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Letter to Editor

Adherence to TARGA: Multi-Dimensional Approach

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We read with interest the article by Varela., *et al*. [1] on depression and adherence to HAART in Chile, an important issue for the success of the effect of HAART, which we would like to comment: First, many studies agree that psychiatric diseases are the comorbidities that affect greater measure of adherence to highly active antiretroviral therapy (HAART) directly or indirectly [2]. Directly because it is the most diagnosed psychiatric illness in patients living with HIV and indirectly because it is a product of other risk factors such as alcohol and drug use, drug side effects, lack of social and family support, attitudes and beliefs of the patient about treatment [2]. Likewise, it has been seen that depression affects the adherence to chronic diseases [3] so that the hypothesis of the association of depression in adherence in HAART is, in our view, valid.

On the other hand, the term adherence is not well defined in the article being a key point to assess it. Adherence is defined as the level at which the actual intake of the medication corresponds to the prescription of this [4], so an optimal adherence is defined as the taking of > 95% of the prescribed doses, which is recommended for a virological suppression optimal and minimize the degree of failure [5]. Adherence to HAART has a multi-dimensional approach, which is why multiple factors must be evaluated in order to confirm the hypothesis of the association of depression and adherence: as those related to treatment (quantity of pills, frequency of dosing,), to the disease (CD4 count and time elapsed since the diagnosis), personal (use of drugs and alcohol, depression) and interpersonal (social support, HIV stigma and trust with health personnel [6,7].

The article, like any observational study, risks several biases. In the description of the demographic characteristics of the participants, a greater proportion of men is observed, and considering that there is more depression in women than in men [8], we could infer that there is an underestimation of the measure of association. Likewise, regression models consider not all the confounders that are read in the literature, which makes it difficult for the reader to know if the effect is really the one shown. In relation to the measure of association, the use of OR in cross-sectional studies with such a high prevalence is not advisable, since it can cause an overestimation of the effect, so the use of the prevalence ratio (PR) is recommended [9].

Finally, the article used a survey to assess whether adherence to treatment existed, this being a quick and economical method. However, it has a moderate specificity and low sensitivity, since its greatest utility lies in cases in which the population is identified as non-adherent [10]. Likewise, we currently have validated questionnaires to evaluate adherence to HAART, but the recommendation of recent studies is to use associated methods to achieve an estimate of adherence as accurately as possible [11]. More studies are needed, not only quantitative, but qualitative or mixed methods to understand the magnitude of the problem of adherence and its association with depression.

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