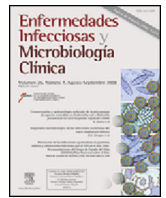




Enfermedades Infecciosas y Microbiología Clínica

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Letter to the Editor

About “Executive summary of the GeSIDA consensus document on control and monitoring of HIV-infected patients”



Acerca de “Resumen ejecutivo del Documento de Consenso de GeSIDA sobre el control y la monitorización de la infección por VIH”

Dear Editor,

We read with great interest the “Executive summary of the GeSIDA consensus document on control and monitoring of HIV-infected patients” of the AIDS Study Group (GeSIDA) of the Spanish Society of Infectious Diseases and Clinical Microbiology.¹ It is a magnificent summary on the main topics related with the control and monitoring of patients infected with the human immunodeficiency virus (HIV) and their continuous follow up, providing clear and useful recommendations.

As stated in this consensus, due to the increasing knowledge regarding HIV medicine, treatment and comorbidities, there is a growing complexity in assessing people living with HIV (PLWH), with a necessary demand for highly specialized units. Although we recognize the difficulties of a comprehensive evaluation of these patients, we miss in this consensus a specific mention of chronic obstructive pulmonary disease (COPD) in PLWH.

Different reviews have described COPD in PLWH, showing an increasing prevalence of COPD in PLWH compared to general population as it happens with other comorbidities.² Smoking is the major predictor of COPD appearance³ and smoking habit is increased in PLWH.² Nevertheless, the relation between COPD and HIV is not limited to tobacco exposure, as exposure to HIV is a predisposing factor for COPD independently from tobacco consumption.⁴ The prevalence of COPD in PLWH can be higher than 10%,⁴ making it a medical condition that implies a considerable burden in quality of life and mortality.⁵ However, COPD in PLWH seems to be largely undiagnosed.⁶

Even though the underlying pathogenesis of COPD in PLWH is not entirely clear, it seems that immune variations such as a low CD4 cell count, a low CD4 nadir, or low CD4/CD8 ratio, that contribute to accelerated aging and are associated with the risk of cardiovascular, renal or neurological comorbidities, are also involved in COPD development.⁷ Decline of respiratory function seems to be higher in PLWH than in HIV negative individuals.⁸ Both lower CD4 cell counts and higher HIV viral load were associated with an accelerated decline of respiratory function (FEV1 and FVC).^{2,8} Additionally, PLWH suffering from COPD, compared to those without such comorbidity, present a higher number of hospitalizations for a respiratory-related condition, a higher incidence of community-acquired bacterial pneumonia,⁷ and higher mortality rates.⁹

On the light of the evidence described, we believe that COPD prevention, diagnosis and treatment in PLWH deserves a more relevant position. We suggest to follow the European AIDS Clinical Society Guidelines regarding chronic lung disease screening in PLWH.¹⁰ These guidelines identify risk patients to be screened as those having three conditions: (1) being 40 years or older, (2) an accumulated smoking history of 10 pack years, and (3) to present in a regular basis respiratory symptoms such as shortness of breath, productive or non-productive cough and wheezing. Patients with these three conditions should be assessed with spirometry with bronchodilation study and CO diffusion capacity test, in order to acknowledge the presence and reversibility of airflow limitations. Furthermore, inquiry regarding tobacco consumption is fundamental for the implementation of risk reduction policies and information about the health benefits of smoking cessation should be provided and encouraged.^{1,10}

In conclusion, we believe that, in addition to other comorbidities, COPD is an important condition for PLWH with relevant implications on life expectancy and quality of life. Unfortunately, it is largely underdiagnosed in PLWH, which might reflect a lack of awareness of its relevance in this population. We believe that the importance of COPD diagnosis and prevention in PLWH should be underlined and that future consensus should include COPD evaluation in their recommendations, as physicians' awareness on its prevention and diagnosis would improve the care we provide to PLWH.

