Original Research Article

Profile of Human Immunodeficiency Virus Patients with Opportunistic Mycobacterium Tuberculosis Pulmonary Infection

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ABSTRACT

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| **Aims:** To determine the profile of sufferers of human immunodeficiency virus infection with Mycobacterium Tuberculosis infection at the Keramat Jati Community Health Center for the period January 2018 - January 2023 based on age, educational status, employment status, history of CD4 levels, clinical stage **Methodology:** This research uses a retrospective methodology. The study population was all patients with a diagnosis of Human Immunodeficiency Virus Infection with Opportunistic Mycobacterium Tuberculosis Infection at the Kramat Jati Community Health Center, East Jakarta. Based on calculations using the Slovin method, the research sample consisted of 34 HIV-TB patients. All sampling approaches are used to carry out the sampling process. HIV-TB patient medical records are one source of data. A total of 5 years, from January 2018 - January 2023. **Results:** It is known that overall the 18-65 year age group recorded the highest rate, namely 94.1%, men recorded the highest rate, namely 79.9%, most of them worked as private employees at 79.4%, most of them had hemoglobin levels <11g/dL at 61.7%, Most had a high school education level at 58.8%, most of the patients had a CD4 count <200 cells/mm3, namely 58.8%, the majority had a total lymphocyte count <1000 cells/mm3 of 82.4%, all patients had clinical stage III of 100%, the majority had positive BTA staining results of 100%.Key populations such as homosexuals, customers of FSW (female sexual workers), FSW (female sexual workers), PWID (Injecting Drug Users), Discorsed Couples and, Children of PLHIV (People in Human Immunodeficiency Virus) are one of the factors that have the potential to influence the number of HIV positive cases. The prevalence of HIV cases in Indonesia in the Homosexual group is 41.2%, in the FSW Customer group it is 11.8%, in FSW is 11.8%, in IDUs it is 23.5%, in discordant couples it is 8.8%, in PLHIV children it is 2.9%. Most of the HIV/AIDS cases with pulmonary TB co-infection in the Kramat Jati District Health Center for the period January 2018 - January 2023 were aged > 18-65 years, male, at least high school education level, and working status as private employees. Apart from that, the majority had Hb levels < 11 g/dl, CD4 count < 100 cells/mm3, total lymphocyte count < 1000 cells/mm3, BTA staining results positive, clinical stage III, and for the Key Population most frequently in homosexuals |

*Keywords: HIV/AIDS with Coinfection of Pulmonary TB, CD4, BTA, Lymphocytes, Key Populations*

1. INTRODUCTION

An infectious disease called Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome attacks white blood cells, lowering the human body's immunity and making people more susceptible to some other diseases. Acquired Immune Deficiency Syndrome (AIDS) is a group of signs and symptoms of a condition that develops as a result of decreased immunity caused by infection with the Human Immunodeficiency Virus.1 Human Immunodeficiency Virus is a member of the retrovirus family, which includes viruses with enzymes (proteins) that can convert their genetic material, RNA, into DNA.2 After infection, the reverse transcriptase enzyme converts Human Immunodeficiency Virus RNA into DNA. A sign of an advanced stage of HIV infection, AIDS is a syndrome or group of disease symptoms characterized by severe immune deficiency. Antibody-positive HIV is not the same as AIDS because AIDS requires one or more disease symptoms caused by cellular immune system deficits.3 Among the top five killers on a world scale, AIDS is in fourth place. One of the countries where the HIV/AIDS pandemic is spreading the fastest in the world is Indonesia. The African continent had the highest number of people infected with HIV in 2019 (25.7 million), followed by Southeast Asia (3.8 million) and the Americas (3.5 million). With 1.9 million people, the Western Pacific has the lowest population. Considering the high number of HIV sufferers in Southeast Asia, Indonesia must increase awareness of the spread and transmission of this virus.4

