Peripheral Nerve Disorders: Chapter 29. HIV peripheral neuropathy (Handbook of Clinical Neurology)

Alberto Alain Gabbai, Adauto Castelo, Acary Souza Bulle Oliveira

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Peripheral neuropathies are the most common neurological manifestations occurring in HIV-infected individuals. Distal symmetrical sensory neuropathy is the most common form encountered today and is one of the few that are specific to HIV infection or its treatment. The wide variety of other neuropathies is akin to the neuropathies seen in the general population and should be managed accordingly. In the pre-ART era, neuropathies were categorized according to the CD4 count and HIV viral load. In the early stages of HIV infection when CD4 count is high, the inflammatory demyelinating neuropathies predominate and in the late stages with the decline of CD4 count opportunistic infection-related neuropathies prevail. That scenario has changed with the present almost universal use of ART (antiretroviral therapy). Hence, HIV-associated peripheral neuropathies are better classified according to their clinical presentations: distal symmetrical polyneuropathy, acute inflammatory demyelinating polyradiculoneuropathy (AIDP) and chronic inflammatory demyelinating polyradiculoneuropathy (CIDP), mononeuropathies, mononeuropathies multiplex and cranial neuropathies, autonomic neuropathy, lumbosacral polyradiculomyelopathy, and amyotrophic lateral sclerosis (ALS)-like motor neuropathy. Treated with ART, HIV-infected individuals are living longer and are at a higher risk of metabolic and age-related complications; moreover they are also prone to the potentially neurotoxic effects of ART. There are no epidemiological data regarding the incidence and prevalence of the peripheral neuropathies. In the pre-ART era, most data were from case reports, series of patients, and pooled autopsy data. At that time the histopathological evidence of neuropathies in autopsy series was almost 100%. In large prospective cohorts presently being evaluated, it has been found that 57% of HIV-infected individuals have distal symmetrical sensory neuropathy and 38% have neuropathic pain. It is now clear that distal symmetrical sensory neuropathy is caused predominantly by the ART's neurotoxic effect but may also be caused by the HIV itself. With a sizeable morbidity, the neuropathic pain caused by distal symmetrical sensory neuropathy is very difficult to manage; it is often necessary to change the ART regimen before deciding upon the putative role of HIV infection itself. If the change does not improve the pain, there are few options available; the most common drugs used for neuropathic pain are usually not effective. One is left with cannabis, which cannot be recommended as routine therapy, recombinant human nerve growth factor, which is unavailable, and topical capsaicin with its side-effects. Much has been done to and learned from HIV infection in humans; HIV-infected individuals, treated with ART, are now dying mostly from cardiovascular disease and non-AIDS-related cancers. It hence behooves us to find new approaches to mitigate the residual neurological morbidity that still impacts the quality of life of that population.

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