Reply to Bradshaw and Danta

To the Editor—We read with interest the comments by Bradshaw and Danta on our article [1] and would like to address several points. Comparing our study to the UK study is problematic because the UK study described a group of men who have sex with men (MSM) during the early and current highly active antiretroviral therapy (HAART) eras (1998–2008) [2]. In contrast, 83% of participants in our study were enrolled during the pre-HAART era. Because sexual practices in the MSM community changed rapidly as effective anti–human immunodeficiency virus (HIV) therapies evolved, a comparison between our study and the UK study may be confounded by changes in sexual behaviors in the gay community between 1984 and 2011.

The authors also state that “rates of URAI [unprotected receptive anal sex] declined in later recruits” and speculate that this decline could be attributed to underreporting. In fact, we did not discuss trends in URAI rates. Rather, we reported this decline could be attributed to underreporting. In fact, we did not discuss this decline could be attributed to underreporting. Furthermore, to address the point raised, we examined the reported rates of URAI and found that those rates for later recruits were comparable to those reported by earlier recruits during follow-up in 2001. Thus, we did not find evidence to support the hypothesis that a greater degree of underreporting of URAI in later recruits occurred. Bradshaw and Danta also note that, in the HIV-infected men recruited from 2001–2003, the hepatitis C virus (HCV) incident rate (IR) declined between 2000–2004 and 2005–2011. However, this was not a statistically significant decline; the 95% confidence intervals (CIs) around the IRs are large and overlap (IR, 6.74 [95% CI, 2.71–10.89] vs 5.16 [95% CI, 2.57–9.23]). Nevertheless, we acknowledge that our finding that HCV incidence did not increase among MSM during this time period is in stark contrast to the 18-fold increase reported in the Swiss HIV Cohort Study (SHCS) [3]. Interestingly, the increase among MSM in the SHCS occurred exclusively between 2008 and 2011. As the SHCS has ongoing enrollment, we will see if the observed HCV increase occurred among a unique group of recent enrollees, and whether this increase continued.

The authors note that the association of syphilis and incident HCV is lost in the non–injection drug use (IDU), non–blood transfusion group in our study, and they assert that this observation is in contrast to associations reported in other studies of HIV-infected MSM. Because >50% of our non-IDU, non–blood transfusion study group was HIV negative, the most appropriate group for comparison in our study is all HIV-infected men among whom, as shown in our Table 5 [1], syphilis was independently associated with incident HCV (relative risk, 2.75 [95% CI, 1.76–4.29]). This argues against the authors’ assertion that the MACS is “a relatively unusual MSM cohort.”

Last, the authors are concerned that HCV antibody–negative recruits who did not have follow-up HCV testing might have been at higher risk for HCV than those with follow-up HCV testing. The proportion of men who reported having had URAI with ≥2 partners prior to enrollment among those included in our study was not different compared to those who did not have follow-up HCV testing (36% vs 34%; P = .39).

Note

Potential conflicts of interest. All authors: No reported conflicts.

All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.