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CIDS Newsletter

August 2016

CLINICAL INFECTIOUS DISEASES SOCIETY

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Editor's note

Dear CIDS members

Hope all of you have registered for CIDSCON in Varanasi on Aug 26-28. Plans are underway to have a tele-link with US ID physicians for a session on "Challenging MDR Cases" on 27th evening.

Please plan on also attending the annual general body meeting scheduled for 27th evening.

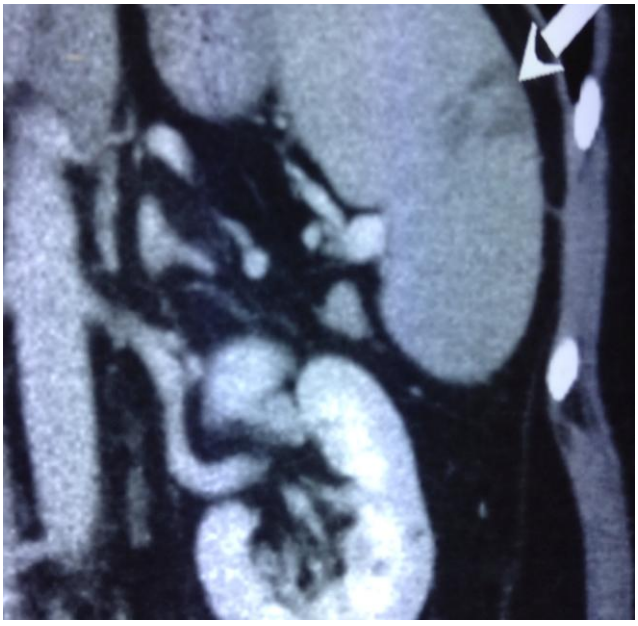
See you in Varanasi!

Sincerely

Ram Gopalakrishnan

Photo quiz

A 49yrs male from Neyveli, TN, c/o fever, abdomen pain, increased frequency of micturition for 9 days. Systemic examination was normal. He had received cefotaxime, amikacin, metronidazole and cefoperozone-sulbactam without improvement.
Usg showed hypoechoic lesions in spleen and liver ? Abscess. Ct scan (photo) showed 3cm hypo dense lesion in rt lobe of liver, mild splenomegaly and wedge shaped peripheral hypo dense lesion in spleen (? Infarcts, ? Less likely abscess).



What is your diagnosis?

Snippets from the literature

Do infectious complications increase after reducing antibiotic prescriptions?

http://www.bmj.com/content/354/bmj.i3410

- Analysis of 610 UK general practices from the UK Clinical Practice Research Datalink.
- Registered patients with 45.5 million person years of follow-up from 2005 to 2014.
- General practices that adopt a policy to reduce antibiotic prescribing for RTIs might expect a slight increase in the incidence of treatable pneumonia and peritonsillar abscess.
- No increase is likely in mastoiditis, empyema, bacterial meningitis, intracranial abscess, or Lemierre's syndrome.
- Even a substantial reduction in antibiotic prescribing was predicted to be associated with only a small increase in numbers of cases observed overall.

This study supports current guidelines promoting reduced antibiotic use for RTIs.

Antibiotic-associated encephalopathy

(courtesy Dr Kalpesh Sukhwani)

Neurology 2016; 86:963–71

The authors reviewed published cases of antibiotic-associated encephalopathy (AAE) and were able to define 3 distinct types of AAE.

Type 1:

- Association with penicillins and cephalosporins (latter especially in renal failure)
- Onset within days of antibiotic initiation
- Myoclonus/seizures common
- Abnormal EEG
- Normal brain MRI
- Resolution within days of antibiotic discontinuation

Type 2:

- Associated with fluoroquinolones, sulfonamides, macrolides, and procaine penicillin
- Onset within days of antibiotic initiation
- Frequent occurrence of delusions and hallucinations; seizures rare
- EEG often normal
- Normal brain MRI
- Resolution within days of antibiotic discontinuation

Type 3:

- Associated with metronidazole
- Onset occurs weeks after antibiotic initiation
- Cerebellar dysfunction is frequent
- Seizures are rare
- Nonspecific EEG abnormalities
- Brain MRI always abnormal

Weekend holidays for ART?

