasting more than 3 months [22]. A recent study by Jiao et al. in a group of outpatients demonstrated chronic pain in 40% of the study population [23], whereas in a 2010 study by Aouizerat et al. pain was reported by 55% subjects, 67% of whom characterized it as frequent or nearly continuous [24].

In comparison with the studies quoted above, our study demonstrated comparable rates of reported pain, with somewhat lower rates of chronic pain. We would like to emphasize that comparing different studies in terms of the rates of pain is very difficult, due to the considerable variations in the study populations. For instance, a population of Thai patients practically cannot be compared with any European patient population, due to their substantial differences, both genetic and cultural. Even comparisons between European and American studies are difficult, as American studies are frequently conducted in very specific populations, e.g. in a population of social outcasts. Another obstacle in comparing the results of different pain-related studies is the lack of a universally accepted definition of chronic pain [25–29]. For example, in an American study by Miaskowski et al. (as well as in our study) chronic pain was defined as pain lasting over 6 months. However, the proportion of the study population reporting pain in that American study (in contrast to that in our study) was very high at 90%. In light of the fact that the population analyzed in the American study had been recruited from the REACH cohort (constituting exclusively the homeless), any reliable comparison with our study is impossible.

The fact that the prevalence of chronic pain in our study was lower than that in the study by Lawson et al. is most likely due to their defining chronic pain as pain lasting over 3 months.

Comparing the results of our study with the studies on chronic pain conducted in HIV-negative adults, chronic pain was considerably more common in the HIV-positive population. The 2006 study by
Breivik et al. has the most similar study design to that of our study, as those authors had adopted the same definition of chronic pain as that in our study, and the study populations were comparable.

Breivik’s study involved several tens of thousands subjects from about a dozen European countries and Israel and showed that 19% of them suffered chronic pain (defined as pain lasting ≥6 months) [30]. A 2014 study by Kennedy et al. also observed chronic pain (defined as pain lasting >3 months) in 19% of adults from a large sample of the general population in the United States [31]. However, a recent, 2016, literature review by Fayaz, regarding the general population of the United Kingdom showed higher rates of chronic pain ranging from 35% to 51% [32]. Like the study by Kennedy et al., the review by Fayaz defined chronic pain as pain lasting 3 months or more.

Another important aspect of our study involved determining the severity of chronic pain. In our study population the average pain intensity over the previous 24 hours was rated as moderate or severe by one in five subjects (22.8%). This is a much lower proportion than that reported in other studies, already mentioned above. For instance, the study by Miaskowski conducted in a cohort of the homeless in San Francisco, showed 92% of the chronic pain cases to be of moderate to severe intensity [33]. Most of the 18 papers on the severity of chronic pain evaluated as part of the already mentioned systematic review by Parker et al. showed moderate to severe pain [19]. In comparison, in the study by Uebelacker the vast majority (81%) of patients with chronic pain rated its average intensity over the previous week as moderate or severe [21]. In Lawson’s study, subjects rated the pain felt at that moment in an 11-point Visual Analogue Scale (VAS), and the median pain severity was 5 (i.e. moderate pain) [22]. The severity of chronic pain in HIV-negative populations can be compared, as before, with that in the 2006 study by Breivik et al., where most subjects rated the last pain they felt as moderate or severe (NRS was used, as in our study).

Comparing the individual studies in terms of pain severity also raises many doubts due to the differences in study methodologies. Comparison difficulties may be due to the differences in the questions on pain intensity, on the period when the pain was present (“right now”, “within the last 24 hours”, “within the last week”), and on the pain intensity “on the average”, “at its worst”, “at its least” in the given period. HIV-positive individuals in Poland may be subject to a greater
stigmatization, particularly self-stigmatization. This, in turn, may lead to lowered expectations in terms of their quality of life and, in consequence, to underrating their pain intensity. The Stigma Index study clearly showed that in the populations of some Eastern European countries (Poland, Estonia, Moldova, Turkey, and Ukraine) stigmatization of HIV-positive individuals is greater than that in Western Europe [34]. In our opinion, future studies aiming to compare the prevalence of pain in HIV-positive populations in various countries should put more emphasis on evaluating the factors that affect the subjective assessment of pain as well as the unquantifiable causative factors responsible for the severity and nature of pain [34].

