Correspondence

Rapid Diagnostic Tests for a Coordinated Approach to Fever Syndromes in Low-Resource Settings

To the Editor—We read with interest the editorial commentary by Crump [1], which emphasizes the need for a syndromic approach to fever in low-resource settings—citing 2 recent epidemics of *Salmonella* Typhi [2, 3], the decreasing proportion of malaria-attributable illness in many areas, and changing vaccination patterns as arguments. We strongly agree with this point and wish to emphasize the role of microbiologic diagnostic tests in this process.

Although the benefits of parasitologic diagnosis of malaria are widely emphasized [4], using malaria diagnosis alone as the cornerstone of linking febrile patients to appropriate care is dangerous. For example, the Institute of Tropical Medicine, Antwerp, was recently asked for assistance by colleagues in the remote Bwamanda health zone of the Democratic Republic of the Congo, which was facing an outbreak of severe malarial anemia in the second half of 2011. A dramatic increase in blood transfusion requirements and in-hospital mortality was observed among children <5 years of age with parasitologically confirmed malaria. Intensified surveillance of bloodstream infections in December 2011 via the national reference laboratory in Kinshasa recovered 57 nontyphoidal *Salmonella* isolates among 135 blood cultures in severely ill children (42%). This large unrecognized outbreak of severe disease from a clonal strain of *Salmonella* illustrates the pitfalls of focusing on a single pathogen, such as malaria, in patients presenting with febrile illnesses in low-resource settings.

Further, widespread adoption of malaria rapid diagnostic tests (RDT) has resulted in dramatic increases in empiric antibacterial use among the three-quarters of febrile patients in whom no malaria is found [5]. This dichotomous diagnostic approach can only fuel emerging antimicrobial resistance in the settings that can least afford it [6].

Choosing rational empiric therapy for patients with febrile syndromes in low-resource settings is complicated by the fact that a large proportion of them may be caused by any of several geographically restricted infections and neglected tropical diseases, such as tick-borne borreliosis [7], visceral leishmaniasis [8], and human African trypanosomiasis. Such infections are severe and treatable but often clinically indistinguishable without confirmatory tests. Making matters worse, very little epidemiologic data underpin clinicians’ assessment of prior probability in vast areas of Africa and Asia.

A syndromic approach to patients with fever that integrates relevant combinations of RDT is urgently needed in many parts of the world. This will require (1) comprehensive epidemiologic studies using reference standard techniques to determine the prevalence of priority diseases that are severe and treatable; (2) validation of existing RDT in field settings and development of new RDT for key pathogens of epidemiologic importance; and (3) evidence-based algorithms incorporating local epidemiological data and setting-specific RDT diagnostic contributions, because the latter can vary substantially by locality [9, 10].

We are working as part of the EU-funded NIDIAG (Neglected Infectious Disease dIAgnosis) consortium to develop such an approach to persistent fever in 4 low-resource countries, with the aim of achieving patient-centered care pathways that will accelerate diagnosis and improve outcomes.

Notes

Financial support. The NIDIAG consortium is supported by the European Commission under the Health Cooperation Work Programme of the 7th Framework Programme (FP7).

Potentially conflicts of interest. All authors: No reported conflicts.

All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

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References


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Clinical Infectious Diseases 2012;55(4):610–1

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DOI: 10.1093/cid/cis466