

Second, Brown et al. ask whether the findings might have been different if more drug-eluting stents had been used. Although coated stents reduce the need for repeat revascularization, they do not alter rates of death or myocardial infarction, as compared with the rates for bare-metal stents, and their effect on the quality of life of patients is marginal on the basis of available studies (a gain in quality-adjusted life-years that ranges from 0 to 0.08).^{1,2}

Third, Brown et al. point out that patients in the COURAGE trial underwent cardiac catheterization and that the small proportion of patients whose anatomy was not suitable for PCI (i.e., those with left main coronary artery disease) were excluded from the study. Many of these high-risk patients could be identified and selected for catheterization on the basis of noninvasive imaging studies.^{3,4} That said, it is true that the COURAGE trial specifically addressed treatment strategy after coronary anatomy was defined. Yet it is uncertain whether a “look but don’t touch” strategy can be executed in clinical practice, given the lack of incentives for the provision of optimal medical therapy in the current health care system.

Finally, Smith expresses concern that we overemphasized the procedural risks of PCI, which was not our intent. We noted that long-term rates of death and myocardial infarction were similar for the two strategies. However, we would also note that most patients discount future events. A strategy that avoids present-day risks may be preferred, even if long-term outcomes are similar.

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Malaria Prevention in Short-Term Travelers

TO THE EDITOR: In his Clinical Practice article on malaria prevention in short-term travelers, Freedman (Aug. 7 issue)¹ offers clinical advice for the family of three described in the vignette. For the 29-year-old wife, who is 15 weeks pregnant and has won a trip to Zambia in a corporate sales competition, it might be best to provide a medical letter that she could give to corporate sales, advising postponement of her trip for a year. In addition, Table 3 of the article, which lists prophylactic drug regimens, does not mention the latest artemisinin-based combination therapy.²

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2. White NJ, Quinhaosu (artemisinin): the price of success. *Science* 2008;320:330-4.

THE AUTHOR REPLIES: Artemisinin derivatives have revolutionized malaria treatment programs worldwide and are the drugs of choice for falciparum malaria in most countries where it is endemic. No artemisinin compound is currently licensed in the United States. Intravenous artesunate is available from the Centers for Disease Control and Prevention (CDC) for emergency use for severe and complicated falciparum malaria (www.cdc.gov/malaria; telephone, 770-488-7788) under an investigational-new-drug (IND) application. An oral combination drug containing artemether and lumefantrine for the treatment of uncomplicated falciparum malaria is currently under expedited review by the Food and Drug Administration. Unfortunately, the extremely short half-life of the artemisinin drugs precludes their use as chemoprophylactic agents.

The advice of the CDC, the World Health Organization, and myself that pregnant women not

travel to areas with malaria is stated in the article. Many possible approaches to dissuading a determined traveler who already has firm plans and tickets in hand are conceivable. The most frequently successful strategy is a change of destination to one allowing a similar experience but without the malaria risk. A specialized travel medicine clinic (listings at www.istm.org and www.astmh.org) would have access to country-by-country malaria maps and would also be familiar with common and practical destinations. Many game parks in South Africa are outside the

malaria zone, though the itinerary described in the vignette is by far the most popular. Delaying the trip by a year would involve exposing an infant to malaria, an equally risky situation, or separating mother and child by thousands of miles for a significant period. Despite our best efforts, pregnant women travel not infrequently to malaria zones, and we need to offer them information on the best possible prevention strategies.

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The FDA and Tobacco Regulation

TO THE EDITOR: The American Heart Association enthusiastically supports the editorial by Curfman et al. (Sept. 4 issue)¹ on a bill that would grant authority to the Food and Drug Administration to regulate tobacco products. We believe that this legislation has several strengths; it would require full disclosure of the ingredients in tobacco products, reduce the burden of tobacco-related illnesses, and especially limit underage smoking. Each day, about 4000 people 12 to 17 years of age will try a cigarette for the first time, and an estimated 1140 persons in this age group become daily smokers.² According to a U.S. Surgeon General's report, about 80% of people who use tobacco begin to do so before 18 years of age.³ A major curtailment of underage tobacco use may be the greatest potential public

health benefit of this legislation. As the incoming president of the American Heart Association, I applaud the position of the *Journal* editors and join with them in expressing unequivocal support for this legislation.

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2. Office of Applied Studies. Results from the 2005 National Survey on Drug Use and Health: national findings. NSDUH series H-30. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006. (DHHS publication no. SMA 06-4194.)
3. National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Preventing tobacco use among young people. Washington, DC: Government Printing Office, 1994.

Restless Legs Syndrome and Spinal Anesthesia

TO THE EDITOR: The restless legs syndrome (RLS) is a common sensorimotor disorder of unknown cause affecting approximately 10% of the population.¹ One uncontrolled study showed that spinal anesthesia caused postoperative RLS.² We conducted a prospective study to determine whether the occurrence of postoperative RLS was associated with the type of anesthesia.

Patients scheduled for surgery and general or spinal anesthesia were recruited from our hospi-

tal's lists of patients undergoing elective surgery (Table 1). Using a standardized questionnaire (see the Supplementary Appendix, available with the full text of this letter at www.nejm.org), one of us interviewed patients — on admission and at 1 and 4 weeks postoperatively — about symptoms, including diagnostic criteria for RLS³ and symptoms of depression and daytime sleepiness. The questions regarding RLS symptoms were interspersed among other questions to mask