
Reply to Anderson

To the Editor—In response to the letter by Anderson [1] entitled “Rotavirus G9 Severity Data Revisited,” I would like to take this opportunity to address his comments. I agree that it is scientifically valid to consider the entire intention-to-treat cohort when assessing the disease severity associated with infection with individual rotavirus strains. Accordingly, a preliminary reanalysis of the intention-to-treat data from placebo recipients has been conducted. This analysis includes all cases of rotavirus gastroenteritis in our study that occurred between the first and second dose of placebo, cases of rotavirus gastroenteritis that occurred within the first 2 weeks after receipt of dose 2, and all cases that occurred from 2 weeks after administration of dose 2 up to 1 year of the patient’s age, but it excludes the 2 second episodes in the 2 infants who experienced them, as previously documented [2]. The median severity of illness (according to the Vesikari severity score) was 11 for rotavirus serotype G1 (hereafter referred to as G1) infection and 14 for rotavirus serotype G9 (hereafter, G9) infection, the difference between which was found to be statistically significant (P = .009). This reanalysis supports our original observations [2, 3]: that more-severe disease is associated with infection with G9.

Recent data support the growing epidemiological importance of G9 in rotavirus disease [4], and experience with human rotavirus vaccine clinical trials has also shown a high incidence of circulating G9 (e.g., up to 60% in Brazil) [2, 5]. Thus, rotavirus vaccines will need to demonstrate efficacy against this serotype. Results of clinical trials of the human rotavirus vaccine have shown high efficacy against G9 in Latin America (90% efficacy against severe disease due to G9); these findings have also recently been confirmed in a trial conducted in a European setting (95% efficacy against severe disease due to G9) [5].

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Potential conflicts of interest. A.C.L.: no conflicts.

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References


Pandemic Influenza Outbreak Planning in Seattle

To the Editor—The News section of the 1 August 2006 issue of Clinical Infectious Diseases [1] includes a reprinted Reuters article dated 7 June 2006 and entitled “U.S. States Plan How to Handle Pandemic Flu Threat” that contains inaccurate information regarding recommendations reportedly being made by Public Health–Seattle and King County (Seattle, WA). Specifically, the article states that, “And in Washington State, the King County public health department in Seattle has warned people that if body bags and refrigerated trucks are in short supply, influenza victims should be buried in backyards, provided that the graves are far from septic systems” [1, pg. iv].

This is not a recommendation Public Health–Seattle and King County has made or will make during a pandemic influenza outbreak or during any other mass-fatality incident. We do not and will not recommend or condone burying of the deceased on private property (e.g., a backyard). This violates current Washington state law [2]. Furthermore, it is essential that every death be recorded and that a death certificate be filed with the county. Private, unauthorized disposition would preclude both of the above.

Public Health–Seattle and King County is currently planning how to properly manage the increased number of deaths that might occur during a pandemic influenza outbreak. In all of our fatality-management planning for pandemic influenza and other multiple-fatality events,

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