Proposal to Adjust the WHO Clinical Staging System

To the Editors:

In the November first issue, Brentlinger et al evaluated the performance of nonphysician clinicians in staging HIV-infected patients using the World Health Organization (WHO) clinical staging system.[1] In many countries with a high HIV burden, nonphysicians are currently taking over many tasks of physicians. It is important in such settings that the quality of care is not compromised through the transfer of tasks.

In the absence of CD4 count testing, the WHO clinical staging is used to estimate the degree of immune deficiency and to decide when to start co-trimoxazole prophylaxis and antiretroviral treatment (ART).[2] In the study by Brentlinger et al, tuberculosis (TB) was the condition most frequently used to define a WHO clinical stage. TB, however, can appear at any CD4 count and is therefore not a good indicator of the degree of immune deficiency. Extrapulmonary TB is more common in patients with a low CD4 count, but particularly in Africa where there is often an important diagnosis delay, patients with pulmonary TB may also present with a very low CD4 count. In the WHO clinical staging system, pulmonary TB is considered as a stage 3 and extrapulmonary TB as a stage 4–defining disease. Staging a patient in this way may not reflect accurately the degree of immune deficiency of that individual patient.

Nowadays, WHO recommends treating all HIV/TB-coinfected patients and all WHO stage 3 and 4 patients with ART and to start ART within 14 days of the start of the TB treatment.[3] Therefore, the difference between WHO stage 3 and 4 has limited clinical relevance in settings where optimal care is offered. However, in many regions of the world access to ART and HIV trained physicians remains limited. In those settings, priority for ART and for referring patients to a specialized center should be given to WHO stage 4 patients. Those patients are at higher risk of dying/developing complications and require a closer follow-up by experienced clinicians. If such patients present with new complaints/clinical signs, clinicians should suspect a concomitant severe opportunistic infection, for example a cryptoccocal infection. Screening all WHO stage 4 patients with a serum cryptococcal antigen test should be considered.[4] Moreover, WHO stage 4 patients, once started on ART, are at higher risk for developing immune reactivation inflammatory syndrome because of severe immune deficiency.[5]

Except for the wasting syndrome (unexplained involuntary weight loss >10% plus either unexplained chronic diarrhoea or fever), conditions of the WHO staging system are not used in combination to define a clinical stage. Studies have shown that anemia and low body mass index are independent predictors of a CD4 count <200 cells per microliter and mortality in HIV TB-coinfected patients.[6,7] We propose to investigate whether using haemoglobin <8 g/dL (a WHO stage 3–defining condition) and/or a body mass index <18 in association with TB (pulmonary or extrapulmonary TB) is not a better way to define a WHO stage 4.

In conclusion, because CD4 count testing is still not available in many rural areas in countries with limited resources, the WHO clinical staging system is still an important tool for patient management. Therefore, it remains important that we monitor how the staging system is used and that we improve the accuracy of it.

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The authors have no funding or conflicts of interest to disclose.

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Low Uptake of Hepatitis C Testing and High Prevalence of Risk Behavior Among HIV-Positive Injection Drug Users in Bangkok, Thailand

To the Editors:

People who inject drugs (IDU) are commonly co-infected with HIV and hepatitis C virus (HCV). HIV/HCV

Supported by Michael Smith Foundation for Health Research.
Parts of the data were presented as poster at the 18th International AIDS Conference, July 18–23, 2010, Vienna, Austria.