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HCV cure: an appropriate moment to reduce cannabis use in people living with HIV? (ANRS CO13 HEPAVIH data)

Tanguí Barré1, Patrick Mercié2, Caroline Lions1, Patrick Miallhès3, David Zucman4, Hugues Aumaitre5, Laure Esterle6, Philippe Sogni7,8,9, Patrizia Carrieri1*, Dominique Salmon-Céron7,10 and Fabienne Marcellin1 on behalf of the ANRS CO13 HEPAVIH Study Group

Abstract

Background: Thanks to direct-acting antivirals, hepatitis C virus (HCV) infection can be cured, with similar rates in HCV-infected and HIV–HCV co-infected patients. HCV cure is likely to foster behavioral changes in psychoactive substance use, which is highly prevalent in people living with HIV (PLWH). Cannabis is one substance that is very commonly used by PLWH, sometimes for therapeutic purposes. We aimed to identify correlates of cannabis use reduction following HCV cure in HIV–HCV co-infected cannabis users and to characterize persons who reduced their use.

Methods: We used data collected on HCV-cured cannabis users in a cross-sectional survey nested in the ANRS CO13 HEPAVIH cohort of HIV–HCV co-infected patients, to perform logistic regression, with post-HCV cure cannabis reduction as the outcome, and socio-behavioral characteristics as potential correlates. We also characterized the study sample by comparing post-cure substance use behaviors between those who reduced their cannabis use and those who did not.

Results: Among 140 HIV-infected cannabis users, 50 and 5 had reduced and increased their use, respectively, while 85 had not changed their use since HCV cure. Cannabis use reduction was significantly associated with tobacco use reduction, a decrease in fatigue level, paying more attention to one's dietary habits since HCV cure, and pre-HCV cure alcohol abstinence (p = 0.063 for alcohol use reduction).

Conclusions: Among PLWH using cannabis, post-HCV cure cannabis reduction was associated with tobacco use reduction, improved well-being, and adoption of healthy behaviors. The management of addictive behaviors should therefore be encouraged during HCV treatment.

Keywords: Cannabis, Marijuana, HIV, Hepatitis C, Sustained virological response, HCV cure, Smoking, Behavioral changes

Introduction

In Western countries, AIDS is no longer the principal cause of death in people living with HIV (PLWH) [1–3]. Accordingly, HIV infection can be considered a chronic disease [4] associated with multiple comorbidities in aging people. In contrast, recent medical advances in hepatitis C virus (HCV) infection, specifically direct-acting antivirals (DAA), provide a quick cure [5], and represent an important turning point in HIV–HCV co-infected people's lives. This clinical change impacts quality of life [6–10] and foster behavioral changes [10, 11].
As psychoactive substance use is highly prevalent in HIV–HCV co-infected patients [12–15], we may expect HCV cure to impact substance use behavior. The benefits of cannabis and cannabinoid use for HIV infection management and less severe treatment side-effects, are widely recognized [16, 17], and PLWH frequently report their therapeutic use [18–22]. However, cannabis use may also promote pulmonary disease [23] and cognitive impairments in PLWH [24]. As cannabis use [14, 15, 21] and cannabis dependence [25] are frequent in HIV–HCV co-infected patients, it is important to explore changes in use after HCV cure. Using data from a cross-sectional survey embedded in the ANRS CO13 HEPAVIH cohort, we aimed to identify correlates of cannabis use reduction following HCV cure in HIV–HCV co-infected cannabis users, and to characterize persons who reduced their use.

Material and methods

Study design and data collection
ANRS CO13 HEPAVIH is an ongoing French national multicenter prospective cohort of HIV–HCV co-infected patients. Initiated in 2005, it investigates clinical and socio-behavioral issues surrounding HIV–HCV co-infection [26]. A total of 1859 patients followed in 29 hospital wards throughout metropolitan France were included in the cohort between October 2005 and March 2016, in three consecutive phases. Designed and implemented in accordance with the Declaration of Helsinki, the cohort and nested surveys were approved by the ethics committee of Cochin University Hospital in Paris. Patients provided written informed consent to participate.

