

EDITORIAL

THE HIV PANDEMIC AND SURGERY

With the HIV pandemic steadily gaining ground in sub-Saharan Africa, the proportion of HIV positive individuals among patients requiring surgery is also steadily increasing. Moreover, the prevalence of HIV in the surgical setting is always higher than in the general population, because immunodeficiency in itself may be complicated by a number of septic and neoplastic conditions amenable to operative treatment. In addition to this, there are similarities in the demography of the HIV pandemic and the other great third world pandemic, trauma: the victims of both are predominantly among the young. For these reasons, in many parts of Africa, surgeons can expect that presently as many as a quarter, if not a third, of patients they operate on are HIV positive. The fear that the numbers have not peaked yet is justified.

The HIV positivity of an individual has far reaching consequences with regard to the indication for the operation, the modality of the procedure and the concomitant treatment. In spite of these consequences, the HIV status of many surgical patients is unknown. This deplorable state of affairs is the result of the exceptionalisation of HIV and not primarily caused by poverty, in other words by the lack of diagnostic equipment. Whilst a surgeon would be attracting criticism if he operated without having ascertained whether his patient is diabetic, anaemic or hypertensive - to give a few examples - he is not allowed to check the HIV status in the same manner, pre-test counselling, signed consent and a higher degree of confidentiality are required. This exceptionalisation, although originally imported to Africa, has been widely accepted because of the sentiments surrounding the disease: the fact that HIV is sexually transmitted and that the history of the pandemic is associated with homosexuality as well as with apes.

Whilst the medical profession must strive to terminate this exceptionalisation, and aim at routine HIV screening before surgery, the reality, at this time, is that the HIV status of many patients is not known - unless they exhibit signs of AIDS. In consequence, the often reiterated rule is to regard everyone as HIV positive. This rule makes eminent sense as far as self protection is concerned: the surgical team must do its utmost to avoid the hazards of accidental infection, principally needle stick injuries. As to the risk of sharp injury and the actual risk of acquiring HIV in the surgical setting, estimates differ widely. Although every effort must be made to avoid hazards, fortunately HIV is not as infectious as many other viruses, otherwise HIV would have become an outstanding occupational hazard for surgeons and for theatre staff. The risk of HIV infection off duty is much greater than at work in the theatre.

To regard everyone as HIV positive is a good rule for self-protection - both in social life and in the theatre - but

the application of the same rule with regard to surgical decisions would have disastrous clinical consequences.

For HIV positivity is an absolute contraindication for transplantation and a relative contraindication for implantation surgery. There is ample evidence that implants, be it joints, heart valves, plates and screws or other prostheses do not do well in HIV positive patients: when the time comes for the immune incompetence to manifest itself clinically, the first infections are often implant related. Relative contraindications exist also with regard to other extensive surgical procedures, from radical cancer surgery to aesthetic surgery. Hence, the indications for operative treatment in individuals who are HIV positive, even in the absence of clinical or laboratory evidence of immuno-deficiency, have to be carefully pondered and individualised. No doubt some people can live with the HIV virus for many years without sliding into AIDS. No doubt that with modern drug intervention the onset of AIDS can be postponed and AIDS itself can be managed for years. These circumstances contribute further to the difficulties in deciding whether in a given HIV positive individual the selection criteria, the indications, the operative procedures and the adjuvant treatment need to be altered.

This individualising, carefully pondering approach to surgery in HIV positive but not immuno-suppressed individuals is increasingly replacing the formerly widespread attitude, namely that HIV positivity alone is no contraindication to any surgery (other than transplantation), an attitude which has replaced the stance prevalent in the early days of HIV history: to deny surgery to anyone who was HIV positive. From the foregoing it should follow, without hesitation, that establishing the HIV status before an operation would be in the interest of patients. For if, unless proven otherwise, everyone is assumed to be HIV positive, countless people would be denied appropriate surgical treatment. Conversely, if one ignored the possibility of the HIV status, one will have an unacceptably high complication rate, immediate as well as delayed.

Once AIDS has supervened two different kinds of situations may apply: the pathology, requiring the contemplation of surgical remedy may be in itself AIDS related, that is, an abscess, a tumour, a ruptured aneurysm, or AIDS may be merely incidental under the circumstances, as it is frequently the case when trauma intervenes.

Emergency surgery for AIDS-related sepsis, bleeding and obstruction is just as life saving as it is in the absence of AIDS and it should never be denied on account of AIDS. Indeed, because of the galloping nature of sepsis in AIDS the operation may be more urgent than it would be otherwise. This is particularly so with regard to peritonitis and perianal sepsis, but applies to other conditions,

empyema thoracis and brain abscess, for instance. Surgery in the presence of, but incidental to AIDS, poses formidable problems. Bleeding should be stopped, obstruction relieved, anatomy and function restored. But.... there are many butts confronting the clinician. Whether one is called upon to operate for AIDS-related pathology or whether the presence of AIDS is incidental, one may have to modify the procedures, one will have to beware of numerous complications attendant to the immunodepressed state - and one will have to judge eligibility for intensive care and resuscitation, like one does in any critical clinical instance: by assessing the prognosis and scoring.

The adaptation of surgeons and surgery to the HIV pandemic is a process which has only begun. At this stage it is not possible to formulate strict guidelines for every eventuality. The science of surgery in HIV and AIDS has yet to evolve. But even after there have been well conducted studies, even after guidelines and standards have been laid down, HIV will remain a mighty challenge to surgeons. However, certain general rules have already emerged. The most important of these rules is that discussions with patient and family prior to decision making as well as throughout the entire period of treatment must be honest and to the point. Euphemisms, ambiguities and distortions of the truth arising from exceptionalisation, commonplace at present, must be eschewed. The second important rule is that counselling, not specific to HIV and AIDS, is and

will remain the primary responsibility of the doctor and must not be shelved off to other cadres notwithstanding the fact that other cadres, "counsellors", may indeed have a useful function, as they demonstrably have in respect to other illnesses, breast cancer and diabetes being good examples.

As experience with surgery in the environment of the HIV pandemic will accumulate, when proper studies will have been conducted and published, guidelines formulated, rules accepted, surgery in the presence of HIV and AIDS will lose the odium with which it is still surrounded. But even then HIV will remain a formidable challenge to surgeons, for no matter how many rules and guidelines will have been elaborated, their application will require good judgment... and good judgment is not science... good judgment is the essence of the art of healing.

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