



Bulletin de veille

« Focus sur 12 pathologies graves »

Juin 2010

Service de Documentation

Le Service Documentation de l'EHESP édite **mensuellement** un bulletin de veille. Celui-ci signale les **articles récents**, parus dans des revues scientifiques de renommée internationale, autour de **12 pathologies graves**, ainsi que sur la **pandémie grippale**. Ce bulletin signale également des **rapports officiels et institutionnels** disponibles en texte intégral.

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Bulletin de veille – Mars 2010 « Focus sur 12 pathologies graves »

Ce bulletin de veille est une **publication mensuelle** qui recueille les publications scientifiques autour des **pathologies** suivantes :

- Bronchite chronique obstructive
- Cancer du poumon
- Dengue
- Dépression
- Diabète
- Grippe A
- Maladie d'Alzheimer
- Maladies cardio-vasculaires
- Maladies liées à l'alcool
- Paludisme
- Pathologies liées à l'obésité
- SIDA
- Tuberculose

La recherche documentaire est effectuée dans la **base de données Medline** et porte sur les **12 titres de revues** suivants :

- American journal of epidemiology
- American journal of public health
- BMC public health
- BMJ (Clinical research ed.) - British medical journal
- International journal of epidemiology
- JAMA : the journal of the American Medical Association
- Lancet
- Nature
- Risk analysis : an official publication of the Society for Risk Analysis
- Science
- Social science & medicine
- The New England journal of medicine

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Articles scientifiques**Bronchite chronique obstructive**[sommaire](#)

- (1) BRAMAN SS, BU-HIJLEH M. **The spectrum of nonasthmatic inflammatory airway diseases in adults.** *Otolaryngol Clin North Am.* 2010 Feb., vol. 43, n° 1, pp.131-1xi
<http://www.ncbi.nlm.nih.gov/pubmed/20172263> ou
<http://dx.doi.org/10.1016/j.otc.2009.11.007>

When the airways are overwhelmed by noxious particles, gases, or microorganisms, inflammatory and immune responses occur that may cause permanent structural changes. One consequence may be an overproduction of mucus and this may overwhelm mucociliary clearance mechanisms and cause a chronic cough phlegm syndrome. The expectorated mucus is usually clear or white (mucoid) but when it becomes infected, the mucus may become purulent and have a yellow or green color. Diseases associated with chronic productive cough discussed in this article include chronic bronchitis, bronchiectasis, and infectious and noninfectious bronchiolitis and their diagnosis and treatment

- (2) KURMI OP, SEMPLE S, SIMKHADA P, SMITH WC, *et al.* **COPD and chronic bronchitis risk of indoor air pollution from solid fuel: a systematic review and meta-analysis.** *Thorax.* 2010 Mar., vol. 65, n° 3, pp.221-228
<http://www.ncbi.nlm.nih.gov/pubmed/20335290> ou
<http://dx.doi.org/10.1136/thx.2009.124644>

BACKGROUND: Over half the world is exposed daily to the smoke from combustion of solid fuels. Chronic obstructive pulmonary disease (COPD) is one of the main contributors to the global burden of disease and can be caused by biomass smoke exposure. However, studies of biomass exposure and COPD show a wide range of effect sizes. The aim of this systematic review was to quantify the impact of biomass smoke on the development of COPD and define reasons for differences in the reported effect sizes. **METHODS:** A systematic review was conducted of studies with sufficient statistical power to calculate the health risk of COPD from the use of solid fuel, which followed standardised criteria for the diagnosis of COPD and which dealt with confounding factors. The results were pooled by fuel type and country to produce summary estimates using a random effects model. Publication bias was also estimated. **RESULTS:** There were positive associations between the use of solid fuels and COPD (OR=2.80, 95% CI 1.85 to 4.0) and chronic bronchitis (OR=2.32, 95% CI 1.92 to 2.80). Pooled estimates for different types of fuel show that exposure to wood smoke while performing domestic work presents a greater risk of development of COPD and chronic bronchitis than other fuels. **CONCLUSION:** Despite heterogeneity across the selected studies, exposure to solid fuel smoke is consistently associated with COPD and chronic bronchitis. Efforts should be made to reduce exposure to solid fuel by using either cleaner fuel or relatively cleaner technology while performing domestic work

- (3) PIOTROWSKI WJ, KURMANOWSKA Z, ANTCZAK A, MARCZAK J, *et al.* **Superoxide anion production by bronchoalveolar lavage cells in relation to cellular composition and lung function in sarcoidosis and chronic bronchitis.** *Pol Arch Med Wewn.* 2009 Dec., vol. 119, n° 12, pp.777-784
<http://www.ncbi.nlm.nih.gov/pubmed/20010463>

INTRODUCTION: Increased generation of superoxide anion (O₂⁽⁻⁾) by bronchoalveolar lavage (BAL) cells has been reported in various inflammatory disorders. However, the clinical relevance of this phenomenon is unclear. **OBJECTIVES:** The aim of the study was to investigate whether production of O₂⁽⁻⁾ is enhanced in smoking-related chronic bronchitis and sarcoidosis, and to assess a relationship between O₂⁽⁻⁾ generation and lung function impairment and changes in BAL cellular pattern. **PATIENTS AND METHODS:** Forty-two patients with sarcoidosis, 24 smokers with chronic bronchitis, and 17 controls were examined. A number/percentage of BAL cells was calculated. Spontaneous and phorbol myristate acetate (PMA)-stimulated O₂⁽⁻⁾ production was

measured in BAL cells. Spirometry was performed. RESULTS: Patients with smoking-related chronic bronchitis produced more O₂(-) spontaneously (6.42 +/-1.24 vs. 15.39 +/-2.47 nmol/106 cells, P = 0.003) and after stimulation (3.73 +/-1.32 vs. 14.76 +/-2.79 nmol/106 cells; P = 0.001). PMA-stimulated excess production correlated with the percentage of neutrophils (r = 0.66, P = 0.0005). In sarcoidosis, only spontaneous production of O₂(-) was higher (vs. 18.07 +/-2.49 nmol/106 cells, P = 0.004) and correlated with the percentage of BAL lymphocytes. There was no correlation between O₂(-) production and lung function parameters. CONCLUSIONS: Patients with smoking-related chronic bronchitis produce more O₂(-), and this phenomenon is related to BAL neutrophils. In sarcoidosis, spontaneous release of O₂(-) from BAL cells is related to the extent of lymphocytic alveolitis. Higher O₂(-) generation did not impair lung function

Cancer du poumon

[sommaire](#)

- (1) DELAGE M, NAOURI M. **Images in clinical medicine. Erythema gyratum repens.** N Engl J Med. 2010 May 13, vol. 362, n° 19, p.1814
<http://dx.doi.org/10.1056/NEJMicm0906654> (accès réservé EHESP)
- (2) WORKMAN P, TRAVERS J. **Cancer: drug-tolerant insurgents.** Nature. 2010 Apr. 8, vol. 464, n° 7290, pp.844-845
<http://dx.doi.org/10.1038/464844a> (accès payant)

Dengue

[sommaire](#)

- (1) DEJNIRATTISAI W, JUMNAINSONG A, ONSIRISAKUL N, FITTON P, *et al.* **Cross-reacting antibodies enhance dengue virus infection in humans.** Science. 2010 May 7, vol. 328, n° 5979, pp.745-748
<http://dx.doi.org/10.1126/science.1185181> (accès réservé EHESP)

Dengue virus co-circulates as four serotypes, and sequential infections with more than one serotype are common. One hypothesis for the increased severity seen in secondary infections is antibody-dependent enhancement (ADE) leading to increased replication in Fc receptor-bearing cells. In this study, we have generated a panel of human monoclonal antibodies to dengue virus. Antibodies to the structural precursor-membrane protein (prM) form a major component of the response. These antibodies are highly cross-reactive among the dengue virus serotypes and, even at high concentrations, do not neutralize infection but potently promote ADE. We propose that the partial cleavage of prM from the viral surface reduces the density of antigen available for viral neutralization, leaving dengue viruses susceptible to ADE by antibody to prM, a finding that has implications for future vaccine design

Diabète

[sommaire](#)

- (1) BAO Y, MA X, LI H, ZHOU M, *et al.* **Glycated haemoglobin A1c for diagnosing diabetes in Chinese population: cross sectional epidemiological survey.** BMJ. 2010, vol. 340, p.c2249
<http://www.ncbi.nlm.nih.gov/pubmed/20478961> (accès réservé EHESP)

OBJECTIVES: To evaluate haemoglobin A1c (HbA(1c)) in diagnosing diabetes and identify the optimal HbA(1c) threshold to be used in Chinese adults. DESIGN: Multistage stratified cross sectional epidemiological survey. SETTING: Shanghai, China, 2007-8. PARTICIPANTS: 4886 Chinese adults over 20 years of age with no history of diabetes. MAIN OUTCOME MEASURES: Performance of HbA(1c) at increasing thresholds for diagnosing diabetes. RESULTS: The area under the receiver operating characteristics curve for detecting undiagnosed diabetes was 0.856 (95% confidence interval 0.828 to 0.883) for HbA(1c) alone and 0.920 (0.900 to 0.941) for fasting plasma glucose alone. Very high specificity (96.1%, 95% confidence interval 95.5% to 96.7%) was

achieved at an HbA(1c) threshold of 6.3% (2 SD above the normal mean). Moreover, the corresponding sensitivity was 62.8% (57.1% to 68.3%), which was equivalent to that of a fasting plasma glucose threshold of 7.0 mmol/l (57.5%, 51.7% to 63.1%) in detecting undiagnosed diabetes. In participants at high risk of diabetes, the HbA(1c) threshold of 6.3% showed significantly higher sensitivity (66.9%, 61.0% to 72.5%) than both fasting plasma glucose ≥ 7.0 mmol/l (54.4%, 48.3% to 60.4%) and HbA(1c) $\geq 6.5\%$ (53.7%, 47.6% to 59.7%) ($P < 0.01$). CONCLUSIONS: An HbA(1c) threshold of 6.3% was highly specific for detecting undiagnosed diabetes in Chinese adults and had sensitivity similar to that of using a fasting plasma glucose threshold of 7.0 mmol/l. This optimal HbA(1c) threshold may be suitable as a diagnostic criterion for diabetes in Chinese adults when fasting plasma glucose and oral glucose tolerance tests are not available

- (2) CARNETHON MR. **Commentary: Heart rate and blood pressure: risk factors or risk markers?** Int J Epidemiol. 2010 Feb., vol. 39, n° 1, pp.223-224
<http://dx.doi.org/10.1093/ije/dyp325> (accès réservé EHESP)

- (3) CRADDOCK N, HURLES ME, CARDIN N, PEARSON RD, *et al.* **Genome-wide association study of CNVs in 16,000 cases of eight common diseases and 3,000 shared controls.** Nature. 2010 Apr. 1, vol. 464, n° 7289, pp.713-720
<http://dx.doi.org/10.1038/nature08979> (accès payant)

Copy number variants (CNVs) account for a major proportion of human genetic polymorphism and have been predicted to have an important role in genetic susceptibility to common disease. To address this we undertook a large, direct genome-wide study of association between CNVs and eight common human diseases. Using a purpose-designed array we typed approximately 19,000 individuals into distinct copy-number classes at 3,432 polymorphic CNVs, including an estimated approximately 50% of all common CNVs larger than 500 base pairs. We identified several biological artefacts that lead to false-positive associations, including systematic CNV differences between DNAs derived from blood and cell lines. Association testing and follow-up replication analyses confirmed three loci where CNVs were associated with disease-IRGM for Crohn's disease, HLA for Crohn's disease, rheumatoid arthritis and type 1 diabetes, and TSPAN8 for type 2 diabetes-although in each case the locus had previously been identified in single nucleotide polymorphism (SNP)-based studies, reflecting our observation that most common CNVs that are well-typed on our array are well tagged by SNPs and so have been indirectly explored through SNP studies. We conclude that common CNVs that can be typed on existing platforms are unlikely to contribute greatly to the genetic basis of common human diseases

- (4) CRUICKSHANK JK. **Survival as a function of HbA(1c) in people with type 2 diabetes.** Lancet. 2010 Apr. 24, vol. 375, n° 9724, pp.1434-1435
[http://dx.doi.org/10.1016/S0140-6736\(10\)60615-0](http://dx.doi.org/10.1016/S0140-6736(10)60615-0) (accès réservé EHESP)

- (5) DE JJ, KOOY A, LEHERT P, WULFFELE MG, *et al.* **Long term treatment with metformin in patients with type 2 diabetes and risk of vitamin B-12 deficiency: randomised placebo controlled trial.** BMJ. 2010, vol. 340, p.c2181
<http://www.ncbi.nlm.nih.gov/pubmed/20488910> (accès réservé EHESP)

OBJECTIVES: To study the effects of metformin on the incidence of vitamin B-12 deficiency (< 150 pmol/l), low concentrations of vitamin B-12 (150-220 pmol/l), and folate and homocysteine concentrations in patients with type 2 diabetes receiving treatment with insulin. DESIGN: Multicentre randomised placebo controlled trial. SETTING: Outpatient clinics of three non-academic hospitals in the Netherlands. PARTICIPANTS: 390 patients with type 2 diabetes receiving treatment with insulin. INTERVENTION: 850 mg metformin or placebo three times a day for 4.3 years. MAIN OUTCOME MEASURES: Percentage change in vitamin B-12, folate, and homocysteine concentrations from baseline at 4, 17, 30, 43, and 52 months. RESULTS: Compared with placebo, metformin treatment was associated with a mean decrease in vitamin B-12 concentration of -19% (95% confidence interval -24% to -14%; $P < 0.001$) and in folate concentration of -5% (95% CI -10% to -0.4%; $P = 0.033$), and an increase in homocysteine

concentration of 5% (95% CI -1% to 11%; P=0.091). After adjustment for body mass index and smoking, no significant effect of metformin on folate concentrations was found. The absolute risk of vitamin B-12 deficiency (<150 pmol/l) at study end was 7.2 percentage points higher in the metformin group than in the placebo group (95% CI 2.3 to 12.1; P=0.004), with a number needed to harm of 13.8 per 4.3 years (95% CI 43.5 to 8.3). The absolute risk of low vitamin B-12 concentration (150-220 pmol/l) at study end was 11.2 percentage points higher in the metformin group (95% CI 4.6 to 17.9; P=0.001), with a number needed to harm of 8.9 per 4.3 years (95% CI 21.7 to 5.6). Patients with vitamin B-12 deficiency at study end had a mean homocysteine level of 23.7 micromol/l (95% CI 18.8 to 30.0 micromol/l), compared with a mean homocysteine level of 18.1 micromol/l (95% CI 16.7 to 19.6 micromol/l; P=0.003) for patients with a low vitamin B-12 concentration and 14.9 micromol/l (95% CI 14.3 to 15.5 micromol/l; P<0.001 compared with vitamin B-12 deficiency; P=0.005 compared with low vitamin B-12) for patients with a normal vitamin B-12 concentration (>220 pmol/l). **CONCLUSIONS:** Long term treatment with metformin increases the risk of vitamin B-12 deficiency, which results in raised homocysteine concentrations. Vitamin B-12 deficiency is preventable; therefore, our findings suggest that regular measurement of vitamin B-12 concentrations during long term metformin treatment should be strongly considered. Trial registration Clinicaltrials.gov NCT00375388

