To the Editor: We conducted a double-blind, randomized, phase 1b clinical trial (ClinicalTrials.gov number, NCT00452088) using the merozoite surface protein 3 (MSP3) vaccine in a malaria-endemic area. A total of 45 children who were 12 to 24 months of age were randomly as-
signed in a 1:1:1 ratio to receive three doses (on days 0, 28, and 56) of MSP3 at a dose of 15 μg, MSP3 at a dose of 30 μg, or hepatitis B vaccine at a dose of 10 μg. Details of ethical approval (which included approval by the national ethics committee of Burkina Faso and written informed consent), study vaccines, safety, and immunogenicity results have been reported previously (see the Supplementary Appendix, available with the full text of this letter at NEJM.org). The study was sponsored by the African Malaria Network Trust through a grant from the European Commission’s EuropeAid Co-operation. The MSP3 vaccine was manufactured by Synprosis, who had no role in the conduct of the study or in preparation of the manuscript.

The trial was not designed to measure vaccine efficacy. However, to monitor safety, passive surveillance of all episodes of illness, including clinical malaria, was maintained during the ensuing malaria-transmission season in a blinded fashion. Since numerous episodes of malaria were recorded, we considered examining the possibility of a protective effect induced by the MSP3 vaccine. A plan to compare the incidence of clinical malaria among the three groups was agreed on before the analysis began. Given the high transmission rate in the study area (>200 microliter or more. Parasitemia at a density of 5000 parasites per microliter was used, similar results were obtained with periods at risk of 715, 563, and 296 days, respectively, and incidence rates of 1.0, 1.6, and 4.1 cases per 100 days, respectively. A total of 8, 10, and 13 children in these groups had an episode of clinical malaria. A log-rank test indicated evidence of a difference in the incidence rate among the three groups (P=0.01). When a threshold density of 10,000 parasites per microliter was used, similar results were obtained with periods at risk of 715, 563, and 296 days, respectively, and incidence rates of 1.0, 1.6, and 4.1 cases per 100 days (P=0.03). The period of analysis shown here starts after full immunization (i.e., 4 weeks after the third immunization, when antibody titers peak), and increases to the end of transmission.

It is unlikely that other efforts to control malaria influenced these results, since this was a randomized trial and the assessment of malaria was conducted in a blinded fashion. Data from the demographic surveillance system indicate that insecticide-treated bed nets were used in only 5 to 10% of households. Neither indoor insecticide spraying nor intermittent preventive treatments were practiced in the area. The study clinic provided free diagnosis and treatment 24 hours a day, so it is likely that most or all episodes of symptomatic malaria were detected. Despite the limitations in sample size and study design, we believe that the findings of this trial warrant further evaluation of this vaccine candidate.

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25TH ANNUAL PRACTICING PHYSICIAN’S APPROACH TO THE DIFFICULT HEADACHE PATIENT

The course will be offered in Rancho Mirage, CA, Feb. 17–20. Contact Dr. Merle L. Diamond, Diamond Headache Clinic Research & Educational Foundation, 1235a North Clybourn Ave., Suite 408, Chicago, IL 60610; or call (877) 706-6363 or (773) 883-2062; or fax (773) 883-2073; or e-mail info@dhc-fdn.org; or see http://www.dhc-fdn.org.

MAYO CLINIC

The following meetings will be held in Rochester, MN:
“28th Mayo Clinic Dermatology Symposium: The O’Leary Meeting” (Sept. 23 and 24); “A Taste of Tropical Medicine: A Global Health Volunteerism Short Preparatory Course” (Oct. 28 and 29); “Geriatric Update for the Primary Care Provider” (Nov. 10); and “21st Annual Mayo Clinic Symposium on Sports Medicine” (Nov 11 and 12).

Contact the Mayo School of Continuous Professional Development, 200 First St. SW, Rochester, MN 55905; or call (800) 323-2688 or (507) 284-2509; or fax (507) 284-0532; or see http://www.mayo.edu/cme; or e-mail cme@mayo.edu.

A Problem in Gestation (September 1, 2011;365:843-8). The images shown as Figures 1 and 2 in the printed Journal (page 846) were swapped: the image for Figure 1 (the MRI scan of the abdomen) was incorrectly shown as Figure 2, and the image for Figure 2 (the ultrasonographic image of the neck) was incorrectly shown as Figure 1. The figure legends were also swapped; the figure titles were correct. Also, in the boldface paragraph beginning “After resection” (page 846), the second sentence should have read, “Maintenance doses of 600 mg of calcium carbonate with 200 IU of vitamin D twice daily were prescribed, in addition to 400 IU of vitamin D3 daily,” rather than “. . . were prescribed, with the addition of vitamin D3 (40 IU daily).” In the paragraph beginning “The approach to the management” (page 847), in the sentence beginning, “Calcitonin, which is classified,” the parenthetical description of a category C medication for pregnant patients was incorrect; it should have read, “(i.e., a medication for which there is no evidence of harm to the fetus, but no adequate, well-controlled studies have been conducted in humans; potential benefits may warrant use of the drug in pregnant women despite potential risks),” rather than “(i.e., a medication for which there is no evidence of harm to the fetus in studies in animals but for which no adequate studies have been conducted in pregnant women).” We regret the errors. The article is correct at NEJM.org.

CORRECTION