

Emergency department attention of patients infected with HIV: current situation after 30 years of the epidemic

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Nearly 30 years have passed since the first cases of patients affected by the then unknown human immunodeficiency (HIV) to the present day, and the disease has become a pandemic that has claimed tens of millions of lives. Moreover, the disease has also resulted in profound social changes, beyond the scope of this editorial. During this painful period, a crucial turning point was reached in 1996 with the introduction of highly active antiretroviral therapy (HAART) which practically turned HIV infection into a chronic disease.

With HAART came a significant improvement in immune status with a consequent reduction of opportunistic events (infections and neoplasm), and ultimately a life expectancy that is increasingly closer to that of the general population^{1,2}. However, new side effects of the treatment and new conditions that arise in the course of increased survival, not directly due to HIV infection itself, mean that current morbidity rates require constant clinical reassessment.

Good immunological and virological control of HIV infection has revealed other coexisting diseases, whose role was previously minor given the poor medium-term prognosis of AIDS victims that prevented their evolution. The paradigm of this is chronic hepatitis C and its complications, now one of the leading causes of morbidity and mortality in these patients³.

In recent years the incidence of cardiovascular disease has increased in these patients, which could be explained by the increase in life expectancy and subsequent biological aging, by metabolic disorders caused by antiretrovirals (dyslipidemia, insulin resistance, diabetes, central obesity) and to the HIV itself⁴⁻⁷.

Moreover, the emergence of new drugs has given rise to new side effects, which in some cases may be acute and severe, such as alterations

of renal function, hypersensitivity reactions or lactic acidosis among others.

At present, new cases of HIV are mostly diagnosed in later stages of infection and therefore with clinical manifestations due to opportunistic infections or malignancies. This is especially relevant to specific groups with difficult access to the health system or where the diagnosis is not readily suspected (eg. older immigrant population and people at risk of social exclusion).

Very important changes have occurred in terms of HIV disease epidemiology. Thus, the predominant risk behavior for infection is no longer drug injection; at present, it is sexual transmission, especially heterosexual. Immediately, this means a globalization of risk and therefore requires, at times, a high degree of suspicion for the diagnosis, since external signs such as injection marks are no longer predominant.

All this means the presence of these patients in the emergency department with care demands which are constantly changing^{8,9}. In short, the panorama of HIV infection has changed for the emergency services. We are no longer faced with a prototype intravenous drug addict, relatively easy to diagnose on the basis of medical and social history (drug addiction, conflict with the law etc). Also immune enhancement has eliminated emergency patients with basically social demands (dementia, extreme cachexia, etc.). Thus, at present, the HIV patient consulting the ED is older, having acquired the disease primarily by risky sexual risk behavior which is not so easily identifiable and often their care demand is for diseases not directly related with HIV, such as liver disease, or for the side effects of antiretroviral treatment.

In a way, all these changes are also reflected in the study by Callejas Perez *et al.* presented in this

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issue of EMERGENCIAS, which describes the profile of ED patients with HIV infection compared with a control group¹⁰.

Another area where ED professionals play an important role is in the treatment of patients with accidental exposure to potentially infectious blood and fluids. Post-exposure prophylaxis should be administered as early as possible (at any time and any day of the year) to be effective and, therefore, many cases of exposure make first contact with the health system through the ED. This requires conscientious and professionals who are knowledgeable on the subject.

Finally, in Spain it is estimated that 30% of people infected with HIV do not know it and they contribute 60-70% to new transmissions¹¹. There are both individual and public health reasons to facilitate early diagnosis of infection. It has been estimated that performing the HIV diagnostic test is justified in terms of cost-effectiveness when the prevalence of infection is greater than 1% in the situation or appropriate disease status indicator^{12,13}. For this reason, the U.S. Centers for Disease Control (CDC) has recommended universal HIV test for any adolescent or adult patient every time they make contact with the health system, except in those that explicitly oppose the measure.

Emergency departments are an ideal environment for the detection of risk and disease, where HIV screening test could be performed, thus favoring early diagnosis and there by help reduce the risk of transmission.

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