Letters to Editor

A Comment on “Prevalence and Factors Associated with Depression among Clinically Stable People Living with HIV/AIDS on Antiretroviral Therapy”

Sir,

I read the article by Algoodkar et al. with considerable interest. The authors reported the prevalence of depression in 100 people living with HIV/AIDS (PLWHAs) undergoing treatment in an antiretroviral therapy (ART) center to be 30%. These findings imply the need for regular screening of PLWHAs undergoing ART for depressive symptoms and appropriate mental health care according to the results of the screening. Nevertheless, I would like to point out two methodological concerns regarding the study:

1. The sample size of the study is quite small, and this reduces its validity. The authors reported excluding patients who reported ART adherence <95%. This needs justification since including these patients would have increased the sample size. Furthermore, including cases regardless of their ART adherence would have allowed comparing the prevalence of depressive symptoms among the PLWHAs who were ART adherent and those who were ART nonadherent.

2. The study did not describe the method used for estimating ART adherence in the PLWHAs, but it was apparently based on a self-report method. Self-reported measures of ART adherence have low sensitivity and tend to overestimate adherence due to the self-desirability bias of the patients. This can result in ART nonadherent cases being erroneously classified as ART adherent. Although the study purposively excluded PLWHAs with ART adherence <95%, still a large proportion reported depressive symptoms and lack of family support. Several previous studies across divergent cultures and health systems have reported the lack of family support as a predictor of poor ART adherence in PLWHAs. The likelihood of achieving good adherence to ART in PLWHAs is also known to be low in those reporting depressive symptoms. However, in contradiction, the results of the Algoodkar (2017) study suggest that nearly 30% of ART adherent patients experience depressive symptoms that are significantly associated with lack of family support. These findings indicate the possibility of some ART nonadherent cases being misclassified as ART adherent and being included in the study.

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Conflicts of interest
There are no conflicts of interest.

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Sir,
This is in response to comments on our paper Algoodkar et al. (2017). We thank Saurav Basu for his interest in our study and his comments. We do accept that our sample size was rather modest. However, we chose our sample carefully and included only clinically stable people living with HIV/AIDS on antiretroviral therapy (ART). We included only patients receiving ART for >2 years and having CD4 cell count >400 cells/mm³. We chose only those who were on the regular treatment with >95% drug adherence and no significant opportunistic infections in the past year. We deliberately excluded subjects with opportunistic infections as their depressive symptoms could be secondary to the infection. Opportunistic infections are more likely in patients with lower ART adherence and lower CD4 cell counts.¹–³ In our study, adherence was assessed by ART center counselors by pill count and medications refill methods, which is one of the standard methods followed.³¹ While the concerns expressed by Simon et al.⁴ are important, we do not think that that applies to our sample. We have taken care not to include nonadherent subjects in our sample.

Our objective was not to find out the prevalence of depression in HIV-infected patients on ART but to document the prevalence of depression in patients who are apparently healthy and stable on ART. This is important as there is a trend toward focusing mainly on pharmacotherapy and giving less importance to psychosocial aspects of care. If the prevalence of depression is high in spite of higher CD4 cells count and stable clinical status, then we should give due importance to the mental health issues in this subgroup. This is what we found in our study. Our results indicate that depression continues to be a significant comorbidity in spite of the immune reconstitution and clinical stability. Earlier studies have indicated variables such as poor family support and non-adherence to medications to be associated with depressive symptoms. Our results suggest that the depressive symptoms can be present even when there is good adherence to ART, and poor family support continues to be associated with depression in our sample. Depression, thus, is a common comorbidity in HIV infection. Clinicians should screen all patients for depression, even when they are clinically stable on ART.

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