ISSN: 2755-1067

Journal of Diseases Disorders & Treatments

SCIENTIFIC Research and Community

Case Report

Open Access

Delayed HIV Diagnosis in an Elderly Female: A Case of Missed Opportunities Across Multiple Specialties

Myra Tariq* and Waleed Jamshed

Manchester University NHS Foundation Trust (MFT), United Kingdom

ABSTRACT

This case highlights a significantly delayed diagnosis of HIV in a 78-year-old female, despite more than 20 clinical encounters over four years. The patient presented with classic HIV indicator conditions, including unexplained weight loss, generalized lymphadenopathy, recurrent infections, and esophageal candidiasis. Due to demographic biases and the absence of routine HIV screening in older, heterosexual individuals, the diagnosis was missed until advanced immunosuppression occurred. Ultimately, an HIV test conducted by the Infectious Diseases (ID) team revealed a CD4 count of 8 cells/mm^3 and a viral load of 346,000 copies/mL. This case underscores the urgent need to adopt inclusive HIV testing practices and eliminate demographic profiling as a barrier to early diagnosis.

***Corresponding author**

Myra Tariq, Manchester University NHS Foundation Trust (MFT), United Kingdom.

Received: November 05, 2025; **Accepted:** November 10, 2025; **Published:** December 15, 2025

Introduction

HIV remains a significant public health concern in the United Kingdom, with approximately 5,000 new diagnoses reported annually [1]. Although great strides have been made in early detection, older adults—particularly those outside traditionally defined high-risk groups—are disproportionately affected by delayed diagnoses. Nearly half of HIV-positive individuals aged over 50 are diagnosed at a late stage, defined by a CD4 count below 350 cells/mm^3 [2]. These delays are associated with worse clinical outcomes, including increased mortality and healthcare utilization.

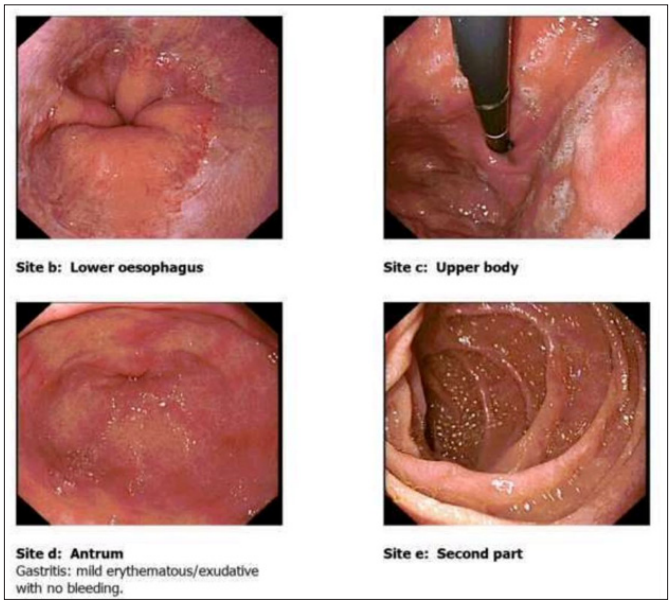
Current testing strategies often fail to incorporate the full spectrum of HIV presentations, especially when the patient does not align with the stereotypical image of someone "at risk." This case report exemplifies how reliance on outdated demographic risk models, fragmented care pathways, and insufficient attention to epidemiological details can result in missed opportunities for early HIV diagnosis.

Case Presentation

A 78-year-old Caucasian female with a background of hypertension and bilateral hip replacements first engaged with the healthcare system in 2012 for orthopedic follow-up. She lived independently, had no history of intravenous drug use, no reported sexual health concerns, and had never been offered an HIV test. She regularly traveled to The Gambia to visit her daughter and grandchildren, a detail that was not consistently recorded in her medical history.

In 2016, during a routine lung screening, a low-dose CT thorax revealed non-calcified pulmonary nodules, which were not deemed suspicious due to their stability. Between 2017 and 2019, the patient experienced intermittent fevers, progressive fatigue, and unintentional weight loss of approximately six kilograms. Examination revealed generalized lymphadenopathy, confirmed radiologically, and subsequent biopsies showed only reactive hyperplasia.

Gastrointestinal symptoms, including dysphagia, bloating, and intermittent diarrhea, emerged in 2019. Workups by gastroenterology and hematology yielded inconclusive results, with autoimmune markers and stool cultures returning negative. Imaging showed continued lymph node enlargement. By early 2020, her dysphagia had worsened significantly, and total weight loss reached 12 kilograms. Esophagogastroduodenoscopy revealed severe candidiasis of the esophagus, which was treated with fluconazole. Despite the accumulation of recognized HIV indicator conditions—namely persistent lymphadenopathy, significant weight loss, and esophageal candidiasis—no HIV test was ordered at this stage.