- (6) DEVRIES JH. **Survival as a function of HbA(1c) in people with type 2 diabetes.** Lancet. 2010 Apr. 24, vol. 375, n° 9724, pp.1433-1434
[http://dx.doi.org/10.1016/S0140-6736\(10\)60614-9](http://dx.doi.org/10.1016/S0140-6736(10)60614-9) (accès réservé EHESP)
- (7) GEBREGZIABHER M, EGEDE LE, LYNCH CP, ECHOLS C, *et al.* **Effect of trajectories of glycemic control on mortality in type 2 diabetes: a semiparametric joint modeling approach.** Am J Epidemiol. 2010 May 15, vol. 171, n° 10, pp.1090-1098
<http://dx.doi.org/10.1093/aje/kwq070> (accès réservé EHESP)

Data on the effect of trajectories in long-term glycemia and all-cause mortality are lacking. The authors studied the effect of trajectories in long-term glycemic control on all-cause mortality in patients with type 2 diabetes. A cohort of 8,812 veterans with type 2 diabetes was assembled retrospectively using Veterans Affairs registry data. For each veteran in the cohort, a 3-month person-period data set was created from April 1997 to May 2006. The average duration of follow-up was 4.5 years. The overall mortality rate was 15.3%. Using a novel approach for joint modeling of time to death and longitudinal measurements of hemoglobin A1c (HbA1c) level, after adjustment for all significant baseline covariates, baseline HbA1c was found to be significantly associated with mortality (hazard ratio = 2.1, 95% confidence interval: 1.3, 3.6) (i.e., a 1% increase in baseline HbA1c level was associated with an average 2-fold increase in mortality risk). Similarly, the slope of the HbA1c trajectory was marginally significantly associated with mortality (hazard ratio = 7.3, 95% confidence interval: 0.9, 57.1) after adjustment for baseline covariates (i.e., a 1% increase in HbA1c level over 3 months was associated with a 22% increase in mortality risk). The authors conclude that a positive trajectory of long-term hyperglycemia is associated with increased mortality

- (8) HEMMINKI K, FORSTI A, BERMEJO JL. **Re: "underlying genetic models of inheritance in established type 2 diabetes associations".** Am J Epidemiol. 2010 May 15, vol. 171, n° 10, pp.1153-1154
<http://dx.doi.org/10.1093/aje/kwq058> (accès réservé EHESP)
- (9) KIM SY, ENGLAND L, WILSON HG, BISH C, *et al.* **Percentage of gestational diabetes mellitus attributable to overweight and obesity.** Am J Public Health. 2010 June, vol. 100, n° 6, pp.1047-1052
<http://dx.doi.org/10.2105/AJPH.2009.172890> (accès réservé EHESP)

OBJECTIVES: We calculated the percentage of gestational diabetes mellitus (GDM) attributable to overweight and obesity. **METHODS:** We analyzed 2004 through 2006 data from 7 states using the Pregnancy Risk Assessment Monitoring System linked to revised 2003 birth certificate information. We used logistic regression to estimate the magnitude of the association between

prepregnancy body mass index (BMI) and GDM and calculated the percentage of GDM attributable to overweight and obesity. RESULTS: GDM prevalence rates by BMI category were as follows: underweight (13-18.4 kg/m²), 0.7%; normal weight (18.5-24.9 kg/m²), 2.3%; overweight (25-29.9 kg/m²), 4.8%; obese (30-34.9 kg/m²), 5.5%; and extremely obese (35-64.9 kg/m²), 11.5%. Percentages of GDM attributable to overweight, obesity, and extreme obesity were 15.4% (95% confidence interval [CI] = 8.6, 22.2), 9.7% (95% CI = 5.2, 14.3), and 21.1% (CI = 15.2, 26.9), respectively. The overall population-attributable fraction was 46.2% (95% CI = 36.1, 56.3). CONCLUSIONS: If all overweight and obese women (BMI of 25 kg/m² or above) had a GDM risk equal to that of normal-weight women, nearly half of GDM cases could be prevented. Public health efforts to reduce prepregnancy BMI by promoting physical activity and healthy eating among women of reproductive age should be intensified

- (10) LANGE RA, HILLIS LD. **Second-generation drug-eluting coronary stents.** N Engl J Med. 2010 May 6, vol. 362, n° 18, pp.1728-1730
<http://dx.doi.org/10.1056/NEJMe1001069> (accès réservé EHESP)
- (11) LESTER H, SCHMITTDIEL J, SELBY J, FIREMAN B, *et al.* **The impact of removing financial incentives from clinical quality indicators: longitudinal analysis of four Kaiser Permanente indicators.** BMJ. 2010, vol. 340, p.c1898
<http://www.ncbi.nlm.nih.gov/pubmed/20460330> (accès réservé EHESP)

OBJECTIVE: To evaluate the effect of financial incentives on four clinical quality indicators common to pay for performance plans in the United Kingdom and at Kaiser Permanente in California. DESIGN: Longitudinal analysis. SETTING: 35 medical facilities of Kaiser Permanente Northern California, 1997-2007. PARTICIPANTS: 2 523 659 adult members of Kaiser Permanente Northern California. Main outcomes measures Yearly assessment of patient level glycaemic control (HbA(1c) <8%), screening for diabetic retinopathy, control of hypertension (systolic blood pressure <140 mm Hg), and screening for cervical cancer. RESULTS: Incentives for two indicators-screening for diabetic retinopathy and for cervical cancer-were removed during the study period. During the five consecutive years when financial incentives were attached to screening for diabetic retinopathy (1999-2003), the rate rose from 84.9% to 88.1%. This was followed by four years without incentives when the rate fell year on year to 80.5%. During the two initial years when financial incentives were attached to cervical cancer screening (1999-2000), the screening rate rose slightly, from 77.4% to 78.0%. During the next five years when financial incentives were removed, screening rates fell year on year to 74.3%. Incentives were then reattached for two years (2006-7) and screening rates began to increase. Across the 35 facilities, the removal of incentives was associated with a decrease in performance of about 3% per year on average for screening for diabetic retinopathy and about 1.6% per year for cervical cancer screening. CONCLUSION: Policy makers and clinicians should be aware that removing facility directed financial incentives from clinical indicators may mean that performance levels decline

- (12) LU TH, ANDERSON RN, KAWACHI I. **Trends in frequency of reporting improper diabetes-related cause-of-death statements on death certificates, 1985-2005: An algorithm to identify incorrect causal sequences.** Am J Epidemiol. 2010 May 15, vol. 171, n° 10, pp.1069-1078
<http://dx.doi.org/10.1093/aje/kwq057> (accès réservé EHESP)

This study aimed to examine the changes in frequency of reporting improper diabetes-related cause-of-death statements on death certificates based on Multiple-Cause Mortality Files of the United States from 1985 to 2005. An algorithm was developed to identify the causes of death with incorrect causal sequences by using decision tables developed by the National Center for Health Statistics. In 1985, 2 or more diagnoses per line were reported on 35% of death certificates with mention of diabetes in Part I of the death certificate. This percentage decreased to 19% in 2005. In contrast, the prevalence of reporting incorrect causal sequences on death certificates on which diabetes was reported in Part I increased from 22% in 1985 to 35% in 2005. The authors suggest that the most plausible explanation of increasing reporting of incorrect causal sequences was the drastic increase of reporting multiple conditions (especially cardiovascular diseases and cancers) among deaths with mention of diabetes, which made the determination of underlying cause of death much more difficult

- (13) MANN DM, BERTONI AG, SHIMBO D, CARNETHON MR, *et al.* **Comparative validity of 3 diabetes mellitus risk prediction scoring models in a multiethnic US cohort: the Multi-Ethnic Study of Atherosclerosis.** *Am J Epidemiol.* 2010 May 1, vol. 171, n° 9, pp.980-988
<http://dx.doi.org/10.1093/aje/kwq030> (accès réservé EHESP)

Several models for estimating risk of incident diabetes in US adults are available. The authors aimed to determine the discriminative ability and calibration of published diabetes risk prediction models in a contemporary multiethnic cohort. Participants in the Multi-Ethnic Study of Atherosclerosis without diabetes at baseline (2000-2002; n = 5,329) were followed for a median of 4.75 years. The predicted risk of diabetes was calculated using published models from the Framingham Offspring Study, the Atherosclerosis Risk in Communities (ARIC) Study, and the San Antonio Heart Study. The mean age of participants was 61.6 years (standard deviation, 10.2); 29.3% were obese, 53.1% had hypertension, 34.9% had a family history of diabetes, 27.5% had high triglyceride levels, 33.8% had low high density lipoprotein cholesterol levels, and 15.3% had impaired fasting glucose. There were 446 incident cases of diabetes (fasting glucose level \geq 126 mg/dL or initiation of antidiabetes medication use) diagnosed during follow-up. C statistics were 0.78, 0.84, and 0.83 for the Framingham, ARIC, and San Antonio risk prediction models, respectively. There were significant differences between observed and predicted diabetes risks (Hosmer-Lemeshow goodness-of-fit chi-squared test for each model: $P < 0.001$). The recalibrated and best-fit models achieved sufficient goodness of fit (each $P > 0.10$). The Framingham, ARIC, and San Antonio models maintained high discriminative ability but required recalibration in a modern, multiethnic US cohort

- (14) MARTEAU TM, MANN E, PREVOST AT, VASCONCELOS JC, *et al.* **Impact of an informed choice invitation on uptake of screening for diabetes in primary care (DICISION): randomised trial.** *BMJ.* 2010, vol. 340, p.c2138
<http://www.ncbi.nlm.nih.gov/pubmed/20466791> (accès réservé EHESP)

OBJECTIVE: To compare the effect of an invitation promoting informed choice for screening with a standard invitation on attendance and motivation to engage in preventive action. **DESIGN:** Randomised controlled trial. **SETTING:** Four English general practices. **PARTICIPANTS:** 1272 people aged 40-69 years, at risk for diabetes, identified from practice registers using a validated risk score and invited to attend for screening. **INTERVENTION:** Intervention was a previously validated invitation to inform the decision to attend screening, presenting diabetes as a serious potential problem, and providing details of possible costs and benefits of screening and treatment in text and pie charts. This was compared with a brief, standard invitation simply describing diabetes as a serious potential problem. **MAIN OUTCOME MEASURES:** The primary end point was attendance for screening. The secondary outcome measures were intention to make changes to lifestyle and satisfaction with decisions made among attenders. **RESULTS:** The primary end point was analysed for all 1272 participants. 55.8% (353/633) of those in the informed choice group attended for screening, compared with 57.6% (368/639) in the standard invitation group (mean difference -1.8%, 95% confidence interval -7.3% to 3.6%; $P=0.51$). Attendance was lower among the more deprived group (most deprived third 47.5% v least deprived third 64.3%; $P<0.001$). Interaction between deprivation and effect of invitation type on attendance was not significant. Among attenders, intention to change behaviour was strong and unaffected by invitation type. **CONCLUSIONS:** Providing information to support choice did not adversely affect attendance for screening for diabetes. Those from more socially deprived groups were, however, less likely to attend, regardless of the type of invitation received. Further attention to invitation content alone is unlikely to achieve equity in uptake of preventive services. **TRIAL REGISTRATION:** Current Controlled Trials ISRCTN 73125647

- (15) MITKA M. **Aggressive lipid, hypertension targeting yields no benefit for some with diabetes.** JAMA. 2010 May 5, vol. 303, n° 17, pp.1681-1683
<http://dx.doi.org/10.1001/jama.2010.492> (accès réservé EHESP)

- (16) NAGAYA T, YOSHIDA H, TAKAHASHI H, KAWAI M. **Resting heart rate and blood pressure, independent of each other, proportionally raise the risk for type-2 diabetes mellitus.** Int J Epidemiol. 2010 Feb., vol. 39, n° 1, pp.215-222
<http://dx.doi.org/10.1093/ije/dyp229> (accès réservé EHESP)

BACKGROUND: Fast heart rate and high blood pressure (BP) at rest may raise risk for the development of type-2 diabetes mellitus (DM). We therefore investigated dose-response and interactive effects of resting heart rate and BP on the incidence of DM in a Japanese population. METHODS: A follow-up study was conducted for 16 828 men and 8368 women aged 30-59 years and apparently healthy at baseline. Incident DM was identified by 'fasting serum glucose \geq 7.00 mmol/l (126 mg/dl)' or/and 'under medical treatment for DM'. Using Cox proportional hazard models, hazard ratio (HR) for incident DM were estimated according to the quartiles of heart rate, systolic or diastolic BP (SBP, DBP), and its linear trends were checked by computing the three indices as continuous variables. Subsequently, interactive effects of slow/fast heart rate (dichotomized by the median) and low/high SBP or DBP (dichotomized by the median) on HR were examined. Baseline age, body mass index, smoking, drinking, exercise and education were computed as conventional confounders. RESULTS: During the follow-up of 125 106 person-years for men and 59 616 person-years for women, 869 men and 224 women developed DM. The multivariate-adjusted HR for incident DM increased across quartiles of heart rate, SBP and DBP in both sexes (linear trend $P < 0.001$ for all). Neither sex showed any significant interactive effects of heart rate and SBP or DBP on HR. CONCLUSIONS: Resting heart rate and BP proportionally raise the risk for DM in middle-aged healthy men and women. Moreover, the adverse effects of fast heart rate and high BP are independent of each other as well as of the influences of conventional confounders

- (17) NANGO E, SAIO T. **Survival as a function of HbA(1c) in people with type 2 diabetes.** Lancet. 2010 Apr. 24, vol. 375, n° 9724, pp.1433-1435
[http://dx.doi.org/10.1016/S0140-6736\(10\)60613-7](http://dx.doi.org/10.1016/S0140-6736(10)60613-7) (accès réservé EHESP)

- (18) PLAGEMANN A, HARDER T, DUDENHAUSEN JW. **Childhood obesity, other cardiovascular risk factors, and premature death.** N Engl J Med. 2010 May 13, vol. 362, n° 19, pp.1840-1841
<http://www.ncbi.nlm.nih.gov/pubmed/20468084> (accès réservé EHESP)

- (19) PRATLEY RE, NAUCK M, BAILEY T, MONTANYA E, *et al.* **Liraglutide versus sitagliptin for patients with type 2 diabetes who did not have adequate glycaemic control with metformin: a 26-week, randomised, parallel-group, open-label trial.** Lancet. 2010 Apr. 24, vol. 375, n° 9724, pp.1447-1456
[http://dx.doi.org/10.1016/S0140-6736\(10\)60307-8](http://dx.doi.org/10.1016/S0140-6736(10)60307-8) (accès réservé EHESP)

