Mortality among HIV-Infected Patients in Resource Limited Settings:
A Case Controlled Analysis of Inpatients at a Community Care Center

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Abstract: Problem statement: Despite massive national efforts to scale up Antiretroviral Therapy (ART) access in India since 2004, the AIDS death rate was 17.2 per 100,000 persons during 2003-2005. In the era of HAART in resource poor settings, it is imperative to understand and address the causes of AIDS related mortality. This collaborative study aimed at defining the predictors of mortality among people living with HIV/AIDS (PLHA) admitted during 2003-2005 to the Freedom Foundation (FF) Care and Support facility, Bangalore, India. Approach: Fifty consecutively selected HIV-infected patients who died during the study period and 50 HIV-infected patients matched by age, gender, route of transmission, nutrition status and stage of disease who survived at least 12 months post-ART were included in this study. The impact on mortality by factors such as: Hemoglobin, CD4+T lymphocyte counts, weight loss and Opportunistic Infections (OIs) were studied. Statistical analyses were done by Chi-square, Fisher’s Exact Test, Kaplan-Meier and multivariate logistic regression. Results: Recurrent diarrhea was a significant risk factor for mortality (OR = 12.25, p = 0.004), followed by a diagnosis of pulmonary tuberculosis (TB) at first admission (OR = 4.86) while TB in general also negatively impacted survival (p = 0.002). Though not statistically significant, Pneumocystis carinii pneumonia, Cryptococcal meningitis and Toxoplasmosis also negatively affected survival. Mortality was high among those not on HAART (81%) while it was significantly reduced (28%) among those on HAART (p<0.001). Patients who died had elevated liver enzymes (p = 0.027) and significant weight loss (p = 0.012). Mortality was high among patients irregular with their medical follow-up (p<0.001). Conclusion: Interventions that facilitate early OI diagnosis and treatment especially diarrhea and TB may reduce mortality in HIV. HAART alone without proper OI management and nutrition did not prevent mortality among PLHA. In resource poor settings, it becomes imperative to focus on low cost tools and increased capacity building along with regular clinical follow-up for diagnosis and early treatment of OIs. Further studies are warranted to explore benefits of initiating HAART earlier than currently recommended.

Key words: HIV-1, tuberculosis, opportunistic infections, antiretroviral therapy, diarrhea

INTRODUCTION

According to India’s National Family Health Survey (NFHS-3), the prevalence of HIV in the country is now 0.3%. Even with this reduced prevalence, India would still contribute to 30% of the HIV epidemic in Asia[1]. The national government is engaged in addressing the devastating HIV/AIDS epidemic utilizing several interventions, including free access to antiretroviral therapy launched in 2004[2]. Although increased access to treatment is likely to reduce mortality among HIV-infected individuals, there are studies in India that show that AIDS-related deaths is still about 9.73% in the present HAART era[3]. Under
the prevailing conditions, it is important for clinicians, epidemiologists and policy makers to understand predictors of mortality in these individuals in order to formulate adjunct measures to prolong disease-free survival among HIV-infected individuals. The study described herein aimed to examine factors that predicted death among inpatients in the clinical setting of guidelines-based HAART access.

MATERIALS AND METHODS

The study was conducted at a community care center run by Freedom Foundation, an Indian non-governmental organization based in Bangalore, India. Bangalore, the capital city of the high-HIV-prevalence State of Karnataka, is also geographically located close to the neighboring high-prevalence States of Tamil Nadu and Andhra Pradesh. This location has ensured adequate diversity of the inpatient population being seen at this care facility. HIV-infected individuals admitted to the inpatient facility between August 2004 and April 2006 was included in the analysis. HIV infection was confirmed in all subjects by three serial rapid HIV antibody tests [4]. Other clinical tests performed included CD4+T lymphocyte counts and basic biochemistry tests such as liver and renal function tests, hemoglobin levels and total and differential white blood cell counts. All patients were prescribed cotrimoxazole prophylaxis based on WHO guidelines.

Between August 2004 and April 2006, there were 1,096 patients who were newly registered at the center and received medical care as either in-patients or at the out-patient clinic; 591 previously seen patients were readmitted. The primary mode of infection among new patients was via unprotected heterosexual intercourse (91%). A retrospective case record analysis was conducted to assess clinical and laboratory findings. All patients were prescribed cotrimoxazole prophylaxis based on WHO guidelines.

A comparison of socio-demographic and clinical factors between survivors and non-survivors presented in Table 1 showed similarity between the two groups. The male-female ratio between survivors and non-survivors were equal. Mean age among survivors was 32.32 years and among non-survivors was 34.70 years. Contact with multiple sexual partners was present in 60 and 52% of both groups respectively and the mean age at first sexual intercourse was approximately 20 years in both groups. There was no significant difference in the weight (mean weight was 46 kg±8.9) or hemoglobin (10.2% + 2.1) of patients in the two groups at the time of first admission.

