To the Editor: Gurgel et al. described the predominance of P[4]G2 rotaviruses in a vaccinated population in Aracaju, northeastern Brazil (*1*). However, several limitations need to be addressed to avoid misinterpretation of data that could lead to loss of confidence in the vaccine in Brazil and other countries.

Brazil was one of the first countries in Latin America to introduce a live, oral, attenuated human rotavirus vaccine into a public-sector health program. Nevertheless, vaccine coverage levels vary considerably across regions (≈40% to >80%) and are ≈50% in some parts of northern and northeastern Brazil. Therefore, drawing conclusions about the vaccine's protection and prevailing rotavirus genotypes in a setting where coverage is still low seems premature.

Two findings require special consideration. First, although the number of patients is small, children <1 year of age showed a reduced risk for severe rotavirus diarrhea among vaccinated (7%) patients compared with nonvaccinated (26%) patients: $p<0.05$; odds ratio (OR) 0.20; exact 95% confidence interval (CI) 0.029–1.24. Second, surveillance was conducted for only 4 months, which did not allow for demonstration of a true representative pattern of strain distribution over time. The sequential changing predominance of rotavirus serotypes occurring over time has been well documented for many years (*2*).

The authors stated that the "vaccine does not afford complete protection against infection" (*1*). For those not paying close attention to data analysis, this statement could be misinterpreted to mean that the vaccine may not protect against P[4]G2. To the contrary, even with a small sample size and low vaccine coverage, additional analyses of the original data show that the live, oral, attenuated human rotavirus vaccine can protect against the 100% predominance of P[4]G2. In a large phase III trial conducted in Latin America and Finland, a nonsignificant but protective trend was observed against severe disease associated with P[4]G2 (*3*). Furthermore, in a subsequent meta-analysis, protection against P[4]G2 rotavirus gastroenteritis of any severity was 81% (95% CI 31–96) and protection against severe rotavirus gastroenteritis was 71% (95% CI 20–91) (*4*).

To reinforce the hypothesis that predominance of P[4]G2 strains in Aracaju is unrelated to vaccine use, it is worth mentioning that P[4]G2 rotaviruses appear to display an ≈10-year cyclic pattern of occurrence in Brazil (*5*). Although the data presented in the original article may cause misinterpretation about vaccine protection, the article highlights the need for well-designed postmarketing studies to assess both vaccine impact and strain surveillance, in compliance with recent World Health Organization recommendations (*6*).

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In Response: We acknowledge the comments by Patel et al. (*1*) and by Linhares and Velázquez (*2*) about our article that documented the presence of a single rotavirus genotype (P[4]G2) in Aracaju, northeastern Brazil, after the introduction of a human, monovalent rotavirus vaccine (*3*). Both letters emphasize that the predominance of P[4]G2 may be caused by a natural genotype variation unrelated to vaccination. We agree that our observation could be explained by natural variation of circulating rotavirus genotypes in the region, but an alternative possibility is that the introduction of the G1P[8] rotavirus vaccine into the childhood immunization schedule created conditions in which P[4]G2 strains had a selective advantage over strains with which the vaccine shares G type, P type, or both.

According to a systematic review of rotavirus genotypes reported in the 25 years preceding introduction of the vaccine in Brazil, the prevalence of P[4]G2 strains varied from 19% (1986–1995) to 12% (1996–2000) to 1% thereafter, thus not reaching the detection rate we observed in Aracaju (R.Q. Gurgel et al., unpub data). Furthermore, in the ensuing 8-month period, no genotype other than P[4]G2 had been detected in Aracaju, suggesting that our initial findings were not spurious (R.Q. Gurgel et al., unpub data). In addition, in a separate study we conducted in Recife, a city 500 km north of Aracaju, we observed a significant increase in the proportion of G2 strains

detected from 47% (21/45) during the 3-month period immediately after vaccine introduction (March 2006–May 2006) to 100% (11/11) during the same 3-month period 1 year after the vaccine introduction (March 2007–May 2007) (*4*). We believe that our findings are consistent with results of field trials that indicated that the vaccine provided relatively less protection against P[4] G2 strains than against other rotavirus strain types (*5*).

The beneficial impact of rotavirus vaccination in northeastern Brazil is reflected in the reduction of the detection rate of rotavirus among severe diarrhea cases in our study in Recife, which fell from 27% (45/166 cases) to 5.0% (11/221 cases) in the postvaccine 3-month reporting periods, respectively (*4*). Our data from Aracaju are indicative of heterotypic protection, although this is not statistically significant (*1*), against P[4]G2 strains. Further postlicensure studies in Brazil are required to document continuing effectiveness of the national vaccination program as well as to closely monitor the circulating rotavirus strain types (*6*).

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Erratum: Vol. 14, No. 4

In the article "Reassortant Avian Influenza Virus (H5N1) in Poultry, Nigeria, 2007" by I. Monne et al., the author affiliations contained errors. Isabella Monne, Tony M. Joannis, Alice Fusaro, Paola De Benedictis, Giovanni Cattoli, and Ilaria Capua are affiliated with Istituto Zooprofilattico Sperimentale delle Venezie, Legnaro, Padova, Italy.

We regret any confusion this error may have caused.