BACKGROUND: Agonists of the glucagon-like peptide-1 (GLP-1) receptor provide pharmacological levels of GLP-1 activity, whereas dipeptidyl peptidase-4 (DPP-4) inhibitors increase concentrations of endogenous GLP-1 and glucose-dependent insulinotropic polypeptide. We aimed to assess the efficacy and safety of the human GLP-1 analogue liraglutide versus the DPP-4 inhibitor sitagliptin, as adjunct treatments to metformin, in individuals with type 2 diabetes who did not achieve adequate glycaemic control with metformin alone. METHODS: In this parallel-group, open-label trial, participants (aged 18-80 years) with type 2 diabetes mellitus who had inadequate glycaemic control (glycosylated haemoglobin [HbA(1c)] 7.5-10.0%) on metformin (≥ 1500 mg daily for ≥ 3 months) were enrolled and treated at office-based sites in Europe, the USA, and Canada. Participants were randomly allocated to receive 26 weeks' treatment with 1.2 mg (n=225) or 1.8 mg (n=221) subcutaneous liraglutide once daily, or 100 mg oral sitagliptin

once daily (n=219). The primary endpoint was change in HbA(1c) from baseline to week 26. The efficacy of liraglutide versus sitagliptin was assessed hierarchically by a non-inferiority comparison, with a margin of 0.4%, followed by a superiority comparison. Analyses were done on the full analysis set with missing values imputed by last observation carried forward; seven patients assigned to liraglutide did not receive treatment and thus did not meet criteria for inclusion in the full analysis set. This trial is registered with ClinicalTrials.gov, number NCT00700817. FINDINGS: Greater lowering of mean HbA(1c) (8.5% at baseline) was achieved with 1.8 mg liraglutide (-1.50%, 95% CI -1.63 to -1.37, n=218) and 1.2 mg liraglutide (-1.24%, -1.37 to -1.11, n=221) than with sitagliptin (-0.90%, -1.03 to -0.77, n=219). Estimated mean treatment differences for liraglutide versus sitagliptin were -0.60% (95% CI -0.77 to -0.43, p<0.0001) for 1.8 mg and -0.34% (-0.51 to -0.16, p<0.0001) for 1.2 mg liraglutide. Nausea was more common with liraglutide (59 [27%] patients on 1.8 mg; 46 [21%] on 1.2 mg) than with sitagliptin (10 [5%]). Minor hypoglycaemia was recorded in about 5% of participants in each treatment group. INTERPRETATION: Liraglutide was superior to sitagliptin for reduction of HbA(1c), and was well tolerated with minimum risk of hypoglycaemia. These findings support the use of liraglutide as an effective GLP-1 agent to add to metformin. FUNDING: Novo Nordisk

- (20) RIVELINE JP, ROUSSEL R, MOHAMMEDI K. **Survival as a function of HbA(1c) in people with type 2 diabetes.** Lancet. 2010 Apr. 24, vol. 375, n° 9724, pp.1433-1435
[http://dx.doi.org/10.1016/S0140-6736\(10\)60612-5](http://dx.doi.org/10.1016/S0140-6736(10)60612-5) (accès réservé EHESP)
- (21) SCHEEN AJ, RADERMECKER RP. **Addition of incretin therapy to metformin in type 2 diabetes.** Lancet. 2010 Apr. 24, vol. 375, n° 9724, pp.1410-1412
[http://dx.doi.org/10.1016/S0140-6736\(10\)60399-6](http://dx.doi.org/10.1016/S0140-6736(10)60399-6) (accès réservé EHESP)
- (22) VIDAL-ALABALL J, BUTLER CC. **Reduced serum vitamin B-12 in patients taking metformin.** BMJ. 2010, vol. 340, p.c2198
<http://www.ncbi.nlm.nih.gov/pubmed/20488912> (accès réservé EHESP)
- (23) YANG Q, LIU T, VALDEZ R, MOONESINGHE R, *et al.* **Improvements in ability to detect undiagnosed diabetes by using information on family history among adults in the United States.** Am J Epidemiol. 2010 May 15, vol. 171, n° 10, pp.1079-1089
<http://dx.doi.org/10.1093/aje/kwq026> (accès réservé EHESP)

Family history is an independent risk factor for diabetes, but it is not clear how much adding family history to other known risk factors would improve detection of undiagnosed diabetes in a population. Using the National Health and Nutrition Examination Survey for 1999-2004, the authors compared logistic regression models with established risk factors (model 1) with a model (model 2) that also included familial risk of diabetes (average, moderate, and high). Adjusted odds ratios for undiagnosed diabetes, using average familial risk as referent, were 1.7 (95% confidence interval (CI): 1.2, 2.5) and 3.8 (95% CI: 2.2, 6.3) for those with moderate and high familial risk, respectively. Model 2 was superior to model 1 in detecting undiagnosed diabetes, as reflected by several significant improvements, including weighted C statistics of 0.826 versus 0.842 (bootstrap P = 0.001) and integrated discrimination improvement of 0.012 (95% CI: 0.004, 0.030). With a risk threshold of 7.3% (sensitivity of 40% based on model 1), adding family history would identify an additional 620,000 (95% CI: 221,100, 1,020,000) cases without a significant change in false-positive fraction. Study findings suggest that adding family history of diabetes can provide significant improvements in detecting undiagnosed diabetes in the US population. Further research is needed to validate the authors' findings

- (24) YANG W. **Diagnosing diabetes using glycated haemoglobin A1c.** BMJ. 2010, vol. 340, p.c2262
<http://www.ncbi.nlm.nih.gov/pubmed/20478958> (accès réservé EHESP)

Dépression

[sommaire](#)

- (1) BOMBARDIER CH, FANN JR, TEMKIN NR, ESSELMAN PC, *et al.* **Rates of major depressive disorder and clinical outcomes following traumatic brain injury.** JAMA. 2010 May 19, vol. 303, n° 19, pp.1938-1945

<http://dx.doi.org/10.1001/jama.2010.599> (accès réservé EHESP)

CONTEXT: Uncertainties exist about the rates, predictors, and outcomes of major depressive disorder (MDD) among individuals with traumatic brain injury (TBI). OBJECTIVE: To describe MDD-related rates, predictors, outcomes, and treatment during the first year after TBI. DESIGN: Cohort from June 2001 through March 2005 followed up by structured telephone interviews at months 1 through 6, 8, 10, and 12 (data collection ending February 2006). SETTING: Harborview Medical Center, a level I trauma center in Seattle, Washington. PARTICIPANTS: Five hundred fifty-nine consecutively hospitalized adults with complicated mild to severe TBI. MAIN OUTCOME MEASURES: The Patient Health Questionnaire (PHQ) depression and anxiety modules were administered at each assessment and the European Quality of Life measure was given at 12 months. RESULTS: Two hundred ninety-seven of 559 patients (53.1%) met criteria for MDD at least once in the follow-up period. Point prevalences ranged between 31% at 1 month and 21% at 6 months. In a multivariate model, risk of MDD after TBI was associated with MDD at the time of injury (risk ratio [RR], 1.62; 95% confidence interval [CI], 1.37-1.91), history of MDD prior to injury (but not at the time of injury) (RR, 1.54; 95% CI, 1.31-1.82), age (RR, 0.61; 95% CI, 0.44-0.83 for > or = 60 years vs 18-29 years), and lifetime alcohol dependence (RR, 1.34; 95% CI, 1.14-1.57). Those with MDD were more likely to report comorbid anxiety disorders after TBI than those without MDD (60% vs 7%; RR, 8.77; 95% CI, 5.56-13.83). Only 44% of those with MDD received antidepressants or counseling. After adjusting for predictors of MDD, persons with MDD reported lower quality of life at 1 year compared with the nondepressed group. CONCLUSIONS: Among a cohort of patients hospitalized for TBI, 53.1% met criteria for MDD during the first year after TBI. Major depressive disorder was associated with history of MDD and was an independent predictor of poorer health-related quality of life

- (2) HAMPTON T. **Depression care effort brings dramatic drop in large HMO population's suicide rate.** JAMA. 2010 May 19, vol. 303, n° 19, pp.1903-1905

<http://dx.doi.org/10.1001/jama.2010.595> (accès réservé EHESP)

- (3) HEDAYATI SS, MINHAJUDDIN AT, AFSHAR M, TOTO RD, *et al.* **Association between major depressive episodes in patients with chronic kidney disease and initiation of dialysis, hospitalization, or death.** JAMA. 2010 May 19, vol. 303, n° 19, pp.1946-1953

<http://dx.doi.org/10.1001/jama.2010.619> (accès réservé EHESP)

CONTEXT: Patients with chronic kidney disease (CKD) experience increased rates of hospitalization and death. Depressive disorders are associated with morbidity and mortality. Whether depression contributes to poor outcomes in patients with CKD not receiving dialysis is unknown. OBJECTIVE: To determine whether the presence of a current major depressive episode (MDE) is associated with poorer outcomes in patients with CKD. DESIGN, SETTING, AND PATIENTS: Prospective cohort study of 267 consecutively recruited outpatients with CKD (stages 2-5 and who were not receiving dialysis) at a VA medical center between May 2005 and November 2006 and followed up for 1 year. An MDE was diagnosed by blinded personnel using the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) criteria. MAIN OUTCOME MEASURES: The primary outcome was event-free survival defined as the composite

of death, dialysis initiation, or hospitalization. Secondary outcomes included each of these events assessed separately. **RESULTS:** Among 267 patients, 56 had a current MDE (21%) and 211 did not (79%). There were 127 composite events, 116 hospitalizations, 38 dialysis initiations, and 18 deaths. Events occurred more often in patients with an MDE compared with those without an MDE (61% vs 44%, respectively, $P = .03$). Four patients with missing dates of hospitalization were excluded from survival analyses. The mean (SD) time to the composite event was 206.5 (19.8) days (95% CI, 167.7-245.3 days) for those with an MDE compared with 273.3 (8.5) days (95% CI, 256.6-290.0 days) for those without an MDE ($P = .003$). The adjusted hazard ratio (HR) for the composite event for patients with an MDE was 1.86 (95% CI, 1.23-2.84). An MDE at baseline independently predicted progression to dialysis (HR, 3.51; 95% CI, 1.77-6.97) and hospitalization (HR, 1.90; 95% CI, 1.23-2.95). **CONCLUSION:** The presence of an MDE was associated with an increased risk of poor outcomes in CKD patients who were not receiving dialysis, independent of comorbidities and kidney disease severity

- (4) NEEDHAM BL, EPEL ES, ADLER NE, KIEFE C. **Trajectories of change in obesity and symptoms of depression: the CARDIA study.** Am J Public Health. 2010 June, vol. 100, n° 6, pp.1040-1046
<http://dx.doi.org/10.2105/AJPH.2009.172809> (accès réservé EHESP)

OBJECTIVES: We investigated whether, over time, baseline obesity is associated with change in depressive symptoms or if baseline symptoms of depression are associated with change in body mass index (BMI) and waist circumference. **METHODS:** We used latent growth curve modeling to examine data from years 5, 10, 15, and 20 of the Coronary Artery Risk Development in Young Adults study ($n = 4643$). We assessed depressive symptomatology with the Center for Epidemiological Studies Depression scale. **RESULTS:** Respondents who started out with higher levels of depressive symptoms experienced a faster rate of increase in BMI (for Whites only) and waist circumference (for Blacks and Whites) over time than did those who reported fewer symptoms of depression in year 5. Initial BMI and waist circumference did not influence the rate of change in symptoms of depression over time. **CONCLUSIONS:** Depressive symptomatology likely plays a role in the development of physical health problems, such as cardiovascular disease, through its association with increases in relative weight and abdominal obesity over time

- (5) PAULSON JF, BAZEMORE SD. **Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis.** JAMA. 2010 May 19, vol. 303, n° 19, pp.1961-1969
<http://dx.doi.org/10.1001/jama.2010.605> (accès réservé EHESP)

CONTEXT: It is well established that maternal prenatal and postpartum depression is prevalent and has negative personal, family, and child developmental outcomes. Paternal depression during this period may have similar characteristics, but data are based on an emerging and currently inconsistent literature. **OBJECTIVE:** To describe point estimates and variability in rates of paternal prenatal and postpartum depression over time and its association with maternal depression. **DATA SOURCES:** Studies that documented depression in fathers between the first trimester and the first postpartum year were identified through MEDLINE, PsycINFO, EMBASE, Google Scholar, dissertation abstracts, and reference lists for the period between January 1980 and October 2009. **STUDY SELECTION:** Studies that reported identified cases within the selected time frame were included, yielding a total of 43 studies involving 28 004 participants after duplicate reports and data were excluded. **DATA EXTRACTION:** Information on rates of paternal and maternal depression, as well as reported paternal-maternal depressive correlations, was extracted independently by 2 raters. Effect sizes were calculated using logits, which were back-transformed and reported as proportions. Random-effects models of event rates were used because of significant heterogeneity. Moderator analyses included timing, measurement method, and study location. Study quality ratings were calculated and used for sensitivity analysis. Publication bias was evaluated with funnel plots and the Egger method. **DATA SYNTHESIS:** Substantial heterogeneity was observed among rates of paternal depression, with a meta-estimate of 10.4% (95% confidence interval [CI], 8.5%-12.7%). Higher rates of depression were reported during the 3- to 6-month postpartum period (25.6%; 95% CI, 17.3%-36.1%). The correlation between paternal and maternal depression was positive and moderate in size ($r = 0.308$; 95% CI, 0.228-0.384). No evidence of significant publication bias was detected.

