

EAR, NOSE AND THROAT (ENT)/OTOLARYNGOLOGY:								
Condition	HIV-Related?	Comorbidity or Complication of HIV?	Evidence-Based Interventions?	Promotes Viral Suppression?	Improves QoL?	Diagnostic Procedure Required?	Anesthesia/Sedation Type if Procedure Needed	References
Chronic Sinusitis	Yes — more common and severe in HIV, especially with CD4 <200; correlates inversely with CD4 count	Complication (immunosuppression-related); also comorbidity in those with preserved immunity	ART (immune reconstitution), antibiotics, nasal corticosteroids; CT/MRI for refractory cases; ENT referral for surgical cases	Indirectly — ART-mediated immune reconstitution reduces recurrence	Yes — reduces chronic congestion, headache, recurrent infections	CT sinus ± endoscopic sinus surgery for refractory cases	Local anesthesia for nasal endoscopy; general anesthesia for functional endoscopic sinus surgery (FESS)	[1-6]
Oral HPV	Yes — HIV increases HPV persistence and oncogenic risk; oral/pharyngeal cancers elevated in PWH	Comorbidity (STI co-infection) and complication (impaired HPV clearance due to immunosuppression)	HPV vaccination (9-valent); ART; treatment of warts (cryotherapy, laser, surgical excision); oral cancer screening	Yes — viral suppression lowers risk of HPV-related cancers	Yes — reduces cancer risk and lesion burden	Oral exam; biopsy of suspicious lesions	Local anesthesia for biopsy	[1-2, 7-8]
Oral Candidiasis	Yes — AIDS-defining indicator of immunosuppression; typically CD4 <200	Complication (opportunistic infection)	ART; topical antifungals (nystatin, clotrimazole); systemic fluconazole for moderate-severe cases	Yes — ART restores immunity and reduces recurrence	Yes — improves oral comfort, nutrition, and medication adherence	Clinical diagnosis (visual exam); KOH prep or culture if atypical	None typically required	[1-2, 9]

ENDOCRINOLOGY:								
Condition	HIV-Related?	Comorbidity or Complication of HIV?	Evidence-Based Interventions?	Promotes Viral Suppression?	Improves QoL?	Diagnostic Procedure Required?	Anesthesia/Sedation Type if Procedure Needed	References
Diabetes	Yes — HIV infection and ART (especially PIs, certain NRTIs, INSTIs) increase insulin resistance and diabetes risk	Comorbidity (metabolic complication of HIV/ART)	ART optimization (avoid offending agents if possible); lifestyle modifications; metformin, GLP-1 RAs; screening per ADA guidelines; A1C may underestimate glycemia in PWH — use fasting glucose	Indirectly — metabolic stability supports ART adherence and engagement in care	Yes — reduces cardiovascular risk, neuropathy, and other complications	Lab-based (fasting glucose, OGTT); no invasive procedure typically required	None	[1, 7, 10-13]
Hypogonadism	Yes — prevalence 13–40% in men with HIV; associated with advanced disease, ART (efavirenz), and functional causes	Comorbidity (endocrine complication)	Morning testosterone testing; LH/FSH to determine primary vs. central; testosterone replacement therapy if confirmed; lifestyle modifications (exercise, weight loss)	Indirectly — treating hypogonadism improves energy, mood, and adherence	Yes — improves fatigue, libido, mood, bone density, body composition	Lab-based (serum testosterone, LH, FSH, SHBG); no invasive procedure	None	[1-2, 14-16]

OpenEvidence AI Review-Selections from Miami-Dade Ryan White Allowable Conditions List

