Letters to the Editor

Poor Response to Chloroquine Therapy in a Case of Sudanese Falciparum Malaria

Sir,

I read the paper by Dr G. Malik et al. (Saud Med J 1990; 11(2): 143–144) regarding recurrence after treatment with several courses of chloroquine despite the absence of reinfection, and its valuable criticism by Ian F. M. Saint-Yves (Saud Med J 1991; 12(2): 158–159). I agree with the comment that taking prophylactic chloroquine 1 day before entering an endemic area is less acceptable than starting prophylaxis 1 week prior to entry. However, I would like to raise some points:

1. After the first course of treatment the patient’s blood was not examined for malarial parasites and the response to chloroquine therapy in terms of parasitaemia was not checked except by reappearance of clinical symptoms.
2. The study done in 1978 on the chloroquine response of the Sudanese strain of *P. falciparum* provided obsolete, inadequate information and was non-dependable as a WHO unpublished document 1979, WHO/MAL/79.910.
3. Standard techniques for detecting resistance of chloroquine therapy were not mentioned.
4. The need for a longer follow-up of patients and frequent blood testing was not emphasized.

Finally, I also agree with Ian F. M. Saint-Yves that a single dose of primaquine 45 mg is required to prevent transmission.

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Metabolic Responses to Ingestion of Dates

Sir,

Last year we reported the first study of the metabolic responses to ingestion of dates, the fruit of the tree *Phoenix dactylifera*, in normal individuals.¹ In that report we stressed the need to gather similar data on diabetic individuals using the different varieties of dates consumed in Saudi Arabia. We are, therefore, heartened to see such a report by Famuyiwa et al. in a recent issue of this journal.² Until these recent publications, there had been no information available concerning the metabolic effects of date ingestion in human subjects despite the historical, socioeconomic and nutritional value of this fruit.

Famuyiwa et al. have confirmed our previous observations in healthy Saudi subjects and have extended their observations in subjects with non-insulin-dependent diabetes mellitus. There are remarkable similarities between the two studies in the normal subjects.

Each study has compared the impact of isocaloric administration of a different variety of ripe dates (Khala in our study and Sukkari in Famuyiwa’s; both types of dates being essentially similar in chemical composition) to that of glucose solution (OGTT), fed in a randomized fashion in a group of normal subjects, similar in age distribution, with blood sampled at a similar frequency of 30 minutes for glucose and insulin. Results obtained were also similar in both the studies. Glucose and insulin area profiles were smaller for dates compared to OGTT (although the former has not achieved statistical significance in the study by Famuyiwa et al. probably related to the fewer subjects compared with ours). The glycaemic index (GI) for the two different varieties of dates was also strikingly similar at 56.

However, there are several issues that need clarification in the study reported by Famuyiwa et al. It appears that although the subjects were fed semi-dried dates, the chemical composition of Sukkari dates was nevertheless based on previously reported data³ for dried dates. Apart from this variable, other important factors need to be considered as well. For example, what was the time lapse between harvesting and feeding of the fruit? Under what specific conditions were the fruits processed and preserved between harvesting and feeding? Clarification of such variables is important since specific conditions for harvesting, processing and storage of the fruit affect the chemical composition of the fruit⁴ and are likely to influence the values for the GI. We found out, for instance, that following an overnight thawing the storage process had resulted in a net weight loss of 15% from dehydration.

Regarding the subjects reported in the study, it would be important to know the body mass index of the normal persons. For the diabetic subjects, the insulin responses reported are difficult to interpret, since they were receiving oral hypoglycaemic agent until the day prior to the study. For both the groups the time lapse of only 2–3 days between the OGTT and oral dates tolerance test (ODTT) may not have been long enough. It is also important to find out if the subjects refrained or not from their usual consumption of dates between OGTT and ODTT.

We would also suggest that termination of the study at 120 min is clearly not adequate and underestimates the incremental area under the curve (IAUC) since both the glucose and insulin responses had not returned to the baseline in the study reported by Famuyiwa et al. Our experience indicates that for a reliable interpretation of IAUC the study should be continued for 180 min in the normal subjects and for the diabetic subjects even longer before the values return to the baseline.⁵

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