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Clinical Features of AIDS in Europe

INTRODUCTION

AIDS syndrome is characterized by opportunistic infections and Kaposi's sarcoma [1]. It is now probable that infective and neoplastic complications of immunologic abnormalities in AIDS take place late in the evolution of the disease, which has a broader clinical spectrum [2]. Moreover, clinical symptoms of the ultimate stage are not predictive of the primary cause of the disease but, rather, are reflective of the opportunistic infections or Kaposi's sarcoma. However, in a great number of cases the occurrence of opportunistic infections or Kaposi's sarcoma is preceded by a relatively long period of symptoms which cannot be attributed to further infections or tumors [3, 4]. The hypothesis that AIDS is caused by a transmissible agent is supported by a wealth of epidemiological data [5–9].

Considering these points, identification of early and prodromal stage of AIDS appears to be of great interest. If early symptoms could be defined and were found to be specific enough to clarify who could be at risk, this would lead to a better understanding of the cause of AIDS, help to determine the best moment for starting treatments when they became available and suggest measures to prevent further transmission (i.e. blood transfusion). Lastly, the analysis of early symptoms may help to determine the full spectrum of this disease.

Additionally, there is specific interest in the clinical disease as seen in African patients being reported in Europe [10–13]. The evaluation of these cases and comparison with European cases may help to determine whether there is a single disease in both populations or more than one causative agent. In this regard, the large number of cases seen in France permits a direct comparison of European and African cases evaluated at the same facilities. Of the 94 cases in France, 42 were diagnosed in two hospitals in Paris (Hôpital Claude Bernard, Hôpital de la Pitié-Salpêtrière). All these patients met the CDC criteria for AIDS. Therefore this report focuses on these patients, but because of the relatively small numbers of African patients seen at these two hospitals, it also includes a more comprehensive summary of all African cases seen in Europe and reported at the conference.

Thirty-one European males (non-Haitian, non-African) were evaluated. Homo- or bisexuality was acknowledged in 27 cases. Mean age was 35.6 yr. Eight patients had Kaposi's sarcoma (KS), 12 patients had opportunistic infections (OI) and 11 patients had both. OI were *Pneumocystis carinii* pneumonia (PCP): 11; digestive candidiasis: 9; cytomegalovirus infections: 9; toxoplasmosis: 4; atypical mycobacteriosis: 1; extensive herpetic infection: 3. Multiple infections were frequent among these patients.

In many patients the earliest symptoms were commonly diarrhea, asthenia and fever. The most frequent symptoms during the early stage were weight loss (81%), pruritis and/or rash (84%), fever (74%) and lymphadenopathy (61%) (Table 1). Of the KS patients the most frequent early symptoms were lymphadenopathy and weight loss. In the OI patients, weight loss, fever, diarrhea and rash were frequently present (but for a shorter duration than that observed in the KS patients). In patients with both KS and OI, fever, weight loss and diarrhea were more prominent than in the patients with either KS or OI alone (Table 1).

In these same hospitals 11 African patients were evaluated. The 8 males and 3 females had an average age of 35 yr. Nine of these patients had OI, including PCP (1), toxoplasmosis (2), cryptococcosis (4), candidiasis (2) and cryptosporidiosis (4). Two African patients presented as Kaposi's sarcoma alone. These 11 patients had a history of symptoms preceding diagnosis including fever (7), weight loss (6) and persistent diarrhea (5). Two also had lymphadenopathy.

Because the number of African cases seen at these hospitals was small, the European experience with African AIDS patients (including these 11 cases) is summarized. In total, 59 African cases were reported from 4 countries in Europe (Belgium, 35; France, 18; Switzerland, 5;

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Czechoslovakia, 1). The male:female ratio among adult cases was 1.5:1. Three were male children, and in all three the mothers had either AIDS (PCP, 1 case) or 'AIDS-related complex' symptoms (2 cases). The average age of the African cases was 34 yr. Opportunistic infections were diagnosed in 55 persons (93%), including 6 who also had KS. Four persons (7%) had KS as the only manifestations of illness. Specific infections diagnosed are given in Table 2. Data regarding early symptoms were unavailable.

