"The term ""AIDS dysmorphic syndrome"" or ""HIV embryopathy"" has been used by some researchers to describe specific facial malformations (i.e., craniofacial dysmorphism), an unusually small head, and growth deficiency in some infants infected with HIV.* Such craniofacial abnormalities have included a prominent, boxlike forehead, large, wide eyes; a flattened nasal bridge, and an unusually pronounced philtrum, which is the vertical groove in the center of the upper lip. Most new cases of HIV infection in young children (pediatric HIV infection) are caused by transmission from the mother during pregnancy, labor and delivery, or breastfeeding (perinatal transmission). Estimates suggest that the transmission rate from untreated HIV-positive mothers in the United States is approximately 12 to 30 percent. (For further information, please see the “Standard Therapies” section of this report below.) Women with HIV infection are most often infected through heterosexual relations with an infected partner or injection drug use. Perinatal HIV infection is thought to affect males and females in relatively equal numbers. As noted above, in some cases, certain dysmorphic features have been observed prior to the onset of symptoms associated with immunodeficiency. However, the significance of such observations has been questioned (see “Symptoms”). Symptoms and findings resulting from immunodeficiency may become apparent during the first or second year of life or later during childhood. Perinatal HIV infection is considered in infants of mothers known to be HIV-positive and/or in infants and children who have certain characteristic symptoms of HIV infection or immune system abnormalities. Infants who are born to mothers with HIV have antibodies against the virus in the bloodstream at birth (passively acquired maternal antibodies). In infants and children who are not infected with HIV, these passive antibodies eventually disappear, usually between six to 12 months, however, in some cases, they may be detectable for up to 18 months. Therefore, testing that detects the presence of HIV antibodies in the blood (serum antibody tests, e.g., enzyme immunoassay and confirmatory Western blot) in a child 18 months or older usually indicates infection; however, such testing is not conclusive in children younger than 18 months. In these children, HIV infection may be confirmed through the repeated use of various specialized viral detection laboratory tests (e.g., HIV viral cultures, a DNA-amplification and copying method known as polymerase chain reaction [PCR]). Additional laboratory tests may also be conducted to assess immune functioning in order to assist in diagnosis and to monitor disease progression and its treatment. Testing may include monitoring of helper T cell numbers (CD4+ cells), the ratio of helper T cells to certain other white blood cells (CD8+ cells), complete blood counts, and blood platelet levels."