

patient's perception of his body.³ A direct effect of testosterone, however, cannot be ruled out. A cross-sectional study of the relation between testosterone levels and depressive symptoms in 856 community-dwelling older men showed that depression was inversely associated with bioavailable testosterone independently of age, weight change, and physical activity.⁴ Bioavailable estradiol was not associated with depressed mood.

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TO THE EDITOR: Belmaker and Agam indicate that a person must feel sad to be depressed. The American Medical Association monograph *Major Depressive Disorder in Primary Care*¹ notes on page 5 that many depressed people do not feel blue but instead present with symptoms such as "fatigue, insomnia, gastrointestinal distress or musculoskeletal pain." On page 4, it is noted that depression is correctly diagnosed by primary care physicians at the time of presentation in only 22% of patients who present with primarily physical symptoms.

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Case 40-2007: A Man with Weakness in the Hands

TO THE EDITOR: In the Case Record involving a 38-year-old man with multifocal motor neuropathy, discussed by Triggs and Cros (Dec. 27 issue),¹ Triggs emphasizes that it is important to distinguish multifocal motor neuropathy from amyotrophic lateral sclerosis or other motor neuron diseases because it responds favorably to immunotherapy. He mentions that plasma exchange, cyclophosphamide, and intravenous immune globulin are all beneficial. However, only treatment with intravenous immune globulins has been shown to be beneficial in randomized, controlled trials.² Cyclophosphamide has been reported to be effective but only anecdotally, and its toxicity precludes long-term use, which is usually necessary in patients with multifocal motor neuropathy. Plasma exchange is a well-established therapy in other immune-mediated neuropathies, such as chronic inflammatory demyelinating neuropathy, but has not been shown to be effective in patients with multifocal motor neuropathy and may lead to deterioration with respect to symptoms.³⁻⁵

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THE DISCUSSANT REPLIES: I agree with Cats and colleagues that plasma exchange has not been shown to be effective in multifocal motor neuropathy. In describing therapy for multifocal motor

neuropathy, the published article states, “Plasma exchange, cyclophosphamide, and intravenous immune globulin are all beneficial. . . .” However, in my original discussion of this case, I mentioned treatment with plasma exchange only in reference to early reports describing treatment of multifocal motor neuropathy with plasma exchange and cyclophosphamide in combination. My original statement was as follows: “Initial treatment studies described beneficial effects of plasma exchange and cyclophosphamide. Prednisone, in contrast, is ineffective and may worsen the disease. Subsequent studies have demonstrated the beneficial

effects of intravenous immunoglobulin in multifocal motor neuropathy and the favorable risk-to-benefit ratio of this therapy relative to that of cytotoxic therapy has made IVIg the initial treatment of choice in these patients.” This statement was changed during the editorial process, and the change erroneously implied that treatment of multifocal motor neuropathy with plasma exchange is beneficial.

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Two Doses of Azithromycin to Eliminate Trachoma in a Tanzanian Community

TO THE EDITOR: Single-dose azithromycin is the first-choice antibiotic for the treatment of trachoma. The World Health Organization (WHO) currently recommends annual mass azithromycin treatment for 3 years in communities in which the prevalence of the clinical sign “trachomatous inflammation–follicular” in children between 1 and 9 years of age is 10% or more.

We previously reported the effect of high-coverage, single-dose mass azithromycin treatment on ocular *Chlamydia trachomatis* infection in Kahe Mpya, Tanzania.¹ In all, 97.6% of residents were treated; the prevalence of ocular *C. trachomatis* fell from 9.5% at baseline to 0.1% 24 months later. We subsequently carried out a second round of mass treatment at 24 months, examined residents at 42 and 60 months, and took conjunctival swabs for testing for *C. trachomatis* by means of a polymerase-chain-reaction assay at 60 months. Just as at 6, 12, and 18 months, at 42 months, persons with active disease (21 of the 821 residents examined at 42 months) were offered tetracycline eye ointment. Field, laboratory, and statistical methods have been described previously,^{1,2} although because we expected the prevalence of infection to be low after the two mass treatments, we combined aliquots from each of five eluted swabs for each assay, intending to retest individual samples if results were positive or equivocal.³ Approval for the study was obtained from ethics committees at the London School of Hygiene and Tropical Medicine and Tumaini University.

At 24 months (when the prevalence of infection was 0.1%¹), the rate of antibiotic coverage

was 93.1% (917 of 985 persons). At 42 months, 821 of 975 residents (84.2%) were examined, as were 859 of 964 (89.1%) at 60 months. The prevalence of trachomatous inflammation–follicular in children between 1 and 9 years of age fell from 16.3% at 24 months to 4.6% at 42 months and 2.6% at 60 months. At 60 months (3 years after the second mass treatment), *C. trachomatis* DNA was not detected in the conjunctiva of any of the 859 residents from whom swab specimens were obtained, suggesting that infection may have been eliminated.

One or two rounds of high-coverage mass treatment with azithromycin may be sufficient to eliminate ocular *C. trachomatis* in communities with moderate levels of infection. In this Tanzanian community, the fall in the prevalence of trachomatous inflammation–follicular lagged considerably behind the fall in the prevalence of infection (Fig. 1). Had WHO recommendations on antibiotic use been followed, three or possibly five annual rounds of mass treatment would have been offered, whereas our data suggest that one round was sufficient. A field-based assay for estimating the prevalence of infection⁴ is needed to guide treatment decisions in the 3 to 5 years after the first distribution of antibiotics for trachoma control.

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