GASTROINTESTINAL:								
Condition	HIV-Related?	Comorbidity or Complication of HIV?	Evidence-Based Interventions?	Promotes Viral Suppression?	Improves QoL?	Diagnostic Procedure Required?	Anesthesia/Sedation Type if Procedure Needed	References
Syphilitic Colitis	Yes — syphilis prevalence is higher in PWH (especially MSM); GI syphilis is rare but more likely in immunocompromised patients	Comorbidity (STI co-infection with GI manifestation)	Penicillin G benzathine (IM) or IV penicillin for neurosyphilis; colonoscopy/sigmoidoscopy with biopsy for diagnosis; must differentiate from IBD	Yes — treating syphilis reduces transient viral load increases and CD4 declines seen with active syphilis	Yes — resolves diarrhea, bleeding, abdominal pain	Colonoscopy or sigmoidoscopy with biopsy; serologic testing	Sedation (moderate/conscious sedation for colonoscopy/sigmoidoscopy)	[9, 17-21]
Diarrhea	Yes — HIV enteropathy damages gut-associated lymphoid tissue; also caused by OIs, ART side effects	Complication (HIV enteropathy, OIs) and comorbidity (ART-related)	ART (immune reconstitution); stool studies for OIs; supportive care (hydration, electrolytes, nutritional support); ART adjustment if drug-related	Yes — ART treats underlying HIV enteropathy	Yes — improves nutrition, hydration, daily functioning	Stool studies; colonoscopy if persistent/unexplained	Sedation for colonoscopy if needed	[1-2, 7]
Esophageal Candidiasis	Yes — AIDS-defining illness; typically CD4 <200	Complication (opportunistic infection)	Systemic fluconazole (14–21 days) is first-line; itraconazole solution as alternative; endoscopy if no response to empiric antifungal therapy within 7 days; ART for immune reconstitution	Yes — ART restores immunity and dramatically reduces incidence	Yes — resolves odynophagia, improves nutrition and medication tolerance	Empiric antifungal trial first; EGD (upper endoscopy) if no response in 7 days	Sedation (moderate/conscious sedation for EGD)	[9, 22-24]
Nausea/Vomiting	Yes — common ART side effect; also caused by OIs, HIV-related GI disease	Comorbidity (ART adverse effect) and complication (OIs, HIV enteropathy)	Antiemetics; ART regimen adjustment if drug-related; evaluate for OIs or other GI pathology	Yes — managing nausea improves ART adherence	Yes — improves comfort, nutrition, medication tolerance	Lab workup; upper endoscopy if persistent/unexplained	Sedation for EGD if needed	[1-2, 7]

OpenEvidence AI Review-Selections from Miami-Dade Ryan White Allowable Conditions List

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GENITOURINARY (GU)/ GYNECOLOGY (GYN)/OBSTETRICS (OB):								
Condition	HIV-Related?	Comorbidity or Complication of HIV?	Evidence-Based Interventions?	Promotes Viral Suppression?	Improves QoL?	Diagnostic Procedure Required?	Anesthesia/Sedation Type if Procedure Needed	References
Abnormal Pap Smear	Yes — PWH have higher rates of cervical dysplasia and HPV persistence; annual Pap recommended for PWH	Complication (HPV-related dysplasia in setting of immunosuppression)	Annual cervical Pap for PWH; colposcopy with directed biopsy for abnormal results (ASC-H, LSIL, HSIL); HPV vaccination; ART	Yes — viral suppression associated with lower risk of HPV-related cancers	Yes — early detection and treatment prevent cervical cancer	Colposcopy with directed biopsy	Local anesthesia (cervical block for colposcopy/biopsy; paracervical block for LEEP/excisional procedures)	[1-2, 14, 25]
Cervical HPV	Yes — HIV impairs HPV clearance; cervical cancer is an AIDS-defining malignancy	Complication (impaired HPV clearance) and comorbidity (STI co-infection)	HPV vaccination (9-valent); annual cervical screening; colposcopy for abnormal cytology; treatment of CIN per guidelines; ART	Yes — viral suppression lowers cancer risk	Yes — prevents cervical cancer progression	Pap smear, HPV co-testing; colposcopy with biopsy for abnormal results	Local anesthesia for colposcopy/biopsy; regional (paracervical) for LEEP	[1, 8, 14, 26]
Erectile Dysfunction	Yes — prevalence 30–50% in men with HIV (vs. general population); HIV is an independent risk factor	Comorbidity (multifactorial: HIV-related, ART-related, psychosocial)	PDE5 inhibitors (caution with PI drug interactions); address psychosocial factors; testosterone replacement if hypogonadal; ART optimization; behavioral therapy	Indirectly — addressing ED improves QoL and engagement in care	Yes — improves sexual health, relationships, psychological well-being	Lab-based (testosterone, glucose, lipids); sexual history questionnaires (IIEF-5)	None typically	[1, 7, 27-32]