Conclusions
The prevalence of pain (including chronic pain) in the evaluated population of Polish HIV-positive patients was higher than that in other HIV-positive and HIV-negative populations reported in the literature. The most significant risk factor for the development of chronic pain in our study group was age, which constitutes a significant clinical and epidemiological problem, considering the aging of the HIV-positive population. It is crucial to develop standards for collaboration between specialist HIV treatment clinics and chronic pain treatment facilities as well as rehabilitation clinics and facilities.

Abbreviations

**cART**: combination antiretroviral therapy

**ART**: antiretroviral therapy

**AUDIT-C**: Alcohol Use Disorders Identification Test Consumption

**BPI**: Brief Pain Inventory

**DN4**: Douleur Neuropathique en 4 Questions

**IDU**: intravenous drug use

**NRS**: a numerical rating scale

Declarations

**Ethics approval and consent to participate**

The study protocol had been approved by the Bioethics Committee (KB/292/2013). All participants gave written informed consent prior to their inclusion in the study.
Consent for publication
Not applicable

Availability of data and materials
The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests
The authors declares that they have no competing interests.

Funding
Not applicable

Authors' contributions
MK, AH designed the research, conceived and conducted the experiments and analyzed the results, wrote the manuscript, collected the data, statistical analysis analyzed the results
WR, BS, KS reviewed and revised the manuscript, collected the data, analyzed the results
All authors read and approved the final manuscript.

Acknowledgements
We would like to thank all participants who participated in this work.

References
1. Mocroft A, Ledergerber B, Katlama C, Kirk O, Reiss P, d'Arminio Monforte A, et al. Decline in the AIDS and death rates in the EuroSIDA study: an observational study. Lancet. 2003;362:22-9. https://doi.org/10.1016/S0140-6736(03)13802-0
2. Jensen-Fangel S, Pedersen L, Pedersen C, Larsen CS, Tauris P, Moller A, et al. Low mortality in HIV-infected patients starting highly active antiretroviral therapy: a
comparison with the general population. Aids. 2004;18:89-97.
https://dx.doi.org/10.1097/01.aids.0000096873.36052.6d

3. Hsue PY, Waters DD. Heart failure in persons living with HIV infection. Curr Opin HIV AIDS. 2017;12:534-9. doi: 10.1097/COH.0000000000000409.

4. Rihana N, Nanjappa S, Sullivan C, Velez AP, Tienchai N, Greene JN. Malignancy Trends in HIV-Infected Patients Over the Past 10 Years in a Single-Center Retrospective Observational Study in the United States. Cancer Control. 2018;25:1073274818797955. doi: 10.1177/1073274818797955.

5. Chimbetete C, Mugglin C, Shamu T, Kalesan B, Bertisch B, Egger M, Keiser O. New-onset type 2 diabetes mellitus among patients receiving HIV care at Newlands Clinic, Harare, Zimbabwe: retrospective cohort analysis. Trop Med Int Health. 2017;22:839-45. doi: 10.1111/tmi.12896.

6. Kowalska JD, Reekie J, Mocroft A, Reiss P, Ledergerber B, Gatell J, d'Arminio Monforte A, Phillips A, Lundgren JD, Kirk O; EuroSIDA study group. Long-term exposure to combination antiretroviral therapy and risk of death from specific causes: no evidence for any previously unidentified increased risk due to antiretroviral therapy. AIDS. 2012;28:315-23. doi: 10.1097/QAD.0b013e32834e8805.

7. Kowalska JD, Wójcik G, Rutkowski J, Ankiersztejn-Bartczak M, Siewaszwewicz E. Modelling the cost-effectiveness of HIV care shows a clear benefit when transmission risk is considered in the calculations - A message for Central and Eastern Europe. PLoS One. 2017;13;12:e0186131. doi: 10.1371/journal.pone.0186131

8. Mocroft A, Bannister WP, Kirk O, Kowalska JD, Reiss P, D'Arminio-Monforte A, Gatell J, Fisher M, Trocha H, Rakhmanova A, Lundgren JD; EuroSIDA Study in EuroCOORD. The clinical benefits of antiretroviral therapy in severely immunocompromised HIV-1-infected patients with and without complete viral suppression. Antivir Ther.
9. Cardoso SW, Torres TS, Santini-Oliveira M, Marins LM, Veloso VG, Grinsztejn B. Aging with HIV: a practical review. The Brazilian journal of infectious diseases: an official publication of the Brazilian Society of Infectious Diseases. 2013;17:464-79.

