Britain is lagging behind other European countries and some American states in detecting HIV positive pregnant women.⁴ Furthermore, even in locations such as ours, where current Department of Health recommendations are being implemented, uptake is disappointingly low. As a matter of urgency, multidisciplinary research needs to be directed towards discovering why pregnant women seem to feel that the social consequences of being identified as HIV positive outweigh the advantages of high quality management for mother and baby. In the meantime the Department of Health should strongly support the recommendations of the Intercollegiate Working Party for Enhancing Voluntary Confidential HIV Testing in Pregnancy, and consideration should be given to implementing an opt-out approach to HIV testing, as approved by the working party of the Institute of Medical Ethics in 1990.⁵

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Contributors: Each of the authors has been involved in the ongoing investigations of antenatal HIV testing at Guy's and St Thomas' Trust and participated in the design of the 1996 uptake study. TAD with the assistance of JK carried out that study, with statistical analysis being coordinated by CV and CDAW. ILC and JEB collated and analysed the 1991-6 uptake data. The paper was written jointly by ILC and JEB with input from the other authors.

Intention to take HIV test before and after prebooking discussion. Values are numbers (percentages)*

		After discussion with midwife			Total
		Yes	No	Don't know	
Before discussion with midwife	Yes	206 (64)	70 (22)	44 (14)	320
	No	13 (5)	238 (90)	12 (4)	283
	Don't know	51 (26)	90 (46)	54 (28)	195
	Total	270 (35)	398 (51)	110 (14)	778

*Some questionnaires were not completed fully.

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Conflict of interest: None.

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Late diagnosis of paediatric HIV infection in south west London

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The family clinic at St George's Hospital provides care for HIV positive children throughout south west London. We are increasingly concerned about the late presentation of many children. This is particularly worrying because in 1992 the Department of Health recommended that all women attending antenatal clinics in areas of higher prevalence (such as Greater London) should be offered an HIV test.¹ If these guidelines had been effective we would have expected most HIV infected children to be recognised in the perinatal period. To assess the scale of the problem we reviewed the method of presentation of vertically infected children in our area.

Patients, methods, and results

We studied the hospital notes of all children who attended our clinic between 1986 and 1996 and identified 48 children with vertically acquired HIV infection. (None of these children had risk factors for horizontally acquired HIV infection.)

Presentation was defined as perinatal if the child was referred at, or around, the time of birth; asymptomatic if the child was referred after the identification of another infected family member or after the incidental finding of signs suggestive of HIV infection; and symptomatic if the child's initial complaint was a clinical

manifestation of HIV infection. Severity of symptoms and immunological status at diagnosis were staged according to the revised CDC classification.² To determine the effect of the Department of Health guidelines, we compared children born before or during 1992 (n=24) with those born after 1992 (n=24).

Age at presentation for the whole group ranged from birth to 9 years (median 19 months). The table shows that a significantly higher proportion of children were born in London after 1992 (5/24 v 17/24; $\chi^2 = 2.1$, $P < 0.001$). The mode of presentation and disease stage at diagnosis were similar in the two groups (χ^2 for trend < 1.0 , $P > 0.2$). Twenty-three children (48%; 95% confidence interval 34% to 62%) presented with infections and 16 (33%; 20% to 46%) presented with manifestations of organ involvement such as lymphadenopathy and parotitis. On examination, 31 children (65%; 52% to 78%) had signs of organ involvement.

Comment

In our area the Department of Health guidelines on antenatal testing have had no effect on the method of presentation of paediatric HIV infection. Since the guidelines were issued in 1992, the mother's HIV infection had been detected by antenatal testing in only one (6%) of the 17 children born in London.

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Patients' characteristics, method of presentation, and stage of disease at diagnosis of 48 children with vertically acquired HIV infection

	Year of birth		Total
	Before or during 1992 (n=24)	After 1992 (n=24)	
Characteristics			
Born in Greater London	5	17	22
Born elsewhere in the United Kingdom	5	1	6
Born in sub-Saharan Africa	14	6	20
Mother of African origin	21	23	44
Mother known to be HIV positive antenatally	2	1	3
Mother confirmed HIV positive	24	24	48
Presentation			
Perinatal	1	1	2
Asymptomatic	3	4	7
Symptomatic	20	19	39
Clinical stage			
N (not symptomatic)	8	5	13
A (mildly symptomatic)	5	4	9
B (moderately symptomatic)	7	7	14
C (severely symptomatic)	4	8	12
Immunological stage			
1 (no evidence of immunosuppression)	8	7	15
2 (moderately suppressed CD4 count)	12	10	22
3 (severely suppressed CD4 count)	4	7	11

Although poor, this detection rate is no worse than that calculated from unlinked anonymous testing in London and south east England as a whole.³ In 1995 the estimated proportion of HIV positive women giving birth who were aware of their diagnosis was 13%. The proportion detected by antenatal testing was 4.8%. These figures are particularly disappointing because antenatal diagnosis allows the use of perinatal antiretroviral therapy, an intervention that dramatically reduces the transmission of HIV from mother to child.⁴ In addition, HIV positive mothers can be advised to avoid breastfeeding as this will also reduce the risk of the infant being infected.

Most HIV positive children in this study were diagnosed after the first year of life. Most presented with

symptomatic disease, usually in the form of repeated or opportunistic infections, but signs of organ involvement (such as lymphadenopathy, parotitis, and hepatosplenomegaly) were identified in two thirds of the children. Prospective studies have shown that 80% of vertically infected children show such signs during infancy.⁵ Wider recognition of these manifestations, together with the awareness that, in London at least, most HIV infected children are of black African origin,³ would probably result in more children being identified before they develop symptoms. Early diagnosis of HIV infection is important because it allows children to benefit from interventions such as prophylaxis against opportunistic infections (especially pneumocystis pneumonia), prompt treatment of established infections, parental education, and social support. Early diagnosis may also be associated with a better response to antiretroviral drugs. It is likely that combination antiretroviral therapy will be most effective in children who start treatment before their immune systems are severely damaged.

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Conflict of interest: None.

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Does uptake of antenatal HIV testing depend on the individual midwife? Cross sectional study

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The risk of vertical transmission of HIV infection can be reduced by at least two thirds with perinatal interventions, including antiretroviral treatment and abstinence from breastfeeding.¹ The Department of Health recommends offering HIV testing to all pregnant women in areas of high seroprevalence,² but uptake and detection rates remain low, with wide variation between centres.³ In 1994-5 only 16% (65/401) of pregnant women infected with HIV in London and south east England were recognised before the birth.⁴ As uptake varies with factors such as the ethnic group of the midwife,⁵ we examined the effect of the midwives' characteristics and site and duration of pre-

test discussion on uptake of testing in an area of high seroprevalence.⁴

Subjects and methods

An antenatal HIV testing programme was introduced in June 1995. All women at their booking visit were offered an HIV test by midwives trained about HIV infection and how to discuss testing. Each midwife was allocated a number (by a senior midwife not involved in the study) and gave details of age, year of qualification, self defined ethnic group, and site of work. For each pregnant woman the midwife's number,