Human Immunodeficiency Virus will encourage patients to get more diseases. Tuberculosis (TB) is a disease co-infection that is often faced by HIV/AIDS sufferers. According to WHO figures, Tuberculosis kills 13% of AIDS patients. Although using ART reduces the chance of contracting TB by 70-90%, TB is still the main cause of death among HIV patients.1 The health problem of Tuberculosis (TB) continues to be a concern throughout the world today. Eradicating the global tuberculosis epidemic is one of the goals of the 2030 Sustainable Development Goals (SDG) to be achieved (WHO, 2016). It has been considered a worldwide emergency by the World Health Organization (WHO) since 1993 (Indonesian Ministry of Health, 2014). In Indonesia, there were 420,994 new cases of Tuberculosis in 2017.5 Men experienced 1 until 4 times as many new Tuberculosis cases in 2017 as women, according to gender. Opportunistic infections (IO) are a common complication of HIV infection and occur naturally over time. One opportunistic disease, TB, is often found in people with HIV infection and can manifest before AIDS, which is often identified at the same time. In 2000, HIV plus TB caused 350,000 deaths globally1 Based on the description above, researchers consider it important to know the profile of sufferers of human immunodeficiency virus infection with Mycobacterium Tuberculosis infection in the Keramat Jati sub-district health center for the period January 2018 - January 2023

2. material and methods

**2.1. Research Design**

This research uses a retrospective methodology, namely research that aims to look back or collect information starting from the consequences that have occurred and then exploring the causes or factors that influence these consequences. Research Place: Kramat Jati Community Health Center, East Jakarta, time: April 2023 – May 2023

**2.2. Population and Sample**

*2.2.1. Population*

The study population was all patients with a diagnosis of Human Immunodeficiency Virus Infection with Opportunistic Mycobacterium Tuberculosis Infection at the Kramat Jati Community Health Center, East Jakarta.

*2.2.2. Sample*

Further research was carried out using sampling. Samples obtained from a portion of all items studied are considered to represent the total population. At the Kramat Jati Community Health Center, East Jakarta, patients with a diagnosis of human immunodeficiency virus infection and opportunistic Mycobacterium Tuberculosis infection were the research samples. Based on calculations using the method above, the study sample population consisted of 34 HIV-TB patients. All sampling approaches are used to carry out the sampling process. HIV-TB patient medical records are one source of data. A total of 5 years, from January 2018 - January 2023, will be used for data collection.

**Inclusion Criteria**

1. All HIV patients with TB opportunistic infections for the period 2018-2023
2. Confirmed positive for HIV based on CD4 results
3. Confirmed positive for Tuberculosis based on BTA or TCM results

**Exclusion Criteria**

1. Medical record data is incomplete

**2.3. How to Collect Data**

This study used secondary data, namely data collected from the medical records of the Kramat Jati District Health Center by collecting patients with human immunodeficiency virus infection with the opportunistic Mycobacterium Tuberculosis infection, data from patients who had HIV. Demographic data collected included age, educational status, employment status, history of parity, gestational age, number of fetuses, and no infections. Data Collection Procedure:

1. Submit a request to the secretariat of the Dean of FK UKI to obtain a cover letter for taking medical records as secondary data in thesis research
2. Submit the letter to the head of the Kramat Jati District Health Center and the medical records section of the Kramat Jati District Health Center
3. Complete the administration of medical record retrieval
4. Collect data in the medical records room of the Kramat Jati District Health Center
5. The data obtained was then processed using the SPSS program

3. results and discussion

**3.1. Research Overview**

This study aims to determine the relationship between HIV/AIDS sufferers and opportunistic infections caused by Mycobacterium Tuberculosis at the Kramat Jati District Health Center. A total of 34 HIV/AIDS patients at the Kramat Jati District Health Center were used as samples from January 2018 to January 2023.

The distribution of patients based on demographics is presented in table 1 below:

**Table 1. Distribution of Respondent Demographic Data**

|  |  |  |
| --- | --- | --- |
| Variable | Number (n) | Percentage (%) |
| Gender | MaleFemale | 277 | 79.420,6 |
| Age | 0-17 year18-45 year | 232 | 5.994.1 |
| Education | Elementary schoolJunior high schoolSenior high schoolAcademyNo School | 152044 | 2.914.758.811.811.8 |
| Job | Private sector employeeHousewifeRestaurant EmployeesJanitorDriverStudentDoesn't work | 27111112 | 79.42.92.92.92.92.95.9 |
| Total |  | 34 | 100 |