10. Bras M, Dordević V, Gregurek R, Bulajić M. Neurobiological and clinical relationship between psychiatric disorders and chronic pain. Psychiatr Danub. 2010;22:221-6.

11. Martini L, Hoffmann F. Comorbidity of chronic back pain and depression in Germany: Results from the GEDA study, 2009 and 2010. Z Evid Fortbild Qual Gesundhwes. 2018;137-138:62-8. doi: 10.1016/j.zefq.2018.10.003.

12. Abram S.E., Haddox J.D. (2000). The Pain Clinic Manual. Lippincott Williams & Wilkins, Philadelphia 2000.

13. Breivik H., Collett B., Ventafridda V., Cohen R., Gallacher D. Survey of chronic pain in Europe: prevalence, impact on daily life, and treatment. Eur J Pain. 2006;10:287-333 doi: 10.1016/j.ejpain.2005.06.009

14. Rumpf HJ, Wohlert T, Freyer-Adam J, Grothues J, Bischof G. Screening questionnaires for problem drinking in adolescents: performance of AUDIT, AUDIT-C, CRAFFT and POSIT. European addiction research. 2013;19:121-7. doi: 10.1159/000342331

15. Dawson DA, Grant BF, Stinson FS, Zhou Y. Effectiveness of the derived Alcohol Use Disorders Identification Test (AUDIT-C) in screening for alcohol use disorders and risk drinking in the US general population. Alcoholism, clinical and experimental research. 2005;29:844-54. doi: 10.1097/01.alc.0000164374.32229.a2

16. Bradley KA, Bush KR, Epler AJ, Dobie DJ, Davis TM, Sporleder JL, et al. Two brief alcohol-screening tests From the Alcohol Use Disorders Identification Test (AUDIT): validation in a female Veterans Affairs patient population. Archives of internal medicine. 2003;163:821-9. doi: 10.1001/archinte.163.7.821
17. Bush K, Kivlahan DR, McDonell MB, Fihn SD, Bradley KA. The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Alcohol Use Disorders Identification Test. Archives of internal medicine. 1998;158:1789-95. doi:10.1001/archinte.158.16.1789

18. Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Annals of the Academy of Medicine, Singapore. 1994;23:129-38.

19. Parker R, Stein DJ, Jelsma J. Pain in people living with HIV/AIDS: a systematic review. J Int AIDS Soc. 2014;17:18719. doi: 10.7448/IAS.17.1.18719.

20. Robbins NM, Chaiklang K, Supparatpinyo K. Undertreatment of pain in HIV+ adults in Thailand. Journal of pain and symptom management. 2013;45:1061-72. doi: 10.1016/j.jpainsymman.2012.06.010

21. Uebelacker LA, Weisberg RB, Herman DS, Bailey GL, Pinkston-Camp MM, Stein MD. Chronic Pain in HIV-Infected Patients: Relationship to Depression, Substance Use, and Mental Health and Pain Treatment. Pain medicine. 2015;16:1870-81. doi: 10.1111/pme.12799.

22. Lawson E, Sabin C, Perry N, Richardson D, Gilleece Y, Churchill D, et al. Is HIV Painful? An Epidemiologic Study of the Prevalence and Risk Factors for Pain in HIV-infected Patients. The Clinical journal of pain. 2015;31:813-9 doi: 10.1097/AJP.0000000000000162

23. Jiao JM, So E, Jebakumar J, George MC, Simpson DM, Robinson-Papp J. Chronic pain disorders in HIV primary care: clinical characteristics and association with healthcare utilization. Pain. 2016;157:931-7. doi: 10.1097/j.pain.0000000000000462.

