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HIV infections and injecting drug users in Greece

241 and 522 new HIV infections among injecting drug users were reported by the Hellenic Center for Disease Control and Prevention (HCDCP) in 2011 and 2012, respectively, in Greece. But the real numbers were probably much smaller because renotification (duplicates and triplicates) could not be checked during the sequential referrals to health-care services (including hospitals, Organization Against Drugs [OKANA], and Therapy Center for Dependent Individuals).[1] Compared with the fewer than 20 cases reported yearly until then, the increase was alarming and impelled a regulation on the transmission of infectious diseases implemented in April, 2012, which very early received severe criticism and ongoing controversy.[2]

A closer look at these reports[1,3] raised questions about the level of the epidemic and the accuracy of the reporting. In 2010, an intensified informative campaign was launched, followed, since June 2011, by an unprecedented number of community interventions implemented by the HCDCP in the historical centre of Athens,[3] in cooperation with non-governmental organisation programmes. More than 3500 injecting drug users and other high-risk groups were screened for HIV by HCDCP units. The results for 2011 remained unpublished, while in 2012 at least 133 HIV-positive cases were actively traced and reported in the official HCDCP Activities Reports.

There is no doubt that these interventions, if implemented properly—by respecting the rights to confidentiality and anonymity, and by providing psychosocial support, treatment, and care—are of utmost importance, both for prevalence studies and for health-care guidance for these vulnerable populations, for whom the traditional surveillance scheme was inefficient. However, by largely changing the surveillance, comparability and evidence-based inference was precluded. It seems that the outbreak reports among injecting drug users were severely biased because of the (unknown) effect of the intensified informative campaigns, the high probability of duplicates, and because of the number of cases (yet largely of unknown number) that were traced actively during the interventions of 2011 and 2012. The bias, in surveillance and reporting, was not evaluated or communicated properly. Health and risk reports should inform decision making correctly, especially during an economic crisis, when the scarce resources have to be prioritised in a way to maximise public health benefits.

I declare that I have no conflicts of interest.

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Yannis Behrakis/Reuters/Corbis

HIV, HCV, and drug use in men who have sex with men

The report by Tony Kirby and Michelle Thornber-Dunwell (July 27, p 295)[1] uncovers an emerging and troubling public health and community issue. The intersection of unprotected sex and use of street and party drugs is likely to amplify the transmission of HIV, hepatitis C virus (HCV), and sexually transmitted infections (STI) in men who have sex with men (MSM).

Indeed the latest report from Public Health England indicates that a large increase in HIV incidence is occurring in MSM in London and that there is the potential for growing and harmful interacting epidemics of HIV, HCV, and drug use. The trends documented in London are likely a harbinger of what is happening in communities of MSM in other urban centres in high-income countries.

We have found that in New South Wales, Australia, HIV notifications have increased by 24% in 2012 compared with 2011—predominantly in MSM. Furthermore, 13·1% of people with HIV are co-infected with HCV and 38% of MSM report using recreational drugs in the past 6 months.[2,3]

These findings demand that there be renewed, enhanced, and integrated HIV, HCV, and STI surveillance, prevention, and treatment services. Given the complexity of risk factors associated with transmission of HIV and HCV, the copromotion of STI testing and treatment services as well as ways to mitigate the secondary harms of substance use, all need to be coordinated so that overlapping viral

For the **report** see http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1215589013442


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disease epidemics can be targeted and contained.

Early diagnosis and treatment is increasingly becoming, or will likely become, the dominant approach to control STIs, HIV, and viral hepatitis. With use of a similar approach for these related infections, it might become more feasible to implement coordinated control strategies that are effective. However, one of the large dangers for which we provide warning is risk disinhibition and primary prevention fatigue, which we are seeing as starting to counteract the benefits of improved access to diagnostic testing and effective treatment.[4] In the longer term, research with vulnerable MSM is needed to better understand the range of relevant factors including how these men perceive risk and balance that against pleasure and the causes of the increased incidence of unprotected sex and substance use.[5] The results of such research can be used to strengthen the health and wellbeing of communities of MSM around the world.

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Poliomyelitis: threats to eradication

The recent isolation of wild poliovirus from Israeli sewage samples[1] (environmental sampling) elucidates an important consideration for polio eradication. The local population has humoral immunity against the poliovirus because of high rates of coverage with inactivated polio vaccine (IPV).[2] But not everyone has mucosal (intestinal) immunity because of removal of oral polio vaccine (OPV) from routine immunisation since 2005, and absence of endemic wild poliovirus conferring natural immunity. People immunised with IPV are protected from disease but the poliovirus replicates in their intestines and is shed with stools for about 3 weeks after initial infection.[3] As a result, with direct person-to-person transmission, wild poliovirus remains in circulation using transient carriers, which is happening at present in Israel.

This situation poses a number of potential threats to the eradication programme. Although Israel has high coverage with IPV, certain groups in the population refuse vaccinations[4] and will not have immunity to the virus if exposed. Individuals having primary humoral immunodeficiencies will not only be at risk for the disease if infected, but could also be shedding the virus for years.[5] The country can become a reservoir of wild poliovirus even though we might not see any cases of the paralytic disease. With movement of people within and across borders, the transient carriers can transport the virus to other areas and countries. IPV-only countries with high coverage can end up being in the same situation as Israel, and the virus can potentially circulate undetected because environmental testing is not done everywhere. Some countries, which have eradicated polio but have low immunisation coverage (eg, Yemen), can have resurgence of the virus and outbreaks of paralytic polio because no travel regulations for vaccination exist.

We cannot afford to ignore these threats. A mass vaccination with OPV in Israel is a potential solution but does not eliminate future risks. IPV-only countries need to consider the implications of this incident and perhaps modify their immunisation policies, and implement enhanced environmental sampling and regulations for international travellers to have OPV vaccination.

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