From the data in table 1 it can be seen that there were 27 male HIV-TB patients (79.9%), 7 people with a proportion of 20.6% were female. In terms of age, data was obtained that there were 2 HIV-TB patients aged 0-17 years with a percentage of 5.9%, while those aged 18-65 years were 94.1% (this age is the age with the highest number of sufferers). Meanwhile, in terms of education, there was one HIV-TB patient with an elementary school education level and a percentage of 2.9%, five patients with a junior high school education level and a percentage of 14.7%, twenty patients with a percentage of 58.8%, four patients with a percentage of 11.8% with an academic education level and four patients with a percentage of 11.8% who did not attend school. Furthermore, From the data it can also be seen that in terms of employment, HIV-TB sufferers are 27 private employees with a percentage of 79.4%, 1 person is a housewife with a percentage of 2.9%, 1 person is a restaurant employee with a percentage of 2.9%, 1 person is a housewife with a percentage of 2.9%, 1 person is a driver with a percentage of 2.9%, and 1 person is a student. people with a percentage of 2.9%, not working as many as 2 people with a percentage of 5.9%.

* 1. **CD4 Distribution in HIV-TB Patients**

The CD4 distribution of HIV-TB patients can be seen in Table 2 below:

Table 2. **CD4 Distribution in HIV-TB Patients**

|  |  |  |
| --- | --- | --- |
| **CD4** | **Frequency** | **Percentage** |
| <200 sel/mm3 | 20 | 58,8% |
| 200 sel/mm3 | 13 | 38,2% |
| >200sel/mm3 | 1 | 2,9% |
| Total | 34 | 100% |

In this study, it was found that the proportion of HIV-TB patients with CD4 levels below 200 cells/mm3 was 20, the percentage of patients with CD4 levels between 200 cells/mm3 and 13 was 38.2%, and the percentage of patients with CD4 levels above 200 cells/mm3 was 1.9%.

* 1. **Distribution of positive results for BTA and TMC in HIV-TB sufferers**

The distribution of BTA and TMC in HIV-TB sufferers can be seen in Table 3 below

**Table 3. Distribution of BTA and TMC in HIV-TB sufferers**

|  |  |  |
| --- | --- | --- |
| **Positive/Reactive** | **Frequency** | **Percentage (%)** |
| Positive | 34 | 100 |

Examination for pulmonary TB is recommended using nucleic acid amplification such as Xpert MTB/RIF or acid-fast bacilli (BTA) staining. In this study, it can be seen that the BTA and TMC results of HIV-TB sufferers were positive in 34 people with a percentage of 100%.

* 1. **Distribution of Lymphocyte Levels in HIV-TB sufferers**

The distribution of lymphocyte levels in HIV-TB sufferers can be seen in Table 4 below

**Table 4. Distribution of Lymphocyte Levels in HIV-TB Patients**

|  |  |  |
| --- | --- | --- |
| **Lymphocyte Levels** | **Frequency** | **Percentage (%)** |
| <1000 /mcL | 5 | 12,7 |
| 1000/mcL-1200/mcL | 28 | 82,4 |
| >1200/mcL | 1 | 2,9 |
| Total | 34 | 100 |

In this study it can be seen that the lymphocyte levels of HIV-TB sufferers with lymphocyte levels <1000/mcL were 5 people with a percentage of 12.7%, with lymphocyte levels of 1000/mcL-1200/mcL there were 28 people with a percentage of 82.4%, with lymphocyte levels >1000/mcL there were 1 person with a percentage of 2.9%

* 1. **Distribution of HB levels in HIV-TB sufferers**

The distribution of hemoglobin levels in HIV-TB sufferers can be seen in Table 5 below:

**Table 5. Distribution of Hemoglobin Levels in HIV-TB Patients**

|  |  |  |
| --- | --- | --- |
| **HB Level** | **Frequency** | **Percentage (%)** |
| <11 g/dL | 15 | 61,7 |
| 11 g/dL | 16 | 21,7 |
| >11g/dL | 3 | 16,5 |
| Total | 34 | 100 |