A cross-sectional survey nested in the ANRS CO13 HEPAVIH cohort was conducted between February 2018 and May 2019 to document patient-reported outcomes, with a focus on perceived changes after HCV cure. All patients enrolled in the cohort and still followed-up in participating clinical centers at the time of the survey were offered to participate. A self-administered questionnaire (SAQ) collected data. The cohort is observational, therefore counselling and advice potentially received by participants depended solely on their physician.

The SAQ included questions related to sociodemographic characteristics, HCV transmission mode, recent substance use, cannabis dependence using the Cannabis Abuse Screening Test (CAST) [27], and reason for using cannabis (therapeutic motive or not). Other questions asked about changes since HCV cure in patients’ use of psychoactive substances (tobacco, cannabis, alcohol, other substances), physical activity, attention paid to dietary habits, and body weight gain. For questions documenting changes in substance use after HCV cure, respondents had to choose one answer among the following four: “No, nothing has changed”, “Yes, my use has decreased”, “Yes, my use has increased”, “Not concerned (no use)”.

Study population
The population of the present study included HCV-cured cannabis users who participated in the cross-sectional survey and answered the SAQ item documenting perceived changes in cannabis use after cure. Patients who answered that they were not concerned by cannabis use were excluded from analyses.

Statistical analysis
First, descriptive statistics were used to present the study population’s main characteristics. Comparisons were performed between patients who reported a reduction in cannabis use after HCV cure and those who did not (Chi-square test for categorical variables, Wilcoxon rank-sum test for continuous variables). Logistic regression models were then run to identify correlates of decreased cannabis use following HCV cure (study outcome). Sociodemographic variables and behavioral changes since HCV cure were tested as potential correlates. Only variables with a liberal p-value < 0.20 in the univariable analyses were considered eligible for the multivariable model. The final multivariable model was built using a backward stepwise procedure. The likelihood ratio test (p < 0.05) was used to define the variables to maintain in the final model.

Second, characteristics of substance use after HCV cure were compared between patients who reduced their cannabis use and those who did not using Chi-square tests. All statistical analyses were performed using SAS software version 9.4 for Windows (SAS, Cary, NC, USA).

Results
Among the 448 survey participants, of the 421 HCV cured, two had no data on post-HCV cure changes in cannabis use. A total of 279 out of 419 patients reported no cannabis use (“Not concerned” answer) and were excluded from the analysis. The study population therefore comprised 140 individuals. Among them, 50 (35.7%) reported to have reduced their cannabis use after HCV cure, five had increased it, and 85 reported no change. The study sample mainly comprised men (74.3%), and median age was 55.7 years (Table 1). Six participants declared they quit cannabis.

