obligation to avoid delay of diagnosis and management of this rare disorder.

We declare that we have no conflicts of interest.

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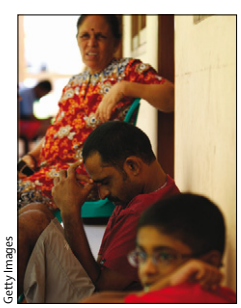
Treatment of HIV infection with drugs for HSV-2 infection



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In their Comment (March 6, p 782)[1] accompanying the study by Lingappa and colleagues,[2] Anne Buvé and Lutgarde Lynen suggest that aciclovir be given to HIV-positive individuals in resource-poor countries as part of a "care package" aimed at slowing disease progression. Indeed, the study shows a reduced risk of HIV-1 disease progression with aciclovir, but its effect is disappointingly modest at 16% over 24 months.

This reduction would have to be matched by the advantages of minimal cost, negligible side-effects, and facility of administration for treatment implementation to be justifiable. Unfortunately, aciclovir carries none of these advantages: it would require the same costly infrastructure required by potent antiretroviral therapy (ART) (clinics, training of medical personnel) and must be taken twice daily long-term, while its cost is similar to that of potent antiretroviral regimens currently used in Africa;[3] meanwhile, it is known to cause blood dyscrasias and other potentially serious side-effects.[4]

Equally importantly, the long-term effects of aciclovir on HIV resistance remain poorly defined. In particular, McMahon and colleagues[5] showed the emergence of the reverse transcriptase mutant variation V75I in 92% of in-vitro viral populations within 3 months of selective pressure of aciclovir. Genotype analyses were not available in Lingappa and colleagues' study.

Efforts to slow HIV disease progression in all populations should never cease. But why not concentrate resources on ensuring equitable access to antiretrovirals for all those in whom treatment is indicated, since potent ART is by far the best studied and most efficient approach to reducing HIV-related morbidity, mortality, and transmission?

We declare that we have no conflicts of interest.

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1 Buvé A, Lynen L. Treating HIV infection with drugs for HSV-2 infection? *Lancet* 2010; **375:** 782–84.
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Authors' reply

We do not think there is disagreement between our point of view, as expressed in the Comment, and the one expressed by Angela Huttner and Alexandra Calmy. We agree that suppressive therapy with aciclovir cannot (yet) be recommended as a strategy to slow down disease progression in HIV-infected patients in low-resource settings. We expressed a lot of caution, as did Lingappa and co-workers,[1] and we suggested that cost-effectiveness studies be done.

The effect of suppressive therapy with aciclovir is indeed modest and implementation of a strategy of continuous treatment with aciclovir might be too costly and too difficult in relation to the expected benefits. Huttner and Calmy give a few reasons why suppressive therapy with aciclovir might not be cost effective, but a more systematic analysis of benefits, costs, and feasibility is needed.

We declare that we have no conflicts of interest.

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1 Lingappa JR, Baeten JM, Wald A, et al. Daily aciclovir for HIV-1 disease progression in people dually infected with HIV-1 and herpes simplex virus type 2: a randomised placebo-controlled trial. *Lancet* 2010; **375:** 824–33.

Mental health in Sri Lanka

In her World Report (March 13, p 880),[1] Nayannah Siva highlights some deficiencies in mental health care in Sri Lanka, but ignores the tremendous scaling up of mental health services over the past few years.

Sri Lanka has a free national health service but the main reason for the inadequate mental health care was the shortage of mental health specialists. The State trains adequate numbers of psychiatrists (88 in 2002–09) but many have migrated to high-income countries. Without a critical mass of advocates, scaling up services becomes a difficult task. However, the dedication of psychiatrists remaining in the country has achieved much. The Mental Health Act of 1873 has been redrafted and a National Mental Health Policy adopted. A National Mental Health Survey has been completed and data for prevalence of most common mental disorders are available.

Psychiatrists' numbers have increased and currently 22 of the 25 administrative districts have a psychiatrist providing care. To cope with the shortage of psychiatrists, a 1-year diploma course was started in 2008 and those who qualified have been appointed to rural