preemptive efforts to eradicate this endemic disease in our community should be made.

Asem Shehaby1  
Hisham Arda2  
Mohammad Sharaf2  
Jossef Damin3

1Dept. of Pathology-Microbiology,  
Faculty of Medicine,  
University of Jordan  
2Dept. of Internal Medicine,  
Faculty of Medicine,  
University of Jordan  
3At-Boukavo Hospital,  
Ministry of Health,  
Jordan

References

Bhaskar, V., Shehabi, A., Mehta, M. C., Kumar, R.,  
Tripoli. Clinical and Experimental Dermatology, 9, 84-88.

Conant, N. F., Smith, D. T., Baker, R. D. X. & Calaway,  

Kennou, M. F. (1978). Dermatophytoses at the Pasteur  
Institute of Tunis. Archives de l'Institut Pasteur de Tunis,  
3, 231-245.

Malhotra, Y. K., Gars, M. P., Kanwar, A. J. & Nasrjan, S.  
Sahorauslet, 3, 181-183.

The frequency of causative dermatophytes in Egypt.  

Shehabi, A. (1976). Ringworm of the scalp in Jordanian  

Accepted for publication 7th February, 1985.

Systematic chemotherapy of febrile cases: a substitute  
strategy for malaria control in rural areas of  
Africa

Malaria is still endemic in 90% of tropical Africa.  
Developing countries meet difficulties in controlling  
the disease due to technical, economic, logistic and  
human problems. However, specific strategies against  
this endemic disease have been developed, such as  
vector control mass drug administration, health  
education and environmental improvement. Their  
efficacy has been proven. But in order to pass from an  
experimentally proven efficacy to large scale imple- 
mentation, it is necessary to employ a "feasible  
strategy".

We suggest such a strategy based upon the result of a  
recent three-year field study. In 12 villages of a  
savanna area of Burkina Faso (West Africa), we  
compared, from 1980 to 1982, two malaria control  
strategies: (i) systematic chemotherapy of febrile  
attacks with a 10 mg/kg body-weight single dose of  
chloroquine, and (ii) chemoprophylaxis for children  
(0 to 9 years) with a 10 mg/kg body-weight weekly  
dose. Chloroquine tablets were distributed by health  
workers directly by the whole population.

The results can be summarized as follows: no  
difference in the infectivity of anopheline vectors was  
noticed in either area. Correctly performed chemo-  
propylaxis over one year produced a fail in the  
parasite rate (children two to nine years) from 51.9 to  
26.2% during the rainy season and from 38.4 to 7.7%  
during the dry season. Immunological studies showed  
that correctly performed chemoprophylaxis during  
one year caused a significant decrease of fluorescent  
antibody levels whereas there was no difference in the  
immunological response between the results of che- 
motherapy in control villages. There was no differ- 
ce in mortality (age group one to two years old)  
between the two control-strategies. The feasibility  
study showed that chemoprophylaxis could be well  
conducted for about one year, but this was followed  
by decreasing interest of the population in chemop-  
rophylaxis while chemotherapy was always accepted.  
In villages where chemoprophylaxis was well con- 
ducted, the consumption of chloroquine to cover the 0  
to nine years group was three times higher than in  
villages where chemotherapies were taken.

This study leads us to propose systematic che- 
motherapy of all febrile cases for malaria control in  
West Africa, where no case of P. falciparum resistance  
to amino-4-quinoline has been demonstrated in semi-

immune and immune populations. We recommend a  
single dose of 10 mg/kg body-weight of chloroquine  
which should cure any possible malaria attack.

This strategy, well accepted by the population, is  
realistic on a large scale in the field within the  
framework of primary health care, permits effective  
control of malaria mortality and is not followed by  
problems related to chemoprophylaxis such as selec- 
tion of P. falciparum-resistent strains, decrease of  
specific immunity, high cost or poor acceptability by  
the population. This investigation received financial support from the  
Malaria Applied Field Research component of the  
UNDP/World Bank/WHO Special Programme for  
Research and Training in Tropical Diseases.

D. Baudon  
J. Roux  
P. Carnevale  
J. L. Rey  
M. B. Meylan  
O. Brandicourt

O.C.G.G.E.—Centre Muraz,  
B.P. 153, Bobo-Dioulasso,  
Burkina Faso,  
West Africa.

Accepted for publication 11th April, 1985.

The experimental transmission of Leishmania mexi- 
cana amazonensis Lainson & Shaw, between hams- 
ters by the bite of Lutzomyia furcata (Mangabeira)  
Ward et al. (1977) reported the experimental transmis-

sion of Leishmania mexicana amazonensis by the  
proven vector Lutzomyia flaviscutellata. The only  
other laboratory transmission of this parasite has  
been by Lu. longipalpis (see Killick-Kendrick et al.  
1977). We report here the transmission of Le. m.  
amazonensis by Lu. furcata.

Strain FLA/BR/83/M7890 was isolated in a hamster  
from a female Lu. flaviscutellata captured on the 11th