Post-HCV cure decrease in cannabis use was associated with tobacco use reduction, pre-HCV cure alcohol
| Variable                        | Total n (%) | Cannabis use reducers n (%) | Cannabis use non-reducers n (%) | p-value | Univariable analyses | Multivariable analysis |
|--------------------------------|-------------|----------------------------|-------------------------------|---------|----------------------|-----------------------|
|                                |             |                           |                               |         | OR 95% CI            | p-value | aOR 95% CI | p-value |
| Gender                         |             |                           |                               | 0.730   |                      |          |            |         |
| Male                           | 104 (74.3)  | 38 (76.0)                 | 66 (73.3)                      | 1.15    | 0.52–2.56           | 0.730    |            |         |
| Female                         | 36 (25.7)   | 12 (24.0)                 | 24 (26.7)                      | 1       |                      |          |            |         |
| Age (median, [IQR] years)      | 55.7 [53.0–58.5] | 56.1 [53.2–58.6]   | 55.4 [52.9–58.5]               | 0.995   |                      |          |            |         |
| HCV transmission mode          |             |                           |                               | 0.123   |                      | 0.130    |            |         |
| Drug injection                 | 91 (65.0)   | 38 (76.0)                 | 53 (58.9)                      | 1       |                      |          |            |         |
| Sexual transmission            | 23 (16.4)   | 6 (12.0)                  | 17 (18.9)                      | 0.49    | 0.18–1.37           | 0.173    |            |         |
| Other                          | 26 (18.6)   | 6 (12.0)                  | 20 (22.2)                      | 0.42    | 0.15–1.14           | 0.089    |            |         |
| Change in tobacco use²         |             |                           |                               | <0.001  | <0.001               | 0.014    |            |         |
| No use                         | 9 (6.4)     | 4 (8.0)                   | 5 (5.6)                        | 4.58    | 1.06–19.78          | 0.041    | 3.84      | 0.67–22.09 | 0.131 |
| Reduction                      | 57 (40.7)   | 35 (70.0)                 | 22 (24.4)                      | 9.11    | 3.96–20.96          | <0.001   | 4.32      | 1.58–11.78 | 0.004 |
| No reduction                   | 74 (52.9)   | 11 (22.0)                 | 63 (70.0)                      | 1       |                      |          | 1         |         |
| Change in alcohol use²         |             |                           |                               | <0.001  | <0.001               | 0.003    |            |         |
| No use                         | 39 (27.9)   | 22 (44.0)                 | 17 (18.9)                      | 9.54    | 3.61–25.24          | <0.001   | 7.71      | 239–24.87 | <0.001 |
| Reduction                      | 34 (24.3)   | 20 (40.0)                 | 14 (15.6)                      | 10.54   | 3.85–28.81          | <0.001   | 3.32      | 0.94–11.72 | 0.063 |
| No reduction                   | 67 (47.9)   | 8 (16.0)                  | 59 (65.6)                      | 1       |                      |          | 1         |         |
| Change in other substance use² |             |                           |                               | 0.004   | 0.018                |          |            |         |
| No use                         | 108 (77.1)  | 35 (70.0)                 | 73 (81.1)                      | 1.20    | 0.43–3.35           | 0.730    |            |         |
| Reduction                      | 11 (7.9)    | 9 (18.0)                  | 2 (2.2)                        | 11.25   | 1.86–68.13          | 0.008    |            |         |
| No reduction                   | 21 (15.0)   | 6 (12.0)                  | 15 (16.7)                      | 1       |                      |          | 1         |         |
| Changes in physical activity²  |             |                           |                               | 0.238   | 0.244                |          |            |         |
| Stable                         | 85 (60.7)   | 26 (52.0)                 | 59 (65.6)                      | 1       |                      |          |            |         |
| Increase                       | 39 (27.9)   | 16 (32.0)                 | 23 (25.6)                      | 1.58    | 0.72–347            | 0.256    |            |         |
| Reduction                      | 16 (11.4)   | 8 (16.0)                  | 8 (8.9)                        | 2.27    | 0.77–6.70           | 0.138    |            |         |
| Changes in fatigue level²      |             |                           |                               | 0.021   | 0.023                | 0.073    |            |         |
| Stable                         | 63 (45.0)   | 15 (30.0)                 | 48 (53.3)                      | 1       |                      |          |            |         |
| Reduction                      | 63 (45.0)   | 30 (60.0)                 | 33 (36.7)                      | 2.91    | 1.36–6.23           | 0.006    | 3.12      | 1.15–8.46 | 0.025 |
| Increase                       | 14 (10.0)   | 5 (10.0)                  | 9 (10.0)                       | 1.78    | 0.52–6.13           | 0.362    | 2.95      | 0.61–14.15 | 0.177 |
| Changes in dietary habits²     |             |                           |                               | <0.001  | <0.001               | 0.045    |            |         |
| Stable                         | 92 (65.7)   | 21 (42.0)                 | 71 (78.9)                      | 1       |                      |          |            |         |
| Paying more attention          | 40 (28.6)   | 25 (50.0)                 | 15 (16.7)                      | 5.64    | 2.52–12.59         | <0.001   | 3.33      | 1.22–9.14 | 0.019 |
| Paying less attention          | 8 (5.7)     | 4 (8.0)                   | 4 (4.4)                        | 3.38    | 0.78–14.69         | 0.104    | 3.01      | 0.48–18.79 | 0.237 |
| Change in body weight²         |             |                           |                               | 0.073   | 0.078                |          |            |         |
| No change or reduction         | 84 (60.0)   | 24 (48.0)                 | 60 (66.7)                      | 1       |                      |          |            |         |
| Variable | Total n (%) | Cannabis use reducers n (%) | Cannabis use non-reducers n (%) | p-value<sup>1</sup> | Univariable analyses | Multivariable analysis |
|----------|-------------|-----------------------------|---------------------------------|---------------------|----------------------|------------------------|
|          |             | Univariable analyses        | Multivariable analysis         |                     |                      |                        |
|          |             | OR 95% CI                   | p-value                        | aOR 95% CI          | p-value              |                        |
| Increase < 5 kg | 33 (23.6) | 14 (28.0) | 19 (21.1) | 1.84 0.80–4.25 | 0.153                |                        |
| Increase ≥ 5 kg | 23 (16.4) | 12 (24.0) | 11 (12.2) | 2.73 1.06–7.02 | 0.038                |                        |

