

the European Union (EU).^{2,3} In those assessments, we stated that European countries are currently at high risk of WPV introduction and that there are areas of low vaccination coverage at increased risk for an establishment of local transmission of WPV.

Importantly, in addition to vaccinating Syrian refugees, ECDC has invited European Member States to assess their national vaccination coverage against polio (we estimate that 12 million residents in the European Union younger than 30 years are unvaccinated), detect areas at risk, and to engage in complementary action, especially among vulnerable groups living in poor sanitary conditions, recommend to travellers to areas with WPV circulation to ensure they have an updated polio vaccination status, enhance their surveillance system based on the requirements established by the Regional Certification Commission for Polio Eradication,⁴ strengthen their existing environmental and enterovirus surveillance to complement acute flaccid paralysis surveillance (with the present suboptimum quality of EU polio surveillance systems it is probable that WPV circulation is not promptly detected), assess their laboratory capacity, and to update their preparedness plans for polio outbreaks.

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Immunisation against meningococcus B: the case of Spain

Federico Martínón-Torres commented recently (Nov 9, p 1552)¹ on the proposal drawn up by the Committee on Immunisation Programmes and Registries on the use of the new vaccine against meningococcal B disease (4CMenB vaccine) in Spain.² As the main contributors to this report,² we would like to express some concerns.

First, from a public health perspective, the 4CMenB vaccine is surrounded by several uncertainties regarding safety, clinical effectiveness, and laboratory surveillance and monitoring, which, together with the decreasing trend in the incidence of invasive meningococcal B disease in Spain, warrant a cautious decision regarding the use of this vaccine in a routine programme at present and reserving it for specific high-risk situations (such as outbreaks) and for immunosuppressed patients.

Second, an economic analysis was not done taking into consideration that the main variables (such as vaccine price, effectiveness, vaccination schedule, effect of fever rates after immunisation on parental acceptability, effect on acquisition of carriage, and duration of protection, are currently unknown). The data and the analyses included in the report² took more than a year to complete and were not done in a hasty way as Martínón-Torres suggests. In addition, the framework for assessment of new vaccines in Spain³ advises taking the economic analysis into consideration (step 3 in the mentioned framework) after criteria such as burden of disease,

efficacy, and safety of vaccine (in step 1), effect of the introduction of the vaccine in the immunisation programme and ethical aspects (in step 2)—have been assessed.³

Third, although the vaccines against meningococcal diseases serogroup B and serogroup C are completely different, Martínón-Torres compares the epidemiological situation of both diseases at the time of authorisation of each vaccine and considers these similar. However, the evaluation done in September, 2000, showed an incidence rate for disease by serogroup C during the 1999–2000 season of 1.01 per 100 000 (404 cases), whereas the incidence rate for disease by serogroup B in the 2011–12 season was about half of that: 0.52 per 100 000 (240 cases).^{2,4}

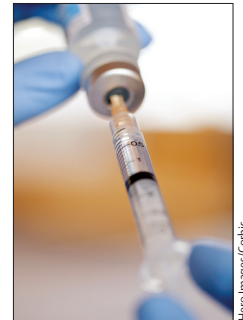
In conclusion, we would like to emphasise that public health decisions regarding the inclusion of a vaccine into the National Immunisation Programme should be made not on emotional and rapid considerations, but only after an in-depth assessment of all epidemiological data and available information concerning the vaccine in the first place; other criteria should be considered afterwards.

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Since 2012, five cases of chronic hepatitis E transmitted through blood transfusions were diagnosed (out of 367 transplantations) in the Paul Brousse Centre (Villejuif, France)⁴ and Créteil liver transplant centre (Créteil, France). Treatment of chronic hepatitis E infection in liver transplant recipients is decreasing immunosuppression and ribavirin. In these patients, eradication of hepatitis E is not always obtained by antiviral drugs, and substantial liver damage might persist, even after viral clearance.

