Routine, Not Risk-Based, Human Immunodeficiency Virus Testing Is the Way to Go

To the Editor—The article by Dybul et al. [1], “Evaluation of Initial CD4 T Cell Counts in Individuals with Newly Diagnosed Human Immunodeficiency Virus Infection, by Sex and Race, in Urban Settings,” justly demonstrates the importance of early diagnosis of human immunodeficiency virus (HIV) infection. Once the CD4 cell count in HIV-infected individuals drops below $200 \times 10^3$ cells/L, there is a significant increase in morbidity and mortality, and, in some instances, there is a decrease in response to therapy [2]. Dybul et al. recommend that enhanced educational efforts be aimed at those individuals who are considered, either by themselves or by their medical providers, to be “at risk.” Nationally, HIV infection is increasing most rapidly among individuals with heterosexual risk, individuals who often underestimate their risk status [3]. Among women in Rhode Island with heterosexual risk factors for HIV, the median number of sexual partners during the previous 10 years is $\sim 3$ [4]. This finding demonstrates that it is not necessarily the number of sexual partners, but the risk status of the sexual partners, that is important.

One way to detect HIV infection more accurately and efficiently is to offer routine screening. With routine screening, no complex risk history would be required. Physicians are often uncomfortable asking patients to reveal sensitive risk-history information [5], and patients may have many reasons for providing false information or just may be uneducated concerning their true risk status [6]. These reasons may be a few of the many factors contributing to the large number of people currently HIV infected in the United States who are unaware of their status [7]. Routine testing would simply require brief pre- and posttest counseling for all patients and would require active refusal to opt out of testing. Offering routine HIV testing would be analogous to the current standard of care that includes routine offering of Pap smears to women between the ages of 18 and 65 years, irrespective of risk. An obvious advantage of this inclusive approach would be the destigmatization of HIV testing. Instead of singling out—on the basis of race, sex, socioeconomic status, or geographical location—one group or class of persons for HIV testing, we should offer routine HIV testing to all sexually active persons under the age of 65. This would also simplify the often clumsy and emotionally burdensome risk-based—history approach to testing.

A study by Phillips et al. has already demonstrated the cost effectiveness of routine testing [8]. HIV is a good disease for screening, because of its long incubation period, its potential for devastation if not treated, and its potential for greatly improved prognosis if intervention is provided early [9, 10]. The sensitivity and specificity of HIV tests are excellent. Routine HIV testing may have less of a behavioral impact than does client-centered risk-reduction counseling linked to HIV testing, but that hypothesis needs to be further explored.

The article by Dybul et al. clearly demonstrates that many individuals, of both sexes and many races, are presenting with unacceptably low CD4 counts at time of HIV diagnosis. Routine HIV testing incorporated into the primary-care setting could make a contribution to earlier identification of infection and, subsequently, for infected individuals, to possible linkage with HIV-specific care and treatment. Ultimately, this approach could be included in the armamentarium to decrease both AIDS and unknown transmission of HIV.

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References