At time of first admission, among the total of 100 patients included in the study, 39% were diagnosed with oral candidiasis, 38% with tuberculosis disease, 35% with oral candidiasis, 38% with tuberculosis disease, and 100 patients included in the study, 39% were diagnosed with oral candidiasis, 38% with tuberculosis disease, and 6% with other opportunistic infections.

Table 1: Comparison of socio-demographic and clinical factors between survivors and non-survivors

| Occupation          | Survivors (n = 50) | Non-survivors (n = 50) | Significance (p-value) |
|---------------------|--------------------|------------------------|------------------------|
| Education           |                    |                        |                        |
| Literate            | 13 (26.0%)         | 7 (14.0%)              | 0.299                  |
| Primary and middle  | 17 (34.0%)         | 17 (34.0%)             | 0.705                  |
| High school         | 14 (28.0%)         | 22 (44.0%)             | 0.096                  |
| Graduate            | 6 (12.0%)          | 2 (4.0%)               | 0.259                  |
| Not available       | 2 (4.0%)           | 2 (4.0%)               | 0.495                  |
| Occupation          |                    |                        |                        |
| Agriculture         | 8 (16.0%)          | 2 (4.0%)               | 0.046                  |
| Daily wage          | 25 (50%)           | 24 (48%)               | 0.841                  |
| House wife          | 5 (10.0%)          | 9 (18.0%)              | 0.249                  |
| Others (salaried workers, petty business) | 12 (24.0%) | 15 (30.0%) | 0.362                  |
| Region              |                    |                        |                        |
| Urban               | 13 (26%)           | 25 (50%)               | 0.013                  |
| Rural               | 37 (74%)           | 25 (50%)               | 0.400                  |
| Multiple sexual     | 30 (60%)           | 26 (52%)               | 0.400                  |
| Partners            | Mean CD4-Tlymphocyte count (cell mm^-3) | 99.80 (±69.81) | 81.95 (±76.59) | 0.100 |
| Mean hemoglobin (gm dL^-1) | 10.54 (±1.89) | 97.75 (±19.19) | 0.090                  |
| Mean baseline weight (kg) | 46.76 (±8.68) | 45.29 (±9.19) | 0.400                  |
Table 2: Opportunistic infections at first admission and mortality multivariate regression

| Factors                        | No. of survivors (n = 50) | No. of non-survivors (n = 50) | p-value | Adjusted odds ratio |
|-------------------------------|---------------------------|-------------------------------|---------|---------------------|
| Pulmonary tuberculosis        | 7                         | 19                            | 0.019*  | 4.86                |
| Tubercular lymphadenitis      | 1                         | 3                             | 0.239   | 4.50                |
| Abdominal tuberculosis        | 2                         | 3                             | 0.399   | 2.49                |
| Tuberculous Meningitis        | 1                         | 2                             | 0.494   | 2.54                |
| Presence any of tuberculosis  | 11                        | 27                            | 0.002*  | 4.16                |
| Pneumocystis jiroveci pneumonia | 1                        | 4                             | 0.279   | 4.09                |
| Cryptococcal Meningitis       | 3                         | 4                             | 0.572   | 1.76                |
| Persistent diathora           | 1                         | 10                            | 0.004*  | 12.25               |
| Toxoplasmosis                 | 1                         | 1                             | 0.504   | 1.72                |
| Cytomegalovirus infection     | 0                         | 2                             | 0.884   | 1.10                |
| Oral candidiasis              | 19                        | 20                            | 0.996   | 1.00                |
| Presumed bacterial pneumonia  | 11                        | 3                             | 0.731   | 0.55                |

28% with chronic diarrhea (diarrhea persisting more than 4 weeks)[5], 7% with cryptococcal meningitis, 5% with Pneumocystis jiroveci pneumonia (PCP) and 14% with presumed bacterial pneumonia. Of the total number of patients with tuberculosis (n = 38), 68.4% had pulmonary tuberculosis, 7.8% had tuberculous meningitis, 10.5% had tuberculous lymphadenitis and 13% had abdominal tuberculosis. Among the patients with diarrhea (n = 28), 22% required frequent admissions. Disseminated cytomegalovirus infection was observed in 4% of non-survivors. The mean CD4 count among survivors at time of first admission was 99.8±69.81 and among non-survivors was 81.95±76.59 (the difference was not statistically significant).

The multivariate logistic regression analysis (Table 2) showed that chronic diarrhea was a highly significant risk factor for mortality (OR = 12.25, p = 0.004). The other infection that negatively affected survival was tuberculosis (4.16 times risk of mortality) (p = 0.002, 95% CI: 1.74-9.93). Although statistical significance was not noted, Cryptococcal meningitis (OR = 1.76, p = 0.57), PCP, (OR = 4.09, p = 0.27) and toxoplasmosis (OR = 1.72, p = 0.5) exhibited a negative trend on patient survival. The causes of mortality in this cohort are shown in Table 3. Non-survivors were also more likely to have elevated liver enzymes 12% (p = 0.027) and accelerated weight loss (p = 0.012). Regular clinical follow-up had a positive impact on survival. Among survivors, 86% came for regular medical consultation, compared to 44% among those who died (regular follow-up was defined as people living with HIV/AIDS, PLHA, visiting the clinic once in three months and/or as advised by the doctor), 81% of those not on HAART died during the study period while among those on HAART, 28% had died which was a significant difference (p<0.001).