Transfusion of blood products not screened for hepatitis E is associated with a risk of chronic hepatitis E infection in immunocompromised patients. Two recombinant hepatitis E vaccines have successfully gone through phase 3 trials,⁵ but they are not yet available and their efficacy on hepatitis E genotype 3 is unknown.

In view of the prevalence of hepatitis E infection in the general population (and therefore in potential blood donors) and the severe consequences of hepatitis E infection in immunocompromised patients, we believe that systematic screening of blood products for markers of hepatitis E infection should be implemented in countries where hepatitis E is endemic, including Germany, Sweden, and France. Because serological testing is poorly sensitive, hepatitis E nucleic acid testing should be considered.

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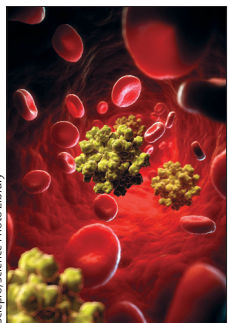
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Should we screen blood products for hepatitis E virus RNA ?

Hepatitis E was first identified during an outbreak of acute hepatitis in the Kashmir Valley in 1978. The causal agent, an enterically-transmitted non-enveloped RNA virus, was identified in developing countries where the most prevalent genotypes are genotypes 1 and 2.¹ Hepatitis E virus is endemic in many developing countries; animals such as swine, boar, and deer are reservoirs of hepatitis E virus genotypes 3 and 4. Human infections occur after ingestion of undercooked meat or liver from infected animals. Very high seroprevalences, up to 16%, have been described in some regions.²

Recently, chronic hepatitis E infections leading to cirrhosis or neurological complications were described in patients with immunodeficiencies in west European countries.³ Chronic hepatitis E infection has been described in patients receiving liver, kidney, pancreas, lung, or heart transplants, after haemopoietic stem cell transplantation, after chemotherapy, in HIV patients, and in patients taking steroids.³

Importantly, hepatitis E virus can be transmitted by blood-derived products. A high prevalence of IgM against hepatitis E virus was observed after transfusions in Asia and in European countries. In Sweden and Germany 1 of 7986 and 1 of 4525 plasma donations tested positive for hepatitis E virus RNA, respectively. 10% of plasma pools tested positive for HEV RNA in Germany.²



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Department of Error

Tyrer P, Cooper S, Salkovskis P, et al. Clinical and cost-effectiveness of cognitive behaviour therapy for health anxiety in medical patients: a multicentre randomised controlled trial. *Lancet* 2014; **383**: 219–25—In figure 1 of this Article, the number of patients who declined to participate or did not complete baseline assessments should have been 3935. The figure has been reformatted for clarification. This correction has been made to the online version as of Oct 22, 2013, and to the printed Article.

Feigin VL, Forouzanfar MH, Krishnamurthy R, et al, on behalf of the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 (GBD 2010) and the GBD Stroke Experts Group. Global and regional burden of stroke during 1990–2010: findings from the Global Burden of Disease Study 2010. *Lancet* 2014; **383**: 245–55—In this Article, on line 7 of the Findings section of the Summary, the sentence should have read “...had significantly increased since 1990 (68%, 84%, 26%, and 12% increase, respectively)”. This correction has been made to the online version as of Oct 25, 2013, and to the printed Article.

Jamison DT, Summers LH, Alleyne G, et al. Global health 2035: a world converging within a generation. *Lancet* 2013; **382**: 1898–955—In this Commission (Dec 7, 2013), Karen H Ulltveit-Moe’s name was spelt incorrectly. In the second paragraph of the section “Macroeconomics studies”, the following phrase should have read “...although health improvements do lead to income growth, they also lead to more than compensatory increases in fertility...” In table 10, in column 2, row 3, the text should have read “bans on trans fats and regulation of salt in processed food”. In figure 16, the text label in the bottom right dark blue box should have read “expanded cancer package”. These corrections have been made to the online version as of Jan 17, 2014.