

appears to be due to earlier diagnosis rather than longer survival as such³. Finally, if ascertainment is not complete and persons lost to follow-up are presumed still alive (as was the case for the reports from UK and US), then the estimated survival is prolonged. Survival estimated would undoubtedly decrease if all deaths were in fact ascertained or subjects were eliminated from the denominator once they are lost to follow-up.

The lack of difference in survival between men and women is likely due to the pathology found in our patients (tuberculosis, diarrhoea, weight-loss)⁴ and, most notably, to the relative infrequency of KS among the Zairian case group. The high frequency of KS among male cases from the UK and US highlights a survival difference by sex that we do not believe is inherently present. Indeed, female cases from the UK and US had survival times that were more comparable to those observed among our own cases in Zaire. Thus, we feel that survival times among European, American and African AIDS cases may prove to be similar. We look forward to further studies in which key parameters can be standardized to allow for more thorough comparisons among cases in these different settings.

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A case of *P. falciparum* malaria from Mali: failure of chloroquine chemoprophylaxis

The existence of chloroquine resistant *P. falciparum* strains in West Africa is well known. To our knowledge, however, in Mali only one case has been registered and adequately studied¹. Until then, epidemiological studies devoted to the identification of chloroquine resistant *P. falciparum* strains in Mali gave negative² or doubtful results³. No cases have been reported in the Northern part of the country. We present the case of *P. falciparum* malaria in a non-immune subject under chloroquine chemoprophylaxis, who travelled to Mali.

The patient was an 18-year-old woman, resident in Italy, who had recently made a 20-day visit to Mali. She had spent the first 4 days in Bamako, then travelled by car to the north of the country, where she spent 9 days in the town of Dire and one day in Timboubctou before flying back to Bamako where she spent the last 4 days.

Four days after her return to Italy, she experienced high fever (up to 40 °C), which did not respond to common antipyretics. Although she had been on regular chloroquine prophylaxis (600 mg chloroquine base per week) since the two weeks prior to leaving Italy, on the fourth day of illness she decided to start therapy with chloroquine. After the first two doses of chloroquine (total of 900 mg chloroquine base), the persistence of high fever led her to seek medical advice. A blood film confirmed the presence of *P. falciparum*, with a parasitaemia of 8%. Considering the elevated parasitaemia, the prolonged and sustained hyperthermia, frequent vomiting and a reduced level of consciousness, the patient was immediately admitted to hospital and treated with standard doses of intravenous quinine and oral tetracycline. Symptoms subsided and parasites disappeared in peripheral blood after 4 days without recurrence within 2 months.

No adequate *in vivo* or *in vitro* chloroquine resistance test were done. However, the presence of high parasitaemia after a regularly taken high dosage chemoprophylaxis plus initial treatment, is highly suggestive of chloroquine resistance. It is possible that transmission occurred in the northern areas of the country. If confirmed this would show further extension of chloroquine resistance into the Sahel.

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