24. Aouizerat BE, Miaskowski CA, Gay C, Portillo CJ, Coggins T, Davis H, et al. Risk factors and symptoms associated with pain in HIV-infected adults. The Journal of the
25. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). American Psychiatric Press Inc, 1994.

26. Classification of chronic pain. Descriptions of chronic pain syndromes and definitions of pain terms. Prepared by the International Association for the Study of Pain, Subcommittee on Taxonomy. Pain Supplement. 1986;3:S1-226.

27. Adler RH. The term "chronic" with respect to pain should be dropped. The Clinical journal of pain. 2000;16:365.

28. Turk DC, Rudy TE. IASP taxonomy of chronic pain syndromes: preliminary assessment of reliability. Pain. 1987;30:177-89. doi:10.1016/0304-3959(87)91073-6

29. Dworkin RH, Turk DC, Peirce-Sandner S, Burke LB, Farrar JT, Gilron I, et al. Considerations for improving assay sensitivity in chronic pain clinical trials: IMMPACT recommendations. Pain. 2012;153:1148-58. doi: 10.1016/j.pain.2012.03.003.

30. Breivik H, Collett B, Ventafridda V, Cohen R, Gallacher D. Survey of chronic pain in Europe: prevalence, impact on daily life, and treatment. European journal of pain. 2006;10:287-333. doi: 10.1016/j.ejpain.2005.06.009

31. Kennedy J, Roll JM, Schraudner T, Murphy S, McPherson S. Prevalence of persistent pain in the U.S. adult population: new data from the 2010 national health interview survey. The journal of pain : official journal of the American Pain Society. 2014;15:979-84. doi: 10.1016/j.jpain.2014.05.009.

32. Fayaz A, Croft P, Langford RM, Donaldson LJ, Jones GT. Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies. BMJ open. 2016;6:e010364. doi: 10.1136/bmjopen-2015-010364.

33. Miaskowski C, Penko JM, Guzman D, Mattson JE, Bangsberg DR, Kushel MB.
Occurrence and characteristics of chronic pain in a community-based cohort of indigent adults living with HIV infection. The journal of pain : official journal of the American Pain Society. 2011;12:1004-16. doi: 10.1016/j.jpain.2011.04.002

34. Sprague L. HIV-related Stigma. Accessed 2 March 2018.

Tables

Table 1 Study group characteristics and selected clinical parameters that may affect the occurrence of pain in HIV-positive individuals

| Study group parameters (n=196)                              | Median | Q1    | Q4    | 6   |
|------------------------------------------------------------|--------|-------|-------|-----|
| Age of subjects at the time of their registration at SC (years) | 31.9   | 26.8  | 3     | 3   |
| Age of subjects at study inclusion (years)                  | 41.0   | 34.4  | 4     | 4   |
| BMI prior to study inclusion (kg/m²)                        | 23.6   | 21.3  | 2     | 2   |
| BP prior to study inclusion: systolic/diastolic (mm Hg)     | 136/88 | 127/80| 14    |
| ART duration (years)                                        | 4.3    | 2.5   | 1     | 1   |
| CD4+ cell count at registration at SC (cells/mcL)           | 350    | 192   | 5     | 5   |
| CD4+ cell count prior to study inclusion (cells/mcL)        | 550    | 424   | 7     | 7   |
| CRP levels at registration at SC (IU)                       | 5.0    | 5.0   | 5     | 5   |
| CRP levels prior to study inclusion (IU)                    | 6.0    | 5.0   | 5     | 5   |
| Serum HGB at registration at SC (g/dL)                      | 14.2   | 12.8  | 1     | 1   |
| Serum HGB prior to study inclusion (g/dL)                   | 15.0   | 13.9  | 1     | 1   |

ART, antiretroviral therapy; BMI, body mass index; BP, blood pressure; CRP, C-reactive protein; HGB – hemoglobin; IU, international units; Q – quartile; SC, specialist HIV/AIDS clinic

