have systematically pointed, particularly in the case of illicit drug users, to the existence, not without tensions or ambiguities, not without risks or consequences, of other modes of engaging the world, of other criteria for evaluating the world. Such criteria are not in play only among illicit drug users, but also among many others that assume risk behaviors. They would align themselves through modes of engaging the world in which life would be valued not more (or scarcely) in duration, but in intensity, as expressed in the formula "the more intense the life, the better".

The problem, in my view, arises when the value that serves as presupposition to the medical practices is taken as an absolute and, as such, comes to be used to disqualify other modes of engaging the world, or to justify in an unproblematic manner any initiative taken in the name of biomedicine, or to justify the denial of access to those initiatives if they are demanded by practitioners of risk behaviors. In other words, the problem arises when problematic ethics are reduced to moral precepts or when, rather than ethically insisting on the qualitative diversity of modes of existence, we content ourselves with opposed moral values, good and bad.

At this point, it is incumbent to state that I do not believe the article under consideration takes such values as absolute. It perhaps does not emphasize the point and maintains it as presupposition… Which brings us to the final point.

In the history of biomedicine, there is virtually no positive development (and developments are many, as appears to be the case of HAART) that has resulted in real change, save in the morbid-mortality tables, at least of symptomatic suffering, that also has not produced numerous wicked effects. Sticking to the context of the article, it suffices to remember that drugs, which today are consumed illicitly and cause ample problems, were, in almost all cases, developed in pharmaceutical laboratories and/or in the name of biomedical presumptions (as was the case for heroin, morphine, cocaine, amphetamines…). It is therefore no mystery that the advent of modern anti-AIDS therapies should result in increased risk behaviors…

1. Weber M. Ensaios de sociologia. Rio de Janeiro: Editora Guanabara; 1982.

Dirce Bonfim de Lima

Centro Biomédico, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brasil.
dircebonfim@alternex.com.br

With regard to the use of anti-retroviral medicines (ARV) among illicit drug users, two aspects should be elaborated: adhesion to treatment and medication toxicity. With regard to the problem of adhesion, given the gravity of this application, it calls attention to the enormous difficulty of patients returning for consultations. If we admit that return is difficult, adhesion to treatment becomes unviable. It thus appears impossible for whatever type of user to abide hours and norms of therapeutic conduct (fasting, medicine interaction, number of pills, etc.).

With regard to medication toxicity, the majority of ARV medications are hepatotoxic to a greater or lesser degree. Cocaine and amphetamines have hepatic toxicity, being able to induce fulminant hepatitis with renal insufficiency and rhabdomyolysis. Because of cardiovascular toxicity, it induces hepatic alterations associated with cardiac insufficiency, rendering other medications hepatotoxic [1].

Chronic consumption of alcohol, which frequently accompanies the use of illicit drugs, can result in alcoholic hepatitis, which induces hepatic deterioration. As such, alterations of the hepatic enzymes in people infected with HIV are frequent, especially with the most potent therapeutic schemes and under the influence of alcohol and other drugs. The prescription of the ARV scheme for this and other special clientele should be considered case by case.

1. Mallat A, Dhumeaux D. Cocaine and the liver. J Hepatol 1991; 12:275-8.