<sup>aOR: adjusted odds ratio; HCV: hepatitis C virus; IC: confidence interval; IQR: interquartile range</sup>

<sup>1</sup> Chi-square (categorical variables) or Wilcoxon rank-sum test (continuous variables)

<sup>2</sup> Self-reported post HCV-cure changes
use abstinence (p = 0.063 for alcohol use reduction), a decrease in fatigue level and paying more attention to one's dietary habits (Table 1).

After HCV cure, regular or daily cannabis use was reported by most patients (54.8%), recreational use being predominant (59.5% of patients). No patient was at high risk of cannabis dependence (Table 2).

Those who reduced their cannabis consumption were more likely to use the drug less frequently, to have recently used other psychoactive substances (excluding alcohol and tobacco) and to smoke fewer tobacco cigarettes after HCV cure (p = 0.068 for alcohol use) (Table 2).

**Discussion**

In this study, approximately one third of PLWH reduced their cannabis use after being cured of HCV. This reduction was associated with a reduction in tobacco use, pre-HCV cure alcohol abstinence, a decrease in fatigue level, and paying greater attention to one's diet.

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**Table 2** Characteristics related to psychoactive substance use according to post-HCV cure reduction in cannabis use (cross-sectional survey nested in the ANRS CO13 HEPAVIH cohort, n = 140)

| Variable                                | Total | Reduction in cannabis use after HCV cure | p-value<sup>1</sup> |
|------------------------------------------|-------|------------------------------------------|---------------------|
| Reason for using cannabis (n = 126)      |       |                                          |                     |
| Therapeutic                              | 51 (40.5) | 16 (34.8) | 35 (43.8) | 0.324 |
| Recreational only                        | 75 (59.5) | 30 (65.2) | 45 (56.3) |         |
| Recent substance injection<sup>2</sup>   |       |                                          |                     |
| No                                       | 139 (99.3) | 50 (100.0) | 89 (98.9) | 0.454 |
| Yes                                      | 1 (0.7) | 0 (0.0) | 1 (1.1) |         |
| Cannabis dependence (n = 129)<sup>3</sup> |       |                                          |                     |
| No risk                                  | 64 (49.6) | 22 (48.9) | 42 (50.0) | 0.904 |
| Low risk                                 | 65 (50.4) | 23 (51.1) | 42 (50.0) |         |
| High risk                                | 0 (0.0) | 0 (0.0) | 0 (0.0) |         |
| Opioid substitution therapy (n = 133)    |       |                                          |                     |
| No                                       | 107 (80.5) | 37 (77.1) | 70 (82.4) | 0.462 |
| Current therapy                          | 26 (19.6) | 11 (22.9) | 15 (17.7) |         |
| Cannabis use frequency (n = 126)         |       |                                          | <0.001              |
| Never                                    | 6 (4.8) | 6 (13.0) | 0 (0.0) |         |
| Sometimes                                | 51 (40.5) | 29 (63.0) | 22 (27.5) |         |
| Regularly or daily                       | 69 (54.8) | 11 (23.9) | 58 (72.5) |         |
| Other substance use<sup>4</sup>          |       |                                          | 0.041               |
| No                                       | 127 (90.7) | 42 (84.0) | 85 (94.4) |         |
| One or more                              | 13 (9.3) | 8 (16.0) | 5 (6.6) |         |
| AUDIT-C score                            | 2.5 [0–5] | 2 [0–4] | 3 [0–5] | 0.245 |
| Alcohol use<sup>5</sup>                  |       |                                          | 0.068               |
| Not at risk                              | 78 (55.7) | 33 (66.0) | 45 (50.0) |         |
| At risk                                  | 62 (44.3) | 17 (34.0) | 45 (50.0) |         |
| Tobacco use (n = 138)                    |       |                                          | 0.001               |
| No current use                           | 19 (13.8) | 11 (22.9) | 8 (8.9) |         |
| 1 to 5 cig/d                             | 32 (23.2) | 17 (35.4) | 15 (16.7) |         |
| 6 to 10 cig/d                            | 41 (29.7) | 12 (25.0) | 29 (32.2) |         |
| More than 10 cig/d                       | 46 (33.3) | 8 (16.7) | 38 (42.2) |         |

