Author's response to reviews


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Author's response to reviews: see over
Dear Prof Paulo Lotufo,

Thank you very much for your response to our manuscript. We appreciate the constructive comments from you and the reviewers, and are grateful for the opportunity to send you a revised manuscript. We have provided a point-by-point response to the issues raised below. We hope that we have addressed your concerns satisfactorily, and that you are now able to accept this paper for publication. If further revision is required then please let us know.

Yours sincerely,

Victoria Hall

Reviewer: Dermot Maher

1. Grouping of countries as belonging to sub-Saharan Africa

There are different ways of grouping countries as belonging to sub-Saharan Africa, so whichever grouping is used needs to be justified and the results of the review using this grouping explained. A pragmatic definition of sub-Saharan Africa as the region of the continent (i.e. African mainland) south of the Sahara takes into consideration ethnic, geographic, and cultural grounds for comparing the epidemiology and public health implications of diabetes in African countries.

We have changed the definition of Sub-Saharan Africa to include only countries that are on the African continent, south of the Sahara. The Indian ocean states of Mauritius and Seychelles have therefore been removed from this definition. Given this change, all references to Mauritius and the Seychelles have been removed from the manuscript, tables and accompanying annexes.

2. Association between HIV and metabolic problems including obesity and insulin resistance.

The statement that “Metabolic changes such as increased lipodystrophy which results in increased insulin resistance, have been observed in HIV-positive patients not accessing treatment” needs to be put into the context that these are the minority cases and by far and away the most common metabolic problem among people with untreated HIV infection, and an almost invariable consequence of chronic untreated HIV infection, is weight loss and wasting. This was acknowledged in the early days of recognition of the problems of HIV infection, when “slim disease” was a common term for AIDS. Thus the necessary qualification to the statement under Results that “HIV and its antiviral treatment increase the risk of obesity and insulin resistance” is to say that it’s much more often (or generally) the antiretroviral treatment and not HIV that can cause metabolic problems including obesity and insulin resistance. The references quoted by the corresponding author are supportive of this qualification.
For example, the review by Young et al (Young F, Critchley JA, Johnstone LK, Unwin NC. A review of co-morbidity between infectious and chronic disease in Sub Saharan Africa: TB and Diabetes Mellitus, HIV and Metabolic Syndrome, and the impact of globalization. Globalization and Health 2009, 5:9 doi:10.1186/1744-8603-5-9) indicates that “HIV Lipodystrophy (HIV-LD) is seen in long term survivors of HIV infection, most of whom are receiving ART”, that “although abnormal lipid profiles are reported in HIV-positive individuals before the onset of ART, hypertriglyceridaemia becomes both more prevalent and severe during treatment, and that “HIV-positive people are at increased risk of IR due to the pro-inflammatory process of HIV, the direct effects of ARTs and also, indirect effects as consequences of ART (for example body fat distribution changes)”.

We have changed the statements referring to the associations between HIV, ART and diabetes in both the abstract and the results sections, to emphasise that the most significant metabolic changes are associated with ART, although recognising that some metabolic changes have been associated with untreated HIV.