Reply to Lomas et al.

To the Editor—We read with attention the letter by Lomas et al. [1] and agree that, as we stated in our article [2], some episodes of viridans group streptococci infective endocarditis in our series could have been misclassified as health care–associated infective endocarditis, rather than community-acquired infective endocarditis. In fact, 7 of 9 viridans group streptococci episodes met the criteria for health care–associated infective endocarditis only on the basis of hospital admission during the previous 6 months [3] and were associated with no other identifiable risk factor. In 1 of the 2 remaining patients, the onset of symptoms was established at 13 days after admission to the hospital for another condition (until that time, the patient had been asymptomatic); in the other patient, fever and persistent bacteremia due to Streptococcus sanguis type 2 began <24 h after a cardiac catheterization. This would support the idea that most viridans group streptococci bloodstream infections are community acquired.

However, when we analyzed these 9 cases of health care–associated infective endocarditis due to viridans group streptococci in more detail, we found that the mean patient age (±SD) was 68.2 ± 14.4 years, that 5 (55.6%) of the patients were women, that the median Charlson score was 2 (range, 0–5), that 6 (66.7%) of the patients had a previously known valvular disease and/or prosthesis, that 6 (66.7%) of the patients had an indication for surgery (although a surgical procedure was only performed in 1 patient, because of a high surgical risk in the remaining patients; the mean [±SD] European system for cardiac operative risk evaluation score [EuroSCORE] in this subgroup of patients was 12.8 ± 4.3 points), that 5 (55.6%) of the patients died during hospitalization, and that the cumulative 1-year mortality was 66.7%. All of these patient characteristics are much closer to those associated with health care–associated infective endocarditis than they are to those associated with community-acquired infective endocarditis in our series and are probably related to a poor general condition. Thus, previous hospital admission could reflect a comorbid status. In conclusion, although the true source of acquisition is questionable, the inclusion of these 9 patients in the health care–associated infective endocarditis group in our study is justified by epidemiological characteristics and by the fact that the prognosis was similar to that for other patients with health care–associated infective endocarditis.

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References


20 Years of HIV-2 Infection in Portugal: Trends and Changes in Epidemiology

To the Editor—The occurrence of HIV-2 infection is geographically restricted, affecting West African countries, such as Guinea-Bissau and Cape Verde [1]. The prevalence of HIV-2 infection is also high in European countries that have socioeconomic relations with this region, such as Portugal and France [1–6].

All evidence points to Guinea-Bissau as the epicenter of HIV-2 infection [7, 8]—in particular to a small area around the Canchungo Medical Centre [7]. Spread of HIV-2 seems to have occurred after 1960–1970, but recent reports show that the interspecies transmission of HIV-2 may have happened as early as 1924 or as late as 1956 [7, 8]. Very likely, the colonial war (1961–1974) contributed to the spread of HIV-2 in Guinea-Bissau, through sexual contacts and blood transfusions as a result of war injuries [1, 6–8]. At the end of the war, in 1974, Portuguese soldiers and Guinean refugees arrived in Portugal, where HIV-2 infection spread by sexual contact and blood products, prior to the universal HIV screening. In fact, HIV-2 was isolated from patients who originated from Guinea-Bissau and Cape Verde [9–11].

Portugal is the European country with the highest prevalence of HIV-2 infection [1–6]. Twenty years after the first cases, very little is known about how much transmission within Europe has contributed to the spread of the infection.

At the Department of Infectious Diseases (Santa Maria Hospital, Lisbon), ∼3000 HIV-infected patients are actively followed up. From 1987 through 2006, 142 adult patients received a diagnosis of HIV-2 infection, which represented 5.4% of all 2653 patients on follow-up for HIV infection at that time. Clinical records were reviewed during 2007. The country of birth was known for 123 (86.6%) of the 142 HIV-2–infected individuals: 83 (67.5%) were born in West Africa (14 [11.4%] in Cape Verde and 69 [56.1%] in...
The high prevalence of HIV-2 infection found could be explained by the large West African community that lives in Portugal. More than one-half of all HIV-2–infected patients were born in Guinea-Bissau, which might reflect migration to Portugal following the civil war in Guinea-Bissau, in 1998–1999 [12]. Indeed, the peak in the number of patients, during 2000–2006, coincided with periods of political instability in Bissau. In our cohort, of 54 patients who received diagnoses in 2000 or later, almost one-half (n = 26) arrived in Portugal after the year 2000 (n = 19) or during 1998–1999 (n = 7).

This study indicates that the number of patients diagnosed with HIV-2 infection in Portugal is likely to increase over the next years. Only one-third of all HIV-2–infected individuals were born in Portugal, without known contact to West Africa, and all but one seem to have acquired the infection through heterosexual contact. African communities residing in Portugal often live rather isolated within the Portuguese society, and, consequently, contacts that may cause HIV infection seem quite limited. This also may explain why the number of Portuguese persons newly diagnosed with HIV-2 infection is rather small, contrary to what is seen for HIV-1. This leaves the impression that HIV-2 infection in Portugal is geographically restricted to those communities, somewhat similar to what is seen in Africa.

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Figure 1. The number of cases of HIV-2 infection in Portugal, by patients’ country of origin.