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Hematuria (Neoplasm-Related)	Yes — PWH at increased risk for kidney and bladder cancers; hematuria found in 25% of PWH in one series	Comorbidity (non-AIDS-defining cancers) and complication (HIV-associated nephropathy, immune complex disease)	Urinalysis; urine cytology; cystoscopy; CT urogram; renal biopsy if nephropathy suspected; cancer treatment per standard guidelines with ART continuation	Yes — viral suppression associated with lower cancer mortality	Yes — early cancer detection improves survival	Cystoscopy; CT urogram; renal biopsy if indicated	Sedation for cystoscopy (local or moderate sedation); sedation/general anesthesia for renal biopsy	[1-2, 33-38]
Pregnancy	Yes — HIV management is critical during pregnancy to prevent perinatal transmission	Comorbidity (requires specialized ART management)	ART initiation as early as possible (preferably preconception); DTG + TAF/FTC preferred regimen; viral load monitoring; cesarean delivery if VL >1000 near delivery; neonatal ARV prophylaxis	Yes — ART during pregnancy achieves/maintains viral suppression, preventing transmission	Yes — prevents perinatal HIV transmission; improves maternal and neonatal outcomes	Routine prenatal labs; HIV VL monitoring; expedited HIV testing if status unknown at delivery	Regional anesthesia (epidural/spinal for labor/delivery/cesarean); general anesthesia for emergency cesarean	[1-2, 39-40]
Scrotal Candidiasis	Indirectly — cutaneous/genital fungal infections are more prevalent in immunocompromised PWH, though scrotal candidiasis is not a classic HIV-defining condition	Comorbidity (fungal infection in immunocompromised host)	Topical antifungals (clotrimazole, miconazole); systemic fluconazole for refractory cases; ART for immune reconstitution; glucose control if diabetic	Indirectly — ART-mediated immune reconstitution reduces fungal infections	Yes — resolves discomfort and skin breakdown	Clinical diagnosis; KOH prep or fungal culture if atypical	None typically	[1, 7, 9, 41]

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Vaginitis	Yes — bacterial vaginosis, vulvovaginal candidiasis, and trichomoniasis are all more prevalent in women with HIV	Comorbidity (altered vaginal flora due to immunosuppression) and complication (increases HIV genital shedding and transmission risk)	Treatment per CDC STI guidelines (same as HIV-negative women); metronidazole for BV/trichomoniasis; azoles for VVC; ART	Indirectly — treating vaginitis reduces HIV genital shedding	Yes — reduces symptoms, decreases HIV transmission risk	Wet mount, KOH prep, vaginal pH, NAAT for trichomoniasis; pelvic exam	None typically	[1, 42-45]

Condition	HIV-Related?	Comorbidity or Complication of HIV?	Evidence-Based Interventions?	Promotes Viral Suppression?	Improves QoL?	Diagnostic Procedure Required?	Anesthesia/Sedation Type if Procedure Needed	References
Gynecological Cancers	Yes — cervical cancer is AIDS-defining; vulvar/vaginal cancers also HPV-related and elevated in PWH	Complication (cervical cancer is AIDS-defining) and comorbidity (non-AIDS-defining gynecologic cancers)	HPV vaccination; cervical screening; colposcopy/biopsy; surgery, chemotherapy, radiation per NCCN guidelines; ART continuation during cancer therapy	Yes — viral suppression associated with lower cancer incidence and mortality	Yes — cancer treatment improves survival and function	Colposcopy, biopsy, imaging (CT/MRI/PET); surgical staging	Ranges: local anesthesia (biopsy) to general anesthesia (surgical staging/debulking, radical hysterectomy)	[1-2, 8, 14, 26]
Prostate Cancer	Not directly HIV-related — screening recommendations same as general population per USPSTF	Comorbidity (age-related; not increased by HIV per current evidence)	PSA screening per USPSTF; biopsy if indicated; standard treatment (surgery, radiation, ADT) with ART continuation; co-management with HIV specialist	Indirectly — ART should continue during cancer treatment	Yes — cancer treatment improves survival	PSA, DRE; prostate biopsy (transrectal or transperineal); MRI	Local anesthesia ± sedation for prostate biopsy; general or regional anesthesia for prostatectomy	[1-2, 14, 26]