CONCLUSIONS: Prenatal and postpartum depression was evident in about 10% of men in the reviewed studies and was relatively higher in the 3- to 6-month postpartum period. Paternal depression also showed a moderate positive correlation with maternal depression

- (6) TORPY JM, BURKE AE, GLASS RM. **JAMA patient page. Depression.** JAMA. 2010 May 19, vol. 303, n° 19, p.1994
<http://dx.doi.org/10.1001/jama.303.19.1994> (accès réservé EHESP)
- (7) YBEMA JF, VAN DEN BK. **Effects of organizational justice on depressive symptoms and sickness absence: a longitudinal perspective.** Soc Sci Med. 2010 May, vol. 70, n° 10, pp.1609-1617
<http://dx.doi.org/10.1016/j.socscimed.2010.01.027> (accès réservé EHESP)

A longitudinal three-wave study among a large representative sample of 1519 employees of various companies in The Netherlands examined how organizational justice (as measured by distributive and procedural justice) was related to depressive symptoms and sickness absence. It was predicted that perceived justice would contribute to lower depressive symptoms and sickness absence, whereas depressive symptoms and absenteeism in turn would contribute to lower perceptions of organizational justice. In line with the predictions, we found that both distributive and procedural justice contributed to lower depressive symptoms, and distributive justice contributed to lower sickness absence in the following year. With regard to reversed effects, sickness absence contributed to lower perceptions of distributive justice to some extent. Moreover, sickness absence was related to higher depressive symptoms a year later. This research shows the importance of justice in organizations as a means to enhance the wellbeing of people at work and to prevent absenteeism

Grippe A

[sommaire](#)

- (1) BAKER MG, THORNLEY CN, MILLS C, ROBERTS S, *et al.* **Transmission of pandemic A/H1N1 2009 influenza on passenger aircraft: retrospective cohort study.** BMJ. 2010, vol. 340, p.c2424
<http://www.ncbi.nlm.nih.gov/pubmed/20495017> (accès réservé EHESP)

OBJECTIVES: To assess the risk of transmission of pandemic A/H1N1 2009 influenza (pandemic A/H1N1) from an infected high school group to other passengers on an airline flight and the effectiveness of screening and follow-up of exposed passengers. DESIGN: Retrospective cohort investigation using a questionnaire administered to passengers and laboratory investigation of those with symptoms. SETTING: Auckland, New Zealand, with national and international follow-up of passengers. PARTICIPANTS: Passengers seated in the rear section of a Boeing 747-400 long haul flight that arrived on 25 April 2009, including a group of 24 students and teachers and 97 (out of 102) other passengers in the same section of the plane who agreed to be interviewed. MAIN OUTCOME MEASURES: Laboratory confirmed pandemic A/H1N1 infection in susceptible passengers within 3.2 days of arrival; sensitivity and specificity of influenza symptoms for confirmed infection; and completeness and timeliness of contact tracing. RESULTS: Nine members of the school group were laboratory confirmed cases of pandemic A/H1N1 infection and had symptoms during the flight. Two other passengers developed confirmed pandemic A/H1N1 infection, 12 and 48 hours after the flight. They reported no other potential sources of infection. Their seating was within two rows of infected passengers, implying a risk of infection of about 3.5% for the 57 passengers in those rows. All but one of the confirmed pandemic A/H1N1 infected travellers reported cough, but more complex definitions of influenza cases had relatively low sensitivity. Rigorous follow-up by public health workers located 93% of passengers, but only 52% were contacted within 72 hours of arrival. CONCLUSIONS: A low but measurable risk of transmission of pandemic A/H1N1 exists during modern commercial air travel. This risk is concentrated close to infected passengers with symptoms. Follow-up and screening of exposed passengers is slow and difficult once they have left the airport

- (2) BAUTISTA E, CHOTPITAYASUNONDH T, GAO Z, HARPER SA, *et al.* **Clinical aspects of pandemic 2009 influenza A (H1N1) virus infection.** N Engl J Med. 2010 May 6, vol. 362, n° 18, pp.1708-1719
<http://dx.doi.org/10.1056/NEJMra1000449> (accès réservé EHESP)

- (3) BENTLEY RA, ORMEROD P. **A rapid method for assessing social versus independent interest in health issues: A case study of 'bird flu' and 'swine flu'.** Soc Sci Med. 2010 Apr. 24, <http://dx.doi.org/10.1016/j.socscimed.2010.03.042> (accès réservé EHESP)

Effective communication strategies regarding health issues are affected by the way in which the public obtain their knowledge, particularly whether people become interested independently, or through their social networks. This is often investigated through localized ethnography or surveys. In rapidly-evolving situations, however, there may also be a need for swift, case-specific assessment as a guide to initial strategy development. With this aim, we analyze real-time online data, provided by the new 'Google Trends' tool, concerning Internet search frequency for health-related issues. To these data we apply a simple model to characterise the effective degree of social transmission versus decisions made individually. As case examples, we explore two rapidly-evolved issues, namely the world-wide interest in avian influenza, or 'bird flu', in 2005, and in H1N1, or 'swine flu', from late April to early May 2009. The 2005 'bird flu' scare demonstrated almost pure imitation for two months initially, followed by a spike of independent decision that corresponded with an announcement by US president George Bush. For 'swine flu' in 2009, imitation was the more prevalent throughout. Overall, the results show how interest in health scares can spread primarily by social means, and that engaging more independent decisions at the population scale may require a dramatic announcement to push a populace over the 'tipping point'

- (4) BROWNSTEIN JS, FREIFELD CC, CHAN EH, KELLER M, *et al.* **Information technology and global surveillance of cases of 2009 H1N1 influenza.** N Engl J Med. 2010 May 6, vol. 362, n° 18, pp.1731-1735
<http://dx.doi.org/10.1056/NEJMs1002707> (accès réservé EHESP)

- (5) MILLER E, HOSCHLER K, HARDELID P, STANFORD E, *et al.* **Incidence of 2009 pandemic influenza A H1N1 infection in England: a cross-sectional serological study.** Lancet. 2010 Mar. 27, vol. 375, n° 9720, pp.1100-1108
[http://dx.doi.org/10.1016/S0140-6736\(09\)62126-7](http://dx.doi.org/10.1016/S0140-6736(09)62126-7) (accès réservé EHESP)

BACKGROUND: Knowledge of the age-specific prevalence of immunity from, and incidence of infection with, 2009 pandemic influenza A H1N1 virus is essential for modelling the future burden of disease and the effectiveness of interventions such as vaccination. **METHODS:** In this cross-sectional serological survey, we obtained 1403 serum samples taken in 2008 (before the first wave of H1N1 infection) and 1954 serum samples taken in August and September, 2009 (after the first wave of infection) as part of the annual collection for the Health Protection Agency seroepidemiology programme from patients accessing health care in England. Antibody titres were measured by use of haemagglutination inhibition and microneutralisation assays. We calculated the proportion of samples with antibodies to pandemic H1N1 virus in 2008 by age group and compared the proportion of samples with haemagglutination inhibition titre 1:32 or more (deemed a protective response) before the first wave of infection with the proportion after the first wave. **FINDINGS:** In the baseline serum samples from 2008, haemagglutination inhibition and microneutralisation antibody titres increased significantly with age (F test $p < 0.0001$). The proportion of samples with haemagglutination inhibition titre 1:32 or more ranged from 1.8% (three of 171; 95% CI 0.6-5.0) in children aged 0-4 years to 31.3% (52 of 166; 24.8-38.7) in adults aged 80 years or older. In London and the West Midlands, the difference in the proportion of samples with haemagglutination inhibition titre equal to or above 1:32 between baseline and September, 2009, was 21.3% (95% CI 8.8-40.3) for children younger than 5 years of age, 42.0% (26.3-58.2) for 5-14-year-olds, and 20.6% (1.6-42.4) for 15-24-year-olds, with no difference between baseline and September in older age groups. In other regions, only children younger than 15 years showed a significant increase from baseline (6.3%, 1.8-12.9). **INTERPRETATION:** Around one child in

every three was infected with 2009 pandemic H1N1 in the first wave of infection in regions with a high incidence, ten times more than estimated from clinical surveillance. Pre-existing antibody in older age groups protects against infection. Children have an important role in transmission of influenza and would be a key target group for vaccination both for their protection and for the protection of others through herd immunity. FUNDING: National Institute for Health Research Health Technology Assessment Programme

- (6) REED C, KATZ JM. **Serological surveys for 2009 pandemic influenza A H1N1**. Lancet. 2010 Mar. 27, vol. 375, n° 9720, pp.1062-1063
[http://dx.doi.org/10.1016/S0140-6736\(09\)62194-2](http://dx.doi.org/10.1016/S0140-6736(09)62194-2) (accès réservé EHESP)
- (7) SANDSTEAD HH, PRASAD AS. **Zinc intake and resistance to H1N1 influenza**. Am J Public Health. 2010 June, vol. 100, n° 6, pp.970-971
<http://www.ncbi.nlm.nih.gov/pubmed/20395565> (accès réservé EHESP) ou
<http://dx.doi.org/10.2105/AJPH.2009.187773> (accès réservé EHESP)
- (8) STEELFISHER GK, BLENDON RJ, BEKHEIT MM, LUBELL K. **The Public's Response to the 2009 H1N1 Influenza Pandemic**. N Engl J Med. 2010 May 19,
<http://dx.doi.org/NEJMp10.1056/NEJMp1005102> (accès réservé EHESP)
- (9) WADDINGTON CS, WALKER WT, OESER C, REINER A, *et al.* **Safety and immunogenicity of AS03B adjuvanted split virion versus non-adjuvanted whole virion H1N1 influenza vaccine in UK children aged 6 months-12 years: open label, randomised, parallel group, multicentre study**. BMJ. 2010, vol. 340, p.c2649
<http://www.ncbi.nlm.nih.gov/pubmed/20508026> (accès réservé EHESP)

OBJECTIVES: To compare the safety, reactogenicity, and immunogenicity of an adjuvanted split virion H1N1 vaccine and a non-adjuvanted whole virion vaccine used in the pandemic immunisation programme in the United Kingdom. **DESIGN:** Open label, randomised, parallel group, phase II study. **SETTING:** Five UK centres (Oxford, Southampton, Bristol, Exeter, and London). **PARTICIPANTS:** Children aged 6 months to less than 13 years for whom a parent or guardian had provided written informed consent and who were able to comply with study procedures were eligible. Those with laboratory confirmed pandemic H1N1 influenza or clinically diagnosed disease meriting antiviral treatment, allergy to egg or any other vaccine components, or coagulation defects, or who were severely immunocompromised or had recently received blood products were excluded. Children were grouped by age: 6 months-<3 years (younger group) and 3-<13 years (older group). Recruitment was by media advertising and direct mailing. Recruitment visits were attended by 949 participants, of whom 943 were enrolled and 937 included in the per protocol analysis. **INTERVENTIONS:** Participants were randomised 1:1 to receive AS03(B) (tocopherol based oil in water emulsion) adjuvanted split virion vaccine derived from egg culture or non-adjuvanted whole virion vaccine derived from cell culture. Both were given as two doses 21 days apart. Reactogenicity data were collected for one week after immunisation by diary card. Serum samples were collected at baseline and after the second dose. **MAIN OUTCOME MEASURES:** Primary reactogenicity end points were frequency and severity of fever, tenderness, swelling, and erythema after vaccination. Immunogenicity was measured by microneutralisation and haemagglutination inhibition assays. The primary immunogenicity objective was a comparison between vaccines of the percentage of participants showing seroconversion by the microneutralisation assay (fourfold rise to a titre of $\geq 1:40$ from before vaccination to three weeks after the second dose). **RESULTS:** Seroconversion rates were higher after the adjuvanted split virion vaccine than after the whole virion vaccine, most notably in the youngest children (163 of 166 participants with paired serum samples (98.2%, 95% confidence interval 94.8% to 99.6%) v 157 of 196 (80.1%, 73.8% to 85.5%), $P < 0.001$) in children under 3 years and 226 of 228 (99.1%, 96.9% to 99.9%) v 95.9%, 92.4% to 98.1%, $P = 0.03$) in those over 3 years). The adjuvanted split virion vaccine was more reactogenic than the whole virion vaccine, with more frequent systemic reactions and severe local reactions in children aged over 5 years after dose one (13 (7.2%, 3.9% to 12%) v 2 (1.1%, 0.1% to 3.9%), $P < 0.001$) and dose two (15 (8.5%, 4.8% to 13.7%) v 2 (1.1%,

0.1% to 4.1%), $P < 0.002$) and after dose two in those under 5 years (15 (5.9%, 3.3% to 9.6%) v 0 (0.0%, 0% to 1.4%), $P < 0.001$). Dose two of the adjuvanted split virion vaccine was more reactogenic than dose one, especially for fever ≥ 38 masculineC in those aged under 5 (24 (8.9%, 5.8% to 12.9%) v 57 (22.4%, 17.5% to 28.1%), $P < 0.001$). CONCLUSIONS: In this first direct comparison of an AS03(B) adjuvanted split virion versus whole virion non-adjuvanted H1N1 vaccine, the adjuvanted vaccine, while more reactogenic, was more immunogenic and, importantly, achieved high seroconversion rates in children aged less than 3 years. This indicates the potential for improved immunogenicity of influenza vaccines in this age group. Trial registration Clinical trials.gov NCT00980850; ISRCTN89141709

- (10) WALLEY T, DAVIDSON P. **Research funding in a pandemic**. Lancet. 2010 Mar. 27, vol. 375, n° 9720, pp.1063-1065
[http://dx.doi.org/10.1016/S0140-6736\(10\)60068-2](http://dx.doi.org/10.1016/S0140-6736(10)60068-2) (accès réservé EHESP)
- (11) ZAROCOSTAS J. **Swine flu pandemic review panel seeks access to confidential documents between WHO and drug companies**. BMJ. 2010, vol. 340, p.c2792
<http://www.ncbi.nlm.nih.gov/pubmed/20501574> (accès réservé EHESP)

Maladies d'Alzheimer

[sommaire](#)

- (1) CARPENTIER N, BERNARD P, GRENIER A, GUBERMAN N. **Using the life course perspective to study the entry into the illness trajectory: the perspective of caregivers of people with Alzheimer's disease**. Soc Sci Med. 2010 May, vol. 70, n° 10, pp.1501-1508
<http://dx.doi.org/10.1016/j.socscimed.2009.12.038> (accès réservé EHESP)

The research community is showing increasing interest in the analysis of the care trajectory of people with chronic health problems, especially dementias such as Alzheimer's disease. However, despite this interest, there is little research on the initial phases of the care trajectory. The fact that the first symptoms of dementia are generally noticed by those surrounding the elderly person suggests that the recognition of the disease is intimately linked to interactions not only amongst family members but also amongst friends, neighbours and health professionals. This study focuses on the period beginning with the first manifestations of cognitive difficulties and ending with the diagnosis of Alzheimer-type dementia. Interviews with 60 caregivers in Montreal, Canada were used to reconstruct how older people with Alzheimer-type dementia enter into the care trajectory. Our methods consisted of the analysis of social networks, social dynamics and action sequences. Our findings are presented in the form of a typology comprised of 5 pathways of entries into the care trajectory that are structured around the following four principles of the Life Course Perspective: family history, linked lives, human agency and organisational effects. We believe that analyses of the initial phases of the care trajectory, such as this one, are essential for the application of effective early detection and intervention policies. They are also central to informing future studies that seek to understand the care experience in its entirety

- (2) PEDERSEN NL. **Reaching the limits of genome-wide significance in Alzheimer disease: back to the environment**. JAMA. 2010 May 12, vol. 303, n° 18, pp.1864-1865
<http://dx.doi.org/10.1001/jama.2010.609> (accès réservé EHESP)
- (3) POMARA N, SIDTIS JJ. **Alzheimer's disease**. N Engl J Med. 2010 May 13, vol. 362, n° 19, pp.1844-1845
<http://dx.doi.org/10.1056/NEJMc1002323> (accès réservé EHESP)
- (4) SESHADRI S, FITZPATRICK AL, IKRAM MA, DESTEFANO AL, *et al.* **Genome-wide analysis of genetic loci associated with Alzheimer disease**. JAMA. 2010 May 12, vol. 303, n° 18, pp.1832-1840
<http://dx.doi.org/10.1001/jama.2010.574> (accès réservé EHESP)