In this study, it can be seen that 15 HIV-TB patients with a hemoglobin level of 11 g/dL had a percentage of 61.7%, 16 HIV-TB patients with a hemoglobin level of 11 g/dL had a percentage of 21.7%, and 3 people. HIV TB patients with a percentage of 16.5% had hemoglobin levels >11 g/dL

* 1. **Distribution of Clinical Stages of HIV-TB sufferers**

The distribution of clinical stages of HIV-TB sufferers can be seen in Table 6 below

**Table 6 Distribution of Clinical Stages of HIV-TB Patients**

|  |  |  |
| --- | --- | --- |
| **Clinical Stage** | **Frequency** | **Percentage** |
| Sage 3 | 34 | 100% |
| Total | 34 | 100% |

In this study, it can be seen that the Clinical Stage of HIV-TB sufferers with Clinical Stage 3 was 34 people with a percentage of 100%

* 1. **Distribution of Key Populations with HIV-TB**

The distribution of key populations suffering from HIV-TB can be seen in Table 7 below

**Table 7. Distribution of Key Populations Suffering from HIV-TB**

|  |  |  |
| --- | --- | --- |
| **Key Populations** | **Frequency** | **Percentage** |
| Homosexual | 14 | 41,2% |
| WPS Customers | 4 | 11,8% |
| IDU | 8 | 23,5% |
| WPS | 4 | 11,8% |
| Discordant Couples | 3 | 8,8% |
| PLHIV children | 1 | 2,9% |
| Total | 34 | 100% |

In this study it can be seen that the Key Population of HIV-TB sufferers with Homosexuals is 14 people with a percentage of 41.2%, among FSW Customers there are 4 people with a percentage of 11.8%, among IDUs there are 8 people with a percentage of 23.5%, among Discordant Couples there are 3 people with a percentage of 8.8%, among couples of PLHIV children there is 1 person with a percentage of 2.9%.

**DISCUSSION**

In discussing the results of this research, the findings obtained in the field will be reviewed, and complemented by discussions based on the findings obtained both from literature theories. This research is qualitative, and in analyzing this qualitative data, the researcher does not rule out the possibility of using quantitative data analysis, to develop and enrich the quantitative data analysis itself, based on the consideration that the existing sample size allows and fulfills the requirements for description and generalization of the population. Quantitative data is used only to a certain extent in analysis and is interpreted following quantitative principles. According to research conducted at the Bali Medika Clinic in Kuta, men make up 81.6% of those with HIV-TB, while women make up 18.4%. Meanwhile, research results for the city of Manado showed that there were 29 male respondents with a proportion of 54.7%, and 24 female respondents with a proportion of 45.3%. Men experienced 1.4 times more new cases of pulmonary tuberculosis in 2017 than women, according to gender. This may be because men are more exposed to risk factors such as smoking and non-compliance with taking medication. According to research findings, 68.5% of all participants were male smokers, and only 3.7% were female smokers (Ministry of Health of the Republic of Indonesia, 2018). The incidence and death rates from tuberculosis have been reduced by a number of symptom management measures.

Research carried out at the Bali Medika Clinic in Kuta stated that 59.2% of cases of HIV-TB pulmonary patients mostly occurred in people aged 15-35 years, and for those over 35 years old it was 40.8. If you look at the age distribution of the PLWHA group, the average age is the productive age that can transmit HIV to other people if they have sexual relations with other people, although they can accidentally infect other people with HIV through wounds and so on. Clinical provisions have been made for countries without adequate diagnostic resources (based on findings from a workshop held in Bangui, Central Africa, in October 1985) as follows:

1. Adults with at least two major symptoms, one mild, and suspected AIDS in the absence of other known immunosuppressive conditions, such as malignancy, severe malnutrition, or prolonged use of corticosteroids.

a. Major Symptoms:

Weight loss of more than 10%, chronic diarrhea for more than 1 month, fever for more than one month (continuous or intermittent).

b. Minor Symptoms:

● Cough for more than one month

● Generalized pruritic dermatitis, Herpes zoster recurrens, Oro-pharyngeal candidiasis, Generalized lymphadenopathy, Chronic progressive disseminated herpes simplex.

