

- (HbA1c) in young patients with type 1 diabetes [in French]. *Presse Med* **2007**;36:1191–5.
3. Longo-Mbenza B, Nkondi Nsenga J, Vangu Ngoma D. Prevention of the metabolic syndrome insulin resistance and the atherosclerotic diseases in Africans infected by *Helicobacter pylori* infection and treated by antibiotics. *Int J Cardiol* **2007**; 121:229–38.
 4. Moghimi J, Toussy J, Babaei M, et al. Effect of *Helicobacter pylori* eradication on short-term control of glycemia in patients with type 2 diabetes mellitus. *Saudi Med J* **2007**; 28:475–6.
 5. Ojetti V, Migneco A, Nista EC, et al. *H. pylori* re-infection in type 1 diabetes: a 5 years follow-up. *Dig Liver Dis* **2007**; 39:286–7.
 6. Toporowska-Kowalska E, Wasowska-Krolkowska K, Szadkowska A, Bodalski J. *Helicobacter pylori* infection and its metabolic consequences in children and adolescents with type 1 diabetes mellitus [in Polish]. *Med Wieku Rozwoj* **2007**; 11:103–8.

This work was part of an MD thesis (G.G.F.-P) at the Faculty of Human Medicine, Universidad Nacional de Piura, Piura, Peru, March 2006.

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Comment on the Cover

TO THE EDITOR—We are pleased to see an illustration by Serefeddin Sabuncuoglu as the cover art of the 15 May 2007 issue of *Clinical Infectious Diseases* and deeply appreciate the editorial decision to highlight

it as an important piece of work in the history of the struggle against infectious diseases. However, some corrections are required to improve the text that aims to explain the illustration.

First, there is a high degree of agreement among the experts that the correct name of the author of the manuscript from which the image was taken, and presumably the physician in the illustration, is Serefeddin Sabuncuoglu, who lived and practiced medicine in northern Anatolia during the 15th century [1]. His birth and death dates are almost accurately documented as 1385 and 1470, respectively, which is another point that needs clarification in the text describing the cover.

Secondly, Serefeddin Sabuncuoglu was a member of a Turkish family with no known Arabic connection. It seems that the Arab surgeon Albucasis's book *at-Tasrif*, which served as a main resource to Serefeddin Sabuncuoglu's book *Cerrahiyeti'l Haniyye*, and the Arabic script of the text led to a false impression that the author was an Arab physician. In addition, the text of Sabuncuoglu's book, which is housed in the Bibliotheque Nationale, is written in Turkish. Several articles derived from this handwritten manuscript can be searched for in the Medline database.

Finally, because of the unique illustrations, all of which are lacking in Albucasis's book, and because of numerous

original additions embedded in the text, Serefeddin Sabuncuoglu's book is clearly more than a translation. The idea that medical procedures may be depicted for teaching purposes regardless of religious prohibitions is revolutionary in nature and has survived and developed over centuries, as is shown in the cover illustration.

Acknowledgments

Potential conflicts of interest. O.S. and O.E.: no conflicts.

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References

1. Uzel I. *Cerrahiyeti'l Haniyye*. Ankara: Türk Tarih Kurumu Yayinlari, **1992**.

Reprints or correspondence: Dr. Osman Sabuncuoglu, Halk Cad. Emin Ongan Sok. 11/7, 34672 Üsküdar/Istanbul, Turkey (sabuncuoglu2004@yahoo.com).

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Viral Infections and Acute Otitis Media in Young Children

TO THE EDITOR—We read with interest the article by Chonmaitree et al. [1], which highlights the association between viral respiratory tract infections and acute otitis media (AOM) complication in young

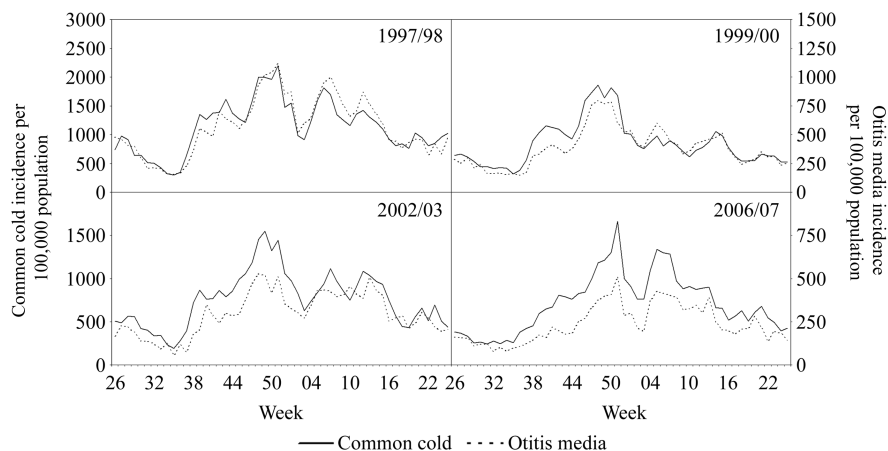


Figure 1. Clinical rate of otitis media and the common cold diagnosed in young children, aged 0–4 years, during 4 sample years. Winter weeks appear at the midpoints of the horizontal axes.

