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HHV-8 seroprevalence in HIV infected and uninfected populations

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Dear Editor,

We thank Owen Ngalamika, Veenu Minhas and Charles Wood for their comments. We agree that at the general population level there are striking differences in HHV-8 seroprevalence across different regions of the world.¹ However, among HIV-positive people the prevalence is more uniform. For example, it was 56% in HIV-positive sexually active adults in Uganda,² 48% in South Africa³ and 51% in Zambia.⁴ Likewise, in an Italian HIV seroconverter cohort it was 37%⁵ and 32% among United States (U.S.) military men who were recently infected with HIV.⁶ In HIV-positive men who have sex with men (MSM) HHV-8 is more common: for example 60% in the Italian cohort.⁵

Based on these data Kaposi Sarcoma (KS) and the effect of ART on reducing its incidence could be quite similar in HIV cohorts from HHV-8 endemic and non-endemic regions. However, differences in the epidemiology of HIV, HHV-8 genotypes and the temporal sequence of HIV and HHV-8 acquisition might influence both the incidence of KS and the effect of ART. Other factors include differences in access to health care resulting in later diagnosis and treatment of HIV infection in sub-Saharan Africa compared to patients in Europe,⁷ and later diagnosis and treatment of KS. Caution is therefore warranted when comparing data from sub-Saharan Africa, Europe and the U.S.

We agree with the authors that more efforts are needed to prevent KS in people living with HIV through early detection of HIV infection and early start of ART. The 2013 WHO ART guidelines, which recommend that asymptomatic adults with CD4 cell counts below 500 cells/µL should start ART, will contribute to this goal.⁸ Measures to prevent HHV-8 infection that will benefit people with and without HIV infection should also be considered. Unfortunately, a clear understanding of the transmission of HHV-8 in different populations and settings, and of the measures to prevent HHV-8 infection are still lacking.

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