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dependent, so the continuous-infusion method proposed by Drs. Schneemann and Imhof seems counterintuitive. No clinical trial of continuous infusion has had sufficient power to demonstrate equal efficacy between continuous infusion and intermittent infusion of amphotericin B deoxycholate.

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Single-Dose Azithromycin for Trachoma

TO THE EDITOR: Solomon et al. (Nov. 4 issue) suggest that the ocular chlamydia that causes trachoma can be eliminated by a single mass antibiotic treatment. Two years after distributing oral azithromycin in a village, they identified only a single infection. The authors state that this finding “contrasts starkly” with the prediction of our mathematical model. Yes and no. We do predict that infection will eventually return after a single mass treatment. However, with 97.5 percent coverage of a moderately infected area, this return may take a long time. Our model predicts that less than 3 percent of persons will be infected at one year — and an even smaller proportion in this case, since Solomon et al. also distributed tetracycline ointment. Furthermore, this estimate is only an expectation (or average), and chance can have a large effect. We recently monitored 24 villages in Ethiopia after a single mass treatment; in some villages, infection was eliminated at two months, and in others it returned relatively rapidly. Unfortunately, the evidence so far suggests that, on average, infection returns after a single mass treatment, but to test this properly, one must look at more than one village.

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THE AUTHORS REPLY: Two main factors differentiate our study from the model of Lietman et al. First, our primary outcome measure was an adjusted geometric mean of the ocular Chlamydia trachomatis load, determined with the use of a quantitative polymerase-chain-reaction assay. The model, in contrast, used the prevalence of active trachoma, which correlates poorly with chlamydial infection. Second, we reported that after high-coverage mass treatment, the load of infection dropped and then continued to fall for at least two years, whereas the model predicted that (in communities like ours, where the disease is mesoendemic) the prevalence of disease would double every four to eight months after a treatment-induced fall. Our results suggest that there may be a threshold level of infection, below which the transmission of trachoma ceases; its return might then depend on reintroduction from the outside by persons with heavy shedding of C. trachomatis. We agree that our data are from only a single community case study but note that six months after mass treatment, six Ethiopian villages studied by Lietman’s group had a prevalence of infection of
Managing the growth of technology: the growth of technology. Managed care’s lack of candor undermined its efforts to control costs and led to patient backlash. Since rationing is politically untenable, government has retreated from these issues. And current efforts at patient cost-sharing with caps will not curb spending for those with high utilization.

However, in order to obtain basic health care, some patients are willing to accept limits on care. We need efficient insurance systems in which patients willing to accept such limits are linked with caring physicians who use innovative practice styles and consider both costs and benefits as they care for their patients. Although this approach may make some uncomfortable, it is both ethical and necessary.

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