



AIDS in Africa

The tragedy of HIV and AIDS in Africa, mentioned in the article "Ottawa students mark '5 wonderful years' in Malawi" (*CMAJ* 1997; 157[9]:1191), by Dr. Kevin Chan, is beyond the comprehension of physicians whose experience of medicine is limited to the developed world. The World Health Organization has just revised its estimates of HIV infection worldwide, and more than 20 million Africans are now believed to be seropositive. I have worked in large hospitals in Africa where the medical wards were primarily "palliative care centres" with, in fact, very little palliation to offer.

But however bad the situation is in countries such as Malawi, it is hardly likely that between 30% and 40% of Malawians are infected with HIV. Such misinformation only reinforces the perception of hopelessness among physicians of goodwill, whom we must mobilize to provide help. I am not aware of the most recent estimates for Malawi, but in general the seropositivity rate for adults is rarely above 20% in the African countries most severely affected — a figure that is nevertheless stunning.

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Received by email

[The author responds:]

After rereading my original article, I agree that I insinuated that the seropositivity rates for HIV are 30% to 40% in Malawi. It is difficult to do an effective population analysis of HIV rates in many parts of Africa. A seropositivity rate of 36% was put forward by a physician at St. John's Hospital in Mzuzu, Malawi, who ar-

rived at the figure by using a sample of outpatient adults arriving at the hospital in 1995 (St. John's Hospital, 1995 statistics, unpublished data). This rate is thus biased toward the sickest and the weakest.

I do think that the rates of HIV and AIDS are too high in Africa, but, like Dr. Tectonidis, I agree that there is hope and a light at the end of the tunnel. For example, the incidence of HIV and AIDS is falling in Uganda because of good public health interventions, improved knowledge and changes in public attitudes. Increasing awareness leads to changes in public policy, and promotion of healthy sexual practices may help us win the battle. That is something we can hope and dream will one day occur.

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A side effect of protease inhibitors

The article "Guidelines for anti-retroviral therapy for HIV infection" (*CMAJ* 1998;158(4):496-505), by Dr. Anita R. Rachlis and colleagues, was timely, informative and well written, but it did not mention an adverse effect of the protease

inhibitor class of drugs. Some patients with hemophilia have experienced increased frequency or severity (or both) of bleeding episodes while taking these drugs.¹⁻³ This adverse effect has been associated with all of the protease inhibitors currently available. The bleeding is spontaneous and tends to occur early in the course of treatment. The frequency of this reaction has not yet been established, because these drugs have been introduced only relatively recently; furthermore, patients and their care givers are accustomed to the unpredictable and episodic nature of bleeding in severe hemophilia, so the association with the drug may not be immediately obvious. The bleeding can be severe and can occur in the usual locations (joints and muscles) or at atypical sites. In my experience, the exaggerated bleeding tendency persists until the protease inhibitor is discontinued, at which time the problem resolves rapidly.

The pathophysiology of this adverse effect is unknown; it is not accompanied by laboratory abnormalities in addition to the patient's congenital deficiency of factor VIII or IX. Reports of bleeding in non-hemophilic patients have most commonly consisted of hematuria accompanying nephrolithiasis, which can complicate the use of indinavir.³ Because it is difficult to envision a bio-