CONTEXT: Genome-wide association studies (GWAS) have recently identified CLU, PICALM, and CR1 as novel genes for late-onset Alzheimer disease (AD). OBJECTIVES: To identify and strengthen additional loci associated with AD and confirm these in an independent sample and to examine the contribution of recently identified genes to AD risk prediction in a 3-stage analysis of new and previously published GWAS on more than 35,000 persons (8371 AD cases). DESIGN, SETTING, AND PARTICIPANTS: In stage 1, we identified strong genetic associations ($P < 10(-3)$) in a sample of 3006 AD cases and 14,642 controls by combining new data from the population-based Cohorts for Heart and Aging Research in Genomic Epidemiology consortium (1367 AD cases [973 incident]) with previously reported results from the Translational Genomics Research Institute and the Mayo AD GWAS. We identified 2708 single-nucleotide polymorphisms (SNPs) with $P < 10(-3)$. In stage 2, we pooled results for these SNPs with the European AD Initiative (2032 cases and 5328 controls) to identify 38 SNPs (10 loci) with $P < 10(-5)$. In stage 3, we combined data for these 10 loci with data from the Genetic and Environmental Risk in AD consortium (3333 cases and 6995 controls) to identify 4 SNPs with $P < 1.7 \times 10(-8)$. These 4 SNPs were replicated in an independent Spanish sample (1140 AD cases and 1209 controls). Genome-wide association analyses were completed in 2007-2008 and the meta-analyses and replication in 2009. MAIN OUTCOME MEASURE: Presence of Alzheimer disease. RESULTS: Two loci were identified to have genome-wide significance for the first time: rs744373 near BIN1 (odds ratio [OR], 1.13; 95% confidence interval [CI], 1.06-1.21 per copy of the minor allele; $P = 1.59 \times 10(-11)$) and rs597668 near EXOC3L2/BLOC1S3/MARK4 (OR, 1.18; 95% CI, 1.07-1.29; $P = 6.45 \times 10(-9)$). Associations of these 2 loci plus the previously identified loci CLU and PICALM with AD were confirmed in the Spanish sample ($P < .05$). However, although CLU and PICALM were confirmed to be associated with AD in this independent sample, they did not improve the ability of a model that included age, sex, and APOE to predict incident AD (improvement in area under the receiver operating characteristic curve from 0.847 to 0.849 in the Rotterdam Study and 0.702 to 0.705 in the Cardiovascular Health Study). CONCLUSIONS: Two genetic loci for AD were found for the first time to reach genome-wide statistical significance. These findings were replicated in an independent population. Two recently reported associations were also confirmed. These loci did not improve AD risk prediction. While not clinically useful, they may implicate biological pathways useful for future research

- (5) STEEL K. **Alzheimer's disease.** N Engl J Med. 2010 May 13, vol. 362, n° 19, pp.1844-1845
<http://www.ncbi.nlm.nih.gov/pubmed/20468086> (accès réservé EHESP)

Maladies cardio-vasculaires

[sommaire](#)

- (1) CRAMER SC. **Brain repair after stroke.** N Engl J Med. 2010 May 13, vol. 362, n° 19, pp.1827-1829
<http://dx.doi.org/10.1056/NEJMe1003399> (accès réservé EHESP)
- (2) LANGE RA, HILLIS LD. **Second-generation drug-eluting coronary stents.** N Engl J Med. 2010 May 6, vol. 362, n° 18, pp.1728-1730
<http://dx.doi.org/10.1056/NEJMe1001069> (accès réservé EHESP)
- (3) LEES KR, BLUHMKI E, VON KR, BROTT TG, *et al.* **Time to treatment with intravenous alteplase and outcome in stroke: an updated pooled analysis of ECASS, ATLANTIS, NINDS, and EPITHET trials.** Lancet. 2010 May 15, vol. 375, n° 9727, pp.1695-1703
[http://dx.doi.org/10.1016/S0140-6736\(10\)60491-6](http://dx.doi.org/10.1016/S0140-6736(10)60491-6) (accès réservé EHESP)

BACKGROUND: Early administration of intravenous recombinant tissue plasminogen activator (rt-PA) after ischaemic stroke improves outcome. Previous analysis of combined data from individual patients suggested potential benefit beyond 3 h from stroke onset. We re-examined the effect of time to treatment with intravenous rt-PA (alteplase) on therapeutic benefit and clinical risk by adding recent trial data to the analysis. METHODS: We added data from ECASS III (821 patients) and EPITHET (100 patients) to a pool of common data elements from six other trials of alteplase for acute stroke (2775 patients). We used multivariate logistic regression to assess the relation of

stroke onset to start of treatment (OTT) with treatment on favourable 3-month outcome (defined as modified Rankin score 0-1), mortality, and occurrence and outcome of clinically relevant parenchymal haemorrhage. The presence of an arterial occlusion was inferred from the patient's symptoms and absence of haemorrhage or other causes of ischaemic stroke. Vascular imaging was not a requirement in the trials. All patients with confirmed OTT within 360 min were included in the analysis. FINDINGS: Treatment was started within 360 min of stroke onset in 3670 patients randomly allocated to alteplase (n=1850) or to placebo (n=1820). Odds of a favourable 3-month outcome increased as OTT decreased ($p=0.0269$) and no benefit of alteplase treatment was seen after around 270 min. Adjusted odds of a favourable 3-month outcome were 2.55 (95% CI 1.44-4.52) for 0-90 min, 1.64 (1.12-2.40) for 91-180 min, 1.34 (1.06-1.68) for 181-270 min, and 1.22 (0.92-1.61) for 271-360 min in favour of the alteplase group. Large parenchymal haemorrhage was seen in 96 (5.2%) of 1850 patients assigned to alteplase and 18 (1.0%) of 1820 controls, with no clear relation to OTT ($p=0.4140$). Adjusted odds of mortality increased with OTT ($p=0.0444$) and were 0.78 (0.41-1.48) for 0-90 min, 1.13 (0.70-1.82) for 91-180 min, 1.22 (0.87-1.71) for 181-270 min, and 1.49 (1.00-2.21) for 271-360 min. INTERPRETATION: Patients with ischaemic stroke selected by clinical symptoms and CT benefit from intravenous alteplase when treated up to 4.5 h. To increase benefit to a maximum, every effort should be taken to shorten delay in initiation of treatment. Beyond 4.5 h, risk might outweigh benefit. FUNDING: None

- (4) LO AC, GUARINO PD, RICHARDS LG, HASELKORN JK, *et al.* **Robot-assisted therapy for long-term upper-limb impairment after stroke.** N Engl J Med. 2010 May 13, vol. 362, n° 19, pp.1772-1783
<http://dx.doi.org/10.1056/NEJMoa0911341> (accès réservé EHESP)

BACKGROUND: Effective rehabilitative therapies are needed for patients with long-term deficits after stroke. METHODS: In this multicenter, randomized, controlled trial involving 127 patients with moderate-to-severe upper-limb impairment 6 months or more after a stroke, we randomly assigned 49 patients to receive intensive robot-assisted therapy, 50 to receive intensive comparison therapy, and 28 to receive usual care. Therapy consisted of 36 1-hour sessions over a period of 12 weeks. The primary outcome was a change in motor function, as measured on the Fugl-Meyer Assessment of Sensorimotor Recovery after Stroke, at 12 weeks. Secondary outcomes were scores on the Wolf Motor Function Test and the Stroke Impact Scale. Secondary analyses assessed the treatment effect at 36 weeks. RESULTS: At 12 weeks, the mean Fugl-Meyer score for patients receiving robot-assisted therapy was better than that for patients receiving usual care (difference, 2.17 points; 95% confidence interval [CI], -0.23 to 4.58) and worse than that for patients receiving intensive comparison therapy (difference, -0.14 points; 95% CI, -2.94 to 2.65), but the differences were not significant. The results on the Stroke Impact Scale were significantly better for patients receiving robot-assisted therapy than for those receiving usual care (difference, 7.64 points; 95% CI, 2.03 to 13.24). No other treatment comparisons were significant at 12 weeks. Secondary analyses showed that at 36 weeks, robot-assisted therapy significantly improved the Fugl-Meyer score (difference, 2.88 points; 95% CI, 0.57 to 5.18) and the time on the Wolf Motor Function Test (difference, -8.10 seconds; 95% CI, -13.61 to -2.60) as compared with usual care but not with intensive therapy. No serious adverse events were reported. CONCLUSIONS: In patients with long-term upper-limb deficits after stroke, robot-assisted therapy did not significantly improve motor function at 12 weeks, as compared with usual care or intensive therapy. In secondary analyses, robot-assisted therapy improved outcomes over 36 weeks as compared with usual care but not with intensive therapy. (ClinicalTrials.gov number, NCT00372411.)

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<http://dx.doi.org/10.1056/NEJMcibr1002359> (accès réservé EHESP)
- (6) MURRAY ET, EZ ROUX AV, CARNETHON M, LUTSEY PL, *et al.* **Trajectories of neighborhood poverty and associations with subclinical atherosclerosis and associated risk factors: the multi-ethnic study of atherosclerosis**. Am J Epidemiol. 2010 May 15, vol. 171, n° 10, pp.1099-1108
<http://dx.doi.org/10.1093/aje/kwq044> (accès réservé EHESP)

The authors used data from the Multi-Ethnic Study of Atherosclerosis and latent trajectory class modeling to determine patterns of neighborhood poverty over 20 years (1980-2000 residential history questionnaires were geocoded and linked to US Census data). Using these patterns, the authors examined 1) whether trajectories of neighborhood poverty were associated with differences in the amount of subclinical atherosclerosis (common carotid intimal-media thickness) and 2) associated risk factors (body mass index, hypertension, diabetes, current smoking) at baseline (January 2000-August 2002). The authors found evidence of 5 stable trajectory groups with differing levels of neighborhood poverty (approximately 6%, 12%, 20%, 30%, and 45%) and 1 group with 29% poverty in 1980 and approximately 11% in 2000. Mostly for women, higher cumulative neighborhood poverty was generally significantly associated with worse cardiovascular outcomes. Trends generally persisted after adjustment for adulthood socioeconomic position and race/ethnicity, although they were no longer statistically significant. Among women who had moved during the 20 years, the long-term measure had stronger associations with outcomes (except smoking) than a single, contemporaneous measure. Results indicate that cumulative 20-year exposure to neighborhood poverty is associated with greater cardiovascular risk for women. In residentially mobile populations, single-point-in-time measures underestimate long-term effects

- (7) PARE G, ANAND SS. **Mendelian randomisation, triglycerides, and CHD**. Lancet. 2010 May 8, vol. 375, n° 9726, pp.1584-1586
[http://dx.doi.org/10.1016/S0140-6736\(10\)60659-9](http://dx.doi.org/10.1016/S0140-6736(10)60659-9) (accès réservé EHESP)
- (8) PIZZI C, DE STAVOLA BL, MEADE TW. **Long-term association of routine blood count (Coulter) variables on fatal coronary heart disease: 30-year results from the first prospective Northwick Park Heart Study (NPHS-I)**. Int J Epidemiol. 2010 Feb., vol. 39, n° 1, pp.256-265
<http://dx.doi.org/10.1093/ije/dyp245> (accès réservé EHESP)

BACKGROUND: Since evidence of a long-term association between routine blood count (Coulter) variables and coronary heart disease (CHD) is inconsistent, the authors analysed white blood cell count (WBC), red blood cell count (RBC), haemoglobin (Hgb), packed cell volume (PCV) and platelet count for their long-term associations with CHD mortality in the first Northwick Park Heart Study (NPHS-I). NPHS-I has follow-up information for >30 years on 2167 White men and 941 White women and holds entry and follow-up data on haematological variables and other known CHD risk factors. **METHODS:** Proportional hazards Cox models were fitted to estimate rate ratios (RRs) for the separate and joint effects of entry and follow-up Coulter variables. **RESULTS:** Entry RBC, PCV and Hgb were significant risk factors for CHD mortality after adjustment for gender but only PCV remained significant after adjustment for potential confounders [RR per 1 standard deviation (SD) increase = 1.17, 95% confidence interval (CI) 1.00-1.37]. This effect was partly reduced when the values of 6 years were analysed (RR per 1 SD increase = 1.10, 95% CI 0.93-1.30). No significant gender, smoking or age/time interactions were identified. PCV was the only significant predictor when all Coulter variables were studied jointly. **CONCLUSION:** PCV was found to predict CHD mortality even after controlling for classical risk factors. This may give some insight into possible mechanisms, such as an influence on thrombin production

- (9) RASMUSSEN K, MAENG M, KALTOFT A, THAYSSSEN P, *et al.* **Efficacy and safety of zotarolimus-eluting and sirolimus-eluting coronary stents in routine clinical care (SORT OUT III): a randomised controlled superiority trial.** *Lancet.* 2010 Mar. 27, vol. 375, n° 9720, pp.1090-1099
[http://dx.doi.org/10.1016/S0140-6736\(10\)60208-5](http://dx.doi.org/10.1016/S0140-6736(10)60208-5) (accès réservé EHESP)

BACKGROUND: In low-risk patients, the zotarolimus-eluting stent has been shown to reduce rates of restenosis without increasing the risk of stent thrombosis. We compared the efficacy and safety of the zotarolimus-eluting stent versus the sirolimus-eluting stent in patients with coronary artery disease who were receiving routine clinical care with no direct follow-up. **METHODS:** We did a single-blind, all-comer superiority trial in adult patients with chronic stable coronary artery disease or acute coronary syndromes, and at least one target lesion. Patients were treated at one of five percutaneous coronary intervention centres between January, 2006, and August, 2007. Computer-generated block randomisation and a telephone allocation service were used to randomly assign patients to receive the zotarolimus-eluting or the sirolimus-eluting stent. Data for follow-up were obtained from national Danish administrative and health-care registries. The primary endpoint was a composite of major adverse cardiac events within 9 months: cardiac death, myocardial infarction, and target vessel revascularisation. Intention-to-treat analyses were done at 9-month and 18-month follow-up. This trial is registered with ClinicalTrials.gov, number NCT00660478. **FINDINGS:** 1162 patients (1619 lesions) were assigned to receive the zotarolimus-eluting stent, and 1170 patients (1611 lesions) to receive the sirolimus-eluting stent. 67 patients (72 lesions) had stent failure, and six patients were lost to follow-up. All randomly assigned patients were included in analyses at 9-month follow-up; 2200 patients (94%) had completed 18-month follow-up by the time of our assessment. At 9 months, the primary endpoint had occurred in a higher proportion of patients treated with the zotarolimus-eluting stent than in those treated with the sirolimus-eluting stent (72 [6%] vs 34 [3%]; HR 2.15, 95% CI 1.43-3.23; $p=0.0002$). At 18-month follow-up, this difference was sustained (113 [10%] vs 53 [5%]; 2.19, 1.58-3.04; $p<0.0001$). For patients receiving the zotarolimus-eluting stent and those receiving the sirolimus-eluting stent, all cause-mortality was similar at 9-month follow-up (25 [2%] vs 18 [2%]; 1.40, 0.76-2.56; $p=0.28$), but was significantly different at 18-month follow-up (51 [4%] vs 32 [3%]; 1.61, 1.03-2.50; $p=0.035$). **INTERPRETATION:** The sirolimus-eluting stent is superior to the zotarolimus-eluting stent for patients receiving routine clinical care. **FUNDING:** Cordis and Medtronic

- (10) SARWAR N, SANDHU MS, RICKETTS SL, BUTTERWORTH AS, *et al.* **Triglyceride-mediated pathways and coronary disease: collaborative analysis of 101 studies.** *Lancet.* 2010 May 8, vol. 375, n° 9726, pp.1634-1639
[http://dx.doi.org/10.1016/S0140-6736\(10\)60545-4](http://dx.doi.org/10.1016/S0140-6736(10)60545-4) (accès réservé EHESP)

