

Visceral Leishmaniasis and HIV co-infection: current challenges and perspectives

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Introduction

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DNDi

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HIV and Leishmaniasis

HIV/AIDS

- 33 million infected
- 2.7 million new cases/year

Leishmaniasis

- 12 million infected
- 2 million new cases/year

VL cases

- Total: 500,000
 - India: 300,000
 - East Africa: 30,000
 - Brazil: 4,000

CL cases

- Total: 1.5 million

HIV and Visceral Leishmaniasis (VL) co-infection

- HIV increases risk of VL > 2000 x
- VL promotes clinical progression of HIV/AIDS
- Target similar immune cells such as CD4
- Both promote a Th2 response

Experience from Mediterranean countries since the 1990s

Dedicated surveillance network

- Shift in population affected
from paediatric to adult: 75% male, IVDU
- Transmission cycle
zoonotic; anthroponotic: shared needles
- New strains: visceral, cutaneous, new
- Relapse; persistent low CD4 count
- Number of cases decreased after HAART

HIV and VL

- Clinical manifestations similar
 - but: most have CD4 < 200
 - may have more co-morbidity!
- Clinical course different
 - lower cure rates
 - more relapse; sec. prophylaxis
 - more drug toxicity
 - higher mortality

Co-infection of HIV and VL is increasing

co-infection

South Asia – India, Nepal

6%

S. America – Brazil

6.5%

Africa

- Sudan

8%

- Ethiopia

40%

Risk factors for increasing co-infection rates

- Increasing HIV rates in VL endemic areas
- Migrant workers
- Increasing overlap of HIV and VL endemic areas
- Access to HAART; CD4 cut-off
- Human reservoir
 - parasites in blood
 - relapse cases
 - Para/post Kala-azar Dermal Leishmaniasis more frequent, more severe

HIV and VL: many unresolved issues

- Epidemiology
 - surveillance
- Immunology
 - immune reconstitution
- Therapy
 - what regimen in each area
 - relapses
 - resistance
 - secondary prophylaxis
 - primary prophylaxis

This symposium

- Update on HIV - VL co-infection from several endemic areas:
 - 5 presentations: hospital and field experience
- Open discussion