AUDIT-C: Alcohol Use Disorders Identification Test Concise; cig/d: cigarette per day
<sup>1</sup> Chi-square (categorical variables) or Wilcoxon rank-sum test (continuous variables)
<sup>2</sup> In the previous 4 weeks
<sup>3</sup> Cannabis dependence assessed by Cannabis Abuse Screening Test [27]. A score < 3 defined 'no risk', a score ≥ 3 and < 7 defined 'low risk', and a score ≥ 7 defined 'high risk'
<sup>4</sup> Any use of other substances (cocaine, heroin, crack, ecstasy, street Subutex, amphetamines, LSD, cathinone) in the previous 4 weeks
<sup>5</sup> At-risk use was defined as an AUDIT-C score ≥ 4 for men and ≥ 3 for women [42]
These results confirm previous findings that HCV cure is accompanied by behavioral changes, including changes in substance use [10, 11]. However, data on these changes are scarce [28], particularly in the HCV cure era, and especially for cannabis use, which is highly prevalent and partly motivated by therapeutic goals in PLWH.

Concomitant reduction in tobacco use is important for PLWH who reduce their cannabis use, as they are highly exposed to tobacco-related harms, a major morbidity and mortality risk factor in this population [29–31]. Cannabis and tobacco use frequently co-occur [32], especially in Europe [33]. Moreover, both drugs seem to reinforce each other [34, 35]. Accordingly, cannabis use impairs the chances of tobacco cessation [36], including in HIV–HCV co-infected people [15]. This phenomenon has also been documented for polysubstance use generally speaking [37, 38].

Our results suggest that HCV cure is an appropriate moment to engage in addictive behavior management, especially using a holistic approach for all substances. Our findings also suggest that lifestyle modifications post-HCV cure may include dietary changes. This is in line with studies showing that HCV cure is associated with increased self-care [39, 40], ability and motivation to plan for the future, self-confidence, and empowerment [40, 41]. However, our results also suggest that a reduction in cannabis (and tobacco) use in the PLWH population does not translate into abstinence.

We did not find any association between a therapeutic motive for cannabis use and post-cure reduction. However, participants who reduced their use were more likely to have experienced a decrease in their level of fatigue. This result suggests that the level of therapeutic benefit which HCV cure brings may only lead to a marginal reduction. Having said that, we cannot exclude reverse causality whereby the decrease in fatigue is the consequence of reduced cannabis use.

One of the study’s main limitations is that it is based on self-reports. We also had no data on physicians’ attitude and counselling regarding substance use after HCV cure. Moreover, we were not able to take into account the time since HCV cure in our models, and therefore the persistence of the observed reductions in use. However, our results still provide clues about the potential of using HCV treatment as a teachable moment for addiction treatment in PLWH.

