

in the absence of a ritonavir-boosted lopinavir group. Moreover, the median age of the children was 6 years and only a small proportion were infants, in whom concerns about high viraemia are greatest.

ARROW also provides us with useful data for the safety of abacavir and provided a test of a three-NRTI regimen in children. Given that viral suppression (<400 cells per μL) was significantly poorer in the three-NRTI maintenance group in the long term, whether this strategy will be useful as a stand-alone primary regimen, in the absence of a four-drug induction period, as well as its efficacy with tuberculosis cotreatment remains to be determined. Management of the common comorbidity of tuberculosis is a challenge in children with HIV,¹³ and more options for antiretroviral regimens suitable to use with rifampicin are needed.

Large and rigorous trials of paediatric HIV treatment are rare. ARROW, by addressing this neglected population, has greatly expanded our knowledge base to improve treatment for children with HIV. Uncertainties about treatment strategies and monitoring should not undermine our efforts to strengthen rollout of ART for children. ARROW provides us with a clear demonstration that excellent clinical outcomes can be attained in children with HIV despite resource constraints that mar our efforts to manage HIV in the settings most affected by this devastating epidemic.

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We declare that we have no conflicts of interest.

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Towards a global brief on aspirin

Non-communicable diseases (NCDs) accounted for two of every three deaths (34.5 million) worldwide in 2010.¹ Addressing the expected increase in NCDs in low-income and middle-income countries will be crucial to achieving the global goal of a 25% relative reduction in premature death owing to NCDs by 2025. In developing countries the focus should be on getting prevention and treatment programmes right, whereas in high-income countries adherence to existing guidelines is key.

An important way to tackle cardiovascular diseases (CVD) is to encourage people to adopt healthier

behaviours and diets. Recently, WHO's *Global Brief on Hypertension* emphasised reducing risk factors.² However, optimum medical treatment for people at elevated risk for CVD is another important issue. Life-long aspirin (daily, low dose) for secondary prevention of CVD is well established and included in many evidence-based guidelines.^{3,4}

Yet adherence to aspirin is a major problem: in the USA, less than half (46.9%) of patients with ischaemic vascular disease were prescribed antiplatelet medication in 2007–08, with rates even lower in primary care.⁵ The

ongoing debate on bleeding risk undoubtedly contributes to these disappointing numbers, along with different interpretations of appropriate antiplatelet treatment. For example, local guidance on antiplatelet treatment during colonoscopy in patients with established vascular disease might state that the person performing the procedure can decide to stop aspirin if necessary.

Is stopping aspirin based on an informed discussion between patient and clinician about competing risks of bleeding and cardiovascular events good medical practice, or does undue caution about possible bleeding undermine adherence to guidelines? The World Heart Federation has advocated⁶ adoption of strong evidence-based targets at national level—one focus should be on making physicians aware of the importance of compliance to aspirin. National heart and stroke associations and other groups need to work together to abolish uncertainty regarding the balance between risks and benefit of aspirin; aspirin's possible role in cancer prevention is also relevant to the debate on aspirin use in primary prevention.⁷ Future changes in aspirin use should be based on rigorous cost-effectiveness analyses, to avoid uncertainty and to demonstrate the effect of improved compliance on reducing NCDs. Perhaps it is time for WHO to develop a

Global Brief on Aspirin, to inspire a stronger focus on the importance of aspirin compliance.

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Call for papers—respiratory medicine

According to the Global Burden of Disease study, chronic obstructive pulmonary disease, lower respiratory infections, and lung cancer were the third, fourth, and fifth most substantial causes of death, respectively, in 2010.¹ Deaths from chronic respiratory diseases are estimated to have totalled 3.78 million in 2010; trachea, bronchus, and lung cancer deaths are estimated to have increased from 1.04 million in 1990 to 1.53 million in 2010, reflecting, among other factors, a substantial rise in smoking-related deaths in developing countries.

In addition to a great need for preventive measures to reduce this shocking toll of morbidity and mortality, improvements are urgently needed in diagnosing and caring for people with respiratory diseases, and in research aimed at design and evaluation of new treatments. We are therefore planning special issues devoted to research on respiratory medicine to coincide with the European Respiratory Society annual congress to be held in Barcelona, Spain from Sept 7–11, 2013.

We welcome high-quality submissions documenting any area of clinical research relevant to respiratory medicine, especially those reporting on late-stage clinical trials, and will select papers for fast-track peer review. Please submit via our e-submission system EES, mentioning this call in your cover letter; the deadline for submissions is May 20. If you are presenting your research at the meeting, please let us know so that successful submissions can be published Online First to coincide with the presentation.

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