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HEMATOLOGY:								
Condition	HIV-Related?	Comorbidity or Complication of HIV?	Evidence-Based Interventions?	Promotes Viral Suppression?	Improves QoL?	Diagnostic Procedure Required?	Anesthesia/Sedation Type if Procedure Needed	References
Anemia	Yes — prevalence ~6.9% in PWH vs. 3.4% in HIV-negative; multifactorial (HIV, OIs, ART toxicity)	Complication (direct viral effect, ART toxicity, OIs)	ART optimization; iron supplementation if deficient; erythropoietin-stimulating agents; treat underlying cause (OIs, drug toxicity); CBC monitoring	Yes — correcting anemia improves energy and ART adherence	Yes — reduces fatigue, improves functional status	CBC, reticulocyte count, iron studies, B12/folate; bone marrow biopsy if unexplained	Sedation or local anesthesia for bone marrow biopsy if needed	[1-2, 7, 46]
Leukopenia	Yes — common in untreated HIV; also ART-related (e.g., zidovudine)	Complication (direct viral effect, ART toxicity)	ART optimization; discontinue offending agents; CBC monitoring; evaluate for OIs or malignancy	Yes — ART restores hematopoiesis	Yes — reduces infection susceptibility	CBC with differential; bone marrow biopsy if persistent/unexplained	Local anesthesia ± sedation for bone marrow biopsy if needed	[1-2, 7, 46]

Condition	HIV-Related?	Comorbidity or Complication of HIV?	Evidence-Based Interventions?	Promotes Viral Suppression?	Improves QoL?	Diagnostic Procedure Required?	Anesthesia/Sedation Type if Procedure Needed	References
Neutropenia	Yes — prevalence ~1.3% in PWH vs. 0.2% in HIV-negative; increases risk of bacterial infections	Complication (direct viral effect, ART toxicity, OIs)	G-CSF (granulocyte colony-stimulating factor); ART optimization; infection prevention; discontinue offending drugs	Yes — ART restores neutrophil counts	Yes — reduces infection risk and hospitalizations	CBC with differential; bone marrow biopsy if persistent/unexplained	Local anesthesia ± sedation for bone marrow biopsy if needed	[1, 7, 26, 46]
Thrombocytopenia	Yes — prevalence ~5.5% in PWH vs. 2.7% in HIV-negative; can be immune-mediated (HIV-ITP)	Complication (immune-mediated, direct viral effect, ART toxicity)	ART (often first-line for HIV-ITP); corticosteroids, IVIG, TPO-receptor agonists for refractory cases; platelet monitoring	Yes — ART is primary treatment for HIV-associated ITP	Yes — reduces bleeding risk	CBC, peripheral smear; bone marrow biopsy if atypical	Local anesthesia ± sedation for bone marrow biopsy if needed	[1-2, 7, 46]

HEMATOLOGY and ONCOLOGY:								
Condition	HIV-Related?	Comorbidity or Complication of HIV?	Evidence-Based Interventions?	Promotes Viral Suppression?	Improves QoL?	Diagnostic Procedure Required?	Anesthesia/Sedation Type if Procedure Needed	References
Polycythemia Vera	No — PV is a JAK2-driven myeloproliferative neoplasm; HIV does not predispose to PV; association is coincidental	Not an HIV comorbidity or complication; coincidental occurrence	Phlebotomy, low-dose aspirin, hydroxyurea, ropeginterferon alfa-2b, ruxolitinib per standard MPN guidelines; ART should continue; monitor for CYP3A4 drug interactions	Not directly — but ART should be maintained during PV treatment	Yes — PV treatment reduces thrombosis risk and symptoms	CBC, JAK2 mutation testing, serum EPO, bone marrow biopsy	Local anesthesia ± sedation for bone marrow biopsy	[47-51]