Lancet HIV
http://dx.doi.org/10.1016/S2352-3018(16)30054-6

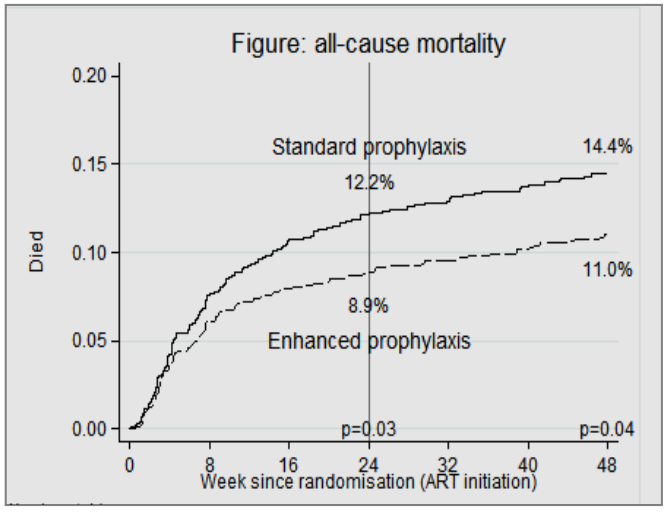
In this open-label, non-inferiority trial (BREATHER), eligible participants were aged 8–24 years, were stable on first-line efavirenz with two nucleoside reverse transcriptase inhibitors, and had HIV-1 RNA viral load less than 50 copies per mL for 12 months or longer. The authors aimed to compare short cycle therapy (5 days on, 2 days off ART) versus continuous therapy (continuous ART). Six (6%) patients assigned to the short cycle therapy versus seven (7%) assigned to continuous therapy had confirmed viral load 50 copies per mL or higher (difference −1·2%, 90% CI −7·3 to 4·9, non-inferiority shown). Two ART-related adverse events occurred in the short cycle therapy group compared with 14 (p=0·02) in the continuous therapy group.

Weekend holidays for suppressed patients on efavirenz based therapy seems to be safe, cheaper and have fewer side effects: patients may end up taking their alcohol but not their ART on weekends!

Enhanced infection prophylaxis reduces mortality in advanced AIDS

http://programme.aids2016.org/Abstract/Abstract/10454

The REALITY 2x2x2 factorial open-label trial (ISRCTN43622374) randomised ART-naïve HIV-infected adults and children >5 years with CD4< 100 cells/mm^3. This randomisation compared initiating ART with enhanced prophylaxis (continuous cotrimoxazole plus 12 weeks isoniazid/pyridoxine (anti-tuberculosis) and fluconazole (anti-cryptococcal/candida), 5 days azithromycin (anti-bacterial/protozoal) and single-dose albendazole (anti-helminth)), versus standard-of-care cotrimoxazole. Median baseline CD4 was 36 cells/mm^3(IQR 16-62) but 47.3% were WHO stage 1/2. 80(8.9%) enhanced versus 108(12.2%) standard prophylaxis died before 24 weeks (adjusted hazard ratio[aHR]=0.73 (95% CI 0.54-0.97) p=0.03;) and 98(11.0%) versus 127(14.4%) respectively died before 48 weeks (aHR=0.75 (0.58-0.98) p=0.04). The number needed to treat/life saved was only 30.



This is a new strategy readily applicable to our patients presenting with advanced disease, obviously after ruling out active OI before starting prophylaxis

Co-trimoxazole as good as sulfadiazine-pyrimethamine for cerebral toxoplasmosis?

HIV Med 2016 Jun 28

In this meta-analysis of 9 studies (5 randomized trials, 3 retrospective cohort studies, and 1 prospective cohort study) of co-trimoxazole for cerebral toxoplasmosis, there were similar rates of clinical response, radiographically measured response, skin rash, gastrointestinal complaints, and drug discontinuation related to adverse effects.
This offers us a simpler treatment regimen for cerebral toxoplasmosis, as sulfadiazine-pyrimethamine combination is not readily available in India.

NNRTI- vs Ritonavir-boosted PI–based Regimens for Initial Treatment of HIV Infection: A Systematic Review and Meta-analysis of Randomized Trials

(courtesy Dr Ashwini Tayade)

Clin Infect Dis 2016 63: 268-280

Previous studies suggest that nonnucleoside reverse-transcriptase inhibitors (NNRTIs) cause faster virologic suppression, while ritonavir-boosted protease inhibitors (PI/r) recover more CD4 cells. However this analysis of 29 trials with 9047 participants found no difference in clinical and viro-immunologic outcomes between NNRTI- and PI/r-based therapy.

Guideline watch

WHO guidelines for HIV infection: 2016 update

These guidelines present several new recommendations, including the recommendation to provide lifelong ART to all children, adolescents and adults, including all pregnant and breastfeeding women living with HIV, regardless of CD4 cell count. WHO has also expanded earlier recommendations to offer PrEP to selected people at substantial risk of acquiring HIV. Alternative first-line treatment regimens are recommended, including an integrase inhibitor as an option in resource-limited settings and reduced dosage of efavirenz, to improve tolerability and reduce costs.

WHO treatment guidelines for drug resistant tuberculosis: 2016 update

The main changes are:

A shorter MDR-TB treatment regimen is recommended under specific conditions. Medicines used in the design of conventional MDR-TB treatment regimens are now regrouped differently based upon current evidence on their effectiveness and safety. Clofazimine and linezolid are now recommended as core second-line medicines in the MDR-TB regimen while paminosalicylic acid is an Add-on agent. MDR-TB treatment is recommended for all patients with rifampicin-resistant tuberculosis, regardless if isoniazid resistance is confirmed or not. Specific recommendations are made on the treatment of children with rifampicin-resistant or MDR-TB. Clarithromycin and other macrolides are no longer included among the medicines to be used for the treatment of MDR-TB. Evidence-informed recommendations on the role of surgery are now included.