### DISCUSSION

Studies from affluent settings show that in the era of HAART, the causes of mortality in people infected with HIV are not all due to AIDS-related events[6,7]. However, in resource poor settings, opportunistic infections still contribute to a large number of AIDS-related deaths and this may be accelerated in those not taking prophylaxis and those unable to access medical care[8].

The study reported herein demonstrates that chronic diarrhea was associated with not only frequent hospitalization but also a higher risk of mortality. Most studies from resource poor settings have focused on TB[9] while studies that focused on diarrhea have mainly looked at the etiology[10-12]. However, this study has been able to demonstrate the importance of being able to diagnose and effectively treat diarrhea in order to decrease morbidity and mortality among PLHA. This also implies that there is still a need to educate PLHA regarding prevention of diarrhea. In India, the tendency to utilize over-the-counter medications to treat diarrhea rather than seek medical care remains a highly prevalent practice among PLHA. A prospective study that examines the outcome of chronic diarrhea among PLHA in resource poor settings is warranted.

TB/HIV co-infection still remains a big challenge, with TB accounting for nearly 13% of AIDS deaths worldwide[13]. Studies from African settings have also shown the relationship between tuberculosis/HIV co-infection and increased mortality[14,15]. Consistent with these observations, studies performed in India have reported over 50% TB/HIV co-infection in their study cohorts with higher mortality in those individuals with TB/HIV co-infection[16-21]. Increased incidence of post-partum TB and associated maternal deaths have also
been reported among HIV-infected women from antenatal clinics\[22\]. Tuberculosis was found to be the most common “AIDS-defining” opportunistic infection among a cohort of HIV-infected individuals in south India, accounting for nearly 50% of all OIs\[23\]. Although mortality associated with TB has remained steady over the years, combined mortality due to HIV/TB coinfection has increased dramatically\[24\]. Tuberculosis is a leading cause of death for HIV-infected individuals, accounting for up to 11% of AIDS-related mortality worldwide\[25\]. A recently published longitudinal study conducted in Uganda indicated that cumulative mortality among HIV-infected patients diagnosed with TB at baseline or follow-up was higher than those HIV-infected without TB\[28\]. The study also demonstrated that TB incidence declined dramatically after subjects were treated with HAART for 6 months. The ongoing high mortality associated with TB is a concern for patients on HAART in areas of high TB prevalence. Much of this mortality may be linked to the late stage at which many subjects in this study initiated HAART.

It is conceivable that HAART has the potential to be effective in preventing both chronic diarrhea and also TB in individuals if therapy had been started at an earlier time point when the CD4+ T lymphocyte counts were higher. Current WHO and Indian National Guidelines recommend initiation of HAART at CD4+ T lymphocyte counts of <200 cells mm\(^{-3}\) or for patients with WHO disease staging III and IV\[26,27\]. However, earlier initiation of HAART when CD4+ T lymphocyte counts are between 200 and 350 cells mm\(^{-3}\), along with improved strategies to diagnose and treat underlying opportunistic infections and extensive adherence counseling may play a role in decreasing mortality by preventing the occurrence of opportunistic infections, especially tuberculosis\[31\]. Prospective research studies exploring this approach are needed in order to weigh the risks and benefits of earlier initiation of HAART.

Major opportunistic infections such as cryptococcal infections, toxoplasmosis and PCP continue to contribute to AIDS-related mortality despite the increased access and utilization of antiretroviral therapy\[28-30\]. Many of those who died also had accelerated weight loss (26%) and low hemoglobin levels (36%), confirming the strong relationships between these markers and mortality\[31,34\]. Weight loss as a prognostic marker of advanced HIV infection has been well studied\[35\]. Poor nutritional intake, metabolic effects of drugs, opportunistic infections and increased catabolism are likely contributing factors\[36\]. Several studies have shown that falling hemoglobin is significantly associated with increased mortality independent of CD4+ T lymphocyte counts in patients with HIV infection\[37,38\].

The studies reported herein are limited by the small sample size as well as the retrospective nature of the study. These limitations not withstanding, the findings of this study have practical implications for managing HIV-infected patients in India.

**CONCLUSION**

The strong association between the presence of chronic diarrhea and early mortality indicates the need for improved diagnostic and preventive methods and aggressive treatment approaches. The same applies to HIV/TB co-infections. The study highlights the importance of having a close linkage between OI management and HAART care services and that this is fundamental for the successful management of HIV/AIDS. For patients with advanced disease, enhanced counseling focusing on adherence to care and frequent follow-up clinic visits could allow for the prevention and early diagnosis of opportunistic infections.

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