DISCUSSION

From this analysis it appears that early clinical symptoms in European AIDS patients are quite similar to those observed in American cases [14–18].

The occurrence of unexplained fever, weight loss, lymphadenopathy or diarrhea in high risk individuals, such as homosexual men or intravenous drug abusers, should prompt the clinician to suspect the possibility of AIDS. Since this disease is a diagnosis by exclusion, all known causes of immunosuppression must be eliminated. A full evaluation of diseases other than AIDS must also be performed before one should refer to the diagnosis of AIDS. Immunologic studies demonstrating alterations in cell-mediated immunity may be useful in categorizing cases with early, non-specific symptoms [3, 4], but the diagnosis of AIDS is not dependent on documenting an immune abnormality.

Various symptoms in high risk groups appear to be suggestive of further AIDS evolution, but they are not necessarily predictive of the later development of KS or OI. For example, lymphadenopathy, intermittent fever and diarrhea have been reported in homosexual men with a unexplained lymphadenopathy syndrome which may persist for more than 2 yr without occurrence of KS or OI [19]. It is now estimated that approximately only 10–15% of lymphadenopathy syndrome patients will eventually develop OI or KS [20]. Lymphadenopathy syndrome may represent a spectrum of disease caused by the same agent(s) of AIDS, but which may not always progress to a life-threatening infection with an opportunistic agent or which may be unrelated.

While the same early symptoms seem to occur in African patients, quantitative comparison is not possible in this stage due to small numbers. The spectrum of overt illness in these patients includes fewer cases of PCP and more of cryptococcosis and tuberculosis than occur in AIDS among Europeans. While the age range of patients is similar, African cases have a less marked sex ratio, 1.5:1, than occurs in cases among Europeans.

In the absence of specific markers or a laboratory test for AIDS the association of these early symptoms in consideration with altered cell-mediated immunity in a high risk individual should alert the physician to the possibility that this patient may develop an AIDS-related illness.

Table 1. Early presenting symptoms in 31 European patients with AIDS (non-African, non-Haitian)

	Diarrhea	Lymphadenopathy	Fever	Weight loss	Pruritis and/or rash	Cough
KS (n = 8)	2 (25%)	6 (75%)	4 (50%)	5 (63%)	3 (37.5%)	1 (12.5%)
OI (n = 12)	7 (58%)	6 (50%)	9 (75%)	10 (83%)	12 (100%)	4 (33.3%)
OI + KS (n = 11)	6 (54%)	7 (64%)	10 (91%)	10 (91%)	11 (100%)	5 (45%)
Total (n = 31)	15 (48%)	19 (61%)	23 (74%)	25 (81%)	26 (84%)	10 (32%)

KS = Kaposi's sarcoma; OI = opportunistic infection. Diarrhea: more than 5 days; lymphadenopathy: in more than 2 other sites than inguinal site; fever: more than 38°C for more than 15 days; weight loss: more than 5 kg in less than 3 months.

Table 2. Opportunistic infections occurring in African AIDS patients evaluated in Europe

	Belgium (35 patients)	France (15 patients)*	Switzerland (4 patients)†	Czechoslovakia (1 patient)	Total
Pneumocystis carinii pneumonia	6	2			8
Toxoplasmosis	4	6	1	1	12
Cryptococcosis	9	5	1		15
Tuberculosis	11	1			12
Candidiasis	10	1	1	1	13
Cryptosporidiosis	3	4	1		8

*Three patients had Kaposi's sarcoma only.
†One patient had Kaposi's sarcoma only.

Since specific treatment is not available, these patients should be observed carefully for the occurrence of OI or KS. Recommendations on the prevention of further transmission should be given to the patient, and consultation with a specialist should be obtained.

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