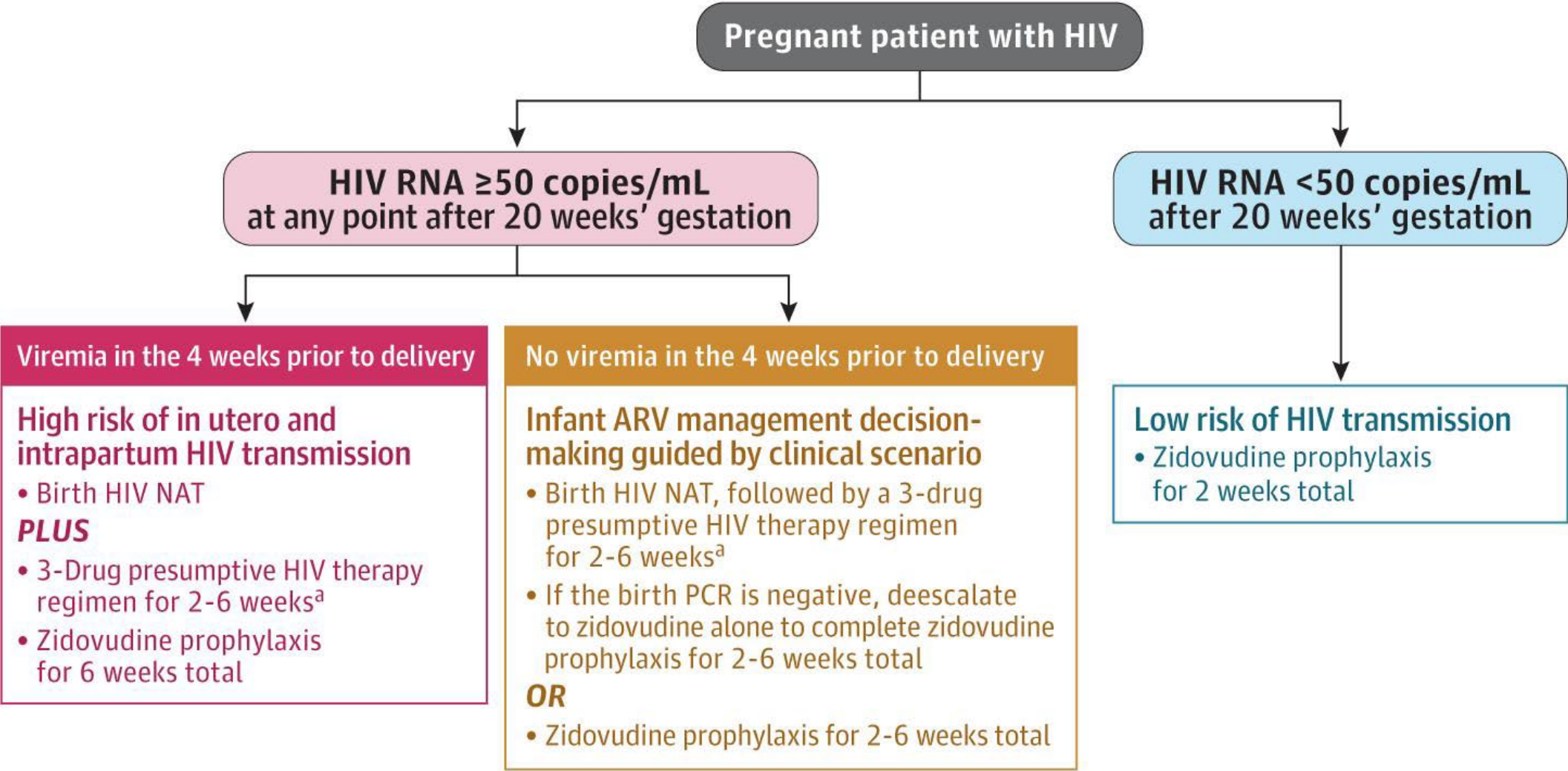
Key overarching principles from the HIVMA/IDSA 2024 Guidance:

