EDITORIAL

Poisoning and HIV: another new opportunity

Intoxicaciones y VIH: otra nueva oportunidad

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We must learn from those who know the most, or at least try to do so. Doing so means wasting time, illusions, and many opportunities by perpetuating ourselves in an ignorance that is not very defensible in our profession. Periodically, whenever we deal with referrals to emergencies or demands that we used to classify as unjustified, a concept that I have been abandoning over the years, I try to reread "my wise men" and think of my clumsiness for not having listened to them. Moreno Millán, in 2007, already told us, in a brilliant editorial in this Journal, that "emergency medicine is no longer just a specialty, but has become a subsystem of the health care model" and warned that we should begin to consider adapting our emergency departments and their resources to the reality of ever-increasing social demand.[1] Fifteen years later, the evolution in demand for care and its consequences in our services has only proved him right.[2]

Despite the obstinacy of those who indefensibly and repeatedly deny us our specialty and, therefore, our professional identity,[3] the activities and functions performed in emergency departments that in the past were not seen as their own are increasing. Examples of this are the consolidation of functional or organizational structures in which emergency professionals are involved (hospitalization at home, follow-up consultations, short-stay units, and, in some centers, toxicology units) or the participation and involvement in care processes or circuits that, until recently were considered outside the specialty and familiar situations such as care for intoxication by licit drugs of abuse (such as alcohol) or complementing care for different reasons for consultation with early detection of an HIV case. Precisely this entity has generated in recent years up to seven scientific publications in this same Journal, some of them focused on the role of emergency physicians in its initial detection.[4-6]

The populations of patients with a first diagnosis of HIV and intoxicated patients have similar sociodemographic and behavioral characteristics, such as age, poor linkage, or adherence to the rest of the health care system, the time of day they are attended, and even their low admission rate, so that in the vast majority of cases the emergency services are the only ones involved. However, although both populations are similar, studies that specifically analyze their linkage are essential, such as that of Losada et al. presented in this issue of EMERGENCIAS.[7]

Losada's article provides us with interesting results that I will try to detail after highlighting two aspects: the originality of his idea, and its bicentric nature, taking advantage of the experience of two centers with a long tradition in the study of both entities, which I include in my particular "group of wise men." As a result, and thanks to the study, we can now know under what circumstances we should be alert to intoxication in HIV patients.

Losada et al., show a group of particular patients and scenarios, with perfectly-identified HIV patients with good adherence to active treatment, who end up in these emergency services after poly-drug use in a sexual encounter (chemsex).[8] This profile, which reaches 20% of their total sample, should not be overlooked, especially if we take into account the dates of the study, which included periods of the pandemic with some limitations of social mobility, sometimes rigorous, confirming the rootedness among its consumers that leads them to overcome any restriction or rule.[9,10]

The results also confirm the existence of poly-consumers of drugs of abuse in a recreational context,[11] 45% of the cases in the article, although this percentage only represents the tip of the iceberg of this social habit since most poly-consumers do not end up in the emergency services. To this should be added a high prevalence of mental pathology in the series, almost 30% of the cases, with no differences between the two groups, but which would corroborate what has been commented above, since this previous psychiatric pathology is generally associated with medication that interacts with consumption or polyconsumption, generates synergies and potentiates adverse effects. All this increases the risk of a potentially poor outcome. Both aspects, as the authors comment, should alert us as they are related to greater complexity in their care and could explain the high mortality in the series

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(1.6%), higher than that described in the international series with the same patient profile (0.5%),[12] or national series for poisoning by other substances (0.9%).[13] These results should make us reflect that we should abandon the false sensation of banality when attending one of these episodes.

Of the polyconsumption, it is worth highlighting the prominence of opiates almost exclusively in the HIV group and, although not analyzed in the study, very probably related to the practice of chemsex. This presence of opiates, for the time being, remains far removed from the consumption figures of other countries where it has reached epidemic proportions.[14] In the non-HIV group, polyconsumption detected the habitual presence of ethanol and cannabis as the most prevalent intoxicants, together with the consumption of drugs of abuse, in a recreational context, which coincides with the results of recent multicenter European studies.[15,16]

I agree with the article's conclusion on the need to know these drug abuse patterns with a greater potential risk of developing complications, which the authors have detected, and the need to make emergency department professionals aware of them. Although it is true that, in general, we start from inadequate toxicological training, the trend is that we will attend to an increasing number of intoxicated patients, and probably with greater complexity, so we must take advantage of this new opportunity. Integrating all this assistance in our increasingly broad doctrine is the only specialty that will do it.

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