Acknowledgments

Financial support. South African Centre for Epidemiological Modelling and Analysis and Institut de Recherche pour le Développement (to C.P.).

Potential conflicts of interest. All authors: no conflicts.

Carel Pretorius,1 Nicolas Bacaër,1 Brian Williams,1 Robin Wood,2,3 and Rachid Ouifki1
1South African Centre for Epidemiological Modelling and Analysis, Stellenbosch, and 2Desmond Tutu HIV Centre, Institute of Infectious Diseases and Molecular Medicine, and 3Department of Medicine, University of Cape Town, Cape Town, South Africa; and 4Institut de Recherche pour le Développement, Bondy, France

References

Reprints or correspondence: Carel Pretorius, South African Centre for Epidemiological Modelling and Analysis, c/o STaAS, Private Bag X1, Matieland, Stellenbosch, 7602 (cpretorius@sun.ac.za).

Clinical Infectious Diseases 2009;48:994–6
© 2009 by the Infectious Diseases Society of America. All rights reserved. 1058-4838/2009/4807-0024$15.00 DOI: 10.1086/597357

Reply to Pretorius et al.

To the Editor—I note with satisfaction that the gauntlet that I dared to throw in a recent commentary [1] on an article published in Clinical Infectious Diseases on the risk of children in Cape Town, South Africa, becoming infected with Mycobacterium tuberculosis [2] has been picked up. The senior author of the original article [2] has joined forces with experts who recognize that it is not directly possible to disentangle age, period, and cohort effects in a single cross-sectional survey, even if that survey spans several age groups [3]. Nevertheless, the sophistication introduced in the reanalysis suggests that my incredulity at an observation that seemingly runs against all intuition—namely, that an unprecedented and continued increase in the sources of infection in the community would have no impact whatsoever on disease transmission to children—must be fundamentally flawed. Indeed, the authors even go a step further and venture to postulate that there is a higher likelihood of a decrease in transmission risk to children when sources of infection have simultaneously been growing exponentially in the same community. Perhaps, if you hear hoof beats, you should look for zebras; after all, this is an observation from Africa.

Acknowledgments

Potential conflicts of interest. H.L.R.: no conflicts.

Hans L Rieder
Department of Tuberculosis, International Union Against Tuberculosis and Lung Disease, Kirchland, Switzerland

Comparison of the Effectiveness of Zanamivir and Oseltamivir against Influenza A/H1N1, A/H3N2, and B

To the Editor—Both our influenza study group [1–5] and Sugaya et al. [6] have reported that oseltamivir is clinically less effective than zanamivir against influenza B in analyses of the duration of fever and viral shedding; our group and Sugaya and colleagues have also reported that zanamivir is almost equally effective for both influenza A and B. Recently, Sugaya et al. [7] compared the clinical effectiveness of oseltamivir with that of zanamivir against influenza A/H1N1, A/H3N2, and B, and they reported that both drugs were equally effective in children. However, no study of these viruses has been reported that compares the effectiveness of zanamivir with that of oseltamivir among large numbers of adult patients, including elderly adults. We analyzed the duration of fever after administration of the first dose of zanamivir or oseltamivir in 858 patients for whom influenza A/H1N1, A/H3N2, or B was diagnosed by virus isolation over the 5 consecutive influenza seasons from 2003–2004 through 2007–2008.

Zanamivir was administered to 411 patients (mean age ± SD, 22.1 ± 14.7 years; range, 5–68 years), of whom 70 had influenza A/H1N1, 193 had influenza A/H3N2, and 148 had influenza B. Oseltamivir was administered to 447 patients (mean age ± SD, 30.9 ± 21.1 years; range, 9–94 years), of whom 79 had influenza A/H1N1, 177 had influenza A/H3N2, and 191 had influenza B. The duration of fever after the first dose of zanamivir or oseltamivir was calculated according to the method reported in our previous studies [2, 5].

For patients with influenza A/H1N1, the mean duration (±SD) of fever was almost the same in patients who received zanamivir therapy (32.0 ± 20.6 h) as it was in those who received oseltamivir therapy (32.8 ± 19.2 h). For patients with influenza A/H3N2, the mean duration

References

Reprints or correspondence: Dr. Hans L. Rieder, Dept of Tuberculosis, International Union Against Tuberculosis and Lung Disease, 3038 Kirchlindach, Switzerland (Hans.Rieder@tbrieder.org).

Clinical Infectious Diseases 2009;48:996
© 2009 by the Infectious Diseases Society of America. All rights reserved. 1058-4838/2009/4807-0023$15.00 DOI: 10.1086/597358