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Ebola Virus Disease in West Africa — The First 9 Months

TO THE EDITOR: The World Health Organization (WHO) Ebola Response Team (Oct. 16 issue)¹ predicted that the current Ebola epidemic would claim a dreadful 20,000 combined cases by early November 2014, assuming no change in the control measures applied in West Africa. The threat that Ebola poses to national public health and social, economic, and security foundations may worsen if a secondary epidemic eventually explodes in the region. Since June 2014, nearby Ghana has been affected by a serious cholera epidemic that was responsible for 12,622 cases as of September 6.² Current cholera and Ebola zones are separated by Ivory Coast, a frequent crossing point for commuters traversing West Africa. To effectively control cholera epidemics, specialized treatment centers, access to potable water, sanitation, and community hygiene awareness are critical. However, in Ebola-affected areas, quarantine units are overwhelmed, many health facilities are dysfunctional after the desertion by staff members who fear viral contamination, and it has become increasingly dangerous to conduct awareness campaigns owing to violence against health and humanitarian workers accused of

spreading Ebola. Likewise, neglecting to rapidly control this cholera epidemic in Ghana could have unpredictable yet potentially devastating consequences.

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No potential conflict of interest relevant to this letter was reported.

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TO THE EDITOR: The WHO Ebola Response Team describes the epidemiology of Ebola virus disease (EVD) in West Africa using anonymized patient-level data generated from EVD surveillance in multiple countries. These data document the demographic profile of patients with EVD, their risk factors, and the course of their illness. We regret that the WHO neither makes this data set publicly available nor provides an interface to extract customized tabulations. Such data sharing could accelerate the discovery of key factors in the epidemic and could yield insight into the economic and demographic drivers of the outbreak. It would also permit a better assessment of possible control scenarios. Current models of EVD transmission^{1,2} are parameterized with the use of outdated data from much smaller Central African outbreaks, which limits their applicability to West Africa. Some patient-level data sets collect-

ed during the West African outbreak are already publicly available,³ and some mobile telephone providers have released call-data records to help predict the spread of EVD.⁴ We encourage the WHO to adopt these practices and share this data set with all researchers who wish to lend their skills to help stop this tragedy.

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THE AUTHOR REPLIES: The WHO receives patient-level data on EVD from the ministries of health of the affected countries, which own the data. After discussion with external research groups, and under specific conditions, the WHO shares these data in order to carry out epidemiologic analysis, as well as the evaluation of interventions. The results of these joint analyses are consolidated by the WHO into recommendations to member states for action in the field. In addition to sharing patient-level data with collaborating institutions, the WHO publishes aggregated data, such as cases reported according to the week and district in Guinea, Liberia, and Sierra Leone, which are made publicly available in regular situation reports.

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Since publication of his article, the author reports no further potential conflict of interest.

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Goal-Directed Resuscitation in Septic Shock

TO THE EDITOR: The Australasian Resuscitation in Sepsis Evaluation (ARISE) Investigators and the Australian and New Zealand Intensive Care Society (ANZICS) Clinical Trials Group (Oct. 16 issue)¹ report that early goal-directed therapy (EGDT) did not reduce mortality at 90 days among patients with early septic shock. During the 72 hours after randomization, both groups in the study received a mean of approximately 6500 ml (70 to 75 ml per kilogram of body weight) of combined crystalloids and colloids (see Table S5 in the Supplementary Appendix of the article, available at NEJM.org). A footnote in Table S5 suggests that 0.9% saline was often used as crystalloid; rapid isotonic saline infusion predictably results in hyperchloremic acidosis.² Hyperchloremia can be associated with reduced gastric mucosal perfusion, renal vasoconstriction, a reduced glomerular filtration rate,³ and even increased

mortality.⁴ Since the exact nature of fluid therapy is crucial in EGDT, can the authors provide data on the specific fluids that patients received both before and after randomization?

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No potential conflict of interest relevant to this letter was reported.

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