Updated HHS Adult and Adolescent Antiretroviral Treatment Guidelines Released

(courtesy Dr Ashwini Tayade)

https://aidsinfo.nih.gov/e-news/archive/2016/7/14

In the What to Start section, TAF/FTC was added as a 2-NRTI option in several Recommended and Alternative Regimens.

Upcoming meetings and conferences

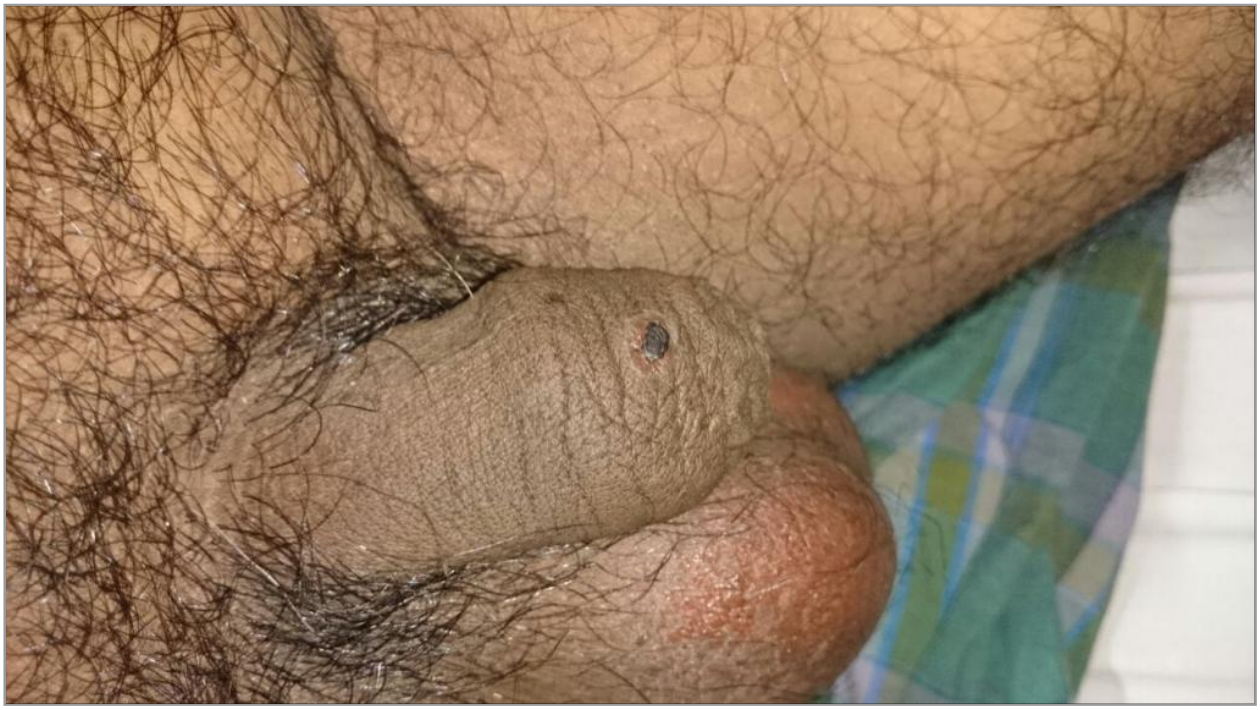
National Conference of AIDS Society of India (ASICON)
Oct 7-9 2016, Mumbai
www.asi-asicon.org

3rd Transplant Infectious Diseases Conference (endorsed by CIDS)
Oct 7-9, 2016, Ludhiana and Chandigarh
Contact Dr Priscilla Rupali (priscillarupali@yahoo.com)

MYCOCON 2016
Nov 11-13, Mumbai
Contact Dr Rajeev Soman (rajeev.soman@yahoo.com)

Answer to photo quiz

Physical exam of genitalia showed an eschar (photo). Scrub typhus serology was positive and he responded rapidly to doxycycline. Scrub typhus has been reported to cause splenic infarcts and a thorough search for eschars, especially around the genital area, is important in making the diagnosis.



Final diagnosis: Scrub typhus with splenic infarct
(case provided by Dr Sheela Nagusah).


CIDS
CIDSCON - 2016
6th Annual Conference of
Clinical Infectious Diseases Society, India
Venue : Banaras Hindu University, Varanasi, Uttar Pardesh
Block your Dates
26th, 27th, 28th, August
2016
Varanasi, India.
Organising Chairman :
Dr.Shyam Sundar
Organising Secretary :
Dr.Jaya Chakravarty
Scientific Committee Chairperson : Dr.Rajiv Soman
For more details Logon to : www.cidscon.in