

Informing children of their HIV status

Carmiola Ionescu (May 13, p 1566)¹ states that an estimated 20% of about 6000 HIV-infected children in Romania have not had their infection disclosed to them. We share the concern about the public-health effect of non-disclosure, and also believe that these children need and have a right to know their infection status.

Although the situation in Romania is unique because of specific modes of HIV transmission, non-disclosure of HIV status to children has occurred in many other countries as well.^{2,3} In 2004 we completed a European multisite study of the psychosocial needs of parents living with HIV.⁴ The overall disclosure rate of parental HIV status to all children was 20% (215/1063), and only 35% of HIV-positive children were informed about their status (35/100; data provided for the eldest child of each family assessed).

Parents taking care of children with HIV are in need of support when facing the dilemma of disclosure. The question remains whether regulations by law promote an informed choice. Qualitative data collected in a Flemish study showed that parents viewed non-disclosure as protective to the child, with HIV-related stigma as well as children's anticipated emotional distress being the main reasons.⁵

There is great need for models of good practice, such as the ones provided by the Romanian Angels Appeal,¹ to assist parents in informing their children. Health-care workers should provide tailored support to children infected and affected by HIV, recognising the long process of disclosure, as well as preparing them for its potential consequences.

We declare that we have no conflict of interest.

*Christiana Nöstlinger,
Robert Colebunders
cnoestlinger@itg.be

Institute of Tropical Medicine, Department of Clinical Sciences, Nationalestraat 155, 2000 Antwerp, Belgium

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ESPRIT trial

The finding by the ESPRIT Study Group (May 20, p 1665)¹ of a 30% reduction in major bleeding among patients treated with aspirin and dipyridamole compared with aspirin alone raises two important questions.

First, what is the mechanism of reduced bleeding in patients treated with aspirin and dipyridamole? Several hypotheses can be proposed. (1) More patients randomised to open-label aspirin and dipyridamole than aspirin alone might have been treated with acid-suppressive therapy (eg, proton-pump inhibitors) to prevent or treat gastrointestinal symptoms caused by dipyridamole, thereby reducing the risk of gastrointestinal bleeding. (2) More patients assigned to aspirin alone than to aspirin and dipyridamole might have undergone cardiac procedures because cardiac events were more common in patients treated with aspirin alone. Cardiac interventions are a common cause of bleeding and haemorrhagic stroke.² (3) A greater proportion of intracranial haemorrhage might have been secondary haemorrhagic transformation of ischaemic stroke in patients assigned aspirin alone compared with patients assigned aspirin and dipyridamole, because

ischaemic strokes were more common in patients treated with aspirin alone.

Second, what was the effect of major bleeding on ischaemic events and death in the ESPRIT study? There is emerging evidence that major bleeding in patients with acute coronary syndromes is associated with an increased risk of recurrent ischaemic events and death, even when the bleeding is not life-threatening.^{3,4} If a similar association between bleeding and outcome existed in ESPRIT, it would account, at least partly, for the superior efficacy of aspirin and dipyridamole compared with aspirin alone, and would underscore the importance of developing and adopting safer treatments that reduce the risk of bleeding while maintaining antithrombotic efficacy.

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*Martin O'Donnell, John W Eikelboom
odonnm@mcmaster.ca

Department of Medicine, McMaster University, HGH McMaster Clinic, Hamilton, Ontario L8L 2X2, Canada

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The ESPRIT Study Group¹ conclude that "the results of ESPRIT, combined with the results of previous trials in the new meta-analysis, provide sufficient evidence to prefer the combination therapy of aspirin and dipyridamole over aspirin monotherapy as anti-thrombotic therapy after cerebral ischaemia of arterial origin". This result is obviously very important for clinical practice. However, some information