Relapses Contribute Significantly to the Risk of Plasmodium vivax Infection and Disease in Papua New Guinean Children 1–5 Years of Age

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Background. Plasmodium vivax forms long-lasting hypnozoites in the liver. How much they contribute to the burden of P. vivax malaria in children living in highly endemic areas is unknown.

Methods. In this study, 433 Papua New Guinean children aged 1–5 years were Randomized to receive artesunate (7 days) plus primaquine (14 days), artesunate alone or no treatment and followed up actively for recurrent Plasmodium infections and disease for 40 weeks.

Results. Treatment with artesunate-primaquine reduced the risk of P. vivax episodes by 28% (P = .042) and 33% (P = .015) compared with the artesunate and control arms, respectively. A significant reduction was observed only in the first 3 months of follow-up (artesunate-primaquine vs control, −58% [P = .004]; artesunate-primaquine vs artesunate, −49% [P = .031]) with little difference thereafter. Primaquine treatment also reduced the risk of quantitative real-time polymerase chain reaction– and light microscopy–positive P. vivax reinfections by 44% (P < .001) and 67% (P < .001), respectively. Whereas primaquine treatment did not change the risk of reinfection with Plasmodium falciparum, fewer P. falciparum clinical episodes were observed in the artesunate-primaquine arm.

Conclusions. Hypnozoites are an important source of P. vivax infection and contribute substantially to the high burden of P. vivax disease observed in young Papua New Guinean children. Even in highly endemic areas with a high risk of reinfection, antihypnozoite treatment should be given to all cases with parasitologically confirmed P. vivax infections.

In areas that are coendemic for Plasmodium falciparum and Plasmodium vivax, the burden of infections and disease caused by P. vivax peaks at an earlier age than that due to P. falciparum [1–6]. In Papua New Guinea (PNG), highly endemic for malaria caused by all 4 Plasmodium species that infect humans [7], P. vivax is the most common cause of malarial illness in infants [8] and toddlers [9], but its incidence decreases rapidly after that age and clinical disease is rare in children >5 years old [3], even though P. vivax infections remain common throughout childhood and into adulthood [10, 11]. The burden of P. falciparum, on the contrary, continues to rise through early childhood, with incidence of P. falciparum malaria peaking in children 3–7 years old [9, 12, 13] and P. falciparum infections remaining prevalent in school-aged children [10, 11].

In PNG, P. vivax and P. falciparum are transmitted by the same mosquito vectors and studies in different PNG lowlands population reported comparable sporozoite rates for P. falciparum and P. vivax in the local vector populations [3, 14, 15]. An important characteristic of P. vivax is related to its capacity to generate long-lasting liver stages (ie, hypnozoites) that after varying periods of dormancy [16] can cause relapsing malaria infection and clinical disease. As a consequence of this ability, a single mosquito inoculation may result in several blood-stage infections, during the
Malaria transmission is moderately seasonal, with transmission peaking in the early wet season (i.e., December through March) [25]. The study area is serviced by a single health sub-center and an aid post. A more detailed description of the study areas is given elsewhere [9].

All children aged 1–5 years living in study villages, whose parents consented to their participation, were tested for G6PD deficiency (OSSMR-D G6PD Assay; R&D Diagnostics). All G6PD-normal children were subsequently randomized to 1 of the 3 groups: (1) artesunate (4 mg/kg/d for 7 days) plus primaquine (0.5 mg/kg/d for 14 days), (2) artesunate alone (4 mg/kg/d for 7 days), or (3) no treatment (control). Owing to a concurrently ongoing mass-distribution of long-lasting insecticide-treated nets (LLINs), which resulted in nearly universal LLINs coverage, treatment of the cohort was delayed until after the LLIN campaign finished in early April 2008.

Immediately before treatment administration, children were assessed for symptoms of febrile illness, a detailed history of bed net use and recent antimalarial treatment was obtained, and a venous blood sample was collected for immunological and molecular studies. Children in control and artesunate arms found to be parasitemic were treated with artemether-lumefantrine (Coartem; Novartis). All treatment doses for the cohorts were administered as direct observed therapy and monitored for side effects.

After completion of treatment children were followed up for the presence of febrile illness actively every 2 weeks and passively throughout the study at the local health center and aid post for the duration of the follow-up (40 weeks). Finger-prick blood samples were collected every 2 weeks for the first 12 weeks and every 4 weeks thereafter from all children seen during active follow-up (active detection of infection, see Supplementary Figure 1). Malaria infection was investigated in all symptomatic children using a rapid diagnostic test (RDT) for malaria (ICT Diagnostics) and 250-µL finger-prick blood samples were collected for confirmation of infection by light microscopy (LM), and quantitative real-time polymerase chain reaction (qPCR). Only RDT-positive and LM-confirmed, RDT-negative symptomatic children were treated with artemether-lumefantrine. All other illness episodes detected were referred to local health center and treated in accordance with PNG treatment guidelines.