- **Viral suppression is urged for all comorbidities** — higher CD4 counts (≥350 cells/μL) and maximal viral suppression are associated with lower 5-year mortality among PWH with any cancer diagnosis and lower incidence of both AIDS-defining and non-AIDS-defining conditions. [1][1]
- **Surgical and procedural decisions** for PWH should be based on shared decision-making and should **not depend on CD4 count or HIV RNA level alone**. [1]
- ART should be **continued during all cancer therapies and surgical procedures**, with modifications only in consultation with an HIV specialist to manage drug-drug interactions. [1][5]
- For conditions requiring anesthesia, PWH should be **appropriately considered for all medical and surgical procedures** without HIV-related stigma or discrimination. [1]

Would you like to explore the specific drug-drug interactions between ART regimens and anesthetic agents or chemotherapy protocols for any of these conditions?

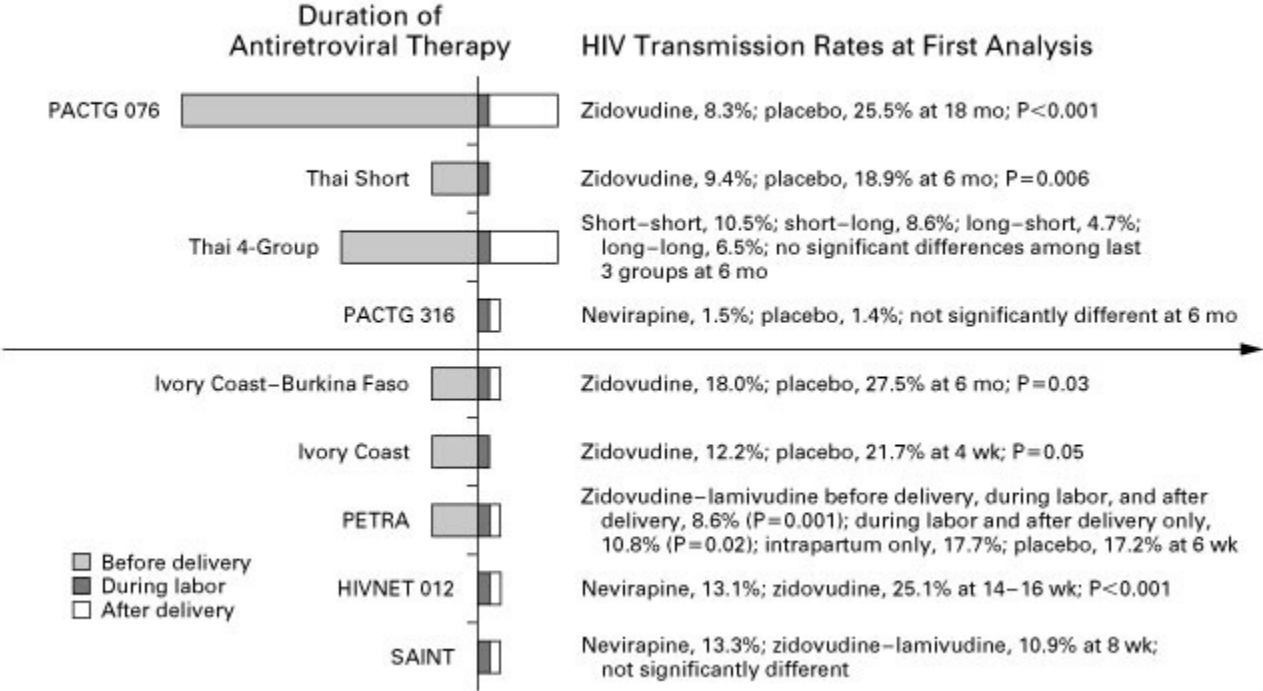
Relevant images

2 items



Algorithm for Antiretroviral (ARV) Treatment of Infants With In Utero or Intrapartum HIV Exposure by Risk of Transmission

 JAMA February 22, 2026



Duration of Antiretroviral Therapy and Perinatal Transmission of HIV-1.

