



CLINICAL INFECTIOUS DISEASES SOCIETY

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Editor's note

*Dear CIDS members,
Hope to see you all in New Delhi at
CIDSCON! Annual members are
encouraged to renew your membership if
not already done so.*

Sincerely

Ram Gopalakrishnan

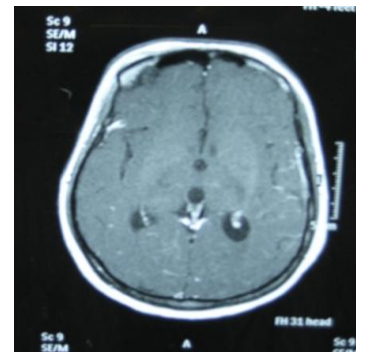
CIDSCON 2015
21 - 23 August | New Delhi

5th ANNUAL CONFERENCE OF THE CLINICAL INFECTIOUS DISEASES SOCIETY

Photo quiz

A 28/F from Tripura presented with fever, headache, vomiting and neck pain for 12 weeks. She had delivered via LSCS under spinal anesthesia 14 weeks ago. She had developed chickenpox 8 weeks ago, treated with acyclovir, lesions resolved. Examination showed prominent neck stiffness, bilateral papilledema. MRI (shown) was read as showing diffuse meningo-encephalitis with nodular enhancing basal exudates and an acute infarct in medial aspect of Rt thalamus. CSF showed 1990 cells (P98,L2), protein of 100 and glucose of 33. She subsequently developed hydrocephalus for which she underwent VP shunt.

What is your diagnosis ?



News from the ID world

Acute encephalitis syndrome (AES)/ Japanese encephalitis virus (JEV) statistics

This chart from the website of the National Vector Borne Disease Control Programme shows that most of the burden of disease falls in Assam, Uttar Pradesh and West Bengal. India traditionally sees a peak of disease in the summer after monsoons.

Directorate of National Vector Borne Disease Control Programme- Delhi
Details of AES/JE Cases and Deaths from 2009-2015

Sl. No.	Affected States/ UTs	2009				2010				2011				2012				2013				2014				2015 (P) till 30.6.2015			
		AES Cases	Deaths	JE Cases	Deaths	AES Cases	Deaths	JE Cases	Deaths	AES Cases	Deaths	JE Cases	Deaths	AES Cases	Deaths	JE Cases	Deaths	AES Cases	Deaths	JE Cases	Deaths	AES Cases	Deaths	JE Cases	Deaths	AES Cases	Deaths	JE Cases	Deaths
1	Andhra Pradesh	49	0	35	0	139	7	7	5	73	1	4	1	64	0	3	0	345	3	7	3	31	0	0	0				
2	Arunachal Pradesh	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	102	9	32	3				
3	Assam	462	92	218	46	469	117	142	40	1319	250	489	113	1343	229	463	100	1388	272	495	134	2194	360	761	165	114	7	28	2
4	Bihar	325	95	0	0	50	7	0	0	821	197	145	18	745	275	8	0	417	143	14	0	1358	355	20	2	74	15	0	0
5	Delhi	0	0	0	0	0	0	0	0	9	0	9	0	0	0	0	0	0	0	0	0	0	0	0	0				
6	Goa	66	3	1	0	80	0	9	0	91	1	1	0	84	0	9	0	48	1	3	1	17	0	0	0				
7	Haryana	12	10	1	0	1	1	1	0	90	14	12	3	5	0	3	0	2	0	2	0	6	1	5	1				
8	Jharkhand	0	0	0	0	18	2	2	2	303	19	101	5	16	0	1	0	270	5	89	5	288	2	90	2	4	0	0	0
9	Karnataka	246	8	7	0	143	1	3	0	397	0	23	0	189	1	1	0	162	0	2	0	75	0	13	0				
10	Kerala	3	0	0	0	19	5	0	0	88	6	37	3	29	6	2	0	53	6	2	0	6	2	3	2				
11	Maharashtra	5	0	4	0	34	17	0	0	35	9	6	0	37	20	3	0	0	0	0	0	0	0	0	0	42	0	5	0
12	Manipur	6	0	1	0	118	15	45	5	11	0	9	0	2	0	0	0	1	0	0	0	16	0	1	0	0	0	0	0
13	Meghalaya	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	212	3	72	3				
14	Nagaland	9	2	9	2	11	6	2	0	44	6	29	5	21	2	0	0	20	0	4	0	20	1	6	0				
15	Punjab	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0
16	Tamil Nadu	265	8	18	0	466	7	11	1	762	29	24	3	935	64	25	4	77	8	33	0	346	4	36	3	220	0	12	0
17	Tripura	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	211	0	14	0	323	0	14	0	84	3	18	3
18	Uttarakhand	0	0	0	0	7	0	7	0	0	0	0	0	174	2	1	0	0	0	0	0	2	0	2	0				
19	Uttar Pradesh	3073	556	302	50	3540	494	325	59	3492	579	224	27	3484	557	139	23	3096	609	281	47	3329	627	191	34	355	58	6	2
20	West Bengal	454	5	57	5	70	0	1	0	714	58	101	3	1216	100	87	13	1735	226	140	12	2385	348	415	78	417	60	23	4
21	Telengna																					155	5	0	0				
	Grand Total	4975	779	653	103	5167	679	555	112	8249	1169	1214	181	8344	1256	745	140	7825	1273	1086	202	10867	1717	1661	293	1310	143	92	11

Snippets from the literature

No time to START is too early for HIV, both in the West and in resource limited settings

N Engl J Med 2015 Jul 14

N Engl J Med 2015; 372:835-845

N Engl J Med 2015 Apr 2; 372:1312

The INSIGHT START Study Group | July 20, 2015 | DOI: 10.1056/NEJMoa1506816

The TEMPRANO ANRS 12136 Study Group | July 20, 2015 | DOI: 10.1056/NEJMoa1507198

Final results of the randomized START study confirm those reported on the interim analysis (see June 2015 CIDS newsletter): early ART at CD4 > 500 reduced serious AIDS-related event, serious non-AIDS-related event, or death from any cause by 57% compared to starting at <500. Most events occurred at CD4 > 500.