The study received ethical clearance by the PNG Institute of Medical Research Institutional Review Board (IRB 07.20) and the PNG Medical Advisory Committee (07.34).

Laboratory Methods
All blood films were read independently by 2 expert microscopists. Slides with discrepant results were reread by a third microscopist. Thick blood films were examined for 100 thick-film fields (under ×100 oil immersion lens) before being declared negative for infection. Parasite densities were recorded following months or even years. Although such relapsing infections are an important source of illness in nonimmune travelers [17], it is unclear how much they contribute to the burden of *P. vivax* malaria in perennially exposed children living in (highly) endemic countries.

Currently primaquine is the only licensed radical treatment for hypnozoites [18, 19]. Because of the concern that primaquine can cause potentially life-threatening hemolysis in Glucose-6-phosphate dehydrogenase (G6PD)-deficient individuals [20], the lack of reliable parasitological diagnosis at most PNG health facilities, and the prevailing perception that given the high transmission level treating hypnozoites may be of little benefit, meant that primaquine treatment was not formally adopted as part of the PNG treatment guidelines until 2010. As a consequence, up to 87% of children with *P. vivax* malaria experience a recurrent *P. vivax* infection within 6 weeks of treatment [21] with approximately 25% of these infections associated with clinical symptoms. It has been suggested that relapses are responsible for the vast majority of these recent infections [22] and that in addition to being the predominant cause of blood-stage infections, they may contribute significantly to *P. vivax* clinical malaria and transmission [16].

The development of high-throughput genotyping methods [23, 24] has greatly increased our ability to study the longitudinal dynamics of *P. falciparum* infections [25, 26] and differentiate new from ongoing or recrudescence infections [27, 28]. Although similar methods now exist for *P. vivax* [29], genotyping cannot differentiate relapses from new infections [30], because relapses are usually genetically distinct from the primary infection [31, 32]. It is therefore not possible to directly quantify the contribution of relapses to the burden of *P. vivax* reinfection and disease by genotyping individual infections in longitudinal studies of participants living in areas of high transmission and thus high reinfection risk. Such a direct estimation is possible only with use of an imaginative study design, wherein relapses are deliberately prevented in a portion of study subjects. Therefore, to assess the contribution of hypnozoites to the burden of *P. vivax* reinfection and disease, we conducted a longitudinal cohort study in children aged 1–5 years old in a hyperendemic area of PNG, where we selectively treated preexisting hypnozoites in a subset of the children.
as the number of parasites per 200 white blood cells and converted to parasites per microliter of blood, assuming counts of 8000 white blood cells/µL [33]. Slides were scored as LM positive for an individual Plasmodium species if the species was detected independently by ≥2 microscopists and/or if subsequent qPCR diagnosis confirmed the presence of the species. Densities were calculated as the geometric mean densities of all positive readings.

Plasma and peripheral blood mononuclear cells were collected from all venous blood samples. The remaining red blood cells were pelleted and aliquoted. Finger-prick blood samples were separated into plasma and cell pellets. DNA was extracted from the cell pellet fraction of all samples using the QIAamp 96 DNA Blood kit (Qiagen), and Plasmodium sp. infections were detected using a 4-species qPCR assay [34].

**Statistical Analyses**

For analysis purposes, clinical malaria was defined as fever (axillary temperature ≥37.5°C) or history of febrile illness within the last 48 hours in the presence of a concurrent Plasmodium sp. infection of any density or P. falciparum >2500/µL and P. vivax >500/µL [35]. The associations between the incidence of clinical malaria and treatment as well as other covariates were assessed by negative binomial regressions. Children were considered at risk from the first day after the last primaquine or artesunate dose until they withdrew, were lost to follow-up, or completed the study. Children were not considered at risk for 14 days after each recurring or new episode. The time to the first P. vivax episode or infection and its association with treatment and covariates were modeled using Cox regression and the proportional-hazards assumption was checked using the test based on the Schoenfeld residuals. The log-rank test was used to test differences between survival curves. In all survival analyses, children were considered at risk until they reached the end point of interest, withdrew, were lost to follow-up or completed the study. Differences between treatment groups at baseline were investigated using $\chi^2$ and Fisher’s exact tests for categorical characteristics and the Kruskal–Wallis test for continuous variables. Tests were 2 tailed, and the confidence level was set at 95%. All analyses were performed using Stata 12 software (StataCorp 2011, release 12; StataCorp).