Conclusion
Among cannabis users living with HIV, post-HCV cannabis reduction was associated with tobacco use reduction, and approached significance for alcohol use reduction. The management of addictive behaviors should be emphasized during HCV treatment, and further research is needed to explore the psychosocial mechanisms at play in smoking behaviors among PLWH, especially regarding cannabis use.

Abbreviations
CAST: Cannabis abuse screening test; DAA: Direct-acting antivirals; HCV: Hepatitis C virus; PLWH: People living with HIV; SAC: Self-administered questionnaire.

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The ANRS C013 HEPAVIH Study Group:
Scientific Committee: D. Salmon (co-Principal investigator), L. Wittkop (co-Principal Investigator & Methodologist), P. Sogni (co-Principal Investigator), L. Estérel (project manager), P. Trimoulet, J. Izopet, L. Serfaty, V. Paradis, B. Spire, P. Carrieri, M.A. Valantin, G. Pialoux, J. Chas, I. Pozoiz-Martín, K. Barange, A. Naqvi, E. Rosenthal, A. Bicant-See, O. Bouchaud, A. Gervais, C. Lascoux-Combe, C. Goujard, K. Lacombe, C. Duvivier, D. Neau, P. Morlat, F. Bani-Sadi; L. Meyer, F. Boujass, B. Autran, A.M. Roque, C. Solas, H. Fontaine, D. Costagliola, L. Pireth, A. Simon, D. Zucman, F. Boué, P. Mailhès, E. Billaud, H. Augault, D. Rey, G. Peytavin, P. Trevot-Sanchez, A. Levier.

Clinical Centers (ward/participating physicians):
APHR Hôpitaux Universitaires Paris Centre, Paris (Médecine Interne et Maladies Infectieuses: D. Salmon, R. Usubillaga; Hépato-gastro-entérologie: P. Sogni; Anatomopathologie: B. Tenais; Virologie: P. Tremeaux); APHP Pitié-Salpêtrière, Paris (Maladies Infectieuses et Tropicales: C. Katlama, M.A. Valantin, H. Sitoua, Médecine Interne: A. Simon, P. Cacoub, S. Nafissa; Hépato-gastro-entérologie: Y. Benhamou, Anatomopathologie: F. Charlotte; Virologie: S. Fourati); APHM Sainte-Marthe, Marseille (Service d’Immun-Hématologie Clinique: I. Pozoiz-Martín, O. Zaege, H. Laroche; Virologie: C. Tamalet); APHP Tenon, Paris (Maladies Infectieuses et Tropicales: G. Pialoux, J. Chas, Anatomopathologie: P. Callard, F. Bendjaballah; Virologie: C. Amiel, C. Le Pendeven); CHU Purpan, Toulouse (Maladies Infectieuses et Tropicales: B. Marchou, Médecine interne: L. A. Leric; Hépato-gastro-entérologie: K. Barange, S. Metivier; Anatomopathologie: J. Selves; Virologie: F. Larroquette); CHU Arche, Nice (Médecine Interne: E. Rosenthal; Infections: A. Naqvi, V. Rio; Anatomopathologie: J. Haudebourg, M.C. Saint-Paul; Virologie: A. De Monte, V. Giordano, C. Partouche); APHP Avicenne, Bobigny (Médecine Interne – Unité VH: O. Bouchaud; Anatomopathologie: A. Martin, M. Ziol; Virologie: Y. Baazza, V. Ivaka-Bande, A. Gerber); Hôpital Joseph Ducuing, Toulouse (Médecine Interne: M. Uzan, A. Bicant-See, D. Gayriup, M.J. Fero-Collados; Anatomopathologie: J. Selves; Virologie: F. Nicot); APHP Bichat – Claude-Bernard, Paris (Maladies Infectieuses: A. Gervais, Y. Yazdanpanah; Anatomopathologie: H. Adile-Biassette; Virologie: G. Alexandre, Pharmacologie: G. Peytavin); APHP Saint-Louis, Paris (Maladies infectieuses: C. Lascoux-Combe, J.M. Molina, Anatomopathologie: P. Bertheau; Virologie: M.L. Chaux, C. Delaugerre, S. Maylin); APHP Saint-Antoine (Maladies Infectieuses et Tropicales: K. Lacombe, J. Bottero, J. Krause; Gérontologie, Anatomopathologie: D. Wendum, P. Cervena, J. Adam; Virologie: C. Viala); APHP Hôpitaux Paris Sud, Bicêtre, Paris (Maladies Infectieuses et Tropicales: D. Vittecocq; Médecine Interne: C. Goujard, Y. Quertaintmont, E. Teicher; Virologie: C. Paller); APHP Necker, Paris (Maladies Infectieuses et Tropicales: O. Lortholary, C. Duvivier; Anatomopathologie: J. Krause, P. M. Girard, Anatomo-pathologie: D. Wendum, C. Delaugerre, S. Maylin); APHP Saint-Louis, Paris (Maladies Infectieuses: C. Lascoux-Combe, J.M. Molina, Anatomopathologie: P. Bertheau; Virologie: M.L. Chaux, C. Delaugerre, S. Maylin); APHP Saint-Antoine (Maladies Infectieuses et Tropicales: K. Lacombe, J. Bottero, J. Krause; Gérontologie, Anatomopathologie: D. Wendum, P. Cervena, J. Adam; Virologie: C. Viala); APHP Hôpitaux Paris Sud, Bicêtre, Paris (Maladies Infectieuses et Tropicales: D. Vittecocq; Médecine Interne: C. Goujard, Y. Quertaintmont, E. Teicher; Virologie: C. Paller); APHP Necker, Paris (Maladies Infectieuses et Tropicales: O. Lortholary, C. Duvivier; Anatomopathologie: J. Krause, P. M. Girard, Anatomo-pathologie: D. Wendum, C. Delaugerre, S. Maylin); APHP Saint-Louis, Paris (Maladies Infectieuses: C. Lascoux-Combe, J.M. Molina, Anatomopathologie: P. Bertheau; Virologie: M.L. Chaux, C. Delaugerre, S. Maylin).
The authors declare that they have no competing interests.

