

or sexually transmitted infection.² All others were diagnosed during hospitalisation for the following conditions: cerebral space-occupying lesions (SOLs),² pneumonia,³ kidney failure,¹ urinary sepsis¹ or stroke.¹ Another 16 (26.2%) patients were diagnosed on an outpatient basis, despite having visited the emergency department on several occasions. Table 1 shows for each patient the number of visits and the main diagnosis for the event. Yet another two (3.2%) patients were diagnosed during a second visit to the emergency department due to a cerebral SOL or pneumonia; each had been assessed on a previous occasion, due to an ulcer or lumbosacralgia. As can be seen, the diseases for which the patients sought care varied widely.

In conclusion, we ought to avoid missed opportunities in contact with these patients with a view to diagnosing HIV early, developing studies that clarify in which population HIV serology should be ordered and improving rates of occult and late diagnosis. A study analysing all of the above-mentioned factors in the HIV-positive population affected by stroke could lead to recommendation or non-recommendation of screening of all or a subgroup of patients affected by this condition.

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In reply to «HIV screening and its possible involvement in patients with stroke»[☆]



En respuesta a «Cribado para la detección de VIH y su posible implicación en los pacientes con ictus»

Dear Editor,

We appreciate the interest raised by our study in the Letter to the Editor “Screening for HIV detection and its possible role in stroke patients” presented in this journal. We would like to respond to some of the points made.

We accept as a limitation, as specified in the original article,¹ that the Minimum Data Set (MDS), the source of our results, lacks such pertinent variables as time since onset of human immunodeficiency virus (HIV) infection, frequency and types of antiretroviral therapy in each year, and changes therein over the course of the study. These variables are impossible to record on hospitalisation discharge reports, on which the MDS is based; however, this type

of study enables comparisons not of cohorts but of the overall population.

Moreover, the variables of age and stimulant drug use were indeed evaluated both in univariate analysis and in the multivariate model. The study objective was to evaluate trends over time in rates of HIV infection in stroke patients over the course of 16 years and whether the increase therein was independent of other factors; this was confirmed in the analysis controlling for these and other potentially confounding variables.

Increasing screening for HIV infection is one of the main objectives established by the Joint United Nations Programme on HIV/AIDS (UNAIDS) for the coming years,² with the purpose of decreasing the high percentages of occult infection and late diagnosis. Recommendations in clinical guidelines range from universal or routine HIV testing in individuals 13–65 years of age, except those who expressly opt out,³ to a more specific or targeted strategy in which people who visit the healthcare system should be screened if they have any condition indicative of HIV infection.^{4,5} The Spanish guidelines, in addition to compiling indications for routine, targeted and mandatory screening, recommend HIV screening in individuals with conditions indicative of HIV infection/AIDS.⁶ The European Centre for Disease Prevention and Control (ECDC) and the World Health Organization (WHO) have developed strategies for targeted screening based on the use of lists of indicative conditions, which at present do not feature stroke.^{4,7}

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Our study found a gradual increase in the percentage of HIV infection in patients hospitalised with stroke independent of the classic risk factors, which supports the role of HIV as a vascular risk factor. It is important to note that age is considered a vascular risk factor when it is equal to or greater than 50,⁸ and the mean age of patients with stroke and HIV infection in our study was 46.8 (SD 11.7),¹ with 66.1% below this threshold. In addition, causes of stroke in patients under the age of 50 remain unknown in up to 33% of cases,⁹ and aetiological study in this population is much more extensive.¹⁰ Therefore, although at present it is not possible to classify stroke as a disease typically associated with HIV, the data presented could point to a recommendation of ordering HIV serology for all hospitalised young patients who experience stroke; however, future studies will be needed to evaluate this measure's cost-effectiveness.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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