Key Populations ECHO Agenda
5/12/2023

Reminders: HIPAA, CME Credit Available, Zoom Chat, Share Your Cameras, Mute Microphones

Presenter	Topic
Anthony DiMartino, MAT	**General ECHO Reminders**
Matthew Huddleston, MD, AAHIVS **Jeannie McIntosh, APRN, FNP-C, AAHIVS** **Brenda Beauchamp, PsyD** **Kara Lewis, PharmD, AAHIVP** **Mikveh Warshaw, PMHNP, CARN-AP** **Jamie Stevens, DNP, PMHNP, CARN-AP**	**Faculty Introductions**
Nichole Petterson, APRN **Mosaic Medical**	**Case Presentation** **HIV Case** **ECHO ID: 101293** New patient to practice, VL <20 CD4 400, hasn't taken medication for many months (and never consistent with medication use given memory loss in repeat TBI (violence as sex worker)). No records/prior CD4 available, presume CD4 has taken a hit, discussed risk/benefit with patient, option for Cabenuva. She is willing. I have concerns she will be unable to keep regular appointments/injections: is this risk worth the anti-inflammatory benefit?
Nichole Petterson, APRN **Mosaic Medical**	**Case Presentation** **HIV Case** **ECHO ID: 101302** Patient on Biktarvy since diagnosis in 2021 with CD4 of 12 (OI of PCP at presentation). Patient doing well, never misses a dose. CD4 was ~300 several months ago, now 200 (VL was 100, now 57). Realize these are normal fluctuations but nervous given low baseline CD4 and persistent viral load, recent complaints of fatigue (tsh, testosterone, cbc, cmp unremarkable). Patient with history of persistent pulmonary infection, last treated mid-August with resolution on imaging. Am I missing drug-drug interactions (he doesn't take other meds for now)/food drug interactions or a more optimal way to take Biktarvy? At what point would you switch meds?

Tatianna Pryce, APRN **Community Health Center, Inc.**	**Case Presentation** **CKP Case** **ECHO ID: 101304** Patient is a 32-year-old trans female. She started gender affirming hormone therapy in January 2022. She has not yet done bottom surgery but is planning on it. She is currently in consult for facial feminization surgery and is completing laser hair removal. She is currently managed on 15 mg Delestrogen valerate IM every 6 days. She is also managed on finasteride for antiandrogen effect as well as 200 mg of progesterone. She reports that she does not take progesterone daily and does not have any particular pattern sometimes 2 days on 3 days off etc. She reports that she has done some research regarding cycling progesterone to mimic a cis-gender female's cycle. She reports that she does notice increased sex drive when she is taking progesterone. She has been having pain with erections but reports that she has not gotten them as frequently. She reports pleasurable sex through receptive anal sex without an erection. She reports having some pain with talking as well as increased urinary urgency. Gender affirming E consult was obtained and a recommendation was made to decrease the time in which she would tuck. Our conversation brought up 3 questions. 1. Has anyone had any experience with managing progesterone cycling vs taking it daily? If so how is it done and what are the benefits vs disadvantages? Is there any evidence that taking progesterone too early in gender affirming care can decrease breast development? 2. Has anyone had anyone on feminizing hormone therapy experience penile discomfort or increasing pain with tucking? What is the usual counseling and when does it warrant further follow up? 3. There was some discussion about how keeping penile tissue relax can lead to better outcomes with feminizing bottom surgery. Can anyone comment on this?

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