CORRESPONDENCE

Treating patients with HIV

Your issue on faced when treating people with HIV discusses a very important subject.

I started my medical career around the time that HIV was first detected. My first personal encounter with the disease was some years ago, when a fellow physician and personal friend was diagnosed as HIV positive. The problems in treating a HIV positive patient were becoming clear at the time. Unfortunately, they remain the same today.

Even well-off people with HIV find it difficult to continue treatment in the long term. For the others, it is just impossible. This is true even after the costs of drugs came down. Only one of the 300 or so patients I have treated could afford HAART therapy (three drugs including a protease inhibitor). Therapy must often be administered to an entire family. Monitoring tests are also expensive. Add to this the loss of pay for patient and attendants. Stigmatisation of the family. In the hospital, immunodeficient people are at risk of infection from nearby patients and passing resistant infections to others. Health professionals are given inadequate protection against infections of all sorts.

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Reference:

1. Health professionals and HIV. *Issues in Medical Ethics* 2002; 10: 79-95.

What about the mother?

This refers to your article on concerns regarding the MTCT trials. (1) NACO's programme to prevent mother to child transmission of HIV, although 'ambitious', was awaited by obstetricians all over the country, particularly in the high prevalence states, for almost five-six years. Many institutes have evidence that seropositivity of HIV amongst women who come in for prenatal care is above 1%, sometimes as high as 4-7%.

It is recommended internationally that all pregnant women should be counselled about the risk of HIV transmission, perinatal transmission and the effect on the foetus, clinical manifestations of HIV infection, preventive measures, the availability of screening tests, the non availability of curative drugs and vaccines, and the existence of antiretroviral drugs. After this, they should be offered testing. This can be described as the most reasonable and effective approach to prevent transmission of HIV from mother to foetus. (2)

One of the primary aims of counseling pregnant women regarding HIV is to inform them about the disease, its mode of transmission and means of prevention and thus lead to primary prevention of the disease. This is accomplished in antenatal clinics where more than 90% of patients receive universal counseling.

Another aim of the PMTCT Programme is to improve antenatal care. This is also taking shape, social workers, nursing staff and counsellors are now counseling women on nutrition, immunisation, contraception, breast feeding, besides HIV-AIDS. This is a welcome change. Antenatal waiting rooms are also getting a face-lift, thanks to PMTCT. However, though the programme is well conceived, the choice of intervention, particularly the ante-retroviral therapy, cannot be justified.

After knowing the HIV status, sometimes as early as the first trimester, a seropositive pregnant woman is not supported with any intervention till the onset of labour. The drug Nevirapine is offered when a patient has received no antenatal care and has come to the hospital at the onset of labour. In the PMTCT programme, except for emergency admissions, most women are supposed to be aware of their sero-status during the antenatal period and will be asking for some action on part of the obstetrician to reduce the transmission to her child.

Why should women not be given the advantage of better antiretroviral therapy, a safer mode of delivery and good infant feeding options? The short course ante-retroviral therapy with Zidovudine has been successfully tried in Thailand as well as by NACO in their initial feasibility trials. It is surprising that NACO recommends nevirapine as a final intervention programme saying that this the most it can give pregnant women who are HIV positive. The amount spent on training, workshops and meetings could be better utilised by giving the target beneficiary the best treatment rather than the poor compromise chosen by NACO.

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Reference:

1. Rajalakshami TK. Programme to prevent mother to child transmission of HIV: Some concerns. *Issues in Medical Ethics* 2002; 10: 92-93.

Everybody does it

The case study 'Cross subsidy in public hospitals' (1) refers to an everyday practice. We have regularly called for more than one lumbar puncture needle, or more than a few disposable needles, and more than one endotracheal tube, so that we can use these on 'poor' patients. I never thought about the implications of such practices as the writer has expressed them. I am trying to hold together a system which is falling apart, while serving my patients. I should challenge the system. Instead, what I am doing is bailing it out.

Ashish Goel, MGIMS, Wardha

Reference:

1. Sreejit EM. Cross-subsidy in public hospitals. *Issues in Medical Ethics* 2002; 10: 100-101.

Questionable ethics and confused regulation

Citalopram, an anti-depressant, was administered by Sun Pharma, on daily labourers as part of bioequivalence studies demanded by an importer. Some patients developed complications; one of them developed gangrene as well as renal complications.

Bioequivalence studies are done establish the therapeutic equivalence of a branded product and its generic (non-branded) version. In India there are no guidelines for bioequivalence studies. Guidelines of the WHO, USFDA and