incidence of tuberculosis. At the 2010 International AIDS Conference, MSF presented data from Lesotho showing similar decreased mortality, need for hospital admission, and loss to follow-up. In the USA and Europe, early treatment initiation is the norm because of clear clinical benefits.

In the face of mounting pressure, the USA reversed its rationing policy in Uganda, theoretically allowing for a continued scale-up. There is room for changing course.

I declare that I have no conflicts of interest.

Tido von Schoen-Angerer
tido.von.schoenangerer@geneva.msf.org

Campaign for Access to Essential Medicines, Médecins Sans Frontières, 1211 Geneva, Switzerland

1 Horton R. Offline: The following day, no one died. *Lancet* 2010; **376:** 316.
2 Médecins Sans Frontières. No time to quit: HIV/AIDS treatment gap widening in Africa. Johannesburg: MSF, 2010. http://www.msfaccess.org/fileadmin/user_upload/diseases/hiv-aids/HIV_report_No_Time_To_Quit_May_2010.pdf (accessed Aug 15, 2010).
3 Kates J, Boortz K, Lief E, Avila C, Gobet B. Financing the response to AIDS in low- and middle-income countries: international assistance from the G8, European Commission and other donor governments in 2009. Washington, DC: Kaiser Family Foundation 2010. http://www.kff.org/hivaids/upload/7347-06.pdf (accessed Aug 15, 2010).
4 Stockman F. US seeks to rein in AIDS program. *Boston Globe* April 11, 2010. http://www.boston.com/news/nation/articles/2010/04/11/us_seeks_to_rein_in_aids_program/ (accessed Aug 15, 2010).
5 Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med* 2010; **363:** 257–65.

Published **Online** September 20, 2010
DOI:10.1016/S0140-6736(10)61430-4

The printed journal includes an image merely for illustration

SEAN SPRAGUE/Still Pictures

Can we increase male involvement in AIDS treatment?

In their excellent Article (Aug 7, p 449),[1] Margaret May and colleagues identify a risk factor for early mortality that seldom receives attention within the funding world or research environment: the issue of male mortality. Using their CD4 model, they found a 32% (95% CI 21–42) reduction in death in women compared with men—a finding consistent with the previous multicountry iDEA analysis[2] and a systematic review.[3]

Why, in the context of evidence-based AIDS planning and increased calls for efficiency, does the international community not recognise this group of patients as increasingly vulnerable to morbidity and mortality?[4] There are no advocacy groups demanding attention to this issue. Although possible explanations for increased mortality among men include men's poor health-care decisions, there is also a culture of blame. But does this warrant our neglect of this population? We think not. Just as women require targeted interventions to access timely testing and treatment, through settings such as antenatal clinics, opportunities that are specific to men and boys might increase access to testing and treatment.

In Uganda, men and boys are difficult to enrol in testing and treatment, and have increased mortality compared with women and girls.[5] Ad hoc HIV-positive men's groups reach out to other men to increase testing and acceptance of results. However, in our experience, funders are unsupportive or unwilling to provide assistance to male-targeted interventions. Thus, male groups lack the sophistication of the female-focused efforts and are unsustainable. Men, whether we blame them for their behaviours or not, represent a necessary population to engage with.

We declare that we have no conflicts of interest.

*Josephine Birungi, *Edward J Mills*
emills@cfenet.ubc.ca

The AIDS Support Organization (TASO), Kampala, Uganda (JB); and Faculty of Health Sciences, University of Ottawa, Ottawa, ON K1H 8M5, Canada (EM)

1 May M, Boulle A, Phiri S, et al. Prognosis of patients with HIV-1 infection starting antiretroviral therapy in sub-Saharan Africa: a collaborative analysis of scale-up programmes. *Lancet* 2010; **376:** 449–57.
2 Braitstein P, Boulle A, Nash D, et al. Gender and the use of antiretroviral treatment in resource-constrained settings: findings from a multicenter collaboration. *J Womens Health* 2008; **17:** 47–55.
3 Muula AS, Ngulube TJ, Siziya S, et al. Gender distribution of adult patients on highly active antiretroviral therapy (HAART) in Southern Africa: a systematic review. *BMC Public Health* 2007; **7:** 63.
4 Greig A, Peacock D, Jewkes R, Msimang S. Gender and AIDS: time to act. *AIDS* 2008; **22**(suppl 2)**:** S35–43.
5 Bakanda C, Birungi J, Mwesigwa R, et al. Rates of mortality by baseline CD4 cell count after initiating antiretroviral therapy among Ugandan HIV+ patients. Presented at the XVIII International AIDS Conference; Vienna, Austria; July 18–23, 2010.

Department of Error

Grimaldi-Bensouda L, Marty M, Pollak M, et al. The International Study of Insulin and Cancer. Lancet *2010;* **376:** *769–70*—In this Correspondence letter (Sept 4), the affiliation for P Boffetta should have been: "Tisch Cancer Institute, Mount Sinai School of Medicine, New York, NY, USA, and International Prevention Research Institute, Lyon, France." The International Agency for Research on Cancer had no involvement in the letter nor in the ISICA study. The affiliations for L Abenhaim should have been: "London School of Hygiene and Tropical Medicine, London, UK; and LA-SER Europe Limited, London W1U 3PZ, UK". Additionally, the conflict of interest statement for M Riddle (MRi) should have read "MRi has received honoraria for consulting and for chairing a consulting group regarding insulin glargine, as well as research grants, speakers' fees, and travel grants from Sanofi-Aventis, research grant support from Eli Lilly, Amylin, and GlaxoSmithKline, and honoraria for consulting from Eli Lilly, Amylin, and Hoffmann LaRoche" and that for L Abenhaim (LA) should have read "LA is a stock owner and chairman of LA-SER, the company conducting the study. LA-SER is an independent research organisation that owns and develops the PGRx database. LA-SER has no commercial interests in any of the products studied. To study the data from PGRx or other sources, LA-SER receives funds and/or other support from regulatory agencies, public sources, academic institutions, private groups, and from the pharmaceutical industry (donor companies include but not exclusively the following, over the past 36 months: AstraZeneca, Boiron, Expanscience, Genevrier, GSK, Janssen-Cilag, Merck/Schering Plough, Negma/Wokhardt, Novartis, Pfizer, and several divisions of Sanofi)." These corrections have been made to the online version as of Sept 20, 2010.

Bang Y-J, Van Cutsem E, Feyereislova A, et al, for the ToGA Trial Investigators. Trastuzumab in combination with chemotherapy versus chemotherapy alone for treatment of HER2-positive advanced gastric or gastro-oesophageal junction cancer (ToGA): a phase 3, open-label, randomised controlled trial. Lancet *2010;* **376:** *687–97*—In figure 4A of this Article (Aug 28), median overall survival in the chemotherapy group should have read 11·1 months. This correction has been made to the online version as of Oct 8, 2010.