other industry, our member companies support initiatives to address the global non-communicable disease (NCD) problem and commend the UN for bringing global attention to this issue, particularly in developing countries.

In 2008, IFBA made five specific commitments to WHO regarding product composition and availability; marketing and advertising to children; consumer nutrition information; the promotion of active, healthy lifestyles for individuals in communities and in the workplace; and collaborative public-private partnerships. We monitor our commitments and post progress reports on the IFBA website. IFBA actively encourages national and small and medium-sized food and non-alcoholic beverage manufacturers and retailers to join us at country and regional levels.

In New York on June 13, 2011, IFBA hosted a discussion with leading members of the UN and public health communities on the complexities and threat of NCDs for development and the benefits of a whole-of-society approach. As reflected in conclusions from that event, we believe strongly that our industry has much to contribute to the fight against NCDs and hope The Lancet would do more to encourage collaborative actions that promote public health.1

The Integrated Academic Training programme at Oxford

In 2006, the Integrated Academic Training programme was initiated in the UK as a result of the Walport report1 on the crisis of decreasing clinical academic numbers. In Oxford, we decided that the most effective way to manage the programme would be to create a dedicated Oxford University Clinical Academic Graduate School (OUCAGS). We wish to highlight both some advantages of this approach and challenges within the overall programme.

One of OUCAGS’s major advantages is that it ensures strategic assessment of the training needs of both the University and the National Health Service (NHS). As a University/Deanery/NHS partnership, a single point of contact is provided, greatly simplifying recruitment, monitoring of progress, interactions with clinicians, career advice, etc. Given the complexity of the arrangements, it is almost impossible to overemphasise the benefits of a single source of knowledge and decision making.

Before OUCAGS, there were widespread feelings of isolation and uncertainty among our academic trainees. A programme of events organised for all trainees, including academic Foundation doctors and clinical PhD students, has addressed this. Various innovations, including international fellowships, a management and leadership programme, and an academic e-portfolio to facilitate joint clinical and academic annual review of competence progression, have been introduced.

Even so, challenges to the success of the programme still exist. A major constraint is the requirement to recruit to single specialties rather than generic posts. This results in lost posts if there are no satisfactory applicants—a problem likely to be exacerbated by national recruitment.

Although the National Institute for Health Research funding mechanism seems simple, in our experience, implementation is extremely confused. In particular, if non-academic clinical staff cannot identify the funding flows, there is reluctance to accept academic posts because of the apparent loss of clinical time.

Furthermore, the guarantee of a specialty training post to academic core trainees leads to suspicion among some consultants and specialist advisory committees that the academic route is chosen to avoid competition in getting a National Training Number, although published evidence for this does not exist; particular difficulties exist in creating posts in smaller specialties because there is little flexibility.

Lastly, the rationale for clinical lecturer funding ceasing 6 months after a certificate of completion of clinical training is obtained, irrespective of academic achievement, is unclear since clinical and academic progress typically are not synchronous.

Nonetheless, the national programme has successfully raised the profile of clinical academic careers and provided a clear career route. Our experience with OUCAGS has allowed an advantageous, coherent, and comprehensive approach to the recruitment and education of clinical academic trainees, which we would encourage others to adopt.

KAF is Director of Oxford University Clinical Academic Graduate School. DB is the Academic Clinical Careers Manager of Oxford University Clinical Academic Graduate School. We declare that we have no other conflicts of interest.

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Call for a World Dengue Day

Dengue fever is a mosquito-borne disease caused by dengue viruses—members of the family Flaviviridae. Severe forms of dengue infection can be fatal and are a leading cause of hospital admission in many parts of the world, placing tremendous pressure on medical resources and
having a heavy economic and societal effect. There has been a 30-fold increase in the number of dengue cases over the past 50 years. Recent studies estimate 50–100 million infections each year, although, owing to under-reporting, this figure could be even higher. The burden of dengue currently falls most heavily on southeast Asia, but dengue has spread throughout Latin America and more than half of the world’s population now lives in dengue-endemic countries. Moreover, increasing numbers of travellers return from endemic regions with dengue, further increasing its spread, and leading to cases of locally acquired dengue in the USA and Europe.

