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In your May 30 Editorial,[1] your rightly draw attention to the need for more widespread testing for HIV infection in the UK. This is important since 28% of individuals in the UK are unaware of their infection,[2] and audits continue to show a similar proportion of patients presenting in late disease where the early mortality associated with treatment is greater.[3]

But to assert that the Department of Health has been inactive in this regard is incorrect. A "Dear Doctor" letter[4] from the Chief Medical and Chief Nursing Officers was sent to all practitioners at the end of 2007, stressing the need to normalise HIV testing and to undertake this in various settings. The Department of Health has also recently disbursed several hundred thousand pounds to fund a series of research projects to assess optimum methods of more widespread testing, and has distributed the booklet *HIV for non-HIV specialists*,[5] which was designed to complement new HIV testing guidelines.

Studies in the UK, funded by the Department of Health, are establishing the acceptability of and usefulness of HIV testing in accident and emergency departments and for new patients in general practice. Testing could be "opt-in", with specific counselling around the value of HIV testing, or "opt-out", where individuals are informed that the test will be done as a part of their care unless they object. If questions about sexuality and risk-taking behaviour were routinely asked and knowledge of the prevalence of HIV in the country of origin of some patients was shared, the importance of testing would become more apparent to both clinicians and patients.

I declare that I have no conflicts of interest.

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We share *The Lancet*'s deep concern[1] about the lack of a credible strategy to diagnose and care for those living with, but unaware of, their HIV in the UK today.

We wish to highlight that, apart from traditionally high-risk areas such as London and the south coast of England, there are areas such as Newcastle upon Tyne in the northeast where surveillance data indicate an HIV prevalence of two or more per 1000. We recently did an audit[2] in Newcastle to determine the number of newly diagnosed HIV infections in 2008. 90 patients had their HIV care started or taken over by our department, of whom 46 had been newly diagnosed. Of the newly diagnosed patients, 27 were late presenters: their median CD4 count was 83 cells/μL (range 4–440). 10 of these 27 patients had a history of a previous indicator disease, of whom 13 had had an AIDS-defining illness on or before presentation. 15 of the 27 late presenters were referred from hospital physicians, five from sexual health services, four from general practice, two from the infectious disease unit, and one from the blood-transfusion service.

The UK National Guidelines for HIV Testing 2008[3] advocate a strategy towards opt-out HIV testing in various new settings, including those aged 15–59 years who register in primary care and those who are admitted to hospitals in areas where the prevalence of HIV is more than two in 1000. One of the key challenges that primary-care and secondary-care services have to tackle is how to provide HIV testing in a way patients would find as acceptable as any other investigation.

ELCO was co-chair of the writing committee of the UK National HIV Testing Guidelines 2008. The other authors declare that they have no conflicts of interest.

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Could early cord clamping harm neonatal stabilisation?


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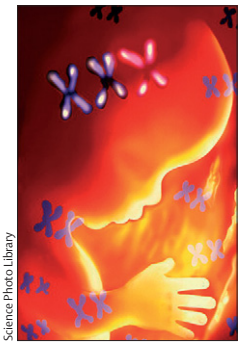
David Odd and colleagues (May 9, p 1615)[1] show that mild perinatal insults, as evidenced by the need for resuscitation, could precede cognitive impairment in children at 8 years. Could early cord clamping be a potential iatrogenic cause of both the need for resuscitation and later outcome?

The placenta does not stop working just because the infant is outside the uterus. It continues to provide gas exchange during the early minutes at physiological transition. Current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service provision dictates immediate cord clamping when infants need resuscitation. Yet as long ago as the 1960s, Yao and others[2] showed that immediate cord clamping results in a 30% lower blood volume and up to a 50% lower red-cell volume for the newborn infant. It is possible that this deficiency could predispose neonates to ischaemic damage.

Such damage might begin with an inflammatory cascade resulting from the hypoxia due to loss of blood volume and components.[3] Meier and colleagues[4] showed that human umbilical stem cells injected into the abdomens of 7-day-old rats within 24 h of a laboratory-induced brain injury prevented spastic paresis, suggesting a timely reparative role when there is an insult. In a series of MRIs in infants with hypoxic-ischaemic encephalopathy, Cowan and colleagues[5] showed little or no indication of damage on the first day, gradually progressing to severe damage by the end of the first week. In infants who do not progress to severe damage, subtle early effects of hypoxia-ischaemia due to blood loss could induce some level of injury which might not be detectable.

We propose that cord clamping is documented for all births, especially in research studies. Otherwise we will never fully understand the effect of interventions in physiological fetal-to-neonatal transition and how to ensure that resuscitation practices cause no harm.

We declare that we have no conflicts of interest.

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What is the "primary" prevention of congenital anomalies?

When the terms primary, secondary, and tertiary prevention were first proposed nearly 50 years ago, they categorised all medical and public health interventions. Recent confusion over how these terms relate to prevention of congenital anomalies could mean that vital efforts are left off the public health agenda.

There is evidence that "primary prevention" of congenital anomalies is being understood in some European countries to include preimplantation diagnosis, and is therefore not making it to the public health agenda because of ethical concerns. Moreover, prenatal diagnosis followed by termination of pregnancy is sometimes referred to as prevention, specifically secondary prevention, which impedes progress with prevention policy. Prenatal screening can be classed as secondary prevention (ie, where early detection results in less severe disease) only where its purpose is to lead to more successful surgical or other treatment, in utero or postnatally. The social and legal acceptability of different forms of prenatal selection varies between European nations. We should however avoid terminological confusion.

There are many measures on a population and individual level that could now, or after more research, reduce the risk of congenital anomalies arising in the first place—ie, primary prevention. These interventions involve nutrition (eg, folic acid supplementation or fortification); prevention of maternal infection and disease (rubella vaccination, periconception care for women with epilepsy or diabetes, avoidance of teratogenic drugs); controlling of chemical exposures from occupational and environmental sources; and special action on pregnancy exposure for major health determinants such as smoking, alcohol, and obesity.

The recent EU communication regarding European action on rare diseases[1] emphasises the need for primary prevention in its true sense. Avoiding confusion in terminology will help us put this recommendation into practice.

The European Surveillance of Congenital Anomalies (EUROCAT) Project Management Committee is: Helen Dolk, Patricia Boyd, Elisa Calzolari, Ester Garne, Martin Haeusler, Lorentz Irgens, Lolkje de Jong van den Berg, Babak Khoshnood, Maria Loane, Vera Nelen, and Hermien de Walle. EUROCAT is co-funded by the EU Public Health Programme and is a WHO Collaborating Centre for the Epidemiological Surveillance of Congenital Anomalies.

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1 Commission of the European Communities. Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the regions on rare diseases: Europe's challenges. http://ec.europa.eu/health/ph_threats/non_com/docs/rare_com_en.pdf (accessed July 15, 2009).

Department of Error

Trikalinos TA, Alsheikh-Ali AA, Tatsioni A, Nallamothu BK, Kent DM. Percutaneous coronary interventions for non-acute coronary artery disease: a quantitative 20-year synopsis and a network meta-analysis. Lancet *2009;* **373:** *911–18*—In table 2 of this Article (March 14), the last four entries of the "Additional indirect" column should read "0 (0)" (ie, no additional indirect data for the DES *vs* BMS comparison). The small differences in the summary relative risks in the last four entries of the "Direct only" and "Combined direct and indirect" columns in this table are ascribed to the different estimation methods we used, as described in the Methods section.