In 2021, following repeated hospital admissions for chest infections, the patient was referred to an Infectious Diseases (ID) specialist. Routine screening by the ID team finally revealed that she was HIV-1 positive. Laboratory findings showed a CD4 count of 8 cells/mm³ and a viral load of 346,000 copies/mL. Further typing confirmed infection with HIV-1 subtype CRF02_AG, which is commonly found in West Africa. The patient was promptly started on antiretroviral therapy and demonstrated gradual immunological recovery over the following months.

Discussion

This case underscores a series of critical shortcomings in current HIV diagnostic practices, particularly as they pertain to older adults. These include demographic assumptions, missed guideline-based screening triggers, disjointed specialty care, and neglected epidemiological context.

One of the most striking aspects of this case is the role of demographic bias in delaying diagnosis. Ageism in healthcare is well-documented, and HIV testing protocols often fail to include older patients who fall outside conventional risk categories [3]. Despite presenting with multiple classical HIV indicator conditions, the patient's age, Caucasian ethnicity, and heterosexual orientation contributed to a perceived low risk that dissuaded clinicians from considering HIV in their differential diagnosis. This pattern is reflected in national data, which shows that 60% of people aged over 65 with HIV in the UK are diagnosed late [4].

Equally concerning is the failure to adhere to well-established national guidelines. The British HIV Association (BHIVA) recommends testing individuals who present with unexplained weight loss, persistent lymphadenopathy, and oral candidiasis—three hallmark conditions this patient experienced [5]. NICE guidelines similarly encourage increased testing in cases of unexplained systemic illness, particularly in populations that may not self-identify as at risk [6]. The lack of a coordinated response to these red flags points to both systemic and educational deficiencies in implementing these guidelines consistently.

Furthermore, the siloed nature of care delivery in this case reveals structural weaknesses in communication across specialties. Despite being seen by gastroenterology, hematology, and respiratory medicine, the absence of a unifying diagnosis led to piecemeal evaluations. There was no single clinician tasked with synthesizing the constellation of findings into a systemic diagnosis. This fragmentation is common in geriatric care and underscores the need for integrated diagnostic pathways, especially when dealing with chronic, unexplained multisystem illness [7].

The epidemiological significance of the patient's annual travel to The Gambia was also overlooked. Subtype CRF02_AG, identified in her case, is endemic to West Africa and has unique virological features that may influence disease progression and treatment response [8]. Travel history should have prompted consideration of infectious diseases with a regional association, especially given her immunological decline. Studies have shown that failure to collect detailed travel histories remains a persistent gap in infectious disease diagnostics, even among experienced clinicians [9].

This case serves as a compelling argument for expanding HIV testing protocols. The adoption of routine, opt-out HIV screening in emergency departments has proven successful in capturing undiagnosed cases, especially among patients who do not perceive themselves to be at risk [10]. Extending this model to outpatient and specialty clinics could help prevent similarly delayed diagnoses. Additionally, auditing adherence to BHIVA and NICE testing guidelines could serve as a quality improvement strategy to close existing practice gaps [11].

Conclusion

The delayed diagnosis in this case highlights how demographic assumptions, fragmented care, and failure to apply guideline-based screening can result in severe clinical consequences. HIV testing must be symptom-driven rather than constrained by outdated demographic profiling. Incorporating inclusive and reflexive testing protocols—particularly in patients presenting with persistent, unexplained systemic illness—could substantially reduce rates of late-stage HIV diagnoses. This is especially crucial for older adults, whose presentations may be atypical and whose risk factors are often overlooked. Clinicians must be encouraged and supported to consider HIV as part of a routine diagnostic workup, regardless of the patient's age, ethnicity, or reported behaviors.

References

1. Public Health England (2021) HIV in the UK: Towards Zero 2030 Report.
2. National AIDS Trust (2020) HIV and Ageing.
3. Gilleece Y (2021) HIV and ageing: clinical considerations for older people living with HIV. Lancet HIV 8: e755-e764.
4. Delpech V (2020) Epidemiology of HIV in the UK: Declining incidence and increasing prevalence. BMJ Open 10: e036549.
5. British HIV Association (2020) BHIVA HIV Testing Guidelines. https://www.bhiva.org/testing-guidelines.
6. NICE. HIV testing: increasing uptake among people who may have undiagnosed HIV (NG60). https://www.nice.org.uk/guidance/ng60.
7. Fulop NJ (2019) Fragmented care and delayed diagnosis: an analysis of system failure. J Health Serv Res Policy 24: 82-89.
8. Peeters M (2020) Genetic diversity of HIV-1: implications for therapy and vaccine development. Lancet Infect Dis 20: e262-e271.
9. Checkley AM (2016) Imported infections: assessing the utility of travel history in clinical diagnosis. Clin Med (Lond) 16: 457-462.

10. GOV.UK. Annual Epidemiological Spotlight on HIV in the North West (2022) https://www.gov.uk/government/publications.

11. UNAIDS (2020) Gambia Country Factsheet.

Copyright: ©2025 Myra Tariq. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.