evidence of efficacy from well-conducted randomised controlled trials will become available to support its use, yet cystic fibrosis teams believe that prevention of RSV infection is intuitively a good policy, and a few have already organised local funding support under the umbrella of a ''chronic paediatric respiratory illness''. Engaging in RSV prophylaxis is a major undertaking for families of infants with cystic fibrosis, and our survey suggests that, given the current lack of an evidence base, only a minority of cystic fibrosis centres in the UK are advocating such a policy.

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A newborn screening programme for congenital toxoplasmosis in the setting of a country with less income

A well-established newborn screening programme for congenital toxoplasmosis has been reported in a European country with low prevalence[1]; however, this programme has also been implemented in countries with lower income but with a higher percentage of newborn infected children. We conducted a study in 11 public health community hospitals in the Department of Quindio, excluding the capital (Armenia), in Columbia; about 4560 children are delivered in these hospitals annually. Infants born from August 2003 to December 2003 were enrolled in the study. Informed consent was obtained from mothers during sampling and results were reported in accordance with the resolution 008430 of 1993 of the Ministry of Public Health concerning medical research in Colombia. All serum samples were tested with the Platelia Toxo IgM Neonatal assay (Bio-Rad, Hercules, California, USA) as recommended by the manufacturer. In all, 322 samples were collected, including 106 dry paper samples from the heel, which about 25% of which were insufficient. Thus, 216 samples were taken in 5-ml tubes at the arm at the first medical check of the newborn (10–30 days after birth). All the poor-quality dry paper samples were taken again at the arm. Five samples showed positive Platelia IgM assay (one from a filter card and four from the tubes). All positive samples were then confirmed on the same sample by testing immunoglobulin (Ig)M and IgA using the ISAGA assay (ISAGA Plus, BioMérieux, Marcy L'Etoile, France) and a commercial western blot assay (ID Blot Toxoplasma DPC Diagnostics, Los Angeles, CA, USA) was performed according to the manufacturer's protocol. Diagnosis of congenital toxoplasmosis was conclusive for two children (a dry paper sample in one case and a tube sample in the other). Both children showed the simultaneous presence of toxoplasma-specific IgM and IgA in ISAGA and western blot assays. Three children with negative ISAGA and ID Blot assays were considered not to be infected. Thus, the prevalence of congenital toxoplasmosis during this newborn screening programme in community hospitals in Quindio was 0.62% (95% confidence interval 2.2 to 0.19). The two infected children were asymptomatic and were treated with weekly doses of pyrimethamine–sulfadoxine for 1 year. Both children remained asymptomatic and without ocular signs or gross neurological problems at the end of the first year of life. Our results show that it is possible to carry out neonatal screening for toxoplasmosis and to identify congenitally infected but asymptomatic children.

We think that in countries such as ours, detection programmes for congenital toxoplasmosis should be established urgently. Newborn screening programmes would be an attractive strategy in countries with less income for two reasons. Firstly, the toxoplasmosis prenatal screening programmes are very costly. Thus, in Colombia, despite their proved effect on the health of Colombian children,[2–4] the public and private health assurance companies are reluctant to implement these programmes. Secondly, a large number of mothers (10–20%) did not have prenatal care, and congenital infections can be detected only in newborns.

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Positive benefit of postnatal treatment in congenital toxoplasmosis

We read the editorial of Gilbert and Desateux.[1] In their analysis, they take into account some newborn screening programmes for congenital toxoplasmosis in developing countries such as Brazil and Mexico, with reported rates of up to a maximum of 20 cases/10 000 live births; however, they did not mention our recent report that found a prevalence of 0.5% in a reference hospital in Colombia.[2] This study found one child who died 1 week after birth. As we had information only on the frequency of deaths in a reference hospital, we carried out a study in a representative sample of all newborns from Quindio and found nearly the same prevalence: 0.6% (see letter in *Archives of Disease in Children* in response to the paper by Schmidt *et al*[3]). Clearly, prevalence is higher in South America than in Europe, but in addition our cases are more symptomatic. In an analysis in 17 children congenitally infected and detected in prenatal and newborn screening programmes, 41% were symptomatic. Two children (11.7%) died before 6 months of age; in four of 13 (30%), there were retinochoroidal lesions with ophthalmological examination and in four of 11 (36%) there was neurological involvement with ultrasound examination.[4] Although only eight children were followed until the first year of life (two died before 6 months of age, thus 7 were lost to follow-up), it is obvious that we did not need this period to conclude that our children are more affected than those reported by the group in Lyon (France), where 12% of children had ocular lesion during their first year of follow-up.[5]

We are concerned about the affirmation (and conclusions that can be derived thereof by paediatricians and parents of infected children) that there is no evidence that postnatal treatment is benefical. This may be true with respect to preventing recurrences of retinochoroidal lesions after the first year of life, but we cannot agree that postnatal treatment and treatments with pyrimethamine and sulfanomids are not beneficial. The recent report of the National Collaborative Chicago-Based, Congenital Toxoplasmosis Study validates a 1-year treatment with pyrimethamine–sulfadiazine by comparing the outcomes with historical controls.[6] As stated in the editorial to this work, a double-blind study, including an arm of untreated patients, was ethically contraindicated. We think that congenital toxoplasmosis is a clinical situation where, in the context of our historical and contemporary knowledge, we can reasonably accept that postnatal treatment is better than no treatment, yet there are no double-blind controlled trials. Particularly in our country, it is easy to obtain a natural history of what happens in cases of no treatment, which are in the majority. Thus, we can agree that more efficacious drugs are needed for postnatal treatment, but to advance new proposals for