**RESULTS**

Of 463 children screened, 449 (97.0%) G6PD-normal children were randomized to artesunate (7 days), artesunate plus primaquine (14 days), or no treatment (Figure 1). Sixteen children were withdrawn from the study or migrated out of the study area between randomization (late January) and the start of the study (mid-April). Therefore, a total of 433 children 1.1–5.6 years old were treated and followed up actively and passively for 40 weeks.

![Figure 1](https://academic.oup.com/jid/article-abstract/206/11/1771/896374)
No significant differences in demographic characteristics and infection status were observed at baseline (ie, before the start of treatment) between treatment groups, nor was there any difference in the distribution of children in each group among study villages (Table 1). There was a tendency for a higher LLIN use in the artesunate group than in the artesunate-primaquine and control groups (P = .053) at baseline. Reported rates of LLIN use during follow-up were comparable between the 3 treatment arms (Table 2).

During follow-up, 92% (range 74%–98%; interquartile range [IQR], 92%–95%) of children were seen at active detection of infection time points (Figure 1). There was no difference in the average number of study contact between treatment arms (likelihood-ratio (LR), 0.21; df = 2; P = .74).

During 40 weeks of follow-up, a total of 271 febrile episodes with *P. vivax* of any density (incidence rate [IR], 0.89) and 115 episodes with *P. vivax* >500/µL (Incidence rate [IR], 0.37) were detected; 132 children (30%) had 1 *P. vivax* malaria episode (any density), and 60 (14%) had ≥2 episodes (maximum, 4). The incidence of *P. vivax* malaria decreased strongly with age (Incidence rate ratio [IRR] for *P. vivax* episodes of any density, 0.81 [95% confidence interval (CI), .73–.91; P < .001]; IRR for *P. vivax* >500/µL, 0.60 [95% CI, .50–.72; P < .001]) and varied between villages (LR for episodes of any density, 16.0; df = 8; P = .042).

The incidence of *P. vivax* malaria of any density differed significantly between the 3 treatment arms (Table 2). Treatment with artesunate-primaquine reduced the risk of *P. vivax* episodes of any density during 40 weeks of follow-up by 28% (95% CI, 1%–52%; P = .042) compared with the artesunate arm and by 33% (95% CI, 8%–52%; P = .015) compared with the control arm. The differences were almost entirely due to a strong reduction in incidence in the first 3 months of follow-up (Figure 2) (IRR for artesunate-primaquine vs control, 0.42 [95% CI,.23–.76; P = .004]; IRR for artesunate-primaquine vs artesunate, 0.51 [95% CI, .27–.94; P = .031]), with little or no difference during the rest of the follow-up (Table 2). In multivariate analyses, only treatment and age were significant predictors of risk of malaria, and adjustment for age did not alter the observed differences between treatment arms (Supplementary Table 1). Similar differences were observed for the time to first or only *P. vivax* episode (Table 2; Figure 2). Interestingly, neither treatment resulted in a significant reduction in the incidence of *P. vivax* malaria episodes with a density >500/µL (Table 2).

In children in the artesunate-primaquine and artesunate arms who successfully cleared preexisting blood-stage infections, differences in the time to first *P. vivax* infection were investigated (Table 3; Figure 2). When diagnosed with qPCR, new *P. vivax* blood-stage infections were detected very rapidly, with 50% of children in artesunate and artesunate-primaquine groups infected by day 23 (IQR, 14–30 days) and day 30 (IQR, 15–56 days), respectively. It took significantly longer until infection became patent by LM, with the difference between treatment arms becoming even more pronounced (median, 29 days for artesunate [IQR, 16–55 days] vs 78 days for artesunate-primaquine [IQR, 42–280]). Overall, the elimination of liver stages through primaquine treatment was found to reduce the risk of qPCR- and LM-positive recurrent blood-stage parasitemia by 44% (95% CI, 28%–57%; P < .001) and 67% (95% CI, 55%–75%; P < .001), respectively. The risk of *P. vivax* parasitemia did not vary with age (LR for qPCR, 1.93 [df = 1; P = .16]; LR for LM, 0.53 [df = 1; P = .47]) but differed significantly among children living in different villages.

