vaccination is recommended in many countries within the European Union. Herein, we draw attention to the increasing risk of HAV in the MSM population, especially in France.

From January to March 2017, 5 cases of acute hepatitis A in unvaccinated MSM were diagnosed in our hospital: the median age of patients was 30 years (range 23 to 41 years). All patients presented with jaundice, liver enzyme elevation >1000 IU/L, and positive immunoglobulin M against HAV. Two were infected with human immunodeficiency virus (HIV) and were being followed in our clinic. The 3 other patients had been admitted to the emergency department. One was HIV-negative taking preexposure prophylaxis (PrEP) with tenofovir disoproxil fumarate (TDF) and emtricitabine (FTC). The 5 patients did not know each other. Genotypic analysis showed the presence of 2 epidemic strains: RVM16-090 in 4 patients and VRD_521_2016 in 1 patient.

Since the early 2000s, unprotected sex in MSM is increasing in many countries. Large-scale PrEP with TDF and FTC has been implemented in France since January 2016 and there are now >3000 MSM taking PrEP. The initial prescription of PrEP was restricted to specialized physicians; however, prescription for maintenance treatment is now available from general practitioners since 1 March 2017.

There has been a large increase in sexually transmitted infections in MSM infected with HIV over the past years, and STIs are also a major problem in MSM taking PrEP.

Our findings and those from other countries suggest that further outbreaks of HAV are likely to occur in MSM. Sustained transmission and outbreaks could be prevented with a level of immunity >70% [7]. Seroprevalence of HAV antibody in MSM in Europe is unknown, but in the adult general population it has been estimated between 20% and 30% in the United States [8] and Europe [9]. In our cohort of MSM with HIV infection (257 patients), HAV antibodies have been found in 76%, with one-quarter of cases secondary to HAV vaccination. HAV immunization is far lower in HIV-negative MSM. For example, in MSM taking PrEP in our hospital (24 patients), 62.5% are seronegative for HAV antibodies.

The availability of the HAV vaccine has been greatly reduced in France and many countries over the past few months due to production issues [10]. This vaccine is no longer available in most French pharmacies and can only be found in scarce pretravel consultations.

Based on our data, because access to the HAV vaccine is so limited, around 24% of MSM infected with HIV and 62% of HIV-negative MSM taking PrEP are likely to be at risk of HAV infection. In this context, avoiding oral anal sex should be recommended for HAV-seronegative MSM. However, no specific health-promotion program has been released to target this issue. There is an urgent need for French health authorities and the pharmaceutical industry to improve access to the HAV vaccine.

Notes

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Q Fever: Confusion Between Chronic Infection and Chronic Fatigue

To The Editor—There is an ongoing confusion between postinfectious subjective syndromes and chronic infection [1]. This is particularly obvious in the context of Lyme disease, which led to conflictual situations between academics, patients' associations, and a certain number of doctors developing alternative diagnostics [2]. As a matter of fact, chronic infections can be defined by demonstrating both the multiplication of a microbe and the presence of an organic lesion. A great confusion has also arisen in the definition of Q fever when cases with subjective syndromes without evidence of

microbial evolution or evidence of focus of infection were qualified as "chronic." This has generated a controversy between the Netherlands' team and its new criteria and our team [1, 3]. We have thus been led to give up the term "Chronic Q fever" and replace it by "persistent focalized infection," which makes it possible to differentiate such cases from persistent subjective syndromes, in which the direct causative role of the microbe is particularly difficult to demonstrate [4]. We have done and realized this because of the ambiguity of the term "chronic infection," which finally imposed itself despite the fact that we had not measured the consequences of this denomination [5]. Indeed, since the work of Emile Durkheim [6], we know that subjective manifestations can be epidemic without being infectious and offer a new cause to subjective syndrome that may open the way to a new "chronic disease." The major benefit of the work reported here [1] is that although the infectious hypothesis had already been ruled out for decades [4], this new randomized study confirmed that antibiotics were inefficient at best and harmful at worst, and that only psychological management could improve noninfectious subjective syndromes attributed to an infectious origin. This work justifies establishing clearly in the future that a chronic infection should only be defined by both the persistence of a microbial activity and by the existence of organic lesions and will benefit to the study of Lyme disease and other infectious diseases as well [2]. Subjective symptoms may either have another explanation or fit in the general concept of "chronic fatigue" rather than chronic infection. Chronic fatigue may be so common that in endemic areas for Q fever, coincidence between the 2 diseases may be reported. However, coincidence is not causality, and here as for chronic fatigue, behavioral therapy is better than antibiotics!

Note

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Reply to Raoult

With interest we read the correspondence of Professor Raoult to our article [1], and we thank him for agreeing with our finding that cognitive behavioral therapy (CBT) is a better treatment option than antibiotics in case of Q fever fatigue syndrome (QFS). However, certain aspects of his concerns need more discussion, especially regarding the existence of QFS and the presumed confusion between QFS, qualified by Raoult as "cases with subjective symptoms," and chronic Q fever.

Many clinicians dealing with QFS patients agree that QFS should be regarded as a separate entity [2–5]. It is accompanied by high morbidity, but in contrast to chronic Q fever, does not account for Q fever-related mortality. The definition of QFS clearly excludes chronic Q fever based on a negative serum polymerase chain reaction (PCR), Q fever serology (ImmunoglobulinG phase I titer < 1:1024), and the absence of signs of endocarditis and vascular infection [1, 6]. Therefore, there is neither controversy nor confusion between QFS and chronic Q fever. Replacement of the terminology of chronic Q fever, a well-recognized and common term for ages, by "persistent focalized infection," is thus not necessary. We feel that the discussion on the definition of chronic Q fever is beyond the scope of our article.

Raoult regards QFS as a "postinfectious subjective syndrome," implying the absence of any somatic origin. His opinion that "an infectious hypothesis has already been ruled out for decades," is not in agreement with a number of papers in the literature [3, 4, 7–12]. In fact, these studies on etiology and the effect of antibiotic treatment were the reason for us to include the doxycycline treatment arm in this study.

We feel it is better to have an open mind when investigating postinfectious chronic fatigue; basically the infectious agent may be only the precipitating factor and not a perpetuating factor, or in the case of persistence of the microorganism, it may also act as a perpetuating factor [13]. Interestingly, we have found that the perpetuating factors in QFS patients clearly differ from those with chronic fatigue syndrome (CFS) [14]. This finding as well as the gender distribution in QFS (52% female compared to 75% in CFS) [14] strongly argue against Raoult's suggestion that QFS is just coincidental CFS in an area with endemic Q fever.

Also we would like to reiterate that effectiveness of CBT does not imply that QFS is a psychological disorder. QFS should be taken seriously as it was the major cause of the Q fever-related economical sequelae during the Dutch outbreak, leading to loss of quality of life and health-related absenteeism [15]. Further research into the pathophysiology is therefore justified, rather than classifying QFS as a subjective syndrome.