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SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Falciparum malaria resistant to chloroquine: implications for prophylaxis

SIR,—The report by Dr C Herzog and others (1 October, p 947) of resistant *Plasmodium falciparum* malaria from east Africa has prompted us to report that we have recently seen three such cases and to comment on recommendations for prophylaxis. R I and R II chloroquine resistant *P falciparum* (WHO classification) have been recognised in east Africa for several years, and there have been at least three recent reports of well documented R III chloroquine resistant *P falciparum* malaria acquired in that region.[1-3] This prompted the Centers for Disease Control in the United States to revise the recommendations for malaria chemoprophylaxis of travellers to east Africa, now advising the combination of chloroquine and Fansidar (pyrimethamine 25 mg and sulfadoxine 500 mg).[4] In contrast, for several reasons, but mainly because of the scarcity of reports of high level chloroquine resistant *P falciparum* on the one hand and of the fear of development of Fansidar resistance on the other hand, the World Health Organisation (WHO) still recommends chloroquine as sole prophylactic agent for travellers in that region, advising, however, that, "persons under regular chloroquine prophylaxis should carry as a precaution a treatment dose of Fansidar, to be taken if fever occurs."[5]

Our three patients all had severe *P falciparum* malaria acquired in Kenya while they were taking chloroquine but not Fansidar prophylaxis. All gave a reliable history of meticulous daily chloroquine prophylaxis with a rather high total dose of 700 mg of chloroquine base per week. Adequate intake and absorption was also proved by the serum chloroquine concentrations (performed in Hoffmann la Roche Laboratory, Basle, by courtesy of Ms Renée Portmann), which were within the therapeutic range of 31-310 nmol/l (10-100 μg/l) for sensitive strains,[2 3] but were nevertheless insufficient to prevent a "breakthrough." Although the parasites could unfortunately not be cultivated and tested in vitro, the serum chloroquine concentrations at which these "breakthroughs" occurred are consistent with a high level of chloroquine resistance, similar to that of the recently isolated R III resistant strains.[1 2]

Our three cases were observed over a short period of time at one hospital. They show that a high level of resistance is probably no longer a rarity in east Africa and, in view of the increasing frequency of similar reports, we believe that chloroquine can no longer be the sole prophylactic agent for non-immune travellers to that region, as still recommended by the WHO.[5] As Fansidar resistance has also emerged in this part of the world, as described by Dr Herzog and his colleagues and by Eichenlaub *et al*,[6] and as *P vivax* attacks might not be adequately prevented by Fansidar alone[7] the association of Fansidar and chloroquine appears to be the best regimen for the prophylaxis of malaria in travellers in this part of the world, unless specific contraindications are present.

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1 Weniger BG, Blumberg RS, Campbell CC, *et al.* High level chloroquine resistance of Plasmodium falciparum malaria acquired in Kenya. *N Engl J Med* 1982;**307**:1560-2.
2 Stuby K, Gorecka M, van Schulthess F, Reber-Liske R. Ein Fall von chloroquinresistenter Malaria tropica aus Ostafrika (Kenia). *Schweiz Med Wochenschr* 1983;**113**:258-60.
3 Chulay J, Spencer HC, Warshow MM, *et al.* Chloroquine-resistant falciparum malaria. *N Engl J Med* 1983;**308**:781.
4 Centers for Disease Control. Revised recommendations for malaria chemoprophylaxis for travellers to East Africa. *MMWR* 1982;**31**:328-30.
5 World Health Organisation. Malaria chemoprophylaxis. *Weekly Epidemiological Record* 1982;**57**: 381-4.
6 Eichenlaub D, Rogler G, Hoffmann HG, Weise HJ. Falciparum malaria despite pyrimethamine/sulfadoxine prophylaxis in five tourists to East Africa. *Lancet* 1982;ii:1041-2.
7 Leilijveld J. Problems with pyrimethamine/sulfadoxine malaria prophylaxis. *Lancet* 1982;i:915.

Stillbirth: a personal experience

SIR,—Dr R J L Oglethorpe's personal paper (22 October, p 1197) emphasised the tragedy of stillbirth and the helplessness of women and their partners in the face of this totally unexpected event. Even when unavoidable, perinatal death challenges obstetricians, paediatricians, and midwives with their apparent failure to ensure the survival of a healthy child. It is therefore not surprising that the care of the parents is handled so poorly in many units.

One way in which this problem may be overcome is by familiarising medical and nursing staff of all grades with the correct and humane approach to the care of the parents and with all the procedures to be followed after stillbirth, including the awkward problems of certification and of arrangements for burial. These guidelines form one section of the protocol for the labour ward at this hospital, ensuring uniformity of approach by staff and avoidance of confusion for the parents and providing an opportunity for them to consider their options in advance, rather than having to take hurried decisions on matters such as whether or not to see the baby and where it should be buried.