HIV-Infected Youths: Transition in Spain Compared to the Netherlands

Dear Editor,

We read with interest the article by Weijsenfeld et al. entitled "Virological and Social Outcomes of HIV-infected Adolescents and Young Adults in the Netherlands before and after Transition to Adult Care," recently published in Clinical Infectious Diseases [1]. Our group, integrated into the Cohort of Vertically HIV-infected children of Spain (CoRISpe), launched a project in 2013 to address evolution of patients after transition. Preliminary results, including 209 youths transferred to adult units (AU) between 1997 and 2013 [2], are consistent with the results published by our colleagues from the Netherlands. However, significant differences in some findings deserve a comment.

As underlined by the authors, in countries with access to therapy many vertically human immunodeficiency virus (HIV)-infected children are nowadays reaching adulthood, and few studies have addressed their long-term evolution after transition to AU. Defining best transition strategies is warranted to optimize retention in care for this special population in years to come [3, 4].

Fifty-nine patients from 4 specialized pediatric centers were included in the Dutch Cohort. Transition process seemed to be in line with international recommendations [3], with adherence and peer support available. However, the authors report a 14% lost-to-follow-up during or right after transition. Our cross-sectional study of the Spanish Cohort, involving centers geographically distributed all around the country with different resources, also showed a 13.9% of losses, occurring most of them, as in the Netherlands, after the first year in AU. Another 4 patients (2%) died after transition, due to malignancies or opportunistic infections, despite having available antiretroviral treatment options. Although most patients do well after transition, we agree with the authors that prolonged care at pediatric units may be extremely helpful in some cases, but, as in the Netherlands, legislation in Spain offers very limited opportunities. As this restriction affects the management of different chronic diseases [4], we invite clinicians and scientific societies to make all efforts to draw attention over this fact from the corresponding institutions.

Reported virological failure (VF) rates immediately before, during, and shortly after transition was high, up to 36%, in the Netherlands. Patients with adherence problems during childhood and those lacking autonomy regarding medication were more likely to experience VF, as suggested by previous studies [5]. In the Spanish Cohort, however, 86.4% of virologically suppressed patients maintained suppression after transition, and 69.9% of patients transferred with cardiovascular > 50 cop/mL, achieved viral suppression once in AU [2]. Median age at transition in Spain was 17.9 years [17–19], compared to 18.8 [18.1–19.5] in the Netherlands, and 98% were born in Spain, in contrast with a 48% of sub-Saharan African patients in the Dutch study. We hypothesized that this fact may have contributed to the difference in rates of VF between the studies. Although socioeconomic and educational background of patients in both cohorts are rather low, difficulties associated to migration may impact the linkage to care and adherence to treatment, especially above the threshold of adulthood. This hypothesis may gain importance, as patients grow older, in countries where immigration is a recent phenomenon, such as Spain, particularly if resources are limited to support adherence and retention in care.

Notes

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Reply to Sainz and Navarro

To the Editor—We thank Sainz and Navarro for their interest in our study on virological and social outcomes of human immunodeficiency virus (HIV)-infected adolescents and young adults (AYAs) in

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the Netherlands before and after transition to adult care [1] and appreciate the opportunity to respond to their comments [2].

We are very pleased to notice that outcomes of perinatally HIV-infected AYAs are gaining increasing interest and are subject for additional research and that these outcomes of AYAs from the Netherlands can largely be translated to Spanish settings [3]. Indeed, similar to the Spanish cohort, in our cohort AYAs who were fully virologically suppressed prior to transition during pediatric care continue to do well after transition to adult care. In both cohorts, similar loss to follow-up rates after transition are described. However, in contrast to the suggestion made by the authors, we do not agree with the authors on the need of routinely prolonged care of AYAs in pediatric care with the aim to improve virological outcomes. Our main results show that the rise in virologic failure (VF) rates starts already before transition and centers around the age range of 18–20 years, regardless of receiving care at a pediatric or adult center. The effect of the actual transition is probably limited. In selective specific individual cases, prolonged care at a pediatric clinic might be helpful to improve virological outcomes. We believe the focus of patient care should be on early preventive measures such as providing information to increase disease knowledge and supporting patients to gain autonomy regarding medication intake, which should both start during pediatric care and, if necessary, continue during adult care. AYAs with a low educational level should receive additional attention, support, and information of HIV-related matters such as basic knowledge of treatment and resistance and preventive measures to reduce transmission.

Comparisons regarding VF rates between the 2 studies are difficult to make owing to large methodological differences (eg, longitudinal versus cross-sectional study design). In our study we defined VF as 2 consecutive HIV RNA measurements >400 copies/mL, whereas it is unclear what definition of VF rate was used in the Spanish cohort. Therefore, we do not have full insight into the number of patients actually experiencing VF in the Spanish cohort. The authors further suggest that migration-associated difficulties might have hampered linkage to care, but we have exclusively included patients if they had been in pediatric care and did not evaluate barriers of linkage to care.

The authors finally address the possibility of increased VF rates in patients born in sub-Saharan Africa, caused by specific social features related to migration. Although we agree on the notification that various social circumstances can affect treatment outcomes, the sub-Saharan birth region was not a significant factor associated with VF (Table 3) [1]. To better understand the effects of contributing factors to virological outcomes, homogeneity in studies and standardized outcome measurements would allow for combining outcomes of these relatively small cohorts.

Notes

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References


Is Plasmodium Species Parasitemia Really Associated With Increased Survival in Ebola Virus–Infected Patients?

To the Editor—We read with interest the article by Rosenke et al about Ebola virus–infected patients treated in an Ebola treatment unit in Monrovia, Liberia [1]. Plasmodium species (spp.) parasitemia was reported to be associated with a 20% increase in survival. The authors mention that because all patients received artemether–lumefantrine (AL) on admission, regardless of the outcome of the Plasmodium spp. parasitemia test, the observed increase in survival was unlikely to be due to the beneficial effect from the malaria treatment. We disagree with this. Indeed, Ebola virus–infected patients with an untreated malaria infection may have an increased mortality risk compared with age and cycle-threshold (Ct) matched controls. Therefore, Ebola virus–infected patients with a malaria coinfection may benefit from antimalaria treatment, while such treatment for patients without malaria may even be harmful. In a study in Foya, Liberia, Ebola virus–infected patients on AL had a worse outcome than patients on an artemether–amodiaquine combination [2]. The explanation for this difference remains unclear, but it was suggested that AL may be harmful in Ebola virus–infected patients because of the risk for fatal arrhythmias in patients with hypokalemia or hypomagnesemia or in the presence of co-medication that may induce QT interval...