Table 2 Univariate logistic regression analysis for the effect of baseline epidemiological parameters

| Variable                        | OR    | 95% CI     | P val |
|---------------------------------|-------|------------|-------|
| Sex                             | 0.60  | 0.28-1.30  | 0.19  |
| Age at study inclusion (per 5-year increase in age) | 1.36  | 1.17-1.58  | <0.0  |
| Route of HIV infection          |       |            |       |
| Heterosexual contact vs. IDU    | 0.54  | 0.21-1.38  | 0.36  |
| Homosexual contact vs. IDU      | 0.33  | 0.14-0.75  | 0.00  |
| Other vs. IDU                   | 2.19  | 0.45-10.5  | 0.07  |
| Unknown vs. IDU                 | 0.56  | 0.18-1.79  | 0.52  |
| Duration of specialist care (per 10-year increment)        | 1.08  | 1.04-1.14  | 0.00  |
| Hazardous alcohol use           | 1.03  | 0.54-2.67  | 0.64  |

CI, confidence interval; IDU, intravenous drug use; OR, odds ratio
Table 3 Univariate logistic regression analysis for the effect of parameters associated with ART

| Variable                                                      | OR     | 95% CI     | P value |
|---------------------------------------------------------------|--------|------------|---------|
| On ART                                                        | 4.81   | 0.61-38.2  | 0.137   |
| Nadir CD4+ cell count (per 100-cell/mcL increment)            | 0.81   | 0.66-1.01  | 0.060   |
| Duration of ART (per 10-year increment)                        | 1.11   | 1.05-1.19  | <0.001  |
| Achieving undetectable viral load (<50 HIV RNA copies/mL after ART initiation) | 2.09   | 0.24-18.3  | 0.506   |
| Viral rebound following complete suppression                   | 2.45   | 1.30-4.59  | 0.005   |
| Previously treated with zidovudine (AZT)                      | 2.00   | 1.06-3.80  | 0.034   |
| Previous treatment with ‘D’ drugs (ddI, ddC, d4T)              | 4.13   | 1.92-8.91  | <0.001  |

ART, antiretroviral therapy

Table 4 Univariate and multivariate logistic regression analyses

| Variable                                                      | Univariate analysis | Multivariate analysis |
|---------------------------------------------------------------|---------------------|-----------------------|
|                                                               | OR      | 95% CI     | P value | OR      | 95% CI     | P value |
| Age at study inclusion (per 5-year increment)                 | 1.36    | 1.17-1.58  | <0.001  | 1.28    | 1.06      | 1.55    |
| Nadir CD4+ count (per 100-cell/mcL increment)                 | 0.81    | 0.66-1.01  | 0.06    | 1.16    | 0.88      | 1.53    |
| Duration of specialist care (per 10-year increment)           | 2.25    | 1.42-3.57  | <0.001  | 0.73    | 0.22      | 2.48    |
| Duration of ART (per 10-year increment)                       | 2.96    | 1.60-5.49  | <0.001  | 1.87    | 0.37      | 9.46    |
| HIV risk group                                                |         |            |         |         |           |         |
| Heterosexual contact vs. IDU                                  | 0.54    | 0.21-1.38  | 0.362   | 0.63    | 0.18      | 2.19    |
| Homosexual contact vs. IDU                                    | 0.33    | 0.14-0.75  | 0.005   | 0.46    | 0.15      | 1.45    |
| Other vs. IDU                                                 | 2.19    | 0.45-10.5  | 0.071   | 1.33    | 0.23      | 7.51    |
| Unknown vs. IDU                                               | 0.56    | 0.18-1.79  | 0.528   | 0.59    | 0.14      | 2.45    |
| Viral rebound following complete suppression                   | 2.45    | 1.30-4.59  | 0.005   | 1.32    | 0.58      | 3.01    |
| Previous treatment with AZT                                   | 2.00    | 1.06-3.80  | 0.0336  | 0.67    | 0.25      | 1.77    |
| Previous treatment with ‘D’ drugs (ddI, ddC, d4T)             | 4.13    | 1.92-8.91  | <0.001  | 2.11    | 0.69      | 6.42    |

AZT, zidovudine; IDU, intravenous drug use

Figures
Figure 1
Declared duration of pain in the pain-reporting subgroup (n=96)

Figure 2
Chronic pain severity (n=57) rated with Brief Pain Inventory (BPI) Short Form