Correspondence

Is Cotrimoxazole Prophylaxis Effective to Prevent Malaria in HIV-Infected Pregnant Women?

TO THE EDITOR—We read with great interest the article by Klement et al. [1] describing a noninferiority trial of cotrimoxazole (CMX) prophylaxis vs sulfadoxine-pyrimethamine intermittent preventive treatment (IPT-SP) against malaria in human immunodeficiency virus (HIV)–infected pregnant women. In this study, they found that prophylaxis with CMX alone was not inferior to the association of CMX and mefloquine IPT on placental infection in women with a CD4 count <350 cells/µL, indicating that CMX used alone provides adequate protection in this population.

Moreover, no information is provided on the details of trial implementation. For instance, given that the median number of antenatal visits was 2 in the IPT group, it would be valuable to know which proportion of women actually received the 3 doses of SP. As a result, it is not clear what is the population of women who fully complied with the protocol and should be included in the per protocol (PP) analysis. Only after a careful reading could we hypothesize that “PP analysis” here was more probably an intention-to-treat (ITT) analysis using the last observation carried forward method. This confusion is problematic for the interpretation of data, because in noninferiority design, the conclusions should rely on both ITT and PP analysis [3].

In summary, it seems difficult to draw definitive answers from this trial, and we agree with the authors’ conclusions that further research is needed to confirm the effectiveness of CMX to prevent malaria in pregnancy in HIV-infected pregnant women. The randomized controlled trial we recently conducted in Benin [7] showed that prophylaxis with CMX alone was not inferior to the association of CMX and mefloquine IPT on placental infection often remain asymptomatic, though women in areas of high malaria transmission often remain asymptomatic, though infection often remain asymptomatic, though women in areas of high malaria transmission are frequently not detected in the peripheral blood [5]. Additionally, pregnant women in areas of high malaria transmission often remain asymptomatic, though this might be modulated by HIV infection [6].

In summary, it seems difficult to draw definitive answers from this trial, and we agree with the authors’ conclusions that further research is needed to confirm the effectiveness of CMX to prevent malaria in pregnancy in HIV-infected pregnant women. The randomized controlled trial we recently conducted in Benin [7] showed that prophylaxis with CMX alone was not inferior to the association of CMX and mefloquine IPT on placental infection in women with a CD4 count <350 cells/µL, indicating that CMX used alone provides adequate protection in this population.

Note

Potential 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.

Lise Denoeud-Ndam,1,6 Valérie Briand,1 Djimon M. Zannou,2,3, Pierre-Marie Girard,4,5 and Michel Cot1,6

1UMR 216, Institut de Recherche pour le Développement, Paris, France; 2Centre de Traitement Ambulatoire, Centre National Hospitalier Universitaire Hubert Koutoukou Maga, Cotonou, and 3Faculté des Sciences de la Santé, Université d’Abomey-Calavi, Benin; and 4Service des Maladies Infectieuses et Tropicales, Hôpital Saint-Antoine, APHP, 5INSERM U707, Université Pierre et Marie Curie, and 6Université Paris Descartes, Paris, France

References


*Present affiliation: Clinical Research Department, Epicentre, Paris, France.
Correspondence: Lise Denoeud-Ndam, MD, PhD, UMR 216, Faculté de Pharmacie, 4 avenue de l’Observatoire, 75270 Paris Cedex 06, France (lisedenoeud@yahoo.fr).

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