

in the exenatide group had a higher mean heart rate, an independent risk factor for mortality.⁵ Thus exenatide is an interesting therapeutic option, but with more than one doubt about its safety in the long term.

We declare that we have no conflicts of interest.

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Authors' reply

We reported that exenatide once weekly versus insulin glargine was more effective in lowering glycated haemoglobin in patients with type 2 diabetes, who were in suboptimal glycaemic control despite maximum tolerated doses of metformin or metformin and sulphonylurea. Additionally, exenatide once weekly, relative to insulin glargine, decreased bodyweight and frequency of hypoglycaemia. Particularly, at week 26, patients treated with exenatide once weekly showed a mean change from baseline in bodyweight of 2.6 kg (SE 0.2), whereas those exposed to insulin glargine had a mean increase in bodyweight of 1.4 kg (0.2).

In this study, no data were collected on dietary intake for several reasons,

including the undesired additional heavy respondent burden; the fact that 72 sites in many different countries all over the world were involved, which precludes comparison; but, most importantly, the well known bias of self-reported food and energy intake, especially in overweight and obese people.¹ Arguments that render unlikely the assumption that gastrointestinal side-effects might have caused malnutrition include: (1) patients who did not have gastrointestinal side-effects during the study had similar bodyweight reductions to those who did report these side-effects; (2) there were no between-group differences in laboratory variables that could signal malnutrition; and (3) there were significant improvements from baseline in quality-of-life variables in both groups.

At 26 weeks, a slight but significant increase from baseline in heart rate of 4 bpm (0.1) was noted in the group treated with exenatide once weekly, but not in the insulin glargine group. Simultaneously, a significant reduction in systolic blood pressure was noted in the exenatide group only. Slight increases in heart rate were previously seen with GLP-1 receptor agonists, as well as concomitant lowering of blood pressure.² The mechanisms underlying these effects are not completely understood. Possible explanations include the vasodilatory properties of these compounds, and their natriuresis-promoting effects.³ These effects were shown to be cardioprotective and renoprotective in a rat model of salt-sensitive hypertension.^{3,4} However, the clinical significance of these findings needs to be determined in the large-scale, long-term outcome studies that are underway.⁵

We declare that we have no conflicts of interest.

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Nurse management of HIV-infected patients

In the CIPRA-SA trial (July 3, p 33),¹ Ian Sanne and colleagues compared the outcomes of nurse-monitored patients with those of doctor-monitored patients in an antiretroviral treatment (ART) programme in South Africa, and concluded that the outcomes of ART services provided by nurses were non-inferior to those provided by doctors. We would like to refer to similar experiences in Ethiopia and Malawi where nurse-management of HIV-infected patients is a common practice.

More than 300 000 patients need ART in Ethiopia and Malawi. Yet, in both countries, there is only one medical doctor for more than 40 000 inhabitants.^{2,3} Consequently, the two countries have adopted the task-shifting approach from more specialised to less specialised health workers. Initiation of ART and patient

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monitoring can be done by trained nurses in Ethiopia and Malawi, whereas in South Africa nurses do not start patients on ART.⁴

A well performing national ART programme focuses on: (1) coverage of ART, (2) quality of care during the clinical encounter, and (3) retention in ART care. The Article by Sanne and colleagues focuses on (2) and (3). Yet, in Ethiopia and Malawi, task shifting has made it possible to reach much higher coverage of ART.^{3,5} Moreover, the current data are reassuring that services by nurses are not inferior to services by doctors.⁵

Despite these successes, countries still face challenges related to career structure and incentive packages for nurses to work in remote areas. Moreover, the unmet need for ART in these countries is still so huge that they need to consider further task shifting to lay providers, the community, and trained AIDS patients themselves.

We declare that we have no conflicts of interest.

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- 1 Sanne I, Orrell C, Fox MP, et al. Nurse versus doctor management of HIV-infected patients receiving antiretroviral therapy (CIPRA-SA): a randomised non-inferiority trial. *Lancet* 2010; **376**: 33–40.
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Bristol-Myers Squibb clarification on didanosine supply

In response to an open letter to Bristol-Myers Squibb from board members of UNITAID (June 26, p 2213),¹ below are important clarifications regarding the supply of didanosine.