BACKGROUND: Whether triglyceride-mediated pathways are causally relevant to coronary heart disease is uncertain. We studied a genetic variant that regulates triglyceride concentration to help judge likelihood of causality. **METHODS:** We assessed the -1131T>C (rs662799) promoter polymorphism of the apolipoprotein A5 (APOA5) gene in relation to triglyceride concentration, several other risk factors, and risk of coronary heart disease. We compared disease risk for genetically-raised triglyceride concentration (20,842 patients with coronary heart disease, 35,206 controls) with that recorded for equivalent differences in circulating triglyceride concentration in prospective studies (302 430 participants with no history of cardiovascular disease; 12,785 incident cases of coronary heart disease during 2.79 million person-years at risk). We analysed -1131T>C in 1795 people without a history of cardiovascular disease who had information about lipoprotein concentration and diameter obtained by nuclear magnetic resonance spectroscopy. **FINDINGS:** The minor allele frequency of -1131T>C was 8% (95% CI 7-9). -1131T>C was not significantly associated with several non-lipid risk factors or LDL cholesterol, and it was modestly associated with lower HDL cholesterol (mean difference per C allele 3.5% [95% CI 2.6-4.6]; 0.053 mmol/L [0.039-0.068]), lower apolipoprotein AI (1.3% [0.3-2.3]; 0.023 g/L [0.005-0.041]), and higher apolipoprotein B (3.2% [1.3-5.1]; 0.027 g/L [0.011-0.043]). By contrast, for every C allele inherited, mean triglyceride concentration was 16.0% (95% CI 12.9-18.7), or 0.25 mmol/L (0.20-0.29), higher ($p=4.4\times 10^{-24}$). The odds ratio for coronary heart disease was 1.18 (95% CI 1.11-1.26; $p=2.6\times 10^{-7}$) per C allele, which was concordant with the hazard ratio of 1.10 (95% CI 1.08-1.12) per 16% higher triglyceride concentration recorded in prospective studies. -1131T>C was

significantly associated with higher VLDL particle concentration (mean difference per C allele 12.2 nmol/L [95% CI 7.7-16.7]; $p=9.3 \times 10^{-8}$) and smaller HDL particle size (0.14 nm [0.08-0.20]; $p=7.0 \times 10^{-5}$), factors that could mediate the effects of triglyceride. INTERPRETATION: These data are consistent with a causal association between triglyceride-mediated pathways and coronary heart disease. FUNDING: British Heart Foundation, UK Medical Research Council, Novartis

- (11) SAVER JL, LEVINE SR. **Alteplase for ischaemic stroke--much sooner is much better**. *Lancet*. 2010 May 15, vol. 375, n° 9727, pp.1667-1668
[http://dx.doi.org/10.1016/S0140-6736\(10\)60634-4](http://dx.doi.org/10.1016/S0140-6736(10)60634-4) (accès réservé EHESP)

- (12) STONE GW, RIZVI A, NEWMAN W, MASTALI K, *et al.* **Everolimus-eluting versus paclitaxel-eluting stents in coronary artery disease**. *N Engl J Med*. 2010 May 6, vol. 362, n° 18, pp.1663-1674
<http://dx.doi.org/10.1056/NEJMoa0910496> (Accès réservé EHESP)

BACKGROUND: Previous studies have established the superiority of coronary everolimus-eluting stents over paclitaxel-eluting stents with respect to angiographic findings. However, these trials were not powered for superiority in clinical end points. METHODS: We randomly assigned 3687 patients at 66 U.S. sites to receive everolimus-eluting stents or paclitaxel-eluting stents without routine follow-up angiography. The primary end point was the 1-year composite rate of target-lesion failure (defined as cardiac death, target-vessel myocardial infarction, or ischemia-driven target-lesion revascularization). RESULTS: Everolimus-eluting stents were superior to paclitaxel-eluting stents with respect to the primary end point of target-lesion failure (4.2% vs. 6.8%; relative risk, 0.62; 95% confidence interval, 0.46 to 0.82; $P=0.001$). Everolimus-eluting stents were also superior with respect to the major secondary end point of the 1-year rate of ischemia-driven target-lesion revascularization ($P=0.001$) and were noninferior with respect to the major secondary end point of the 1-year composite rate of cardiac death or target-vessel myocardial infarction ($P<0.001$ for noninferiority; $P=0.09$ for superiority). The 1-year rates of myocardial infarction and stent thrombosis were also lower with everolimus-eluting stents than with paclitaxel-eluting stents (1.9% vs. 3.1%, $P=0.02$ for myocardial infarction; 0.17% vs. 0.85%, $P=0.004$ for stent thrombosis). Target-lesion failure was consistently reduced with everolimus-eluting stents as compared with paclitaxel-eluting stents in 12 prespecified subgroups, except in the subgroup of patients with diabetes (6.4% vs. 6.9%, $P=0.80$). CONCLUSIONS: Everolimus-eluting stents, as compared with paclitaxel-eluting stents, resulted in reduced rates of target-lesion failure at 1 year, results that were consistent in all patients except those with diabetes, in whom the results were nonsignificantly different. (ClinicalTrials.gov number, NCT00307047.)

- (13) TIMMIS A. **NICE and chest pain diagnosis. NICE replies**. *BMJ*. 2010, vol. 340, p.c2391
<http://www.ncbi.nlm.nih.gov/pubmed/20442231> (accès réservé EHESP)

- (14) TSENG HF, SLEZAK JM, QUINN VP, SY LS, *et al.* **Pneumococcal vaccination and risk of acute myocardial infarction and stroke in men**. *JAMA*. 2010 May 5, vol. 303, n° 17, pp.1699-1706
<http://dx.doi.org/10.1001/jama.2010.529> (accès réservé EHESP)

CONTEXT: Multiple studies have shown that preventing influenza by vaccination reduces the risk of vascular events. However, the effect of pneumococcal polysaccharide vaccine on vascular events remains controversial. OBJECTIVE: To examine the association between pneumococcal vaccination and risk of acute myocardial infarction (MI) and stroke among men. DESIGN, SETTING, AND PARTICIPANTS: A prospective cohort study of Kaiser Permanente Northern and Southern California health plans with 84 170 participants aged 45 to 69 years from the California Men's Health Study who were recruited between January 2002 and December 2003, and followed up until December 31, 2007. The cohort was similar to the population of health plan members and men who responded to a general health survey in California on important demographic and clinical characteristics. Demographic and detailed lifestyle characteristics were collected from surveys. Vaccination records were obtained from the Kaiser Immunization Tracking System. MAIN

OUTCOME MEASURE: Incidence of acute MI and stroke during the follow-up period in men who had no history of such conditions. RESULTS: During follow-up, there were 1211 first MIs in 112,837 vaccinated person-years (10.73 per 1000 person-years) compared with 1494 first MI events in 246,170 unvaccinated person-years (6.07 per 1000 person-years). For stroke, there were 651 events in 122,821 vaccinated person-years (5.30 per 1000 person-years) compared with 483 events in 254,541 unvaccinated person-years (1.90 per 1000 person-years). With propensity score adjustment, we found no evidence for an association between pneumococcal vaccination and reduced risk of acute MI (adjusted hazard ratio [HR], 1.09; 95% confidence interval [CI], 0.98-1.21) or stroke (adjusted HR, 1.14; 95% CI, 1.00-1.31). An inverse association was also not found in men of different age and risk groups. The results appeared to be consistent, because using more specific International Classification of Diseases, Ninth Revision codes for the outcome definition did not change the estimations. CONCLUSION: Among a cohort of men aged 45 years or older, receipt of pneumococcal vaccine was not associated with subsequent reduced risk of acute MI and stroke

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<http://www.ncbi.nlm.nih.gov/pubmed/20442230> (accès réservé EHESP)
- (16) WALD DS, BESTWICK JP. **C-reactive protein measurement and cardiovascular disease.** Lancet. 2010 Mar. 27, vol. 375, n° 9720, pp.1077-1078
[http://dx.doi.org/10.1016/S0140-6736\(10\)60468-0](http://dx.doi.org/10.1016/S0140-6736(10)60468-0) (accès réservé EHESP)
- (17) WALLIS A, SAUNDERS T. **Imaging transient ischaemic attack with diffusion weighted magnetic resonance imaging.** BMJ. 2010, vol. 340, p.c2215
<http://www.ncbi.nlm.nih.gov/pubmed/20435634> (accès réservé EHESP)
- (18) WEBSTER MW, ORMISTON JA. **Sorting out drug-eluting stents.** Lancet. 2010 Mar. 27, vol. 375, n° 9720, pp.1060-1062
[http://dx.doi.org/10.1016/S0140-6736\(10\)60402-3](http://dx.doi.org/10.1016/S0140-6736(10)60402-3) (accès réservé EHESP)
- (19) WIJEYSUNDERA HC, MACHADO M, FARAHATI F, WANG X, *et al.* **Association of temporal trends in risk factors and treatment uptake with coronary heart disease mortality, 1994-2005.** JAMA. 2010 May 12, vol. 303, n° 18, pp.1841-1847
<http://dx.doi.org/10.1001/jama.2010.580> (accès réservé EHESP)

CONTEXT: Coronary heart disease (CHD) mortality has declined substantially in Canada since 1994. OBJECTIVE: To determine what proportion of this decline was associated with temporal trends in CHD risk factors and advancements in medical treatments. DESIGN, SETTING, AND PATIENTS: Prospective analytic study of the Ontario, Canada, population aged 25 to 84 years between 1994 and 2005, using an updated version of the validated IMPACT model, which integrates data on population size, CHD mortality, risk factors, and treatment uptake changes. Relative risks and regression coefficients from the published literature quantified the relationship between CHD mortality and (1) evidence-based therapies in 8 distinct CHD subpopulations (acute myocardial infarction [AMI], acute coronary syndromes, secondary prevention post-AMI, chronic coronary artery disease, heart failure in the hospital vs in the community, and primary prevention for hyperlipidemia or hypertension) and (2) population trends in 6 risk factors (smoking, diabetes mellitus, systolic blood pressure, plasma cholesterol level, exercise, and obesity). MAIN OUTCOME MEASURES: The number of deaths prevented or delayed in 2005; secondary outcome measures were improvements in medical treatments and trends in risk factors. RESULTS: Between 1994 and 2005, the age-adjusted CHD mortality rate in Ontario decreased by 35% from 191 to 125 deaths per 100,000 inhabitants, translating to an estimated 7585 fewer CHD deaths in 2005. Improvements in medical and surgical treatments were associated with 43% (range, 11% to 124%) of the total mortality decrease, most notably in AMI (8%; range, -5% to

40%), chronic stable coronary artery disease (17%; range, 7% to 35%), and heart failure occurring while in the community (10%; range, 6% to 31%). Trends in risk factors accounted for 3660 fewer CHD deaths prevented or delayed (48% of total; range, 28% to 64%), specifically, reductions in total cholesterol (23%; range, 10% to 33%) and systolic blood pressure (20%; range, 13% to 26%). Increasing diabetes prevalence and body mass index had an inverse relationship associated with higher CHD mortality of 6% (range, 4% to 8%) and 2% (range, 1% to 4%), respectively. **CONCLUSION:** Between 1994 and 2005, there was a decrease in CHD mortality rates in Ontario that was associated primarily with trends in risk factors and improvements in medical treatments, each explaining about half of the decrease

Maladies liées à l'alcool

[sommaire](#)

- (1) **The mental health of UK military personnel revisited.** Lancet. 2010 May 15, vol. 375, n° 9727, p.1666
[http://dx.doi.org/10.1016/S0140-6736\(10\)60717-9](http://dx.doi.org/10.1016/S0140-6736(10)60717-9) (accès réservé EHESP)
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<http://dx.doi.org/10.1056/NEJMc1002801> (accès réservé EHESP)

Paludisme

[sommaire](#)

- (1) **Malaria 2010: more ambition and accountability please.** Lancet. 2010 Apr. 24, vol. 375, n° 9724, p.1407
[http://dx.doi.org/10.1016/S0140-6736\(10\)60601-0](http://dx.doi.org/10.1016/S0140-6736(10)60601-0) (accès réservé EHESP)
- (2) ADAMS P. **Rainy season could hamper Haiti's recovery.** Lancet. 2010 Mar. 27, vol. 375, n° 9720, pp.1067-1069
<http://www.ncbi.nlm.nih.gov/pubmed/20352657> (accès réservé EHESP)
- (3) BIEDRON C, PAGANO M, HEDT BL, KILIAN A, *et al.* **An assessment of Lot Quality Assurance Sampling to evaluate malaria outcome indicators: extending malaria indicator surveys .** Int J Epidemiol. 2010 Feb., vol. 39, n° 1, pp.72-79
<http://dx.doi.org/10.1093/ije/dyp363> (accès réservé EHESP)

BACKGROUND: Large investments and increased global prioritization of malaria prevention and treatment have resulted in greater emphasis on programme monitoring and evaluation (M&E) in many countries. Many countries currently use large multistage cluster sample surveys to monitor malaria outcome indicators on a regional and national level. However, these surveys often mask local-level variability important to programme management. Lot Quality Assurance Sampling (LQAS) has played a valuable role for local-level programme M&E. If incorporated into these larger surveys, it would provide a comprehensive M&E plan at little, if any, extra cost. **METHODS:** The Mozambique Ministry of Health conducted a Malaria Indicator Survey (MIS) in June and July 2007. We applied LQAS classification rules to the 345 sampled enumeration areas to demonstrate identifying high- and low-performing areas with respect to two malaria program indicators-'household possession of any bednet' and 'household possession of any insecticide-treated bednet (ITN)'. **RESULTS:** As shown by the MIS, no province in Mozambique achieved the 70% coverage target for household possession of bednets or ITNs. By applying LQAS classification rules to the data, we identify 266 of the 345 enumeration areas as having bednet coverage severely below the 70% target. An additional 73 were identified with low ITN coverage. **CONCLUSIONS:** This article demonstrates the feasibility of integrating LQAS into multistage cluster sampling surveys and using these results to support a comprehensive national, regional and local programme M&E system. Furthermore, in the recommendations we outlined how to

integrate the Large Country-LQAS design into macro-surveys while still obtaining results available through current sampling practices

- (4) BLOOM BR. **Support for global health**. Science. 2010 May 14, vol. 328, n° 5980, p.791
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The past decade has seen an unprecedented surge in political commitment and international funding for malaria control. Coverage with existing control methods (ie, vector control and artemisinin-based combination therapy) is increasing, and, in some Asian and African countries, childhood morbidity and mortality from malaria caused by *Plasmodium falciparum* are starting to decline. Consequently, there is now renewed interest in the possibility of malaria elimination. But the ability of the parasite to develop resistance to antimalarial drugs and increasing insecticide resistance of the vector threaten to reduce and even reverse current gains. *Plasmodium vivax*, with its dormant liver stage, will be particularly difficult to eliminate, and access to effective and affordable treatment at community level is a key challenge. New drugs and insecticides are needed urgently, while use of an effective vaccine as part of national malaria control programmes remains an elusive goal. This Seminar, which is aimed at clinicians who manage children with malaria, especially in resource-poor settings, discusses present knowledge and controversies in relation to the epidemiology, pathophysiology, diagnosis, treatment, and prevention of malaria in children