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Outbreak of *Chlamydia psittaci* pneumonia in the Region of Murcia[☆]



Brote de neumonía por *Chlamydia psittaci* en la Región de Murcia

Dear Editor,

Psittacosis or ornithosis is a worldwide zoonosis caused by *Chlamydia psittaci* (*C. psittaci*). Birds are the main reservoir, and transmission occurs by direct contact or by inhalation of respiratory secretions or dry faeces of infected birds.¹ The cases of human psittacosis described in Spain, both sporadic and epidemic, are rare and often associated with people connected to birds.² We report an outbreak of pneumonia due to *C. psittaci*, of which the focus of infection was an unauthorised centre for the sale of exotic birds.

During the months of March and April 2019, four members of the same family, residents of Murcia, went to the emergency department with a fever, severe headache, cough and general malaise. A chest X-ray was performed, observing in all of them pulmonary infiltrates located in different lobes. The haematological and biochemical parameters were normal except for C-reactive protein, which was elevated in all of them (Table 1). As a history of interest, they reported having been in direct contact with a couple of lovebirds, which had died in the days prior to them falling ill. Given the symptoms and the contact with the birds, serologies were performed for the detection of anti-*C. psittaci* antibodies. The serological study was performed using indirect immunofluorescence (IIF) (*Chlamydophila pneumoniae* IFA IgG, Vircell, Granada), collecting serum samples in the acute phase and convalescent phase (at 3 weeks).

For the definition of cases, the criteria of the Centers for Disease Control and Prevention (CDC) were used³: 1) Confirmed case: clinically compatible and confirmed in a laboratory; 2) Probable case: clinically compatible and epidemiological link to a confirmed case or positive serology.

Three of the four family members had seroconversion at three weeks, while in the fourth the serology remained negative; however, he was treated as a probable case of psittacosis as he had compatible symptoms, an epidemiological relationship with the other patients, and a good response to treatment.

After the outbreak was declared, a fifth patient in contact with sick lovebirds acquired in the same centre went to the emergency department with a similar clinical picture, requiring hospital

admission for respiratory distress. This person was considered a confirmed case after initial positive serology of *C. psittaci*.

The evolution in all cases was favourable, with a combination of doxycycline or macrolide plus a fluoroquinolone or a third-generation cephalosporin being administered as treatment.

In similar episodes that occurred in Spain, the cause of the outbreaks was contact with infected lovebirds, with the disease being contracted by both buyers and workers in hatcheries and sales centres^{1,4,5}; however, in this case only the buyers of the birds were affected. Usually, *C. psittaci* infection is mild and presents as atypical pneumonia with high fever, headache and dry cough, symptoms which were present in our patients.⁶ However, cases of severe respiratory infection and fatal consequences in outbreaks similar to that which occurred have been reported, requiring the admission of patients in intensive care units with prolonged stays.^{1,4} In our case, hospital admission was only necessary in two of the patients, while the rest were treated on an outpatient basis, with good progress in all of them.

In the diagnosis of psittacosis, the clinical interview is of great importance because the symptoms that occur can be indistinguishable from other atypical pneumonias. For this reason, knowing whether the patient has been in contact with birds can be key when requesting microbiological studies that confirm it. Currently, there are no commercialised molecular techniques and carrying out cultures of *C. psittaci* is complex and not available to all laboratories. This makes serology, together with symptoms and epidemiology, the basis of the diagnosis of psittacosis.^{1,3}

In this case, the microbiological diagnosis was made using serology, since the polymerase chain reaction (PCR) technique is not included in our laboratory's portfolio of services. A drawback of the serological diagnosis is the possible appearance of cross-reactions with other species of the genus *Chlamydia*. However, in our case the antibody titres against *C. psittaci* were high and no antibodies against other species were observed.

Tetracyclines are the treatment of choice for psittacosis; however, macrolides have been shown to be an equally effective alternative.² All of our patients received a combination of a tetracycline or a macrolide plus a second antibiotic, with marked improvement observed in all of them.

Although psittacosis is not a disease that it is mandatory to report in Spain, we consider it advisable to report cases to epidemiological surveillance systems to perform an active search for patients and implement preventive measures that limit their spread.⁴

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