characteristics, all patients were initially on OHA and diet therapy. All 46 patients in the hyperinsulinemic group had good glycemic control with OHA and were non-insulin requiring for glycoemic control. In the non-hyperinsulinemic group 6 patients (11%) became insulin requiring after initial therapy with OHA.

To summarize, three clinically and biochemically distinct subgroups could be identified under the broad category of 'early onset type 2 diabetes'. They were:

- **A subgroup who**
  - were non-obese,
  - had explosive onset of diabetes,
  - had significantly low family history of diabetes,
  - did not have fasting hyperinsulinemia,
  - had low prevalence of complications at diagnosis,
  - had poor response to OHA and were insulin requiring in 46% of cases.

This subgroup of patients constitute possibly LADA.

- **A subgroup who**
  - had higher BMI,
  - fasting hyper-insulinemia,
  - significant positive family history of diabetes in parents and siblings,
  - higher prevalence of complications at diagnosis, and
  - were non-insulin requiring for glycoemic control.

They constitute possibly the true early onset Type 2 diabetic patients.

- **A single case of maturity onset diabetes of young (MODY), who had positive three generation family history, was obese, did not have any microvascular complication, was non-insulin requiring and did not have any markers of insulin resistance like acanthosis nigricans or skin tags.**

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Sir,

The nevirapine is one of the most common available and prescribed drugs in AIDS. However, this drug has absolutely no role in PEP in HIV/AIDS. If prescribed for PEP may lead to serious adverse effects. The same is being emphasized in the present case.

The present case, a 38 year old female, nurse by occupation got percutaneous occupational exposure to blood of an HIV+ve patient four weeks prior to presentation to our hospital. She got deep prick with the needle of syringe which she had used to draw blood sample of the patient while trying to recap the needle. The patient was known to be HIV +ve and he died after few days of this incident. As such, exposure code was 3 and status code was 2 (as per NACO guidelines) which warranted the use of expanded regimen for PEP. The physician attending her prescribed a combination of lamivudine + zidovudine + nevirapine and in the fourth week of prophylaxis she developed a maculopapular rash all over the body (Figs. 1-3) for which she was referred to this hospital. She was advised ELISA for HIV on 22nd day after exposure by attending physician. Hospital refers to this hospital. She was advised ELISA for HIV on 22nd day after exposure by attending physician. Guidelines for the investigation after exposure recommend testing at baseline and at interval of 6 weeks, 12 weeks and 6 months after exposure. ELISA for HIV before 4 weeks has no value other than establishing that the exposed individual was negative for HIV at baseline. Although PCR for RNA is not recommended for routine use, this test is of help if we want to detect infection (before ELISA becomes +ve) at early stage. Drug (nevirapine) dechallenge was performed and other two drugs were allowed to continue which improved condition of patient after 4 weeks of dechallenge. Since literature suggests no role of drugs like anti-allergic or corticosteroid in this type of rash hence was no treatment was given in this case also for the rash. The patient is on follow up presently.

In prospective studies the average risk of HIV transmission after a percutaneous exposure to HIV-infected blood has been estimated to be approximately 0.3%. Rationale for HIV PEP include the pathogenesis of HIV infection, particularly the time course of early infection; the biological plausibility that infection can be prevented or ameliorated by using antiretroviral drugs and direct or indirect evidence of the efficacy of specific agents used for prophylaxis. A combination of drugs with activity at different stages in the viral
replication cycle (e.g., nucleoside analogues with a PI) theoretically could offer an additional preventive effect in PEP, particularly for occupational exposures that pose an increased risk of transmission. CDC or NACO guidelines for PEP recommend a 4 week course of lamivudine (150mg) + zidovudine (300 mg) twice a day (Basic regimen) and the addition of a third drug for PEP following high-risk exposures (expanded regimen) is based on demonstrated effectiveness in reducing viral burden in HIV-infected persons. Indinavir (800mg 8hrly) or nelfinavir (750mg TDS) or efavirenz (600mg OD) are recommended as first-choice agents for inclusion in an expanded PEP regimen.1

This type of reaction (maculopapular rash) is well known with the use of nevirapine especially in individuals with normal CD4 count. During 1997–2000, a total of 22 severe adverse events in persons who had taken nevirapine-containing regimens for occupational or nonoccupational postexposure prophylaxis were reported to FDA.2 Severe hepatotoxicity occurred in 12 (one requiring liver transplantation), severe skin reactions in 14, and both hepatic and cutaneous manifestations occurred in four. Because the majority of occupational exposures do not lead to HIV infection, the risk for using a nevirapine-containing regimen for occupational PEP outweighs the potential benefits. The same rationale indicates that nevirapine should not be used for PEP. The idea behind publishing the case was to highlight the ignorance on the part of prescribing physician regarding the CDC/NACO guidelines for PEP for HIV. The present case also pleads for creating awareness among health care professional, especially the doctors, as what needs to be done after occupational exposure to HIV, so that unnecessary investigations and unwarranted treatment can be avoided.

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Epidemiologic Features of Gastric Cancer