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Disease eradication is possible and ethical

In his Perspectives piece (June 27, p 2192),¹ Arthur Caplan questions whether disease eradication should be eschewed for “aggressive and effective disease management”. Emphasis is placed on defining eradication, but not on clarifying how these two concepts would differ in practice. Herein lies the problem: in developed countries, a single episode of poliovirus transmission would be cited as a failure of effective disease management. The logical endpoint of Caplan’s proposal is that, in abandoning eradication, we should accept that poliovirus transmission will occur, not in developed communities, but elsewhere.

Caplan argues that eradication would mean exchanging vigilance for indifference, but is quiet on the human suffering associated with diseases such as poliomyelitis and HIV/AIDS. Vigilance, prophylaxis, research, and surveillance are not ends in themselves; they are the means for preventing disease. Health-care structures would not lose capacity for future disease control despite stopping training in how to recognise and treat the specific target disease. Caplan’s concern is not supported by history: eradicating smallpox has in no way hindered polio control or containment of severe acute respiratory syndrome.

Relaxing polio eradication will result in more cases and greater costs.² The diversion of funds from local

problems is an argument for better primary health care globally, not for halting eradication efforts. Resurgent polio would be a major local problem globally if allowed to re-establish a foothold.

With poliovirus type 2 gone for a decade,³ we should take heart that, having invested for only 20 years in serious eradication efforts, with much success, a world without poliomyelitis is not only possible, but ethical.

I declare that I have no conflicts of interest.

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Author’s reply

I thank Stephen Lambert for his comments. I think, however, he fails to engage the core of my argument.

There are numerous reasons to believe that polio eradication, as well as the eradication of most diseases, is not possible. To create public policies on the basis of the presumption that eradication is a viable goal risks both complacency and vulnerability. My point was not to suggest that the world “relax” efforts at polio control but rather to argue that polio control as opposed to eradication might be the best that can reasonably be achieved.

In an age of patient autonomy, bioterror, limits on disease surveillance, and strained health-care system budgets, talk of eradication could well prove very dangerous to public health.

I declare that I have no conflicts of interest.

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Adverse events in diabetes drug trial

The LEAD-6 trial (July 4, p 39)^{1,2} presents safety data less transparently than efficacy data. The rate of serious adverse events with liraglutide was twice that with exenatide, but confidence intervals and p values are omitted, by contrast with the efficacy outcomes. The definition of serious adverse events included mortality and hospital admissions, but neither is described. These data should be supplied.

I declare that I have no conflicts of interest.

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Authors’ reply

Christoph Pechlaner raises concerns that there were no statistical comparisons for the incidence of serious adverse events (liraglutide 12/235 [5.1%]; exenatide 6/232 [2.6%]). The study was not powered to investigate differences between treatment groups in terms of adverse events. We have, however, done a post-hoc analysis to address the concern over serious adverse events. An odds ratio was calculated by use of a cumulative logit model with severity levels (severe, moderate, mild, none) as ordinal categorical response variables. There was no significant difference between the serious adverse events for liraglutide and exenatide: odds ratio 2.03 (95% CI 0.75–5.51, p=0.16). Similar analyses by use of the χ^2 test and Fisher’s exact test showed no significant difference between the serious adverse events in the treatment groups (p=0.16 and 0.23, respectively).

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