 NEJM June 12, 2002

I need to research each of these conditions in relation to HIV to build a comprehensive table. Let me start with broad searches.

Now I have sufficient evidence to construct the comprehensive table. Let me compile the information.

Below is a comprehensive reference table addressing each condition in the context of HIV. The table draws primarily from the **HIVMA/IDSA 2024 Primary Care Guidance** (Horberg et al.), the [\[1\] IAS-USA 2024 Recommendations](#), the [\[3\] HHS Perinatal Guidelines](#), the [\[4\] OI Guidelines](#), the [\[5\] NCCN Cancer in People with HIV Guidelines](#), the [\[6\] CDC STI Treatment Guidelines](#), and additional condition-specific literature a

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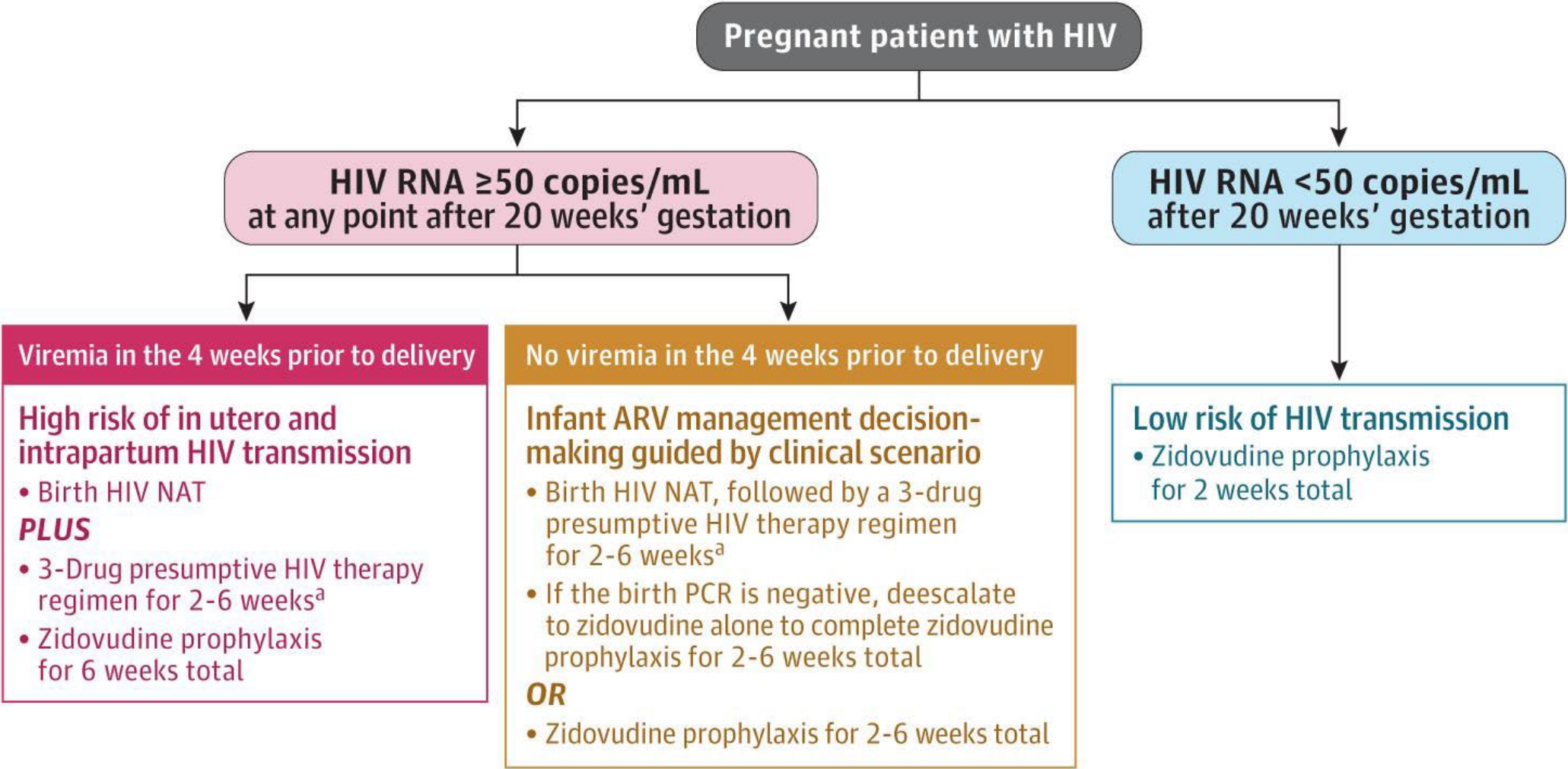