children. We, too, have previously reported a close association between the common cold and AOM [2], using clinical diagnosis data collected from a sentinel general practitioner surveillance network based in England and Wales that reports new episodes on a weekly basis [3]. The seasonality of these 2 clinically diagnosed conditions is remarkably similar in both young children, aged 0–4 years (figure), and older children, aged 5–14 years (data not shown). The diagnosis of the common cold is more frequent than the diagnosis of AOM, at a ratio of ~2:1 for both age groups. We also consider the clinical features that prompt a diagnosis of AOM to be a fundamental part of the disease process rather than a secondary complication. We support the notion that understanding the viral etiology of AOM in young children will improve patient treatment through reductions of inappropriately prescribed antibiotics.

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References

1. Chonmaitree T, Revai K, Grady JJ, et al. Viral upper respiratory tract infection and otitis media complication in young children. *Clin Infect Dis* 2008; 46:815–23.
2. Fleming DM, Elliot AJ, Nguyen-van Tam JS, Watson JM, Wise R. A winter's tale: coming to terms with winter respiratory illnesses. London: Health Protection Agency, 2005.
3. Birmingham Research Unit of the Royal College of General Practitioners. The Birmingham Research Unit. Available at: http://www.rcgp.org.uk/continuing_the_gp_journey/bru.aspx. Accessed 26 February 2008.

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Asymptomatic Malaria Associated with Protection: Not Causal

TO THE EDITOR—I write in response to the article “Long-term asymptomatic carriage of *Plasmodium falciparum* protects from malaria attacks: a prospective study among Senegalese children,” published in *Clinical Infectious Diseases* [1]. The title of this article is misleading, and the authors do not demonstrate this conclusion in their findings. They show that asymptomatic parasitemia is associated with a reduced risk of malaria attacks. This is not surprising, because the ability to carry parasites asymptotically is related to a previous exposure to malaria and is a result of immunity. Individuals with parasite carriage at any point in time are more likely than others to be at risk for malaria, because they live in an area in which malaria is found; therefore, carriage of malaria parasites is likely to be a reflection of previous exposure and not, as the authors conclude, a protective factor. The authors show in figures 1 and 2 of the article [1] that individuals who did not have parasitemia had an increased risk of clinical malaria attacks, compared with those who had asymptomatic carriage, presumably because the former had less immunity to malaria (which was attributable to less exposure). The authors could demonstrate this if they examined serological samples obtained from the study subjects for various malaria antigens.

Indeed, to control malaria, all infections must be treated. Individuals with asymptomatic parasitemia are likely to be most responsible for the ongoing transmission of malaria, because they do not receive treatment and can continue producing gametocytes for a long time. Therefore, although controlling malaria generally will reduce immunity in the community and, thus, increase the likelihood of an infection becoming a clinical case, the chance of becoming infected will be reduced. It is time to forget the idea that asymptomatic carriage is a benefit to the individual or the community. To eliminate or erad-

icate malaria, we have to get rid of the parasite.

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Reference

1. Males S, Gaye O, Garcia A. Long-term asymptomatic carriage of *Plasmodium falciparum* protects from malaria attacks: a prospective study among Senegalese children. *Clin Infect Dis* 2008; 46:516–22.

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Reply to Gosling

TO THE EDITOR—First, I would like to acknowledge Dr. Gosling [1] for his interesting remarks. However, I think that he has provided a fragmentary analysis of our results [2], which has led to a misinterpretation. Our results were based on epidemiological observations that were analyzed using suitable statistical tools. The results must be interpreted as a whole, and they should not be split up into independent parts (e.g., malaria attack data should not be separated from parasite density data). We observed that, in a seasonal transmission area, children harboring parasites during the so-called “non-transmission season” have a reduced risk of malaria attack and a higher level of parasite density during the transmission season. These 2 aspects of the results, repeatedly observed over 2 years of study, cannot be evaluated separately and require us to consider their significance. The main conclusion of our study was that this very specifically defined group of children has a very particular response to *Plasmodium falciparum* infection. To our knowledge,