2. If there are at least two major symptoms and two mild symptoms in children and there are no other immunosuppressive conditions—such as cancer, severe malnutrition, long-term use of corticosteroids, or other causes—the condition is suspected to be “AIDS.”

a. Major Symptoms

● Weight loss or slow and abnormal growth

● Chronic diarrhea for more than one month

● Fever for more than one month

b. Minor Symptoms

Recurrent generalized infections, oropharyngeal candidiasis, and generalized lymphadenopathy chronic cough, widespread dermatitis, HIV infection in the mother.3

The fact that young people are among the first to engage in sexual activity in many cities only highlights the need to provide reproductive health information as early as possible to young women and young men who may engage in commercial sex. The background to this type of work shows that various groups of men are at risk of contracting HIV(+)/AIDS due to working apart from the family, through frequent movement of commercial sex.

4. Conclusion

Based on research that has been carried out at the Kramat Jati District Health Center regarding the profile of sufferers of human immunodeficiency infection Virus with opportunistic infection Mycobacterium Tuberculosis in the Keramat Jati sub-district health center for the period January 2018 - January 2023, several things can be concluded, including: 1) HIV-TB patients at the Kramat Jati District Health Center in the period January 2018 - January 2023, there were 34 patients aged 18-65 years, with the highest number being 94.1%, which is the age with the lowest number of sufferers; 2) Based on the gender of the most frequent HIV-TB patients in this study, 27 men were suffering from HIV-TB with a percentage of 79.9%; 3) Based on CD4, the most frequent HIV-TB patients were those with CD4 levels <200 cells/mm3, 20 people with a percentage of 58.8%’ 4) In this study it can be seen that the BTA and TMC results are the Gold Standard examination for HIV-TB sufferers with positive results in 34 people with a percentage of 100%;5) Based on the lymphocytes of HIV-TB patients, the most numerous were 28 people with a lymphocyte level of 1000/mcL-1200/mcL with a percentage of 82.4%; 6) Based on the level of education, the majority of HIV-TB patients are at the high school education level, 20 people with a percentage of 58.8%; 7) Based on hemoglobin levels, the most frequent HIV-TB patients were those with hemoglobin levels <11 g/dL, 15 people with a percentage of 61.7%; 8)Based on the employment of most HIV-TB patients, there are 27 private employees with a percentage of 79.4%’ 9) Based on the Key Population, the majority of HIV-TB patients are Homosexual, 14 people with a percentage of 41.2%’ 10) Based on the Clinical Stage, the most HIV-TB patients are Clinical Stage 3, 34 people with a percentage of 100%

References

1. Health K. InfoDatin: Indonesian Center for Health Data and Information. 2020; Available from: https://www.kemkes.go.id/downloads/resources/download/pusdatin/infodatin/infodatin 2020 HIV.pdf
2. Gallant, Joel, Sindoro Alexander AY. 100 Questions and Answers about HIV and AIDS. Jakarta: index, 2010; 2010. 236 p.
3. Katiandagho D. Epidemiology of HIV-AIDS. Bogor; 2018. 208 p.
4. Barnett T, Prins G. HIV/AIDS and security: fact, fiction and evidence-a report to UNAIDS. 2006.
5. Nunn P, Williams B, Floyd K, Dye C, Elzinga G, Raviglione M. Tuberculosis control in the era of HIV [Internet]. 2005. Available from: www.nature.com/reviews/immunol
6. Hendrick RE, Helvie MA. United States preventive services task force screening mammography recommendations: Science ignored. American Journal of Roentgenology. 2011;196(2):112–6.
7. Kumar, Abbas, Abul K. Abbas and CJon. Robbins and Cotran pathologic basis of disease. 2015. 928 p.
8. Budisuari MA, Mirojab A. Policy for Preventing HIV/Aids Transmission from Mother to Child (Case Study in Surabaya City). Health Systems Research Bulletin [Internet]. 2011;14(4 Oct):411–21. Available from:

