

Editorial

Trachoma in Latin America: an opportunity for elimination

Trachoma is still the leading infectious cause of blindness world-wide (1). Caused by *Chlamydia trachomatis*, this chronic conjunctivitis is part of a host of Neglected Tropical Diseases that plague resource-poor communities world wide. The World Health Assembly passed a resolution calling for the Elimination of Blinding Trachoma by the year 2020 (2), and the Pan American Health Organization has recently endorsed this resolution specifically for trachoma in the Americas.

How big is the burden of trachoma in the Americas? Clearly, at one time trachoma was a public health problem all through the Americas; at one time 80% of the United States Public Health Service budget was devoted to screening for this disease. However, trachoma declined as the socioeconomic status of all countries improved, and eventually was forgotten by the public health authorities, except those working in the more marginalized populations. Now, there is an opportunity with the renewed emphasis on Neglected Tropical Diseases and the push towards declaring trachoma elimination to identify the pockets of trachoma and undertake strategies for control once and for all.

Hotez and colleagues have estimated about 1.1 million persons currently have trachoma in Latin America in three countries, accounting for 1.3% of the Global Disease Burden in Latin America (3). Brazil, Guatemala, and Mexico were cited as still endemic, based on reports from 2003. However, the identification of endemic areas is far from complete, and the finding of trachoma in indigenous populations in Brazil can only mean that other populations that roam throughout the Amazonian basin may also be affected (4). We know that trachoma is a significant problem when found in nomadic persons, as the programs for control must be implemented across country boundaries; this is well illustrated by the lack of control of trachoma in the Maasai populations of Tanzania and Kenya, who move freely between the two countries.

The article by Miller, Gallego and Rodríguez in this issue (5) then is very important in raising awareness that trachoma is present in the Colombian region of Vaupés. The authors conducted this study under extreme circumstances, and are to be congratulated for their efforts. The images that accompany the article leave no doubt that trachoma certainly was a problem in the past, as indicated by the trichiasis cases found in these communities. The current extent of the problem of active trachoma is less clear. Clinical diagnosis of active, follicular trachoma can be confusing when the disease has low prevalence as it must be differentiated from other causes of follicular conjunctivitis, such as vernal conjunctivitis. While the image of trachomatous inflammation - follicular (TF) is certainly compelling, confirmation of cases using modern diagnostic tests for *C. trachomatis* would have been very helpful. Nevertheless, the finding of cases in this vulnerable population cannot be ignored and sounds an alarm that further action is required to plan a strategy.

The authors have reported on the SAFE strategy recommended by the World Health Organization for trachoma control: Surgery to correct trichiasis, antibiotic to control infection, and face washing and environmental improvements to reduce transmission. Also, they have concluded that further confirmatory surveys be conducted. We agree with a phased-in approach to planning for trachoma control at this stage, and would suggest the following as a result of this study:

1. A plan to offer surgical services to correct the imminent risk of blindness posed by trichiasis needs to be devised by local health authorities. Cases will not come on their own without knowledge of affordable quality services they can access. Indigenous health workers and/or the health promoters should be taught to find cases of trichiasis and make sure they are brought to the nearest facility for trichiasis surgery, and that trained and certified surgeons can operate on them at low or no cost.
2. The burden of active trachoma in this region needs to be determined, using cluster survey methods that will estimate the prevalence in 0-9 year old children as recommended by WHO. The cases should be confirmed using a diagnostic test to leave no doubt as to their origin. More experience with such methods is being developed in Latin America for NTD work, and could easily be applied to trachoma mapping.

3. As a result of the findings of the mapping, an approach to trachoma control needs to be devised by Colombia. Ideally, this would include coordination of activities with Brazil and Peru in an unprecedented multi-national collaboration to eliminate a blinding disease.

There is strong commitment by partners in WHO, PAHO, and non-governmental organizations to have the Americas be the first region to report elimination of trachoma. Studies such as these are crucial to the start of raising awareness, and starting efforts to address how trachoma control will be accomplished so as to achieve the goal of elimination by 2020.

References

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