The TEMPRANO study done in Africa was a trial with a 2-by-2 factorial design to assess the benefits of early antiretroviral therapy (ART), 6-month isoniazid preventive therapy (IPT), or both among HIV-infected adults with high CD4+ cell counts. The primary end point was a composite of diseases included in the case definition of AIDS, non-AIDS-defining cancer, non-AIDS-defining invasive bacterial disease, or death from any cause at 30 months. The risk of death or severe HIV-related illness was lower with early ART than with deferred ART (adjusted hazard ratio, 0.56) and was lower with IPT than with no IPT (adjusted hazard ratio, 0.65).

It is time to offer ART to all, a change in the pendulum compared to a decade or two ago. The benefit of IPT was also apparent and it is time to shed our reluctance to follow this WHO-endorsed approach to preventing TB, provided of course active TB has been first excluded.

Changing concepts on pneumonia requiring hospitalization: only ~10-20% of bacterial etiology and no role for macrolides

The first study looked at 2320 hospitalized adults with radiographic evidence of pneumonia (93%) of whom 498 patients (21%) required intensive care and 52 (2%) died. Despite extensive testing, a pathogen was detected only in 38%: one or more viruses in 23%, bacteria in 11%, bacterial and viral pathogens in 3%, fungal or mycobacterial pathogen in 1%. The most common pathogens were human rhinovirus 9% and influenza virus 6%. *Streptococcus pneumoniae* was the commonest bacterium (5%).

A second prospective study looked at >2500 episodes in hospitalized PCV/HiB vaccinated US children (mean age 2) where 21% required intensive care, and <1% died: 66% were of viral etiology. *Mycoplasma pneumoniae* was more common among children 5 years of age or older than among younger children (19% vs. 3%).

A third study of 2283 patients at seven hospitals from the Netherlands where the median age of the patients was 70 years was able to determine an etiology in only a minority of them. *Streptococcus pneumoniae* (15.9%) and *Haemophilus influenzae* (5.8%) were the commonest and “atypical” pathogens were found in only 2.1%. Neither β -lactam-macrolide combination therapy nor fluoroquinolone monotherapy appeared to be better than β -lactam monotherapy for non-severe community-acquired pneumonia. There was no significant difference in 90-day mortality rates.

These studies suggest that viruses are the commonest cause of pneumonia requiring hospitalization across age groups and call into question the role of atypical pathogens and macrolide addition in non-seriously ill patients.

A new treatment option for prostatitis caused by resistant GNB?

Clin Infect Dis published 10 June 2015,
10.1093/cid/civ436

Indian clinicians sometimes have to deal with patients who develop prostatitis caused by ESBL producing or carbapenem resistant Enterobacteriaceae, for which there are no reliable oral options. Fosfomycin tromethamine has recently been approved and marketed in India for single 3g dose treatment of uncomplicated cystitis. This case series describes two patients whose prostatitis responded to prolonged courses of fosfomycin. Further studies are needed for this difficult to treat infection.

Combination treatment for VL-HIV co-infected patients in Bihar

Clin Infect Dis published 30 June 2015,
10.1093/cid/civ530

The investigators describe the safety and efficacy of treating visceral leishmaniasis in patient from Bihar with HIV-VL co-infection with concurrent intravenous liposomal amphotericin B and oral miltefosine. All patients were encouraged to start or continue on antiretroviral therapy (ART). The regimen was safe, well tolerated, with lower relapse rates than monotherapy. Not initiating ART and concurrent tuberculosis were independent risk factors for mortality

Upcoming conferences and meetings

2nd Indian Transplant Infectious Diseases Conference

October 2-3, Chennai

<http://www.cmch-vellore.edu/pdf/events/tid.PDF>

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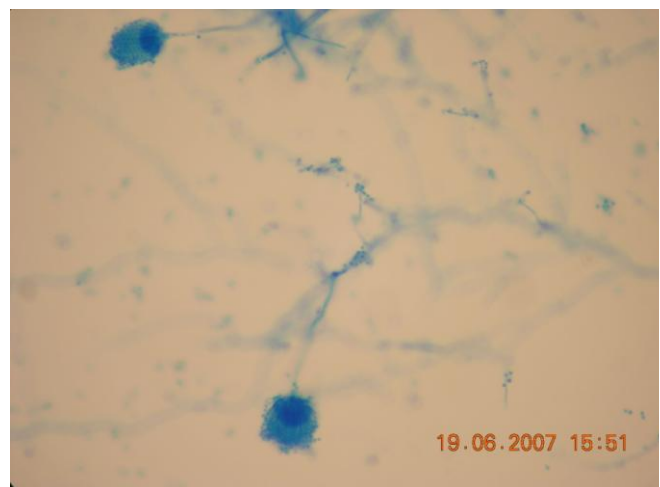


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Last date for Abstract Submission - 1st June 2015. [Submit Now](#)

Answer to photo quiz



Ventricular CSF from time of VP shunt insertion showed growth of *Aspergillus flavus* at 10 days. The presumed source of the infection into the brain was the spinal anesthetic. The patient improved on voriconazole.

Diagnosis: *Aspergillus flavus* meningitis.