<http://ejournal.litbang.depkes.go.id/index.php/hsr/article/view/1386>

1. National Strategy for Tuberculosis Control in Indonesia 2015.
2. Radji M. Immunology and Virology. Jakarta: ISFI Publishing; 2010.
3. Reichenbach A, Bringmann A, Reader EE, Pournaras CJ, Rungger-Brändle E, Riva CE, et al. National Guidelines for HIV Management Medical Services. Prog Retin Eye Res. 2019;561(3):S2–3.
4. Indonesian Ministry of Health. TB-HIV manual for officers. 2016;7.
5. Patient P, NonT hiv AND, Rscm T hiv DI. PROFILE OF TB-HIV AND NON-TB-HIV PATIENTS AT RSCM Zulkifli Amin, Anna Uyainah 1, Evy Yunihastuti 2, Zubairi Djoerban 3. 2013;41(4):195–9.
6. Pustil RL. Global AIDS. AIDS. 2003;17 Suppl 4.
7. Directorate General of PP and PL 2014. Disease Control and Environmental Health.
8. Statistics on HIV/AIDS Cases in Indonesia. 2016;75.
9. Edward C. MD Klatt. Pathology of HIV/AIDS 27th Version. 2016. 450 p.
10. Grouzard, Veronique; Rigal, Jean, Sutton M. Clinical Guildines: Diagnosis and treatment manual. 2016. 450 p.
11. Mulyadi, Fitrika Y. Relationship between Tuberculosis and HIV / AIDS. Idea Nursing Journal. 2012;2(2):163–6.
12. Cahyawati F. Management of TB in People with HIV / AIDS. Mirror of the World of Medicine. 2018;45(9):704–8.
13. AN H. HIV/AIDS management book: current, comprehensive and multidisciplinary. Airlangga University Press; 2019.
14. Education J, Health J, Recreation D, Sports F, Undiksha DK. HIV INFECTION (HUMAN IMMUNODEFICIENCY VIRUS) IN TUBERCULOSIS PATIENTS I Made Kusuma Wijaya. FMIPA UNDIKSHA III Year National Seminar. 2013.
15. UNAIDS. AIDS by the Numbers 2016. Unaids [Internet]. 2016;1–25. Available from: http://www.unaids.org/sites/default/files/media\_asset/AIDS-by-the-numbers-2016\_en.pdf
16. Nasarudin J, Zn AU, Karjadi TH, Rumende CM. Prevalence of Rifampicin Resistance in TB-HIV Patients and Influencing Factors. Ina J CHEST Crit and Emerg Med. 2015;vol.3(No.1):11–8.
17. Ajmala IE, Wulandari L. ARV Therapy in TB-HIV Co-Infection Patients. Journal of Respiration. 2019;1(1):22.
18. Taha M, Deribew A, Tessema F, Assegid S, Duchateau L, Colebunders R. Risk Factors of Active Tuberculosis in People Living with HIV/AIDS in Southwest Ethiopia: A Case Control Study. Ethiop J Health Sci. 2011;21(2):131–9.
19. Surjanto E, Subagio YS, Marsabessy QL. Profile of Tuberculosis-HIV Coinfection Patients at Moewardi Hospital Surakarta 2010-2011. J Respir Indo. 2012;32(2):85–8.
20. Permitasari DA, Sofro MAU. Tuberculosis in HIV/Aids Patients at Dr. Hospital. Kariadi Semarang Journal of Media Medika Muda Tuberculosis in Hiv / Aids Patients at Dr. Hospital Dr. Young Medika Media. 2012;
21. Kamya MR, Semitala FC, Quinn TC, Ronald A, Njama-Meya D, Mayanja-Kizza H, et al. Total lymphocyte count of 1200 is not a sensitive predictor of CD4 lymphocyte count among patients with HIV disease in Kampala, Uganda. Afr Health Sci. 2004;4(2):94–101.
22. Wesnawa MADP, Putra INN. Profile of Patients Coinfected with TB-HIV Profile of Patients Coinfected with TB-HIV Made Agustya Darma Putra Wesnawa, I Nyoman Nama Putra Profile of Patients Coinfected with TB-HIV. J Respir Indo. 2016;36(3):175–81.
23. Janis HWJ, Porotu'o J, Rares FES. Diagnostic Results of Mycobacterium Tuberculosis in Cough Patients ≥ 2 Weeks with Ziehl-Neelsen Staining at the DOTS Polyclinic, Prof. Hospital. Dr. R.D. Kandou Manado. e-Biomedic Journal. 2017;5(2).