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Authors’ reply

We thank Louisa Pollock and colleagues and David Southall and colleagues for their thoughtful comments, and particularly for highlighting current efforts to improve paediatric emergency and critical care in limited-resource settings.

Pollock and colleagues are in agreement with us that the evidence base for existing guidelines should be improved and that additional research is needed to address gaps in management and implementation. They also agree that these guidelines should include the entire continuum from Integrated Management of Childhood Illness to hospital care. We have proposed strengthening paediatric advanced life-support guidelines at varying levels of available resources with suggestions for appropriate resource substitutions. This includes integration of guidelines into existing primary care programmes in community settings, where early recognition of critical conditions and initiation of time-sensitive treatment has improved clinical outcomes, including reduced mortality in children younger than 5 years.

Pollock and colleagues also agree with the importance of a systematic approach to critically ill or injured children. We have characterised this systematic approach specifically in terms of patient assessment and categorisation of illness (by type and severity), which then drives appropriate triage and further management. We take the position that training in this systematic approach should be more widely disseminated if possible in the prehospital setting. We have acknowledged the efficacy of Emergency Triage Assessment and Treatment in reducing paediatric inpatient mortality where implementation has been feasible and are interested to learn about plans to regularly update these resources on the basis of current evidence, such as occurs in paediatric advanced life-support courses in high-income settings.

Finally, we agree with Pollock and colleagues about the priority of addressing barriers to guideline implementation and the caveats expressed by Southall and colleagues with respect to the implementation of paediatric emergency care training in limited-resource settings.

To achieve desired improvements in global paediatric advanced life-support training, management, and implementation, strong international collaboration is paramount. We believe such collaboration between like-minded groups can lead to regular evidence updates which can then guide us to our common goal—a significant reduction in global under-5 mortality.

The views expressed herein are those of the authors, and do not necessarily reflect the official policy or position of the Department of Defense, or the US Government. We declare that we have no conflicts of interest.

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High-risk drug practices in men who have sex with men

Tony Kirby and Michelle Thornber-Dunwell (Jan 12, p 101) highlight a “perfect storm” for HIV and hepatitis C transmission in high-risk drug practices in men who have sex with men (MSM). As part of an ongoing investigation of the continuing shigellosis epidemic in MSM in the UK, we did in-depth interviews that explored the lifestyle and sexual behaviour of 12 MSM diagnosed with Shigella flexneri serotype 3a.

Mephedrone, ketamine, crystal methamphetamine, and γ-butyrolactone had been used by most MSM (nine of 12) during sexual encounters. “Slamming” —a term probably used to reduce the social stigma of injecting recreational drugs—occurred at sex parties and was reported by two.

Drug use seemed linked to disinhibiting behaviour and pushing boundaries to seek new sexual experiences, including fisting and scat play. Condom use was rare, and most encounters were anonymous and arranged through internet sites. Most men (nine) were HIV positive (two who were negative are retesting), reported high numbers of sexual partners in the past year (median 60), and had had gonorrhoea (nine) and chlamydia (seven). A small number of infections of syphilis, lymphogranuloma venereum, and hepatitis C were also identified. Lymphogranuloma venereum and syphilis outbreaks have been reported...
in recent years in MSM with similar patterns in sexual behaviour, and the potential for further infectious disease outbreaks and HIV transmission is clear.4,5 Both HIV-positive and HIV-negative MSM need to be aware of the adverse effect of certain recreational drugs on their sexual health. HIV and sexual health clinicians should discuss recreational drug use with their patients and refer them to appropriate treatment services when indicated.

We declare that we have no conflicts of interest.

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In their report on the consequences of high-risk drug practices on the London gay scene, Tony Kirby and Michelle Thornber-Dunwellquote UK Health Protection Agency (HPA) data for incidence of HIV and hepatitis C virus (HCV) co-infection in men who have sex with men (MSM), which show a decrease from 7·38 per 1000 person-years in 2008 to 1·46 per 1000 person-years in 2011. However, as Kirby and Thornber-Dunwell also note, these figures could be a substantial underestimate and might even be increasing.

In its annual report on hepatitis C in the UK,7 the HPA makes only a brief reference to sexual transmission of HCV in HIV-positive MSM and instead focuses extensively on hepatitis C in intravenous drug users (IDUs). There is a danger of the HPA being complacent by ignoring issues relating to infection prevention in MSM in this key report. Although the prevalence of HCV among HIV-positive IDUs is higher than in HIV-positive MSM (83·7% vs 7·2%), in absolute numbers there are more MSM than IDUs known to be co-infected in the UK.3

Rates of HCV reinfection are particularly high in HIV-positive MSM in London compared with Hamburg (Germany) and Amsterdam (Netherlands).4 The National AIDS Trust5 considered it striking that there is no agreed strategic approach to the epidemiology of sexually transmitted hepatitis C in HIV-positive gay men in the UK, given the increasing importance of morbidity and mortality from liver disease in co-infected patients. The increase in high-risk drug practices described by Kirby and Thornber-Dunwell makes the need for a national strategy even more urgent.

We declare that we have no conflicts of interest.

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**Polio eradication: getting the basics right**

Your Jan 5 Editorial (p 1)1 argues for bringing polio eradication back on track in Pakistan through ensuring security for immunisation workers, going beyond the “polio only” agenda, and integration of polio vaccination into routine health and immunisation programmes. This viewpoint and other analyses2 have rightly highlighted the worsening security conditions and increasing inaccessibility to vaccination in Pakistan as the root cause of failure in polio eradication. Recent efforts by WHO also focused on significantly boosting the number of polio eradication officers at national, provincial, and district levels.

Yet this overall focus on polio, security, and winning hearts and minds has taken focus away from the role of the crumbling routine immunisation programme itself. Poor governance, corruption and staff absenteeism, and political instability and corruption have all weakened the public infrastructure through which polio eradication initiatives are delivered.3 Routine immunisation services fail to vaccinate nearly a third of children, and, in recent months, more than 200 babies have died in Sindh province from measles alone.4

Strengthening of the routine immunisation programme is crucial because: (1) it is not possible to provide security to 90 000 lady health workers during country-wide vaccination campaigns—they are an obvious soft target for terrorism; (2) in the run-up to the forthcoming parliamentary elections, polio does not have a big role; and (3) high-risk population groups (mainly of Pashtun ethnicity) resist polio vaccination campaigns owing to their religious and cultural beliefs.5

If the world does not want to miss another public health deadline, it is imperative to address the systemic problems that have plagued the routine immunisation programme in Pakistan. This will require accurate, context-specific communication, and perhaps integration with vaccination against other diseases the communities consider more important than polio.

We declare that we have no conflicts of interest.

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