Ric N Price[1,2,3], Walter RJ Taylor[1,2],, Kamala Thriemer[3] , Nicholas J White[1,2], Nicholas P Day[1,2]

1 Mahidol-Oxford Tropical Medicine Research Unit (MORU), Faculty of Tropical Medicine, Mahidol University, Bangkok, Thailand

2 Centre for Tropical Medicine and Global Health, Nuffield Department of Medicine, University of Oxford, Oxford, UK

3 Global and Tropical Health Division, Menzies School of Health Research and Charles Darwin University, Darwin, Australia

We agree that radical cure of vivax malaria needs to be deployed more widely. The question is how do we achieve this. Shortening the treatment course and thereby improving adherence is an important step in the right direction [1]. Primaquine regimens are usually extended over 14 days to reduce the daily dose and thereby improve tolerability and safety. The main risk is haemolysis in patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency. The main reason why the prolonged regimen is still recommended is the lack of G6PD testing in vivax endemic countries[2]. Novel point of care G6PD tests herald a new era, in which the utility of different dosing regimens can be explored [3, 4].

We agree with Karunajeewa and James that the adverse effects of 8-aminoquinolines should not be trivialised, but equally they should not be exaggerated. Whilst the adverse events following the 7-day primaquine regimen in the IMPROV study give rise for caution, we believe that they can be mitigated by point of care screening for G6PD deficiency, administering primaquine with food to reduce abdominal pain and by promoting awareness and understanding of the haemolytic risk so that patients can stop taking primaquine at the first signs of significant haemolysis. However even with these interventions adverse events will inevitably occur; this “irreducible risk” will vary considerably with the local context.

The increased uptake of safe and effective radical cure, either with primaquine or tafenoquine, will require an integrated package of interventions, patient education and community engagement. Ultimately the public health benefit of the 7-day regimen will rest on minimising the risk of serious adverse events and weighing this risk against the considerable (and usually underestimated) benefits in preventing recurrent *P. vivax* infection and its associated morbidity and mortality.

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