Leaving Against Medical Advice:

A patient with AIDS complicated by disseminated Mycobacterium avium complex, cryptococcal meningitis, HIV-associated nephropathy, and more

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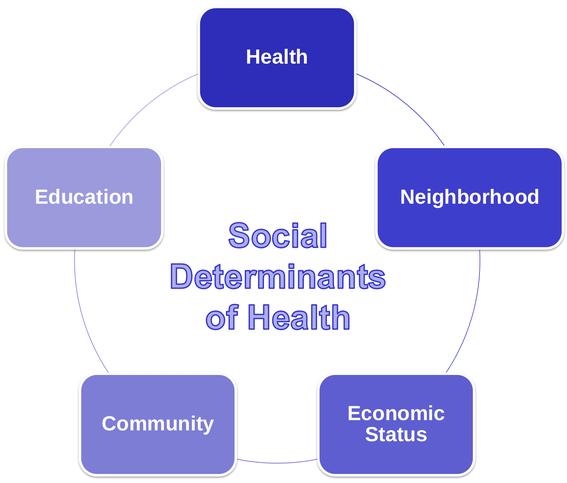
Background

Patients with HIV/AIDS who are admitted to the hospital often require intensive inpatient therapies, treatment plans organized by specialists, and close follow-up after discharge. However, persons with HIV/AIDS are at a higher risk of leaving against medical advice (AMA); about 13% in comparison to the general population with just over 1%[1].

13% of persons with HIV/AIDS leave AMA

This is often attributed to a mix of social determinates of health including high risk lifestyles, comorbid psychiatric illnesses, and increased perception of stigma[2].



Patients who leave AMA are more likely to have adverse events, delayed treatment of infections, and increased morbidity. This case highlights that in a patient with signs of intending to leave AMA, it is vital to have close outpatient follow-up scheduled and prepare their prescriptions soon as treatment plans are finalized.

Case Presentation

A 27-year-old female with history of HIV/AIDS (CD4 count of 11), HFrEF (EF of 30-35%), cryptococcal meningitis, and C. difficile colitis was transferred for a higher level of care after being brought in for altered mental status. The patient was tachycardic, hypotensive, and hypoglycemic, with anasarca present on exam. She was found to have disseminated Mycobacterium avium complex (dMAC) and cryptococcal meningitis. She also had an acute kidney injury, suspected to be secondary to HIV-associated nephropathy. A kidney biopsy was recommended to confirm the diagnoses but was declined by the patient. She had anemia and profound thrombocytopenia that resolved after initiation of antiretroviral therapy (ART).

She was found to have trichomoniasis and genital herpes and was started on treatment but declined testing for other sexually transmitted infections. For most of her hospital stay, psychiatry determined she lacked capacity to leave against medical advice. However, the last consultation for an assessment of capacity determined that she did have capacity to make decisions. Her overall nutrition status and ability to perform activities of daily living were suboptimal at that time. She had often refused labs, medications, and physical/occupational therapy sessions during admission. Attempts were made to get her placed in skilled nursing facilities and long-term acute care facilities. However, she was denied as she was not stable enough for transfer.

Before leaving AMA, she was able to receive most of her medications (including her dMAC and cryptococcal treatments). Unfortunately, the prior authorization for her ART was not finished processing, and she was unwilling to wait on its completion. She was scheduled for close follow-up with infectious disease. However, she missed her infectious disease appointment, the call to reschedule, and was ultimately deemed lost to follow-up.

Discussion

Over 1% of all hospital admissions end with patients leaving AMA[3]. Persons with HIV/AIDS are at an increased risk of doing so and may be some of the most vulnerable patients to leave without safe discharge. Persons with HIV/AIDS often require specialized formulations of medications that may necessitate insurance prior authorizations and approval. In these instances, starting the paperwork before the patient is ready for discharge can be beneficial, to decrease the risk of time without medications upon discharge, particularly in the setting of patients with an increased likelihood of leaving AMA. Having medications ready in advance could be lifesaving. In cases when patients are at increased risk of leaving AMA, providers should:

- Initiate medication authorization as soon as possible
- Schedule follow-up appointment and inform patient
- Counsel patient on strong return precautions

This case demonstrates the importance of anticipating patients' choices to mitigate the risks of leaving AMA.

References

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