

An Indian Perspective on HIV-associated Lymphomas

Stefan K. Barta

Department of Oncology, Montefiore Medical Center, Albert-Einstein College of Medicine, New York, USA

Address for correspondence: Dr. Stefan K. Barta, Department of Oncology, Montefiore Medical Center, Albert-Einstein College of Medicine, 111 East 210th Street, Hofheimer 100, Bronx, New York, USA. E-mail: sbarta@montefiore.org

It has been more than 30 years since the first case of the acquired immunodeficiency syndrome (AIDS) epidemic was described. Although the incidence of new human immunodeficiency virus (HIV) infections has declined, HIV/AIDS remains an immense global healthcare problem. It is estimated that more than 7000 people are infected with HIV every day, but only less than 50% of the people living with HIV are believed to be aware of their infection. In fact, 97% of these new infections occur in low- and middle-income countries.^[1]

Despite the declining incidence, HIV/AIDS has become the sixth leading cause of death globally, following a nearly 400% increase in the number of deaths since 1990 to 1.5 million people in 2010.^[2] One of the most common causes of death in HIV-infected patients is cancer, frequently lymphoma.^[3] In the developed world, the outcomes of HIV-positive patients with cancer have dramatically improved since the availability of combination antiretroviral therapy (cART) in 1996. Today, patients with lymphoma treated with cART and lymphoma-directed therapy can achieve outcomes approaching those of HIV-negative patients.^[4] In the article that accompanies this editorial, Lakshmaiah *et al.*^[5] report in a retrospective observational study their experience with HIV-positive patients treated at a single tertiary center in India for different types of HIV-associated lymphomas (Hodgkin lymphoma [HL], diffuse large B cell lymphoma [DLBCL], plasmablastic lymphoma [PBL], and primary central nervous system lymphoma [PCNSL]). Out of 44 patients, 18 opted for

treatment. Patients with HL had a complete response rate (CRR) of 80%, and three out of five were alive and disease-free after a median follow up of 21 months; patients with DLBCL had a 75% CRR and the median 3-year overall survival was 56%; one out of two patients with PBL and PCNSL were alive and disease-free after 33 and 13 months, respectively. These outcomes are comparable to what is expected in Western countries.

While this is an important and encouraging finding, another result presented by Lakshmaiah *et al.*^[5] in their manuscript appears even more notable: Nearly 60% of the patients who were newly diagnosed with HIV-associated lymphoma (26 out of 44) never returned for treatment. Importantly, all of these patients had no prior knowledge of their HIV status. They had been referred for lymphoma treatment, but once informed about the positive result of their HIV test, they did not return for follow up. Regrettably, the survival for those patients, for whom the survival status could be ascertained, was only 7 months. This is the same survival rate as was seen in patients with HIV-associated lymphomas in developed countries before adequate HIV- and lymphoma-directed therapies were available.

One can only speculate about the exact reasons for why patients choose to forgo available and effective therapy, but the stigma and perception of HIV/AIDS, most certainly are the chief contributors.^[1] Therefore, the most important lesson we can learn from the study by Lakshmaiah *et al.*^[5] is that while good outcomes can be achieved for HIV-positive patients with lymphoma in India, these improvements are not available to the majority of patients. Many lives could simply be saved by a fundamental change in the perception of AIDS. While this report inspires optimism, it also shines a light on a major problem: The lack of education in patients and their environment. If this impediment is acted upon, there is indeed hope that we can swing the tide in the battle against AIDS in middle- and low-income countries.

Access this article online

Quick Response Code:



Website:
www.najms.org

References

1. UNAIDS Global Report 2012. (Accessed April 21, 2013, at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/2012120_UNAIDS_Global_Report_2012_en.pdf).
2. Lozano R, Naghavi M, Foreman K, Lim S, Shibuya K, Aboyans V, *et al*: Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: A systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 2012;380:2095-128.
3. Simard EP, Pfeiffer RM, Engels EA. Mortality due to cancer among people with AIDS: A novel approach using registry-linkage data and population attributable risk methods. *AIDS* 2012;26:1311-8.
4. Dunleavy K, Wilson WH. How I treat HIV-associated lymphoma. *Blood* 2012;119:3245-55.
5. Sirsath NT, Channaviriappa LK, Nagendrappa LK, Dasappa L, Sathyanarayanan V, Setty GBK. Human Immunodeficiency Virus - Associated Lymphomas: A Neglected Domain. *N Am J Med Sci* 2013;5:432-7.

How to cite this article: Barta SK. An Indian perspective on HIV-associated lymphomas. *North Am J Med Sci* 2013;5:438-9.

Source of Support: Nil. **Conflict of Interest:** None declared.

Announcement

Android App



Download
**Android
application**

FREE

A free application to browse and search the journal's content is now available for Android based mobiles and devices. The application provides "Table of Contents" of the latest issues, which are stored on the device for future offline browsing. Internet connection is required to access the back issues and search facility. The application is compatible with all the versions of Android. The application can be downloaded from <https://market.android.com/details?id=comm.app.medknow>. For suggestions and comments do write back to us.