The first Association of Southeast Asian Nations (ASEAN) Dengue Day was held on June 15, 2011, to focus attention on the disease burden associated with dengue and to highlight the crucial need to develop more effective prevention and control strategies. ASEAN member states represent more than 600 million individuals who bear the major part of the global burden of dengue. The ASEAN Dengue Day was an encouraging step in the fight against dengue, and an example of the shift from reactive programmes to forward planning and long-term prevention strategies against dengue infection. Surin Pitsuwan, Secretary-General of ASEAN, noted that dengue prevention and control is a shared responsibility that needs to be addressed in a coordinated and united way, and with a sense of urgency.

Given the increasing scale of the dengue problem, a united, global response will be required to bring it under control. For this reason we, as dengue researchers, physicians, and public health representatives from around the world, propose the establishment of a World Dengue Day, to underscore the effect of dengue worldwide and to encourage a much-needed global response. The institution of World TB Day and World Rabies Day has raised awareness of these diseases and led to renewed momentum and greater intensity in the efforts towards their elimination. A World Dengue Day will acknowledge the burden borne by dengue-endemic countries and drive efforts to meet the challenge of dengue. Greater awareness of the disease, together with the development of new diagnostics, drugs, and vaccines, will help to make dengue a preventable disease.

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Department of Error

Abraham WT, Adamson PE, Bourke KC, et al. Wireless pulmonary artery haemodynamic monitoring in chronic heart failure: a randomised controlled trial. Lancet 2011; 377: 658–66—In this Article (Feb 19), the first sentence of the fifth paragraph in the Statistical analysis section on page 661 should have started: ‘‘Prespecified supplementary analyses were heart-failure-related hospitalisations during the entire randomised follow-up (Andersen-Gill model).’’ Additionally, during internal auditing of this study in preparation for data presentation to regulatory authorities, a small number of unreported events were uncovered. One additional heart-failure-related hospital admission occurred within the 6-month primary endpoint. There is no significant effect on the primary and secondary endpoints presented within the original article, and in all cases the study outcomes remain highly positive with all study endpoints remaining significant. For the primary endpoint of rate of heart-failure-related hospital admissions at 6 months, 88 heart-failure-related hospital admissions occurred in the treatment group compared with 120 in the control group (rate 0.32 vs 0.44, hazard ratio [HR] 0.72, 95% CI 0.60–0.85, p=0.002) resulting in a 28% reduction. For the secondary endpoint of proportion of patients admitted to hospital for heart failure during the first 6 months, 55 patients (20%) in the treatment group were hospitalised for heart failure compared with 80 patients (29%) in the control group (relative risk reduction 0.71, 95% CI 0·52–0·96, p=0·02). For the prespecified supplementary analysis, six additional heart-failure-related hospital admissions occurred during the entire study follow-up. 158 heart-failure-related hospital admissions occurred in the treatment group compared with 254 in the control group (HR 0.63, 95% CI 0·52–0·77, p=0·001), resulting in a 37% reduction. The treatment group had a lower risk of death or first heart-failure-related hospital admission over the entire study follow-up (HR 0.73, 95% CI 0·57–0·94, p=0·016). These corrections have been made online to the relevant sections of the Summary, table 2, the second and third paragraphs of the Results, and figure 3, as of Feb 3, 2012.

Glaszer C, Boachie C, Buckley B, et al. Urinary incontinence in men after formal one-to-one pelvic-floor muscle training following radical prostatectomy or transurethral resection of the prostate (MAPS): two parallel randomised controlled trials. Lancet 2011; 378: 328–37—This Article (July 23) should have contained the following conflicts of interest statement: “IB has received travel expenses from Artelabs, Medtronic, and Pfizer. All other authors declare no conflicts of interest.” This correction has been made to the online version as of Feb 3, 2012.