Figure Algorithm for Antiretroviral (ARV) Treatment of Infants With In Utero or Intrapartum HIV Exposure by Risk of Transmission Short WR, Sheth AN, Ciaranello A. [HIV During Pregnancy and Infant Feeding](#). Jama.

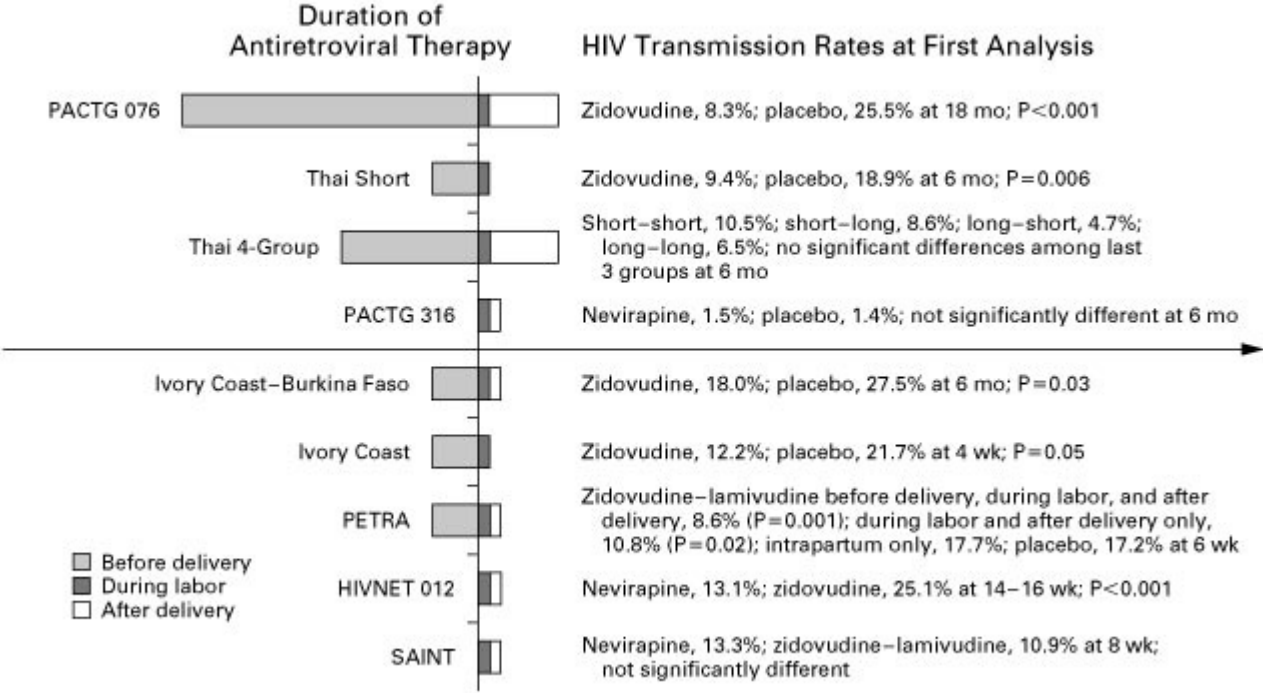


Figure 1 Duration of Antiretroviral Therapy

2026;;2845515. doi:10.1001/jama.2026.0943.
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