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COMPREHENSIVE GERIATRIC ASSESSMENT IN OLDER ADULTS LIVING WITH HIV INFECTION

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EDITORIAL

Older people living with HIV often face major health challenges, including multimorbidity, polypharmacy, frailty, and disability. They may also present with chronic low-grade inflammation, accelerated immunosenescence, cumulative toxicity from prior treatments, and social vulnerability, all of which contribute to a discrepancy between biological and chronological age (1–3). Consequently, decision-making based solely on chronological age is no longer clinically reasonable or ethically justifiable in this population.

A comprehensive geriatric assessment (CGA) provides a holistic, structured, and oriented approach to identifying the most relevant problems and potential changes, while placing the patient at the center of care and recognizing what matters most to them throughout the care process (4-8).

In a recent article published in the Case Reports journal, Céspedes-Sierra *et al.* (9) present the case of a man diagnosed with stage 3C HIV at 50 years of age, clearly illustrating the phenomenon of accelerated aging in people living with HIV. Throughout the case, the authors describe the progressive development of multiple comorbidities (type 2 diabetes mellitus, chronic kidney disease requiring hemodialysis, miliary tuberculosis, among others) and classic geriatric syndromes (falls, cognitive impairment, malnutrition, pressure ulcers, incontinence, paralysis, among others), which made the patient go from being a fully autonomous person to being totally dependent for performing basic activities of daily living (Barthel index 0/100) and have a high score on prognostic scales. This case also demonstrates the biopsychosocial vulnerability of this population, the complex processes they must undergo to overcome acute and severe conditions during hospitalization, and their limited capacity for rehabilitation. The latter is largely attributable to the presence of homeostenosis and the development of frailty, factors that contribute to severe functional deterioration.

In this case, after recognizing the patient's poor rehabilitation potential and high risk of mortality, it was decided that the best option was to enroll him in a home-based palliative care program focused on symptom control, family support, and respect for the patient's wishes (9). Consequently, the patient spent his final days at home, where he ultimately died.

Using this case, the authors argue that timely implementation of CGA can help guide the goals of care, prevent unnecessary interventions, and facilitate advance care planning that is better aligned with the patient's clinical condition and values. This approach can optimize the patient's quality of life during the aging process, promote a dignified death, and provide support for the caregiver (9).

This report is relevant for several reasons. First, it provides evidence that older persons living with HIV experience accelerated physiological aging associated with chronic inflammation, accumulation of cellular and molecular damage, and social vulnerability, which translates into an increased risk of

developing geriatric syndromes at a relatively young chronological age. Second, it highlights the practical implications of continuing to use arbitrary age cut-off points for a multidimensional and comprehensive assessment such as CGA, which may hinder optimal patient care. Finally, it demonstrates how the lack of a structured geriatric perspective may lead to the implementation of multiple high-cost interventions that ultimately fail to provide any meaningful clinical benefit and instead may negatively impact the quality of life of both patients and their caregivers.

From a methodological perspective, the main strength of the article lies in the clinical and narrative depth of the case. The authors do not limit themselves to listing diagnoses but describe the patient's functional, cognitive, emotional, and social course, allowing the reader to identify, in almost every paragraph, the classic domains of CGA. In this sense, the article conveys a strong message for clinical practice: in older people with HIV, CGA enables the systematic identification of clinical, functional, cognitive, affective, and social problems that often go unnoticed during consultations focused only on viral load or CD4 count; it allows stratifying frailty and functional expectancy, providing a more realistic framework for discussing the appropriateness of invasive interventions; and it facilitates the explicit definition of care goals aligned with the patient's values and wishes, integrating the palliative approach from early stages when appropriate (10-12).

In conclusion, this case illustrates that the CGA is not merely a list of assessment scales, but a valuable tool in the shared decision-making process. Its application offers the opportunity to promote an in-depth and empathic dialogue among healthcare professionals, the patient, and their family, allowing prognosis, wishes, and preferences to be addressed with the goal of providing individualized care, avoiding unnecessary harm, and guiding patients through care trajectories that are more consistent with their needs and wishes.

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