### Table 1. Demographic and other Key Characteristics of Treatment Groups Before Start of Treatment

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Artesunate</th>
<th>Artesunate-Primaquine</th>
<th>Control</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male patients, No.</td>
<td>75</td>
<td>52</td>
<td>68</td>
<td>49</td>
</tr>
<tr>
<td>Age, mean (SD), y</td>
<td>3.1 (1.1)</td>
<td>3.2 (1.2)</td>
<td>3.3 (1.2)</td>
<td>3.3 (1.2)</td>
</tr>
<tr>
<td>Village of residence, No. (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utamup</td>
<td>12</td>
<td>8</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Utamup</td>
<td>38</td>
<td>26</td>
<td>28</td>
<td>20</td>
</tr>
<tr>
<td>Utamup</td>
<td>133</td>
<td>94</td>
<td>120</td>
<td>86</td>
</tr>
<tr>
<td>Abbreviation: SD, standard deviation.</td>
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(LR for qPCR, 19.1 \([df=8; P=.008]\); LR for LM, 49.4 \([df=8; P<.001]\)). Adjustment for village differences did not significantly change the treatment effects.

The treatment had no significant effect on the likelihood of being reinfeeted with *P. falciparum*, as detected with either qPCR (Table 3) \((P=.85)\) or LM \((P=.40)\). During follow-up, only 158 children experienced febrile episodes with any concurrent *P. falciparum* parasitemia (IR, 0.51), and 95 with *P. falciparum >2500/µL* (IR, 0.30). Thirty children had >1 *P. falciparum* episode (any density). Children in the artesunate-primaquine arm were significantly less likely to become ill with *P. falciparum* malaria than those in the control arm (Table 2) (IRR for all *P. falciparum*, 0.51 \([95\% \text{ CI}, .32–.81; P=.004]\); IRR for *P. falciparum >2500/µL*, 0.53 \([95\% \text{ CI}, .31–.89; P=.018]\)), but not those in the artesunate arm (all *P. falciparum*, \(P=.61\); *P. falciparum >2500/µL*, \(P=.22\)). The incidence of *P. falciparum* malaria of any density varied significantly among villages \((P<.001)\) but showed no association with age \((P=.86)\), whereas *P. falciparum >2500/µL* showed a nonlinear association with age \((P=.005)\) but did not vary among villages. Adjustment for village of residence or age did not significantly change the associations of treatment with incidence of *P. falciparum* malaria (data not shown).

**DISCUSSION**

By selectively removing liver stages from some but not all children, we demonstrated that relapses cause approximately 50% of infection and more than 60% of clinical episodes in the first 3 months of follow-up, with little effect thereafter. The Chesson strain of *P. vivax* \([36]\) that is present in the Southwest Pacific is known to have a short relapse frequency

| Table 2. Incidence of *Plasmodium vivax* and *Plasmodium falciparum* Malaria in Treatment Groups |
|----------------------------------|------------------------------------------|------------------------------------------|------------------------------------------|------------------------------------------|
|                                  | Placebo                                  | Artesunate                               | Artesunate-Primaquine                     |
|                                  | Events | PYR | Incidence | Events | PYAR | Incidence | IRR (95% CI) | Events | PYAR | Incidence | IRR (95% CI) | \(P\)     |
| *P. vivax* malaria               |                                  |                                          |                                          |                                          |
| Any density                      |                                  |                                          |                                          |                                          |
| 9-mo follow-up                   | 105    | 102.2 | 1.03     | 99     | 103.9 | 0.93      | 0.91 (0.69–1.24) | 67     | 97.8 | 0.69      | 0.67 (0.48–0.92) | .037     |
| 0–3 mo                           | 37     | 33.3  | 1.11     | 31     | 33.9  | 0.91      | 0.82 (0.51–1.31) | 15     | 32.3 | 0.46      | 0.42 (0.23–0.76) | .009     |
| >3 to 9 mo                       | 68     | 68.9  | 0.99     | 68     | 70.0  | 0.97      | 0.98 (.70–1.39) | 52     | 65.4 | 0.76      | 0.81 (.56–1.16)  | .446     |
| *P. vivax >500/µL*               |                                  |                                          |                                          |                                          |
| 9-mo follow-up                   | 42     | 104.6 | 0.40     | 42     | 106.1 | 0.40      | 0.98 (.62–1.57) | 31     | 99.1 | 0.31      | 0.78 (.47–1.28)  | .549     |
| *P. falciparum* malaria          |                                  |                                          |                                          |                                          |
| Any density                      |                                  |                                          |                                          |                                          |
| 9-mo follow-up                   | 69     | 103.6 | 0.67     | 55     | 105.4 | 0.52      | 0.79 (.52–1.18) | 34     | 98.9 | 0.34      | 0.51 (.32–.81)  | .015     |
| 0–3 mo                           | 11     | 34.4  | 0.32     | 8      | 34.9  | 0.23      | 0.71 (.28–1.83) | 2      | 32.9 | 0.06      | 0.19 (.04–.87)  | .041     |
| >3 to 9 mo                       | 58     | 69.2  | 0.84     | 47     | 70.6  | 0.67      | 0.80 (.51–1.25) | 32     | 66.0 | 0.48      | 0.57 (.35–.94)  | .083     |
| *P. falciparum >2500/µL*         |                                  |                                          |                                          |                                          |
| 9-mo follow-up                   | 42     | 104.6 | 0.40     | 32     | 106.3 | 0.30      | 0.75 (.47–1.20) | 21     | 99.5 | 0.21      | 0.53 (.31–.89)  | .053     |
| **First or only malaria episode**|                                  |                                          |                                          |                                          |
| *P. vivax*, any density          |                                  |                                          |                                          |                                          |
| 73                               | 73.3  | 1.00  |          | 74     | 78.1  | 0.95      | 0.95 (.69–1.31) | 45     | 82.2 | 0.55      | 0.55 (.38–.80)  | <.001    |
| *P. vivax >500/µL*               | 34     | 91.8  | 0.37     | 35     | 92.3  | 0.38      | 1.04 (.59–1.83) | 25     | 90.3 | 0.28      | 0.70 (.38–1.29) | .379     |
| *P. falciparum*, any density     | 50     | 88.0  | 0.57     | 39     | 92.7  | 0.42      | 0.74 (.49–1.13) | 30     | 90.6 | 0.33      | 0.58 (.37–.92)  | .017     |
| *P. falciparum >2500/µL*         | 35     | 94.4  | 0.37     | 29     | 96.4  | 0.30      | 0.81 (.50–1.33) | 19     | 94.8 | 0.20      | 0.54 (.31–.95)  | .085     |

