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Letter to the Editor

Prevalence and predictors for lipodystrophy syndrome among HIV infected children on anti-retroviral therapy

Sir,

First of all, the efforts made by the authors in trying to find out the prevalence and more importantly the predictors of lipodystrophy syndrome in HIV infected children on anti-retroviral therapy is much appreciated.[1] But, the study was undertaken with the patients mostly (72%) on stavudine based therapy which is not currently being used as first line therapy in adolescents and adults due to many long-term toxicities including lipodystrophy.[2] The strong association is also very evident in the present article and makes the finds of high prevalence of these metabolic abnormalities predictable. Clinical method applied for assessing "fat redistribution" encompassed both 'lipo-atrophy' and 'lipo-hypertrophy'. Therefore, the high prevalence of fat redistribution (39.8%) may be due to the wasting present in these children secondary to their malnutrition which would contribute to 'lipo-atrophy' and thus fat redistribution. A recent study from Northern India also reported lipo-atrophy to be most frequent type of fat redistribution in such children.[3] More objective methods of fat redistribution like measurement of skin fold thickness using calipers, bioelectric impedance or DEXA (Dual energy x-ray absorptiometry) would certainly have made the measures more robust.[4,5] Again the authors did not take into account the nutritional intake of these children, which would certainly affect all the measures of lipodystrophy syndrome. Furthermore, metabolic abnormalities were defined as the presence of hyperlipidemia and/or hyperglycemia, as HDL (High density cholesterol) and LDL (Low density cholesterol) were not measured. Low HDL and high LDL are documented to be important metabolic abnormality in children receiving highly active anti-retroviral therapy (HAART).[3,6] So, not measuring LDL and HDL might have actually undermined the prevalence of metabolic abnormalities in the studied population. To conclude, we would like to make another important observation that, though the authors have not stressed on the fact that 34% children had hypertriglyceridemia and 8% children had hypercholesterolemia even before start of anti-retroviral therapy. This is in accordance with another recent large pediatric study that documented prevalence of hypertriglyceridemia and hypercholesterolemia in 28% and 2% of ART naïve HIV infected children respectively, again emphasizing that it is not only the ART but HIV itself that predisposes these children to metabolic abnormalities and lipodystrophy syndrome.[7]

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