

Availability of stroke units in Colombia

In *The Lancet Neurology*, Sheila Ouriques Martins and colleagues presented the recommendations of the first Latin American Stroke Ministerial meeting that took place in Gramado, Brazil, in 2018.¹ In their Policy View, they provide a map of the stroke centres in Latin America and outline strategies to decrease the burden of stroke.

However, we want to highlight that the data for stroke services in Colombia might be better (ie, more centres might be available for stroke care) than reported in this Policy View. For example, our institution is a primary stroke centre with the capability of treating patients with thrombectomy; our primary stroke programme is certified by the Joint Commission International.² With this programme, we provide acute stroke care, measured by quality standards regarding time from the event to access to acute care, neuroimaging diagnosis, and treatment. Also, this programme has an educational component for patients, families, and communities. Our hospital has a stroke unit with a dedicated area for stroke treatment and we follow up our patients for more than 90 days (outpatient setting) after the stroke, with a team (including rehabilitation) providing full-time hospital care during the acute phase. Three more hospitals in Colombia (Bogotá, Bucaramanga, and Cali) are expected to receive a similar certification and open new stroke units in the next few years.

Additionally, the Policy View mentioned that only three private hospitals deliver thrombectomy for the whole country and we also consider this number to be inaccurate. We surveyed the Neurointerventional Colombian Committee, which is a branch of the Colombian Society of Radiology, and received email and telephone answers from 21 neurointerventionalists working in 34 centres across Colombia that do thrombectomy, and at least 14 of them offer 24 h service. Endovascular

treatment is available in the largest cities of Colombia (presented according to population size: Bogotá, Medellín, Cali, Barranquilla, Cúcuta, Bucaramanga, and Tunja).

These data mean that in Latin America, following Brazil and Chile, Colombia has the third best provision for acute stroke care according to the information provided by the authors of the Policy View. In Colombia, there are various centres providing stroke care according to the data that we have gathered, which reflects the efforts by many physicians and hospitals to improve the quality of acute stroke management.

We declare no competing interests.

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- 1 Ouriques Martins SC, Sacks C, Hacke W, et al. Priorities to reduce the burden of stroke in Latin American countries. *Lancet Neurol* 2019; **18**: 674–83.
- 2 Joint Commission International. JCI-accredited organizations. [https://www.jointcommissioninternational.org/about-jci/jci-accredited-organizations/?c=Colombia&a=Primary Stroke Program](https://www.jointcommissioninternational.org/about-jci/jci-accredited-organizations/?c=Colombia&a=Primary%20Stroke%20Program) (accessed May 6, 2019).

Sleeping sickness in the Democratic Republic of the Congo

Adrian Burton¹ discusses the potential of fexinidazole as the first oral treatment for eradication of human African trypanosomiasis (HAT), and how this drug is particularly welcome in light of recent publications about latent carriers—humans, as well as animals. Fexinidazole is indeed a tremendous breakthrough, and—alongside acoziborole—a potential gamechanger for elimination and possible eradication

of HAT. There is an important distinction between elimination and eradication: WHO defines elimination as “reduction to zero of the incidence of disease or infection in a defined geographical area”, and eradication as “permanent reduction to zero of the worldwide incidence of infection”.² WHO has targeted elimination of HAT “as a public health problem” by 2020, defined as an annual incidence of less than 1 per 10 000 individuals in 90% of endemic areas, and a global number of cases of HAT below 2000. WHO aims to achieve elimination of infection, reaching and sustaining zero cases of HAT, by 2030. This target is not equivalent to permanent eradication of the pathogen, and we are still working to achieve elimination of HAT as a public health problem—here is our perspective from the field.

For many years DR Congo yielded more than 60–80% of the world’s HAT caseload. Recently, great progress has been made towards WHO’s goals for HAT elimination, despite a difficult political period. The strategy of the National Sleeping Sickness Control Programme in DR Congo (PNLTHA-DRC) is based on case detection and treatment, through active screening by mobile teams and passive screening in fixed health structures, in line with WHO guidelines. Since 2001, PNLTHA managed to screen between 2–2.5 million people per year for HAT, with a dip in 2010–12 because of declining donor funding. The number of confirmed HAT cases has steadily declined since 1998, in large part explained by this massive screening effort (figure).

We agree that HAT can rebound to epidemic levels after periods of control, with the last alarming peak occurring in the late 1990s when international support for HAT screening was completely withdrawn. To prevent history from repeating itself, we need new and multiple strategies to tackle both the infection and the vector (tsetse flies).³ In 2015, PNLTHA formed a consortium with research institutes