Abbreviations: IRR, ; PYAR, ; PYR.
Figure 2. Time to first *Plasmodium vivax* clinical episode (any density) and reinfection as demonstrated by quantitative real-time polymerase chain reaction (qPCR) and light microscopy (LM). Differences between groups were tested by log-rank tests.
Figure 3. Time to first Plasmodium falciparum clinical episode (any density) and reinfection as demonstrated by quantitative real-time polymerase chain reaction (qPCR) and light microscopy (LM). Differences between groups were tested by log-rank tests.
The demonstrated large contribution of relapses to the burden of \textit{P. vivax} infections and (mild) disease not only leads to a better understanding of \textit{P. vivax} epidemiology but also has important implications for clinical practice and formulation of treatment guidelines. The high rate of relapses is almost certainly the principal reason for the higher prevalence,
multiplicity, and incidence of *P. vivax* infection and disease in early childhood [8, 9, 39], contributing substantially to the much faster acquisition of immunity to *P. vivax* compared with *P. falciparum* [3]. Furthermore, relapses may significantly contribute to transmission, because *P. vivax* gametocytes closely follows asexual parasitemia. It will therefore be difficult to achieve a sustained reduction in *P. vivax* transmission, leading to local elimination, without targeting the hypnozoite reservoir [42, 43]. Although relapses seem to be predominantly associated with mild disease, without appropriate antirelapse therapy, children will be exposed to chronic blood-stage infections (or reinfections) with *P. vivax* that can lead to severe anemia in their cumulative effect [44, 45].

These findings have important public health relevance: even in areas with intense transmission and thus high risk of reinfection, strong efforts should be made to eradicate *P. vivax* hypnozoites in all cases of parasitologically confirmed *P. vivax* infection. The only currently available drug that effectively attacks the dormant hepatic reservoir is primaquine. Although the effect of primaquine against hypnozoites has been known for >50 years [18] and radical cure with primaquine is part of World Health Organization and many national treatment guidelines [19], concerns about its safety in persons with (severe) G6PD deficiency have hampered its programmatic implementation. The recent development of RDTs that specifically detect *P. vivax* will facilitate the recognition and diagnosis of this species. Poor adherence to the current 14-day primaquine schedule, the lack of therapeutic alternatives, and the lack of reliable, point-of-care (rapid) tests for G6PD deficiency remain major obstacles, which urgently need to be addressed if the recent reductions in global *P. vivax* burden are to be sustained and local elimination achieved [43, 46].

### Supplementary Data

Supplementary materials are available at The Journal of Infectious Diseases online (http://jid.oxfordjournals.org/). Supplementary materials consist of data provided by the author that are published to benefit the reader. The posted materials are not copypedited. The contents of all supplementary data are the sole responsibility of the authors. Questions or messages regarding errors should be addressed to the author.

### Notes

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