Differences in progression of HIV infection between men and women

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Proportions (% confidence intervals) of respondents who had nebulisers in their practice and those who took peak flow meters on house calls and changes in respondents’ responses between 1989 and 1994

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<td>% (95% confidence intervals)</td>
<td>% (95% confidence intervals)</td>
<td>No. of pairs</td>
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<tr>
<td>Nebuliser in practice</td>
<td>91.4 (87.5 to 95.3)</td>
<td>98.6 (96.6 to 100.2)</td>
<td>146</td>
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<tr>
<td>Takes meter on house calls</td>
<td>9.7 (6.3 to 8.3)</td>
<td>3.6 (2.8 to 4.1)</td>
<td>146</td>
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*Positive values indicate increase. ¦Signed rank statistic.

In Evans and colleagues’ study 44% of the practitioners either carried a nebuliser or said that one was available in their surgery. The difference in proportions of practices with a nebuliser is 54% (95% confidence interval 45% to 62%) between their study and ours. Similarly, 54% of the practitioners in Evans and colleagues’ study carried a peak flow meter and the difference in proportions is 19% (9% to 29%). The differences in the proportions are therefore significant, with more practices having nebulisers yet fewer practitioners usually taking meters on house calls in Northern Ireland. Although this may reflect the different methods and emphases of the two surveys, it suggests that important inter-regional differences in asthma care by general practitioners may exist. This has important implications for research into asthma care by general practitioners because we cannot assume that care in one geographical region is representative, any attempt to draw generalisable conclusions will require a national sample.

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1 Evans SA, Stone J, Hardy C. Are general practitioners equipped to manage acute severe asthma? BMJ 1994;309:1486. (3 December).

The study in 1989 was conducted while R K McKinley held a research fellowship from the Department of Health and Social Security (Northern Ireland) in the department of general practice at the Queen’s University of Belfast, and the study in 1994 was financed by a grant from the National Asthma Campaign.

Chickenspo in the tropics

EDITOR,—In their editorial on immunisation against chickenpox Lainie Friedman Ross and John D Lantos fail to recognise that chickenpox is more severe in the tropics than in temperate climates.1 The reason for this lies in the differences in the age specific incidence of chickenpox between the regions. In Singapore the peak incidence of chickenpox occurs in adolescence and young adulthood2 and is associated with low hered immunity to chickenpox in the young adult population.3 In recent times this trend has also been observed in populations living in temperate regions.4 Although chickenpox is benign in childhood, in adults it is associated with more severe disease. In pregnant women it is also associated with the risk of chickenpox in the unborn fetus and newborn infant. The social costs of the disease would also be expected to be higher than those estimated for populations in which chickenpox occurs mainly in childhood. It is therefore erroneous to assume that chickenpox is benign in all populations.

Since vaccination against chickenpox is most efficacious in childhood, a universal immunisation programme should be targeted at young children. The epidemiology of chickenpox and its age specific incidence should be taken into consideration when the issue of mass chickenpox in a particular population is addressed. In this regard, universal immunisation of populations living in the tropics may be justified.

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Differences in progression of HIV infection between men and women

EDITOR,—Alessandro Cozzi Lepri and colleagues report little difference in progression of HIV infection between men and women in the Italian seroconversion study.1 We have examined this issue in the CD4 HIV cohort study, one of the largest continuing studies of a seroprevalent cohort (a cohort of people with HIV infection in whom the date of seroconversion is not known). The study has enrolled over 6000 participants from all transmission groups, including nearly 2800 women.2 In the Swiss survey there was no evidence for differences between the sexes in either progression to different degrees of CD4 lymphocytopenia or progression to death when differences in DC4 cell counts at entry were taken into account in the analysis.3

The authors emphasise the importance of incident cohorts (cohorts in which the date of seroconversion is known) for analysis of differences in progression of HIV infection. The similar results that we obtained from a seroprevalent cohort indicate, however, that time since infection may have no independent prognostic importance when CD4 cell counts are considered in the analysis. Indeed, this conclusion was reached in analyses of several incident cohorts, including the Italian seroconversion study.4 Therefore, while incident cohorts are indispensable for answering several important questions, seroprevalent cohorts may offer advantages in other situations. One advantage is the generally larger sample size, and therefore greater statistical power; this is needed to detect or exclude smaller differences in the progression of disease. For example, the study by Cozzi Lepri and colleagues, based on 854 patients and 42 deaths, could not exclude the possibility of a 79% increase in mortality from AIDS among women compared with men. Conversely, an analysis of the Swiss HIV cohort study based on 2871 patients and 761 deaths showed that such substantial differences can be excluded with confidence.5

The only difference between the sexes found by Cozzi Lepri and colleagues related to AIDS defining cytomegalovirus infection. The authors conclude, on the basis of four cases among women and none among men (P = 0.01), that this infection may be a more common AIDS defining event among women. We have examined this supposition in the Swiss study by analysing the incidence of disseminated cytomegalovirus infection in participants who were infected either by injecting drugs or heterosexual and who were free of AIDS at registration. Both univariate and multivariate analyses indicate that there is no significant difference between women and men in the occurrence of disseminated cytomegalovirus infection over a mean follow up of three years—if anything, there is a trend to the opposite direction (table). This analysis thus fails to confirm the results of Cozzi Lepri and colleagues. Because of the large number of AIDS-defining conditions tested, their finding may be a false positive result due to a type I error. Indeed, applying a Bonferroni-type correction renders their P value non-significant.

In conclusion, the examples presented here show how analyses of incident and seroprevalent cohorts can sensibly complement each other.

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1 Cozzi Lepri A, Pezzi R, Dorrucchi M, Phillips AN, Rezza G, and the Italian Seroconversion Study. HIV disease progression in seroprevalent and incident HIV-infected drug user and heterosexual sex and followed for up to nine years from seroconversion, BMJ 1994;309:1537-42. (10 December.)

Heart muscle disease related to HIV infection

EDITOR,—We agree with Peter F Currie and colleagues that the aetiology of heart muscle disease in HIV infection is unknown.1 Given that most HIV infection occurs in the developing world, conditions such as rheumatic heart disease may contribute to cardiac complications in HIV infection even though a significant interaction has not yet been noted.2 We report a case of rheumatic heart disease with laboratory features and echocardiographic findings that are characteristic of rheumatic heart disease.

A 28 year old African immigrant presented with