

Correspondence: Growth and Nutrition of HIV Seropositive Children from West Bengal Under Direct Care of Medical Caregivers

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Dear Editor,

We read with great interest, the original article by Chattopadhyay A et al., in the May 2016 issue of your journal [1]. At first, we would like to commend the authors for their endeavour but at the same time feel that few clarifications are required and also would like to make the following comments which would benefit the general reader of JCDR:

1. The aim of the study reads "To evaluate nutritional status of HIV seropositive children.... and examine the role of nutritional intervention and HRT on their growth indices". In 'interventions', the authors state that "seropositive children received HRT along with advices and dietary prescriptions..... Normal counterparts all except HRT". First, for the purpose of an interventional study the authors needed to describe the intervention in a greater detail, such as the duration and type of HRT, age at initiation of HRT, age at which dietary advice/prescription given, compliance to the intervention (nutritional and HRT), etc, [2]. Second, if the control group also received the nutritional intervention of "advices and dietary prescriptions" then it would not be possible to study its role on growth of the case group. Third, the best study design to examine the role of HRT on the growth parameters of HIV infected children would be to compare their growth parameters pre and post HRT.

2. The authors state that "Each patient aged between 2–10 years attending the outpatient Apex HIV Clinic was included in the study as a case during the study period". The exclusion criteria have not been clearly stated. This raises concerns that HIV infected children suffering from any other serious illnesses (infective, neoplastic, etc.,) which are known to affect the nutritional status were also included in the 'cases'. It is also stated that 10.7% HIV infected children (6) had thalassemia and one had haemophilia. The growth in these children will definitely be affected by the anaemia and joint deformities secondary to haemarthrosis respectively.

3. The case and control group was proved to be comparable in respect to age, birth weight, time of weaning and duration of breast feeding. But it would have been better if they also looked at other parameters that are expected to influence the nutrition and thus growth of these children such as family size, socio-economic status, etc.

4. The authors also state that a questionnaire was developed "that focused on respondents; social demographic/economic characteristics and their influence on the nutritional status of the children" but no data pertaining to the same has been provided.

5. It was observed that HIV infected children in the 9 year age group had significantly better growth parameters (weight for age and height for age) than the controls. The authors explained this by stating that "improved attention to diet and nutrition in our clinic has enhanced ART acceptability and adherence which has subsequently led to growth parameters within normal range for age and sex in these patients". But no data of ART adherence is provided to support such claims and also the observed differences did not persist in the 10 year age group. Perhaps, such an observation was 'by chance' and only reflects one of the effects of having small number of children in each age group.

6. Even in the absence of CD4 counts and immunological stage of the disease, the WHO clinical stage of the HIV disease in the infected children and its correlation to their nutritional status could have been looked at, providing another valuable information.

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