

The AIDS Pandemic

TO THE EDITOR: As a clinician who delivers antiretroviral therapy in Africa, I have to stress just how far we are from achieving the goal articulated by former president William J. Clinton in his Sounding Board article on the AIDS pandemic (May 1 issue).¹ In Kenya, a great deal of medical care is supplied by non-physician clinical officers and nurses who lack oversight and have relatively little training. There is no requirement or mechanism for continuing medical education, and brief instructional seminars will not be sufficient. A model involving the use of unsupervised nonphysician providers in rural areas is unlikely to succeed and may instead lead to the “antiretroviral anarchy” feared by Harries et al.² The alternative of relying on physicians ignores the fact that most Kenyan doctors are located in urban areas, where only 16 percent of the country’s inhabitants live.³

Policymakers should recognize that access to care and high-quality care are not the same, and the former does not guarantee the latter. The provision of dignified care to patients with human immunodeficiency virus (HIV) infection in resource-poor settings presents the most daunting challenge in the history of modern medicine. Yet this task will prove infinitely more straightforward than offering salvage therapy to those with advanced disease.

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TO THE EDITOR: The excellent Sounding Board articles by Clinton and Gayle¹ describe the magnitude of the AIDS problem and the resources required to address it. In the context of needing to achieve the maximal value for each dollar spent, an issue that is not mentioned is the potential diversion of AIDS funds to education about abstinence and “abstinence-until-marriage” programs. There is little or no valid scientific evidence that this form of abstinence education is an effective intervention for the prevention of AIDS. One anticipates even less

chance of success in an environment where, as Mr. Clinton describes it, conditions are so extreme that trained teachers are dying faster than they can be replaced. If the diversion of up to a billion dollars is a political prerequisite for obtaining any funding, then it must be accepted. But before conceding, public health officials within and outside of the current administration should be educating Congress (and the public) about more valuable uses for those dollars in AIDS prevention.

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TO THE EDITOR: The history of the HIV–AIDS pandemic in the developing world — the subject of the articles by Clinton, by Gayle, and by Reynolds et al. (May 1 issue)¹ — is both inspiring and frustrating. Each achievement in the industrialized world raises our hope of success. Thanks to the global efforts, multinational pharmaceutical companies have agreed to provide highly active antiretroviral therapy at discounted prices. Now there are thousands of people in the developing world who are getting the benefits of such therapy, which was initially thought to be a blessing of the Western world. But substandard HIV diagnostic kits are causing much harm in the developing world. Blood transfusion and mother-to-child transmission remain major routes for the spread of HIV and AIDS. We need to motivate the large, multinational companies that make diagnostic tools to provide high-quality kits for screening and monitoring to developing countries at discounted prices. Reliable tests will improve the safety of blood for transfusions and facilitate prenatal screening and monitoring of patients receiving highly active antiretroviral therapy. The use of such therapy without monitoring can encourage irrational medical practices and the development of drug-resistant disease.

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DR. REYNOLDS AND COLLEAGUES REPLY: We agree that in areas where resources are limited, a key requirement for the expansion of HIV treatment is the provision of an adequate laboratory infrastructure. The availability of affordable diagnostic and monitoring assays, as well as quality-assurance programs for laboratories, will be crucial. In-country training programs in the use of HIV diagnostic tools and clinical monitoring should be an essential component of

the global effort to treat HIV and AIDS. We support the efforts of a number of recent programs, including the Uganda-based Academic Alliance for AIDS Care and Prevention in Africa, that include training and the transfer of technology in order to facilitate the sustainable laboratory and clinical infrastructure required to fight HIV and AIDS, as well as other infectious diseases.

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Restless Legs Syndrome

TO THE EDITOR: The Clinical Practice article by Earley on the restless legs syndrome (May 22 issue)¹ does not mention medications that are not used in the United States but are relevant to readers in other countries. In the section on dopamine agonists, there is no mention of the use of cabergoline, which has been shown to be effective in open-label and double-blind trials and is used fairly commonly for the treatment of the restless legs syndrome in Europe.^{2,3} In our view, the long half-life of cabergoline makes it a particularly useful drug in terms of rebound and the augmentation of symptoms. In advanced cases, the overnight infusion of apomorphine can be very effective, as reported previously.⁴ Similarly, rotigotine given by means of a continuous

delivery system was also shown to be effective in a recent double-blind trial.⁵

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Enfuvirtide for Prophylaxis against HIV Infection

TO THE EDITOR: In their review article on a new class of drugs that inhibit human immunodeficiency virus type 1 (HIV-1) fusion, Kilby and Eron (May 29 issue)¹ underline the virologic and immunologic benefit of enfuvirtide for drug-resistant HIV-1 infection. In our opinion, this new compound also deserves attention for antiretroviral prophylaxis because it acts before the virus enters the cell, it has activity against resistant strains of HIV when the source of infection is a patient with resistance to multiple anti-HIV drugs, and its subcutaneous route of administration may immediately ensure effective

serum levels. The use of enfuvirtide in combination with other antiretroviral drugs should be considered for prophylaxis against HIV-1 infection in cases of high-risk exposure to a patient with multidrug-resistant virus.

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