were fully aware while writing the article, has been highlighted in several studies particularly from developed countries, as rightly pointed out.

While we agree with these views, the question remains–should we, particularly in developing countries like ours, where, by and large, natal and perinatal events are not effectively managed due to lack of facilities, completely ignore the identified natal factors (43.8%) which could possibly be the cause of cerebral palsy. As such the natal factors can not probably be looked upon as mere associations.

In developing countries, more well controlled and prospective studies are required before fully endorsing the views originating from the developed countries.

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HIV Infection in Multi Transfused Thalassemic Children

Prevalence of HIV-1 or HIV-2 infections is of interest to Hematologists/Pediatricians engaged in the management of thalassemia. Prevalence of HIV infection is on the rise in our country. Already, over 1 million people are estimated to be infected with HIV infection(1). Seropositivity of HIV infection in multitransfused patients has been reported to vary between 4 to 24.6% of children(2-4). Seropositivity for HIV-1 from other institutions of Delhi has been reported as 9.3 and 8.9%, respectively(5,6). In our study 91 patients of thalassemia between the ages of 7 months to 21 years (55 males, 26 females) on regular transfusion were screened for HIV-1 infection by ELISA. These children had received 2 to 203 (mean 44) blood transfusions prior to their screening. All these children were sero negative. Thus, in the city of Delhi prevalence of HIV-1 infection varied between 0 to 9.3 with overall prevalence in 25 of 369 thalassemia children (6.77%). Our data supports the studies of Singh *et al.*(7).

It is most likely that all these children got the infection through blood transfusion. However, the possibility of infection through contaminated needles and syringes cannot be ruled out, as none of the hospitals of Delhi can afford use of disposables. Since these children are at higher risk, it is suggested that in all these cases disposables should be used and the blood given should be free of HIV infection. Even blood testing by antibody detection method (ELISA) does not offer 100% safety, as blood may be infectious even in the absence of antibodies (window period). So far in our country sero-surveillance studies have only been conducted for HIV-1 infection. There is need to undertake such studies for HIV-2 infection as well. Seropositivity in donors has been reported as 1.03% by ICMR(8). Though HIV screening is mandatory in our country but by and large blood banks in small towns and cities do not do so. Since blood demand is far higher than its availability, especially in towns and small cities, it is possible that professional blood donors moved to smaller

cities/towns to escape detection. There they may get more money and their blood is easily accepted.

Knowing well that HIV is a dreaded disease and blood is a potential source of transmission, it is mandatory that only HIV seronegative blood be administered in all parts of our country, and all possible precautions be undertaken for the prevention of spread of HIV infection.

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Comments

The points raised by Charan *et al.* are both pertinent and topical. As to why of two groups of thalassemics from the same city, one group is HIV free and one group not is difficult to explain. An outbreak of seropositivity among the blood donors of the latter group [as has been reported earlier from Pune(1)] is a distinct possibility. This angle is being closely examined by us at the moment.

Though the use of disposable syringes and needles is certainly an important step in the prevention of cross-infection with HIV, the correct 'disposal of disposables', by incineration or otherwise, is perhaps equally important. In this regard, our Thalassemia Unit is probably among the first to follow the correct techniques of waste disposal.

The point raised about HIV-2 is relevant. HIV-2 infection in India is a reality. Though we have not observed HIV-2 infection among multitransfused children with