and non-AIDS-related mortality accounted for 76.7% and 45.4% of deaths, respectively. COPD was the most common cause of death in PLWH, accounting for 5.7% of total deaths.

COPD is a chronic obstructive pulmonary disease characterized by chronic inflammation and airflow limitation leading to respiratory symptoms and functional impairment. The disease is caused by chronic exposure to noxious particles or gases, often in combination with smoking, and is more prevalent among individuals with HIV.

COPD is a significant health burden worldwide, and its prevalence is increasing in the general population, particularly in regions with high smoking rates. Among PLWH, the prevalence of COPD is even higher due to the叠加 effect of HIV and smoking, which can further exacerbate respiratory symptoms and disease progression.

In the context of PLWH, COPD is associated with increased rates of hospitalization, mortality, and healthcare costs. The management of COPD in PLWH requires a comprehensive approach that addresses both the underlying HIV infection and the respiratory symptoms associated with COPD.

In conclusion, the burden of COPD among PLWH is significant and requires interventions to improve outcomes and reduce mortality. Further research is needed to better understand the mechanisms underlying COPD in PLWH and to develop effective strategies for its prevention and management.

References
respectively, of the total deaths (19% and 18% after excluding AIDS-defining illnesses).³

Another possible explanation, independent of the coding systems, could be that although PLWH frequently visit doctors and are linked to care, their lungs tend to be less tested and therefore less diagnosed with COPD. COPD underdiagnosis is a universal phenomenon, both in general and hospital-based populations.⁴ Spirometry is not actually implemented in most hospitals as a routine test for PLWH, despite guidelines having begun to include algorithms regarding this comorbidity.⁵ This underdiagnosis would then lead to an underreporting of deaths.

Both of these possible explanations, if true, may reflect a worrisome problem: COPD is not yet perceived as a relevant concern in PLWH care. This potential issue may also have caused collateral effects, as few research groups are presently addressing this particular comorbidity. In the last 10 years (2008–2017), only 191 articles indexed in Medline and related to HIV mention in their title, abstract, or keywords the term “COPD”, while in the same period, 931 articles and 8437 articles mention “cardiovascular” and “cancer”, respectively.

It is important to note that the scientific community still possesses an astonishing lack of knowledge in how COPD and HIV relate to each other. We do not yet have enough evidence regarding the effects of chronic HIV infection in the lungs; how these affect the local immunity, even in the presence of effective antiretroviral treatment; and how to optimize the management of COPD in PLWH, apart from implementing smoking cessation and programs to identify individuals with COPD. Further lung research in HIV is needed, and most, if not all, PLWH might be recommended to perform a baseline spirometry to aid in tracking their general and HIV-related health.

As a conclusion, we consider that the impact of COPD in terms of PLWH mortality could have been systematically and grossly underestimated in western countries. This misclassification phenomenon could have lead physicians to minimize COPD role as a comorbidity in this population.

References


Francisco Fanjul, a,b,*, 1 Joan Soriano a,*, 1

a Unidad de Enfermedades Infecciosas, Hospital Universitari Son Espases, Palma de Mallorca, Spain 
b Institut d’Investigació Sanitària Illes Balears (IdiSBa), Palma de Mallorca, Spain 
c Servicio de Neumología e Instituto de Investigación, Hospital Universitario de la Princesa (ISI), Universidad Autónoma de Madrid, Madrid, Spain 
d Methodological and Scientific Consultant of SEPAR, Spain

* Corresponding author.

E-mail address: franciscof.fanjul@ssib.es (F. Fanjul).

1 www.separ.es.

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