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<http://dx.doi.org/10.1126/science.328.5980.842> (accès réservé EHESP)

- (11) FERRIMAN A. **Fighting malaria with scarves**. BMJ. 2010, vol. 340, p.c2566
<http://www.ncbi.nlm.nih.gov/pubmed/20460336> (accès réservé EHESP)

- (12) HSIANG MS, ABEYASINGHE R, WHITTAKER M, FEACHEM RG. **Malaria elimination in Asia-Pacific: an under-told story**. Lancet. 2010 May 8, vol. 375, n° 9726, pp.1586-1587
[http://dx.doi.org/10.1016/S0140-6736\(10\)60350-9](http://dx.doi.org/10.1016/S0140-6736(10)60350-9) (accès réservé EHESP)

- (13) HURTLEY S, ASH C, ROBERTS L. **Tuberculosis & malaria. Landscapes of infection. Introduction.** Science. 2010 May 14, vol. 328, n° 5980, p.841
<http://dx.doi.org/10.1126/science.328.5980.841> (accès réservé EHESP)
- (14) KAPPE SH, VAUGHAN AM, BODDEY JA, COWMAN AF. **That was then but this is now: malaria research in the time of an eradication agenda.** Science. 2010 May 14, vol. 328, n° 5980, pp.862-866
<http://dx.doi.org/10.1126/science.1184785> (accès réservé EHESP)

The global research community must take up the challenge to work toward the eradication of malaria. In the past, malaria research has focused on drugs and vaccines that target the blood stage of infection, and mainly on the most deadly species, *Plasmodium falciparum*, all of which is justified by the need to prevent and treat the disease. This work remains critically important today. However, an increased research focus is now being placed on potential interventions that aim to kill the parasite stages transmitted to and by the mosquito vector because they may represent more vulnerable targets to stop the spread of malaria. Here, we highlight some of the research into malaria parasite biology that has the potential to provide new intervention targets for antimalarial drugs and vaccines

- (15) MACKINNON MJ, MARSH K. **The selection landscape of malaria parasites.** Science. 2010 May 14, vol. 328, n° 5980, pp.866-871
<http://dx.doi.org/10.1126/science.1185410> (accès réservé EHESP)

Malaria parasites have to survive and transmit within a highly selective and ever-changing host environment. Because immunity to malaria is nonsterilizing and builds up slowly through repeated infections, commonly the parasite invades a host that is immunologically and physiologically different from its previous host. During the course of infection, the parasite must also keep pace with changes in host immune responses and red-blood-cell physiology. Here, we describe the "selection landscape" of the most virulent of the human malaria parasites, *Plasmodium falciparum*, and the adaptive mechanisms it uses to navigate through that landscape. Taking a cost-benefit view of parasite fitness, we consider the evolutionary outcomes of the most important forces of selection operating on the parasite, namely immunity, host death, drugs, mosquito availability, and coinfection. Given the huge potential for malaria parasite evolution in the context of the recently renewed effort to eradicate malaria, a deeper understanding of *P. falciparum* adaptation is essential

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[http://dx.doi.org/10.1016/S0140-6736\(10\)60134-1](http://dx.doi.org/10.1016/S0140-6736(10)60134-1) (accès réservé EHESP)

- (17) MONTGOMERY CM, MUNGUAMBE K, POOL R. **Group-based citizenship in the acceptance of indoor residual spraying (IRS) for malaria control in Mozambique.** Soc Sci Med. 2010 May, vol. 70, n° 10, pp.1648-1655
<http://dx.doi.org/10.1016/j.socscimed.2010.01.020> (accès réservé EHESP)

In 2006, the Mozambican Ministry of Health expanded its existing Indoor Residual Spraying (IRS) programme into Manhica District in the south of the country. Widespread household coverage is required to have a significant impact on malaria transmission, making acceptability fundamental to success. Between 2006 and 2008 we conducted anthropological research in order to understand acceptability of IRS in the context of the implementation process, policy debates, local and regional politics and historical processes. In the first phase of this qualitative study, conducted between January and April 2006, 73 interviews and 12 focus groups were conducted with key stakeholders from 14 locales in and around the town of Manhica: householders, community leaders, health care professionals, sprayers, and District officials. Analysis revealed IRS to be broadly acceptable despite very low levels of perceived efficacy and duration of effect. In contrast to previous studies which have linked acceptance to a reduction in mosquitoes, nuisance biting

and malaria, we found people's compliance with the programme to be founded on a sense of group-based citizenship. The involvement of local governmental leaders in the intervention appears to have led many to accept spraying as part of their civic duty, as decreed by post-war decentralisation policy in rural areas. We discuss the implications of this 'passive' form of compliance for the acceptability and sustainability of malaria control and other public health programmes

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[http://dx.doi.org/10.1016/S0140-6736\(10\)60609-5](http://dx.doi.org/10.1016/S0140-6736(10)60609-5) (accès réservé EHESP)
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<http://www.ncbi.nlm.nih.gov/pubmed/20478965> (accès réservé EHESP)
- (20) MOSZYNSKI P. **Disappearance of drugs undermines Uganda's fight against malaria**. BMJ. 2010, vol. 340, p.c2611
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- (21) MOSZYNSKI P. **Lack of awareness of problems with treatments threatens malaria control efforts**. BMJ. 2010, vol. 340, p.c2295
<http://www.ncbi.nlm.nih.gov/pubmed/20423972> (accès réservé EHESP)
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[http://dx.doi.org/10.1016/S0140-6736\(10\)60582-X](http://dx.doi.org/10.1016/S0140-6736(10)60582-X) (accès réservé EHESP)
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<http://dx.doi.org/10.1126/science.328.5980.850> (accès réservé EHESP)
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[http://dx.doi.org/10.1016/S0140-6736\(10\)60322-4](http://dx.doi.org/10.1016/S0140-6736(10)60322-4) (accès réservé EHESP)

BACKGROUND: There is a need for new artemisinin-based combination therapies that are convenient, effective, and safe. We compared the efficacy and safety of pyronaridine-artesunate with that of artemether-lumefantrine for treatment of uncomplicated P falciparum malaria.

METHODS: This phase 3, parallel-group, double-blind, randomised, non-inferiority trial was undertaken in seven sites in Africa and three sites in southeast Asia. In a double-dummy design, patients aged 3-60 years with uncomplicated P falciparum malaria were randomly assigned in a 2:1 ratio to receive pyronaridine-artesunate once a day or artemether-lumefantrine twice a day, orally for 3 days, plus respective placebo. Randomisation was done by computer-generated randomisation sequence in blocks of nine by study centre. Intervention tablets contained 180 mg pyronaridine and 60 mg artesunate; control tablets contained 20 mg artemether and 120 mg lumefantrine. Both treatments were given according to bodyweight. The primary efficacy outcome

was PCR-corrected adequate clinical and parasitological response (ACPR) rate at day 28 in the per-protocol population. Non-inferiority was shown if the lower limit of the two-sided 95% CI for the difference between groups was greater than -5%. This study is registered with ClinicalTrials.gov, number NCT00422084. FINDINGS: 1272 patients were randomly assigned to treatment (pyronaridine-artesunate, n=849; artemether-lumefantrine, n=423). The per-protocol population consisted of 784 patients in the pyronaridine-artesunate group and 386 patients in the artemether-lumefantrine group. PCR-corrected ACPR rate at day 28 was 99.5% (780 patients; 95% CI 98.7-99.9) in the pyronaridine-artesunate group and 99.2% (383 patients; 95% CI 97.7-99.8) in the artemether-lumefantrine group (treatment difference 0.3%, 95% CI -0.7 to 1.8; p=0.578). There were 509 (60.0%) adverse events in 849 patients assigned to pyronaridine-artesunate and 241 (57.0%) in 423 patients assigned to artemether-lumefantrine. The most frequent drug-related adverse event was eosinophilia (pyronaridine-artesunate, 53 events [6.2%]; artemether-lumefantrine 24 events [5.7%]). 21 (2.5%) patients in the pyronaridine-artesunate group and seven (1.7%) in the artemether-lumefantrine group discontinued study drugs or were withdrawn from the study. Mild and transient increases in alanine aminotransferase and aspartate aminotransferase concentrations were seen in the pyronaridine-artesunate group but not in the artemether-lumefantrine group. INTERPRETATION: Efficacy of pyronaridine-artesunate was non-inferior to that of artemether-lumefantrine for treatment of uncomplicated falciparum malaria. Pyronaridine-artesunate should be considered for inclusion in malaria treatment programmes. FUNDING: Shin Poong Pharmaceutical and the Medicines for Malaria Venture

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<http://dx.doi.org/10.1126/science.328.5980.847> (accès réservé EHESP)

Pathologies liées à l'obésité

[sommaire](#)

- (1) **A new row to hoe.** Nature. 2010 Apr. 1, vol. 464, n° 7289, p.650
<http://dx.doi.org/10.1038/464650a> (accès payant)
- (2) DE FG, RENDINA D, STRAZZULLO P. **Childhood obesity, other cardiovascular risk factors, and premature death.** N Engl J Med. 2010 May 13, vol. 362, n° 19, pp.1841-1842
<http://www.ncbi.nlm.nih.gov/pubmed/20468085> (accès réservé EHESP)
- (3) HAN JC, LAWLOR DA, KIMM SY. **Childhood obesity.** Lancet. 2010 May 15, vol. 375, n° 9727, pp.1737-1748
[http://dx.doi.org/10.1016/S0140-6736\(10\)60171-7](http://dx.doi.org/10.1016/S0140-6736(10)60171-7) (accès réservé EHESP)

Worldwide prevalence of childhood obesity has increased greatly during the past three decades. The increasing occurrence in children of disorders such as type 2 diabetes is believed to be a consequence of this obesity epidemic. Much progress has been made in understanding of the genetics and physiology of appetite control and from these advances, elucidation of the causes of some rare obesity syndromes. However, these rare disorders have so far taught us few lessons about prevention or reversal of obesity in most children. Calorie intake and activity recommendations need reassessment and improved quantification at a population level because of sedentary lifestyles of children nowadays. For individual treatment, currently recommended calorie prescriptions might be too conservative in view of evolving insight into the so-called energy gap. Although quality of research into both prevention and treatment has improved, high-quality multicentre trials with long-term follow-up are needed. Meanwhile, prevention and treatment approaches to increase energy expenditure and decrease intake should continue. Recent data suggest that the spiralling increase in childhood obesity prevalence might be abating; increased efforts should be made on all fronts to continue this potentially exciting trend

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<http://www.ncbi.nlm.nih.gov/pubmed/20352658> (accès réservé EHESP)
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<http://dx.doi.org/10.1001/jama.2010.585> (Accès réservé EHESP)
- (6) KIM SY, ENGLAND L, WILSON HG, BISH C, *et al.* **Percentage of gestational diabetes mellitus attributable to overweight and obesity.** Am J Public Health. 2010 June, vol. 100, n° 6, pp.1047-1052
<http://dx.doi.org/10.2105/AJPH.2009.172890> (accès réservé EHESP)

OBJECTIVES: We calculated the percentage of gestational diabetes mellitus (GDM) attributable to overweight and obesity. METHODS: We analyzed 2004 through 2006 data from 7 states using the Pregnancy Risk Assessment Monitoring System linked to revised 2003 birth certificate information. We used logistic regression to estimate the magnitude of the association between prepregnancy body mass index (BMI) and GDM and calculated the percentage of GDM attributable to overweight and obesity. RESULTS: GDM prevalence rates by BMI category were as follows: underweight (13-18.4 kg/m²), 0.7%; normal weight (18.5-24.9 kg/m²), 2.3%; overweight (25-29.9 kg/m²), 4.8%; obese (30-34.9 kg/m²), 5.5%; and extremely obese (35-64.9 kg/m²), 11.5%. Percentages of GDM attributable to overweight, obesity, and extreme obesity were 15.4% (95% confidence interval [CI] = 8.6, 22.2), 9.7% (95% CI = 5.2, 14.3), and 21.1% (CI = 15.2, 26.9), respectively. The overall population-attributable fraction was 46.2% (95% CI = 36.1, 56.3). CONCLUSIONS: If all overweight and obese women (BMI of 25 kg/m² or above) had a GDM risk equal to that of normal-weight women, nearly half of GDM cases could be prevented. Public health efforts to reduce prepregnancy BMI by promoting physical activity and healthy eating among women of reproductive age should be intensified

- (7) LANTZ PM, GOLBERSTEIN E, HOUSE JS, MORENOFF J. **Socioeconomic and behavioral risk factors for mortality in a national 19-year prospective study of U.S. adults.** Soc Sci Med. 2010 May, vol. 70, n° 10, pp.1558-1566
<http://dx.doi.org/10.1016/j.socscimed.2010.02.003> (accès réservé EHESP)

Many demographic, socioeconomic, and behavioral risk factors predict mortality in the United States. However, very few population-based longitudinal studies are able to investigate simultaneously the impact of a variety of social factors on mortality. We investigated the degree to which demographic characteristics, socioeconomic variables and major health risk factors were associated with mortality in a nationally-representative sample of 3617 U.S. adults from 1986 to 2005, using data from the 4 waves of the Americans' Changing Lives study. Cox proportional hazard models with time-varying covariates were employed to predict all-cause mortality verified through the National Death Index and death certificate review. The results revealed that low educational attainment was not associated with mortality when income and health risk behaviors were included in the model. The association of low income with mortality remained after controlling for major behavioral risks. Compared to those in the "normal" weight category, neither overweight nor obesity was significantly associated with the risk of mortality. Among adults age 55 and older at baseline, the risk of mortality was actually reduced for those who were overweight (hazard rate ratio = 0.83) and those who were obese (hazard rate ratio = 0.68), controlling for other health risk behaviors and health status. Having a low level of physical activity was a significant risk factor for mortality (hazard rate ratio = 1.58). The results from this national longitudinal study underscore the need for health policies and clinical interventions focusing on the social and behavioral determinants of health, with a particular focus on income security, smoking prevention/cessation, and physical activity

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<http://dx.doi.org/10.1001/jama.2010.517> (accès réservé EHESP)
- (10) MONTEIRO CA, GOMES FS, CANNON G. **The snack attack.** Am J Public Health. 2010 June, vol. 100, n° 6, pp.975-981
<http://dx.doi.org/10.2105/AJPH.2009.187666> (accès réservé EHESP)
- (11) NEEDHAM BL, EPEL ES, ADLER NE, KIEFE C. **Trajectories of change in obesity and symptoms of depression: the CARDIA study.** Am J Public Health. 2010 June, vol. 100, n° 6, pp.1040-1046
<http://dx.doi.org/10.2105/AJPH.2009.172809> (accès réservé EHESP)

