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Since publication of his article, the author reports no further potential conflict of interest.

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DOI: 10.1056/NEJMc1205423

Dengue

TO THE EDITOR: Simmons et al. (April 12 issue)¹ mention appropriate therapeutic alternatives for the management of the hemodynamic and hematologic complications of dengue. However, the authors make no mention of symptomatic treatment, which is important in most patients with dengue. Some studies suggest that analgesic and antipyretic treatment during the febrile phase may influence the prognosis. Specifically, in a prospective cohort, the use of dipyron was associated with an increased risk of dengue hemorrhagic fever (relative risk, 7.29; 95% confidence interval [CI], 1.79 to 29.34; $P=0.002$).²

Moreover, a cumulative dose of 1 g of aspirin or more was prospectively associated with an increased risk of spontaneous bleeding in patients with suspected dengue (relative risk, 4.4; 95% CI, 2.14 to 9.05; $P<0.001$).³ Nonetheless, the use of nonsteroidal antiinflammatory drugs (e.g., diclofenac and ibuprofen) has not been associated with dengue complications. However, these analgesics are not widely recommended because of the risk of gastrointestinal bleeding. Therefore, paracetamol (acetaminophen) appears to be the safest medication to control symptoms such as fever, malaise, and ache,⁴ which cause most of the disability from dengue.⁵

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No potential conflict of interest relevant to this letter was reported.

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TO THE EDITOR: In their description of dengue, Simmons et al. report symptoms and findings that call for excluding possible acute infection with the human immunodeficiency virus (HIV).¹⁻⁴ Both dengue and HIV infection are found in tropical areas, especially among young adults. The Caribbean region has the world's second highest HIV prevalence and increasing dengue outbreaks. We have seen opportunities to diagnose HIV that have been missed because screening tests were not done or were done too early, or because dengue IgM antibodies were falsely positive. Inadequate medical-history taking about unsafe behaviors and lack of HIV reverse-transcriptase-polymerase-chain-reaction (RT-PCR) testing have created problems, even in patients hospitalized for dengue. There has also been confusion about repeat HIV screening, which should be performed 3 weeks after initial testing. Delayed diagnosis of HIV may have severe consequences for patients and their partners, given the increased risk of transmission during primary HIV infection. Hence, adults with denguelike syndrome should be offered HIV screening tests and even RT-PCR testing for HIV at either the first visit or at follow-up visits, particularly if patients have risk factors. Both diseases should be considered in symptomatic adult travelers from tropical areas.

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THE AUTHORS REPLY: Reducing dengue morbidity and mortality requires a systematic approach that is focused on early recognition and careful management of complications, in particular plasma leakage. During the febrile phase of the illness, oral fluids should be encouraged to maintain adequate hydration. Regular clinical monitoring is essential to identify warning signs without delay and to ensure prompt hospitalization for close observation and parenteral-fluid therapy if indicated. In view of the thrombocytopenia and coagulation derangements known to be associated with dengue, acetaminophen (paracetamol) has for many years been recommended by the World Health Organization as the drug of choice for fever and symptomatic relief, with the proviso that both the dose and interval of administration should be carefully controlled.^{1,2} Given the potential risk for severe bleeding, aspirin and all nonsteroidal anti-inflammatory drugs are expressly contraindicated if the diagnosis is suspected.

We agree with Abel et al. that acute HIV infection should be included in the differential diagnosis if the clinical picture and epidemiologic background are appropriate. As indicated in the review, patients with dengue commonly present with nonspecific flulike symptoms, and a wide range of viral, bacterial, and parasitic infections should be considered, depending on the context. From a global perspective, the majority of symptomatic dengue infections still occur among residents of endemic areas, particularly children, but the ongoing geographic expansion of the virus and increasing rates of international travel mean that travelers who are potentially infected with dengue may present to health services anywhere in the world. Clearly, dengue should be considered in such cases, but assessing the epidemiologic risks of other infections is equally important to ensure a correct diagnosis.

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Since publication of their article, the authors report no further potential conflict of interest.

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DOI: 10.1056/NEJMc1205584

Glycemic Management of Type 2 Diabetes Mellitus

TO THE EDITOR: Recently, the *Journal* published the results of two trials showing the effectiveness of bariatric surgery in inducing remission of type 2 diabetes (April 26 issue).^{1,2} Like many bariatric surgeons, we think that attention to this subject is overdue. Given that the article on management of type 2 diabetes by Ismail-Beigi (April 5 issue)³ focused on a seemingly excellent candidate for bariatric surgery, we were disappointed that the surgical option was not considered worthy of inclusion in the recommendations.

Ismail-Beigi contends that data showing long-

term effectiveness of bariatric surgery for weight loss are lacking, but we disagree; such data have been published in the *Journal*. Sjöström and colleagues followed patients for a mean of 10.9 years before concluding that bariatric surgery was associated with long-term weight loss (and decreased mortality).⁴

If a medical therapy possessed characteristics similar to bariatric surgery — that is, if a one-time, low-risk application was associated with durable remission of type 2 diabetes in most patients and decreased long-term mortality — would