Reply to Denoeud-Ndam et al

To the Editor—We thank Denoeud-Ndam and colleagues for their comments [1] regarding our article describing a non-inferiority trial of cotrimoxazole (CMX) prophylaxis vs sulfadoxine-pyrimethamine intermittent preventive treatment (IPT-SP) against malaria in human immunodeficiency virus (HIV)–infected pregnant women with a CD4 count >200 cells/µL [2].

Most of the limitations were raised in the Discussion section of our article, such as the sample size. The choice of clinical malaria rather than placental infection as primary outcome was made because we estimated that exhaustive placental histological examination was not realistic in the field conditions. However, we evaluated as a secondary outcome placental histology, and we achieved 52.4% of results, which was already a great challenge. Our results showed no significant difference in placental infection between the CMX and IPT-SP groups. Furthermore, prematurity, still births, and low birth weight (LBW) rates were similar in both groups. Mean birth weights were similar to those of the general population in the area. Of note, LBW is a biased indicator of the consequence of gestational malaria, as both HIV and anemia are also associated with increased risk of LBW.

A lower CD4 cell count at baseline and a longer follow-up duration in the CMX group disadvantaged CMX prophylaxis, by leading to an underestimated effect on malaria incidence in HIV-infected pregnant women. On the other hand, SP efficacy is probably being underestimated as only few women had received 3 doses during their pregnancy, thus reflecting real life in the rural and semirural African context, where Plasmodium falciparum malaria prevails.

This trial alone cannot definitively answer the question of whether cotrimoxazole prophylaxis is effective to prevent malaria in HIV-infected pregnant women. However, we believe that it helps to fill an important evidence gap regarding the effectiveness of CMX to prevent malaria in this specific population, and its consequences in their offspring.

CMX is the one drug that is cheap and readily available for free for most HIV-infected patients, which could help to prevent not only malaria but other opportunistic infections. In our opinion, CMX should be given to all HIV-infected pregnant women in sub-Saharan Africa.

Note

Potential conflicts of interest. Both authors: No potential conflicts of interest.

Both 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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