Correspondence

Determination of the Incidence of Tuberculosis in Low-Income Countries

To the Editor—We read with interest the report by The Antiretroviral Therapy in Low-Income Countries Collaboration of the International epidemiological Databases to Evaluate AIDS (IeDEA) and The ART Cohort Collaboration on tuberculosis (TB) after initiation of antiretroviral therapy in low-income and high-income countries [1]. The authors do not mention the number of patients who were already receiving treatment for TB when the antiretroviral therapy was started (were the data not available?). However, they do mention that programs in lower-income countries routinely screened patients for TB before they commenced HAART. It is unclear to us whether patients being given treatment for TB at the start of HAART were included in the analysis. We propose that they should have been excluded from the study population if the aim of the study was to determine the incidence of TB and to compare the incidence rate-ratios for new TB infections. Indeed, in contrast to in high-income countries, in low-income countries, TB is one of the main reasons to initiate HAART. In Malawi, for example, from July through September 2005, 12% of the patients who started HAART did so because of TB [2]. During treatment for TB, by definition, these patients cannot develop a new TB infection. We suppose that, if this approach were taken, the conclusions of the report would remain the same, but the calulations may change slightly. If the number of patients not receiving treatment for TB who started HAART is used as the denominator, the real incidence of TB in low-income countries will be even higher, particularly soon after the initiation of HAART.

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