HIV-1 and HIV-2 in Spain

Although HIV-1 (human immunodeficiency virus type 1) is prevalent in Central Africa,1 and in the USA and Western Europe, very few cases of HIV-1 infection have been reported in West Africa, excepting the Ivory Coast.2,3 In contrast HIV-2 is common in West Africa, where the virus was isolated for the first time, but only sporadic cases of HIV-2 infection have been described in Western Europe2 and the USA.4 In Spain, HIV-1 infection rates are high among subjects from classical high risk groups (haemophiliacs, drug abusers and male homosexuals),5 and some drug abusers have combined HIV-1 and HIV-2 infections.6 However, recent sero-epidemiological studies carried out in Spain have shown that HIV-2 infection is restricted to immigrants from West Africa living in Barcelona.7 From 1984 to July 1991, 604 African and North African immigrants living in Barcelona were treated for various reasons in the Dermatologic and Internal Medicine Services of a general hospital. All of these patients were also studied to learn the incidence of HIV-1 and HIV-2 infection. Serum samples were screened by ELISA (Organon, Pasteur), Western-Blood 1–2 (Pasteur) and Pepti-Lav (Pasteur).

Except for 45 Moroccan patients, all were blacks from West Africa (80%, Gambia; 12%, Senegal; 3%, Mali; 2%, Guinea-Konakry; and 3%, other neighbouring countries). All but 25 were men. The age of the patients ranged from 16 to 42 years. The average time in Spain was 4 years. The only risk factor for HIV-1 infection was heterosexual intercourse with low socioeconomic status prostitutes, among whom HIV-1 infection is common.8 Forty-three patients (of the total) were seropositive to HIV-1 (7%). Ten of 462 patients were seropositive to HIV-2 (2%). One patient had concomitant HIV-1 and HIV-2 infection. No patient from Morocco was seropositive for either HIV-1 or HIV-2.

The prevalence of HIV-2 infection in our series throughout this period was constant, and is similar to that of healthy control people in West Africa.9 However, we have observed a dramatic increase in the number of HIV-1 infected cases from 1988 onwards (0% in the first four years, 10% in the last three years) during the same period.

It could be that HIV-1 seropositive patients were infected in Africa, and that the increased incidence in the last years could be coincidental with a similar increase in the incidence of HIV-1 infection in their home countries. However, recent data show that the incidence of HIV-1 is still low among the control population in most countries of West Africa. In the series of patients taken together, these features strongly suggest that HIV-1 was not imported, but acquired in Spain, probably through sexual intercourse with prostitutes. Five patients with HIV-1 infection had AIDS, and three of them have already died. Another seven had opportunistic infections and/or ARC. None of the patients with HIV-2 infection had AIDS, but some suffered from minor immunologic abnormalities. African immigrants should be considered as a high risk population for HIV infection because they come from a region in which HIV-2 is endemic and due to their use of unregulated prostitutes frequently infected by HIV-1.

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