To the Editor:

We thank Dr van Hecke and colleagues for their insightful remarks. Primarily we should like to emphasise that it is not the migrants - who may come from countries with low levels of AMR - that are necessarily importing AMR, but the conditions on the migrant journey that subsequently facilitate the development and spread of AMR, which is an important distinction. In general terms, we agree that our analysis is constrained by the available data and that better documentation of migrant health is highly desirable. We also think that clinically important AMR is a critical issue, although clinical AMR usually reflects AMR carriage. We agree, and did note in our paper, that the published data are heterogenous, and that small sample sizes (which contributed to wide confidence intervals) are potential limitations in this research. Comparison groups are a significant issue in migrant health-related research and have hindered research to date; although the host population is sometimes used in studies, it would be ideal to have data from the migrants’ country of origin which is frequently not available, particularly in areas of war or natural disaster. The available data we found is principally around skin and soft tissue infections and diarrhoea, which are common and important infections, but we do agree that there is a need for further studies around AMR in respiratory tract infections. We are currently investigating the specific issue of drug-resistant tuberculosis in migrant populations and have recently published a systematic review and meta-analysis in an attempt to better define the current issues regarding infection risk and drug resistance in this population and facilitators to improved screening and detection [1,2].

References

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