Competing interests

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Author details

1. Aix Marseille Univ, Inserm, IRD, SESSTIM, Sciences Economiques & Sociales de la Sante & Traitement de L'Information Medicale, ISSPHAM, 35 boulevard Jean Moulin, 13005 Marseille, France.

2. Centre Hospitalier Universitaire (CHU) de Bordeaux, Pôle Médecine Interne, Service de Médecine Interne et Immunologie Clinique, Bordeaux Population Health Research Center UMR 1219, CIC-EC 1401, Université de Bordeaux, Pl. Amelie Raba Léon, 33000 Bordeaux, France.

3. Centre Hospitalier de Bourg-en-Bresse, Service d'Infectiologie, 900 Rte de Paris, 01012 Bourg-en-Bresse, France.

4. Réseau Ville-Hôpital, Service de Médecine Interne, Foch Hospital, 40 Rue Worth, 92150 Suresnes, France.

5. Centre Hospitalier de Perpignan, Service des Maladies Infectieuses et Tropicales, 20 Av. du Languedoc, 66000 Perpignan, France.

6. SPED, Inserm, Bordeaux Population Health Research Center, Team MORPH3UE, UMR 1219, CIC-EC 1401, Université de Bordeaux, 146 Rue Léo Sagnat 11, Bordeaux, France.

7. Université Paris Descartes, 12 Rue de l'École de Médecine, 75006 Paris, France.

8. INSERM U1223, Institut Pasteur, 25 rue du Docteur Roux, 75015 Paris, France.

9. Hôpital Cochin, 27 Rue du Faubourg Saint-Jacques, 75014 Paris, France.

10. Service Maladies Infectieuses et Tropicales, AP-HP, Hôpital Cochin, 27 Rue du Faubourg Saint-Jacques, 75014 Paris, France.

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