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NEUROLOGIC SIGNS AND SYMPTOMS FREQUENTLY MANIFEST IN ACUTE HIV INFECTION

Joseph Kamtchum-Tatuene, Wan Aliaa Wan Sulaiman, Liverpool, UK; Alain Lekoubou, Charleston, SC: According to the article by Hellmuth et al.,¹ the prevalence of neurologic signs and symptoms in acute HIV infection is 53%. Although not apparent in the title, only mild neurologic findings were reported in otherwise healthy homosexual men infected with HIV-1 subtype CRF01-AE. It is possible that cases of acute HIV infection that manifest as neurologic emergencies were missed, such as stroke, Guillain-Barré syndrome, meningitis, encephalitis, and myelitis.^{2,3} Moreover, other HIV-1 subtypes (notably subtype D) are more virulent and might induce more neurologic symptoms.⁴ Therefore, the real prevalence and spectrum of neurologic involvement in acute HIV infection were probably underestimated.

When also considering the results presented by Hellmuth et al., it appears that neurologists are expected to be involved in the management of at least 1 out of 2 patients acutely infected with HIV. Consequently, neurologists have a key responsibility in ensuring timely diagnosis and treatment of HIV infection to help improve patients' short- and long-term outcomes. Being on the front line in the war against HIV, neurologists should have a low threshold for screening patients for HIV infection regardless of severity of symptoms and risk factors.⁵

Author Response: Joanna Hellmuth, Victor Valcour, San Francisco; Serena Spudich, New Haven, CT: We thank Kamtchum-Tatuene et al. for the comments and interest in our article.¹ We

agree it is critical to engage neurologists in HIV testing for new, unexplained neurologic findings, even if mild. Along with the standard HIV antibody assay, plasma HIV RNA must be ordered to detect acute HIV. Diagnosing acute HIV is an opportunity to rapidly initiate treatment, to decrease HIV transmission during a highly infectious stage,⁶ to reduce the size of a patient's latent HIV reservoir,⁷ and possibly to decrease the chance of developing fulminant neurologic manifestations.

Our study participants were identified through voluntary HIV testing, which happened to occur within days or weeks of infection. It is conceivable that this methodology may underestimate the prevalence or severity of neurologic issues in acute HIV, as individuals with more pronounced neurologic disorders may have first presented to other clinical providers. In addition, all participants rapidly initiated combination antiretroviral therapy, which may have minimized development of neurologic issues during the study.

The neurologic findings we identified in acute HIV were often mild and may not have prompted neurologic referral and evaluation. Thus, our study argues for greater vigilance of all providers regarding neurologic presentations of acute HIV.¹

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Neurologic signs and symptoms frequently manifest in acute HIV infection

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