pp 550–1). However the discussion around HIV risk factors is somewhat flawed. In their paper they refer to intimate family members as separate to sexual partners implying that HIV is transmitted by close family contact other than sexual intercourse. This is unlikely, for example once mother to child transmission during pregnancy has been ruled out we do not consider children to be at continued risk from normal day to day intimate contact with their infected parents. There have been isolated cases of transmission between siblings and non-sexual family members, but these are few and far between.[1] The authors suggest that the patient was infected during a period of time when she was caring for her sister who, unbeknown to her, was dying of an AIDS-related illness. This would be an unlikely method of HIV transmission. Acquisition of HIV by caring for a family member with the virus, even when not taking any precautions for intimate caring activities, is extremely rare.[2,3]

In a significant minority of people diagnosed with HIV in the UK it is difficult to ascertain an obvious risk factor.[4] It is most likely that a seemingly low-risk sexual partner did, in fact, have a high risk and was HIV positive. By incorrectly classifying this patient's risk for HIV the authors miss the real point about early HIV testing, which is that the decision whether to test should not be based on a history of risk factors but rather on whether the symptoms or condition being investigated could be HIV related. If one constantly asks oneself could this be HIV related and tests patients irrespective of the presence of risk factors (with their consent) then we will start to make some headway in the quest to diagnose HIV infection earlier.

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The significance of early HIV testing (2)

Editor – The recent lesson of the month by Menezes *et al* raises a number of issues (*Clin Med* October 2008 pp 550–1). Clearly, early consideration of HIV infection as a possible diagnosis is vital in unusual, undiagnosed cases if one is to prevent severe and serious consequences. This becomes even more important in a non-genitourinary setting, as in this case, and I am pleased to note that the authors emphasise this in their paper.

The article highlights the fact that while HIV may be an early consideration in certain marginalised groups and in individuals with certain behaviours, it still needs to be explored in cases with no obvious risk factors or in those who deny risky sexual behaviour. Clinicians need to take a non-judgemental and empathic approach to differing lifestyles when offering HIV testing and not an exceptional one as this creates further barriers. Non-HIV specialists challenging the exceptionalism associated with HIV testing will further allay patients' fears and concerns (which are real) and hopefully stop perpetuating the discrimination and stigma associated with an HIV diagnosis.

I am, however, disappointed that the authors made little attempt to trace the source of their patient's infection, concentrating instead mainly on the neurological issues. I am also concerned that disclosing the HIV status of the patient's sister and the fact that the patient cared for her during the terminal stages of her (sister's) illness, seems to suggest that the patient's HIV infection may have been contracted from her sister! This simply perpetuates one of the vast plethora of myths surrounding HIV infection. Equally disappointing is that no mention is made of whether the HIV specialist team was involved post-diagnosis. Something that may have happened years ago and been forgotten or something that the patient is in denial about or genuinely unaware of, always remains a possibility. Though rare, these instances do occur and highlight the need to involve the specialist team post-diagnosis who ensure that risk assessment and partner notification/contact tracing is dealt with in an appropriate manner. This, we know, is extremely important to prevent further transmission.

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In response to both letters

The main objectives of our lesson were to focus on the need for early HIV testing in those patients with an unusual disease course, whether in a neurological or general medical setting, even in the case of an initial denial of a specific risk factor, and to emphasise the prolonged diagnostic course and the delay in management that can result in its absence.

I have been made aware as a result of the responses obtained in relation to our article that our lesson seemed to suggest that our patient had contracted HIV infection by caring for her sister who had died of AIDS and that no source-tracing had been performed, and for this I, on behalf of all the authors of the article, would like to apologise. However, I have to state that the regional HIV specialist team was involved once our patient's diagnosis was confirmed and an attempt to trace the source of the infection was indeed made. This revealed that the patient had been, at some point, in sexual contact with her sibling's spouse (who had been HIV positive at the time) and had contracted the disease sexually and not by caring for her ailing sister as our article seemed to suggest.

I would also like to take this opportunity to reiterate that in such a setting, the absence of an early HIV test might result in a prolonged and tortuous investigatory course, a delayed definitive diagnosis and a delay in treatment of HIV/AIDS and its associated conditions.

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