OBJECTIVES: We investigated whether, over time, baseline obesity is associated with change in depressive symptoms or if baseline symptoms of depression are associated with change in body mass index (BMI) and waist circumference. METHODS: We used latent growth curve modeling to examine data from years 5, 10, 15, and 20 of the Coronary Artery Risk Development in Young Adults study (n = 4643). We assessed depressive symptomatology with the Center for Epidemiological Studies Depression scale. RESULTS: Respondents who started out with higher levels of depressive symptoms experienced a faster rate of increase in BMI (for Whites only) and waist circumference (for Blacks and Whites) over time than did those who reported fewer symptoms of depression in year 5. Initial BMI and waist circumference did not influence the rate of change in symptoms of depression over time. CONCLUSIONS: Depressive symptomatology likely plays a role in the development of physical health problems, such as cardiovascular disease, through its association with increases in relative weight and abdominal obesity over time

- (12) PLAGEMANN A, HARDER T, DUDENHAUSEN JW. **Childhood obesity, other cardiovascular risk factors, and premature death.** N Engl J Med. 2010 May 13, vol. 362, n° 19, pp.1840-1841
<http://www.ncbi.nlm.nih.gov/pubmed/20468084> (accès réservé EHESP)
- (13) PUHL RM, HEUER CA. **Obesity stigma: important considerations for public health.** Am J Public Health. 2010 June, vol. 100, n° 6, pp.1019-1028
<http://dx.doi.org/10.2105/AJPH.2009.159491> (accès réservé EHESP)

Stigma and discrimination toward obese persons are pervasive and pose numerous consequences for their psychological and physical health. Despite decades of science documenting weight stigma, its public health implications are widely ignored. Instead, obese persons are blamed for their weight, with common perceptions that weight stigmatization is justifiable and may motivate individuals to adopt healthier behaviors. We examine evidence to address these assumptions and discuss their public health implications. On the basis of current findings, we propose that weight stigma is not a beneficial public health tool for reducing obesity. Rather, stigmatization of obese individuals threatens health, generates health disparities, and interferes with effective obesity intervention efforts. These findings highlight weight stigma as both a social justice issue and a priority for public health

- (14) RUSSELL M, TREVISAN M, STRANGES S. **Childhood obesity, other cardiovascular risk factors, and premature death.** N Engl J Med. 2010 May 13, vol. 362, n° 19, pp.1840-1842 <http://dx.doi.org/10.1056/NEJMc1002801> (accès réservé EHESP)
- (15) SPEAKMAN JR. **FTO effect on energy demand versus food intake.** Nature. 2010 Apr. 1, vol. 464, n° 7289, p.E1 <http://dx.doi.org/10.1038/nature08807> (accès payant)

An intronic single nucleotide polymorphism (SNP) (rs9939609) close to the fat mass and obesity associated gene (FTO) was the first SNP to be discovered with common variants linked to body mass index; at least seven studies in humans have implicated this SNP with variations in food intake and satiety, and four studies have rejected an effect on energy expenditure normalized for body weight. Fischer et al. recently constructed a mouse in which the homologous Fto gene was inactivated (Fto(-/-)) and showed that these mice were protected from obesity. This observation strongly implicates the effects of the intronic SNP rs9939609 as arising due to an effect on the closest gene (FTO). However, the suggested mechanism underlying this effect in mice was opposite to that in humans. The Fto(-/-) mice showed no significant differences in food intake relative to wild-types litter-mates but had an elevated metabolic rate. The apparent contrasting effects of the gene in humans and mice is worthy of closer investigation

- (16) TROTTER LJ, BOWEN DJ, BERESFORD SA. **Testing for racial/ethnic differences in the association between childhood socioeconomic position and adult adiposity.** Am J Public Health. 2010 June, vol. 100, n° 6, pp.1088-1094 <http://dx.doi.org/10.2105/AJPH.2009.173492> (accès réservé EHESP)

OBJECTIVES: We tested the association between 2 measures of childhood socioeconomic position (SEP) and adult body mass index (BMI), stratified by race and ethnicity. METHODS: We used regression analyses to examine associations between adult BMI and 2 measures of childhood SEP (maternal education and whether the head of the child's household was working class), adjusted for a robust set of adult SEP measures, in a sample of 2068 adults from Los Angeles County, California. RESULTS: Maternal educational attainment was associated with a lower median adult BMI among Whites (8% decrease for high school diploma and 9% decrease for a college degree, compared with no high school diploma). A maternal high school diploma was associated with a 6% decrease in median adult BMI among Hispanics and an 11% decrease among Blacks. Our measure of childhood working-class status was not correlated with adult BMI. CONCLUSIONS: Our results suggest that childhood SEP is independently associated with adult BMI. However, our results also suggest that the effect may depend on which measures of SEP are used and that some aspects of childhood SEP may matter more for adult BMI than others

- (17) TZOULAKI I, SOVIO U, PILLAS D, HARTIKAINEN AL, *et al.* **Relation of immediate postnatal growth with obesity and related metabolic risk factors in adulthood: the northern Finland birth cohort 1966 study.** Am J Epidemiol. 2010 May 1, vol. 171, n° 9, pp.989-998 <http://dx.doi.org/10.1093/aje/kwq027> (accès réservé EHESP)

The authors examined associations between postnatal growth velocity through age 2 years and metabolic outcomes at age 31 years in a population-based birth-cohort study of 3,778 Finns (1966-1998). Approximately 8 height measurements and 9 weight measurements were obtained from birth to age 2 years. Peak height velocity (PHV) and peak weight velocity (PWV) in infancy were derived from parametric growth curves fitted to longitudinal height and weight growth data. Body mass index (BMI), waist circumference (WC), high density lipoprotein (HDL) cholesterol, triglycerides, glucose, systolic and diastolic blood pressure (BP), and the metabolic syndrome were measured at age 31 years. PHV was significantly positively associated with systolic and diastolic BP and WC in adulthood. For each 8-cm/year (2-standard-deviation) increase in PHV, WC increased by 1.60 cm (95% confidence interval: 0.73, 2.46), after adjustment for potential confounders, including birth weight. PWV was significantly associated with adulthood systolic BP, WC, and BMI. A 4-kg/year higher PWV was associated with a 1.87-cm (95% confidence interval:

1.08, 2.65) larger WC in adulthood, after adjustment for potential confounders. HDL cholesterol (direct), triglycerides (inverse), and metabolic syndrome (inverse) displayed associations with PWV only after BMI was accounted for. These results showed that growth during the immediate postnatal period is associated with adulthood obesity and BP. Lifestyle changes from early life might be important in reducing adulthood obesity and high-BP risk

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- (1) BLOOM BR. **Support for global health.** Science. 2010 May 14, vol. 328, n° 5980, p.791
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OBJECTIVE: To estimate the risk and probability of heterosexual transmission of HIV-1 from infected people taking combined antiretroviral treatment. DESIGN: Cross sectional and prospective cohort studies. SETTING: HIV clinic in Madrid, Spain. PARTICIPANTS: Stable heterosexual couples with one partner with HIV-1 infection (index partner) and the other reporting this sexual relationship as the only risk exposure. MAIN OUTCOME MEASURES: HIV seroprevalence in non-index partners at enrolment and seroconversions in follow-up according to antiretroviral treatment taken by the index partner. RESULTS: In 476 couples in which the index partner was not taking antiretroviral treatment, HIV seroprevalence at enrolment in non-index partners was 9.2% (n=44), whereas in 149 couples in which the index partner was taking combined antiretroviral therapy no partner was infected (P<0.001). During follow-up, the 341 serodiscordant couples in which the index partner was not taking antiretroviral treatment had about 11 000 acts of intercourse without condoms, 50 natural pregnancies, and five HIV seroconversions (0.0004 per unprotected intercourse; 95% confidence interval 0.0001 to 0.0010); 294 of these couples always used condoms, accounting for about 42 000 acts of intercourse, 136 risk exposures from condom failure, and one HIV seroconversion. The relative risk associated with condom use was 0.07 (0.01 to 0.58). In 144 couples the index partner was taking combined antiretroviral treatment; they accounted for over 7000 unprotected acts of intercourse and 47 natural pregnancies but no HIV seroconversion (0 to 0.0005 per unprotected intercourse). CONCLUSIONS: The heterosexual infectivity of HIV-1 in individuals taking effective antiretroviral treatment is low. Avoidance of unprotected intercourse and receipt of antiretroviral treatment by the infected partner in accordance with protocols are complementary measures to prevent HIV transmission

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BACKGROUND: Little is known about the causes of death in human immunodeficiency virus (HIV)-infected women in the era of combination antiretroviral therapy (ART). **METHODS:** In the French nationwide Mortalite 2000 and 2005 surveys, physicians reported causes of deaths in HIV-infected adults in 2000 and 2005, using a standardized questionnaire. We used multivariate logistic regression models to study the association between gender and AIDS-defining causes of death, adjusting for other characteristics. **RESULTS:** Of the 1013 HIV-infected adults who died in 2005, 247 (24%) were women. Half of women were infected through heterosexual contacts, compared with 25% men. In 2005, the proportion of AIDS-defining causes of death was higher in women than in men (43 vs 34%; $P = 0.01$), whereas it had been the same in 2000 (47% in women and men). In 2005, women died less frequently than men from respiratory malignancies (lung, ear/nose/throat) and cardiovascular disease (9% of all causes of death in women compared with 16% in men; $P = 0.004$), and suicides or accidents (4 vs 9%; $P = 0.02$). Socio-economic precariousness, younger age, less alcohol and tobacco consumption and lack of prior ART explained the higher proportion of deaths from AIDS in women compared with men. **CONCLUSIONS:** The higher proportion of AIDS-related deaths in women is probably explained by two factors: (i) some HIV-infected women, especially migrants in poor socio-economic conditions, may not have access to optimal care; and (ii) a lower prevalence of risk factors for respiratory, cardiovascular and violent deaths means that the risk of dying from non-AIDS causes may be lower in women

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OBJECTIVES: We examined changes in socioeconomic status (SES) and Black to White inequalities in HIV/AIDS mortality in the United States before and after the introduction of highly active antiretroviral therapy (HAART). **METHODS:** Taking a fundamental cause perspective, we used negative binomial regression to analyze trends in county-level gender-, race-, and age-specific HIV/AIDS mortality rates among those aged 15 to 64 years during the period 1987-2005.

RESULTS: Although HIV/AIDS mortality rates decreased once HAART became available, the declines were not uniformly distributed among population groups. The associations between SES and HIV/AIDS mortality and between race and HIV/AIDS mortality, although present in the pre-HAART period, were significantly greater in the peri- and post-HAART periods, with higher SES and White race associated with the greatest declines in mortality during the post-HAART period. **CONCLUSIONS:** Our findings support the fundamental cause hypothesis, as the introduction of a life-extending treatment exacerbated inequalities in HIV/AIDS mortality by SES and by race. In addition to a strong focus on factors that improve overall population health, more effective public health interventions and policies would facilitate an equitable distribution of health-enhancing innovations

Tuberculose

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Understanding the epidemiology and clinical course of tuberculosis is hampered by the absence of a perfect test for latent tuberculosis infection. The tuberculin skin test (TST) is widely used but suffers poor specificity in those receiving the bacille Calmette-Guerin vaccine and poor sensitivity in individuals with human immunodeficiency virus (HIV) infections. TST responses for a target population in Harare, Zimbabwe (HIV prevalence, 21%), recruited in 2005-2006, were interpreted by using a separate calibration population in Harare, for which interferon-gamma release assays (enzyme-linked immunosorbent spot (ELISpot)) results were also known. Statistical fitting of the responses in the calibration population allowed computation of the probability that an individual in the target population with a given TST and HIV result would have tested ELISpot positive. From this, estimates of the prevalence of tuberculosis infection, and optimal TST cutpoints to minimize misdiagnosis, were computed for different assumptions about ELISpot performance. Different assumptions about the sensitivity and specificity of ELISpot gave a 40%-57% prevalence of tuberculosis infection in the target population (including HIV-infected individuals) and optimal TST cutpoints typically in the 10 mm-20 mm range. However, the optimal cutpoint for HIV-infected individuals was consistently 0 mm. This calibration method may provide a valuable tool for interpreting TST results in other populations

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More than 36 million patients have been successfully treated via the World Health Organization's strategy for tuberculosis (TB) control since 1995. Despite predictions of a decline in global incidence, the number of new cases continues to grow, approaching 10 million in 2010. Here we review the changing relationship between the causative agent, *Mycobacterium tuberculosis*, and its human host and examine a range of factors that could explain the persistence of TB. Although there are ways to reduce susceptibility to infection and disease, and a high-efficacy vaccine would

boost TB prevention, early diagnosis and drug treatment to interrupt transmission remain the top priorities for control. Whatever the technology used, success depends critically on the social, institutional, and epidemiological context in which it is applied

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BACKGROUND: Low weight for height is an established risk factor for tuberculosis (TB), and recent studies suggest that overweight is a protective factor. No previous systematic review has been done to explore the consistency and establish the gradient of this apparent 'dose-response' relationship. METHODS: A systematic literature review was carried out to identify cohort studies that collected data on weight and height at baseline and that used a diagnosis of active TB as the study outcome. Weight-for-height measures used in the original studies were transformed into body mass index (BMI). Exponential trend lines were fitted to each data set. RESULTS: Six studies were included. In all of them, there was a log-linear inverse relationship between TB incidence and BMI, within the BMI range 18.5-30 kg/m². The average slope gave a reduction in TB incidence of 13.8% [95% confidence interval 13.4-14.2] per unit increase in BMI. The dose-response relationship was less certain at BMI <18.5 and >30 kg/m². CONCLUSION: There is a strong and consistent log-linear relationship between TB incidence and BMI across a variety of settings with different levels of TB burden. More research is required to test the relationship at very low and very high BMI levels, to establish the biological mechanism linking BMI with risk of TB and to establish the potential impact on the global TB epidemic of changing nutritional status of populations

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Mycobacterium tuberculosis has a penetrance of its host population that would be the envy of most human pathogens. About one-third of the human population would have a positive skin test for the infection and is thus thought to harbor the bacterium. Globally, 22 "high-burden" countries account for more than 80% of the active tuberculosis cases in the world, which shows the inequitable distribution of the disease. There is no effective vaccine against infection, and current drug therapies are fraught with problems, predominantly because of the protracted nature of the treatment and the increasing occurrence of drug resistance. Here we focus on the biology of the host-pathogen interaction and discuss new and evolving strategies for intervention

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We calculated population-based tuberculosis (TB) rates among HIV-infected persons in New York

City from 2001 through 2005 using data from the city's TB and HIV/AIDS surveillance registries, and we examined those rates using linear trend tests and incidence rate ratios (IRRs). HIV-infected individuals had 16 times the TB rate of a "non-HIV" population (HIV status negative or unknown; IRR = 16.0; 95% confidence interval = 14.9, 17.2). TB rates declined significantly among the US-born HIV-infected population (P (trend) < .001) but not among the foreign-born HIV-infected population (P (trend) = .355). Such disparities must be addressed if further declines are to be achieved

Rapports , dossiers en ligne et articles supplémentaires**Nouvelles publications**[sommaire](#)**Coupe du monde de la FIFA, Afrique du Sud 2010- Risques sanitaires associés Mai 2010.**

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Dépression

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