Letter to the Editor

HIV Infection in Children

The article on "Clinical Profile and Natural History of children with HIV Infection"[1] gives an excellent exposition of a burning clinical and social problem.

The following points if clarified would add more insight into this rapidly emerging clinical problem. The age range of the subjects is mentioned as 0.75 mth to 18 mth. I understand this itself is an eye opener as the youngest is less than 1 mth old and the oldest is 15 yr. The age and sex wise distribution of the subjects presented in a table is most welcome to all those who are interested in the subject. 7 out of 109 children (6.4%), who were HIV positive had parents who were negative and had no blood transfusion. This point and the probable causes for this need more clarification. Such cases to the tune of 6.4% are alarming. This will be a real question mark in the social and scientific scenario, especially when parents are liable to litigate the hospitals or doctors accusing it as hospital acquired infection. The author's view regarding this and also the view of other experts in the subject are hereby solicited.

Regarding clinical features, we have seen multiple molluscum contagiosm, exaggerated Insect Bite Reaction (IBR), papular urticaria, tuberculosis, parotitis and association with positive Anti nuclear antibody (ANA) and double stranded DNA antibody among the presenting features of HIV infection.

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REFERENCE

1. Lodha R, Upadhyay A, Kapoor V and Kabra S.R.Clinical profile and natural history of children with HIV infection. *Indian J Pediatr* 2006; 73 : 201-204.

Author's Reply

We thank Dr Elizabeth for the interest shown in our article.[1] We will like to remphasize our observation. The youngest child diagnosed to have HIV infection was less than a mth old was diagnosed on the basis of DNA PCR test. The age distribution will be dependent on the type of facility. A referral center, like ours, is likely to report a wide range. On the other hand, in clinics in high prevalence areas with good PMTCT programs are more likely to have younger children. The sex distribution may actually reflect the pattern of gender-biased health seeking behavior in the region.

We did have 6.4% children where the mode of transmission was not clear-the parents being seronegative and lack of history of use of blood products in children. Similar observations have been made in Africa as well.[2] The possible modes could be parenteral injections and sexual abuse. Use of injections is fairly common; many of which could be unsafe.[3] It is estimated that more than 200,000 new HIV infections may occur every year worldwide due to unsafe injections.4 However, the same may be very difficult to prove. In our experience, there wereno litigations by the families of such children. However, at the same, this highlights the need for improving the injection safety record. The other possible mode of transmission in this scenario could be sexual abuse. This again may be difficult to confirm if the history is not forthcoming.

We also do observe insect bite hypersensitivity as a common problem. However, molluscum contagiosum is not common in our patients. Co-infection with tuberculosis is quite common (>25%); screening all children with HIV infection for tuberculosis is a routine practice.

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REFERENCES

1. Lodha R, Upadhyay A, Kapoor V, Kabra SK. Clinical profile and natural history of children with HIV infection. *Indian J Pediatr* 2006; 73 : 201-204.
2. Hiemstra R, Rabie H, Schaaf HS *et al.* Unexplained HIV - 1 infection in children-documenting cases and assessing for possible risk factors. *S Afr Med J* 2004; 94 : 188-193.
3. Bhave S, Kamath SS, Shah R. Injection safety and Indian Academy of Pediatrics. *J Indian Med Assoc* 2005; 103 : 228-230.
4. Hauri AM, Armstrong GL, Hutin YJ. The Global Burden of Disease Attributable to contaminated Injections given in Health Care Settings. *Int J Std Aids* 2004; 15 : 7-16.