HOW TO MANAGE HIV IN TURKEY ?

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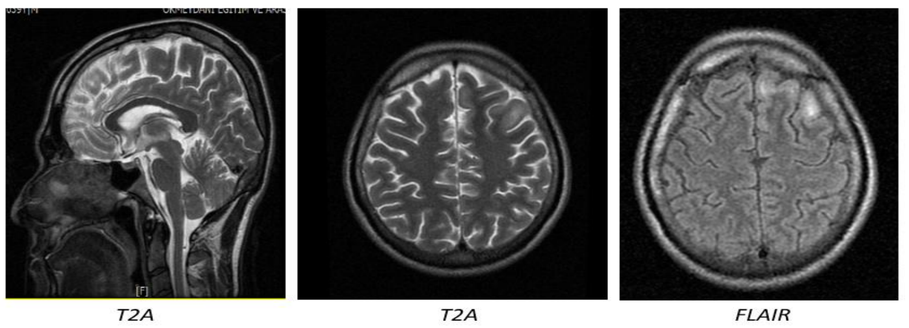
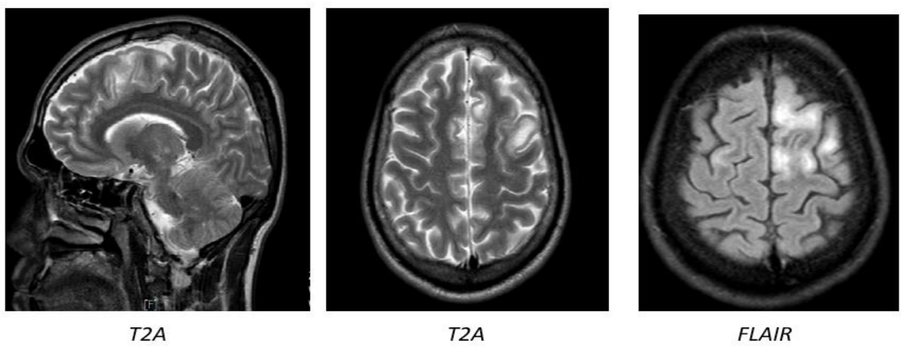
There are 16.644 HIV/AIDS cases reported in Turkey since 1985, 79% being male and 15,3% being foreign.The highest incidence is between people aged 25-34. According to the data from Institution of Public Health in Turkey, mode of transmission is recorded only in 60% of the cases. Among the sexually transmitted cases, 2/3 of those are reported as heterosexual transmission. However as we know from multi-centered studies performed in Istanbul and our clinical practice, ratio of homosexual transmission is higher. Even though the overall incidence of HIV/AIDS worldwide is declining, newly diagnosed cases have increased by 4 times in the past 5 years in our country. Some of the proposed reasons of this outbreak include the increase in MSM population, improving social network among the risky population, increased migration, avoiding getting tested and treated because of social stigmata.

CASE

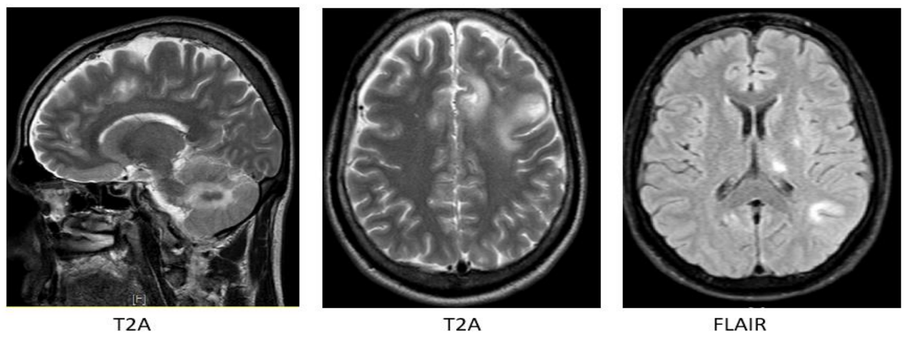
A forty-year-old man who was diagnosed with AIDS about one month ago presented to our emergency department with latency and anomia which started last week. HIV RNA was 1.560.000 copies/mL and CD4 T cell count was 206 cells/mm3 at the administration. We evaluated him for ART and EVG/COBI/FTC/TDF was started. Cranial MRI with contrast revealed diffuse cortical contrast enhancing lesions ***(Picture-1).*** He was started on TMP/SMX with a preliminary diagnosis of toxoplasmic encephalitis. CSF analysis showed slight hypoglycorrhachia and elevated protein level with 8 leukocytes and 37 erythrocytes. There was no microorganism with direct microscopy and the CSF culture was negative. The india ink stain was negative for cryptococcus and CSF mycobacterium PCR was negative.TMP/SMX was stopped on the eleventh day of treatment after no clinical response was observed and toxoplasma IgG test was negative. On the 21th day of ART, another cranial MRI was performed which revealed progressive multifocal asymmetrical lesions in infratentorial and supratentorial neural parenchyma (with progression and new lesions) ***(Picture-2).*** The patient now with a CD4 T cell count of 319 cells/ mm3 was evaluated at the neuro-radiology council and it was decided to focus on the diagnosis of PML-IRIS.We excluded the diagnosis of CNS lymphoma by MR spectroscopy. Even though CSF multiplex PCR and JC virus tests were negative, PML with CNS-IRIS was considered with his clinical and radiological findings.He then was started on high dose prednisolone and acyclovir. Control cranial imaging on the 10th day of steroid treatment showed prominent regression of the lesions ***(Picture-3).*** The patient was discharged after tapering steroids with no neurological sequelae.



Picture-1

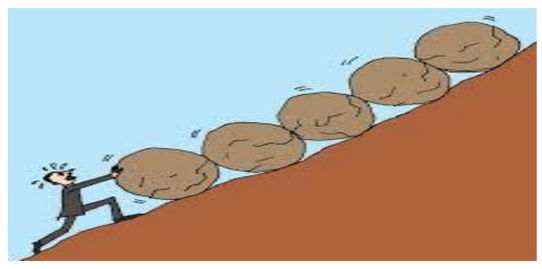


Picture-2



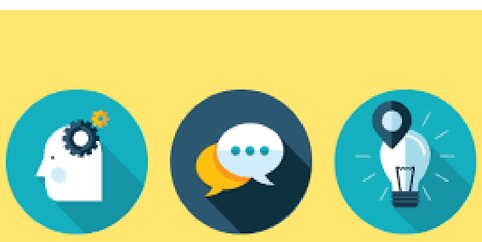
Picture-3

Challenges



➢Lower than presumed rate of reported STD cases (treatment without ordering diagnostic tests and problems with reporting STDs especially in dermatology, urology and gynecology clinics; insufficient STD screening in HIV clinics) (In a study performed in Istanbul, TPHA(+/- RPR) positivity among HIV/AIDS patients is 13%)
➢Vulnerability of unemployed women and the difficulty in reaching the hospital
➢Insufficient education about sexual health and HIV among school children (very low rate of condom use)

Strategies



✓Collaboration with non-governemental organizations to raise the awareness among risky population and provide easily accessible anonymous tests
✓Collaboration with female organizations to raise the awareness among monogamous housewives who constitute the majority of our female patients.
✓Providing consulting service in test centers
✓Improving the physical conditions in HIV clinics
✓Education of physicians working in disciplines other than infectious diseases