Bristol-Myers Squibb is committed to helping ensure paediatric patients remain on treatment. There is no supply shortage at this time and we expect being able to provide uninterrupted access to didanosine. The supply risk for didanosine 25 mg and 50 mg tablets is a result of a striking increase in demand for didanosine, despite supply forecasts we requested from purchasing organisations and the absence of changes in treatment guidelines. There is no supply risk for other forms of didanosine.

We have taken, and will continue to take, several actions to avoid a supply shortage. On identification of the risk, we immediately built up the inventory of didanosine to twice the level of 2009 demand. We are working with purchasing organisations to allocate available supply to children consistent with the product's labelling, prioritising those already receiving the medicine to help prevent treatment lapses.

We are also working with regulatory authorities to accelerate the review of the new manufacturing site. Site inspections took place in August; this is a positive indication that approval could occur before the end of 2010. Didanosine is already being produced at the new site; therefore, product can be shipped on site approval.

Bristol-Myers Squibb continues to work with urgency to help ensure patients have a continuous supply of didanosine and we are committed to timely, transparent communications with UNITAID and the HIV community.

I am an employee and stock owner of Bristol-Myers Squibb.

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- 1 Kamal-Yanni M, Nichols K, Tallah E, Otswana N. Open letter to Lamberto Andreotti, Chief Executive Officer, Bristol-Myers Squibb. *Lancet* 2010; **375**: 2213.

Department of Error

Sanne I, Orrell C, Fox MP, et al, for the CIPRA-SA Study Team. Nurse versus doctor management of HIV-infected patients receiving antiretroviral therapy (CIPRA-SA): a randomised non-inferiority trial. Lancet 2010; 376: 33–40—In figure 1 of this Article (July 3), the number of patients allocated to the nurse group and analysed should have been 404, and the number allocated to the doctor group and analysed should have been 408. Additionally, the fifth line of the results section should have read “404 individuals were randomly assigned to the nurse group and 408 to the doctor group”. These corrections have been made to the online version as of Sept 24, 2010.

Paavonen J, Naud P, Salmerón J, et al, for the HPV PATRICIA Study Group. Efficacy of human papillomavirus (HPV)-16/18 AS04-adjuvanted vaccine against cervical infection and precancer caused by oncogenic HPV types (PATRICIA): final analysis of a double-blind, randomised study in young women. Lancet 2009; 374: 301–14—In figure 2 of this Article (July 25, 2009), several numbers were incorrect in the last box. The sixth paragraph of the Results section should read “A high level of protection was noted against persistent infections with HPV-16/18 in the ATP-E cohort: vaccine efficacy was 94.3% (96.1% CI 91.5–96.3; p<0.0001) against 6-month persistence, and 91.4% (86.1–95.0; p<0.0001) against 12-month persistence (webappendix p 1).” In table 3, many of the data for “6-month persistent infection” and “12-month persistent infection” were incorrect. The first sentence of the last paragraph of the Results section should read “In the ATP cohort for immunogenicity, 99.5% of women who were initially seronegative for the corresponding vaccine type seroconverted for HPV-16 and HPV-18 at month 7 (861 of 865 for HPV-16, 925 of 930 for HPV-18), and 100% of those assessed at month 36 had seroconverted for both vaccine types (webappendix p 8).” In the webappendix, many of the data were incorrect. These corrections have been made to the online version and webappendix as of Sept 24, 2010.

Klazen CAH, Lohle PNM, de Vries J, et al. Vertebroplasty versus conservative treatment in acute osteoporotic vertebral compression fractures (Vertos II): an open-label randomised trial. Lancet 2010; 376: 1085–92—In figure 3 of this Article (Sept 25), the number of patients at risk in the conservative treatment group at 100 days should have been 25. This correction has been made to the online version as of Sept 24, 2010, and to the printed Article.