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CIDS Newsletter

November 2015

CLINICAL INFECTIOUS DISEASES SOCIETY

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Editor's note

Dear CIDS members

Old issues of the newsletter have been posted on our society website for open access.

Ram Gopalakrishnan

News from the ID World

The Oral Polio Vaccine Can Go 'Feral,' but WHO Vows to Tame It! (courtesy Dr Surabhi Madan)

WHO has announced the beginning of a program to phase out oral polio vaccine and eventually switch to the injectable version. This is overcome to the problem of vaccine-derived polio cases. In 2014, there were 56 vaccine-derived cases reported globally as opposed to regular polio cases which have fallen to just a couple dozen a year.

WHO is ordering every country still using oral polio vaccine to switch to a safer oral vaccine in April 2016. The first step in the WHO plan is to drop Type 2 polio virus from the new oral vaccine. Of the three types of virus in the vaccine, Type 2 accounts for roughly 90 percent of vaccine-derived paralysis cases. Type 2 itself has not been seen in the wild since 1999.

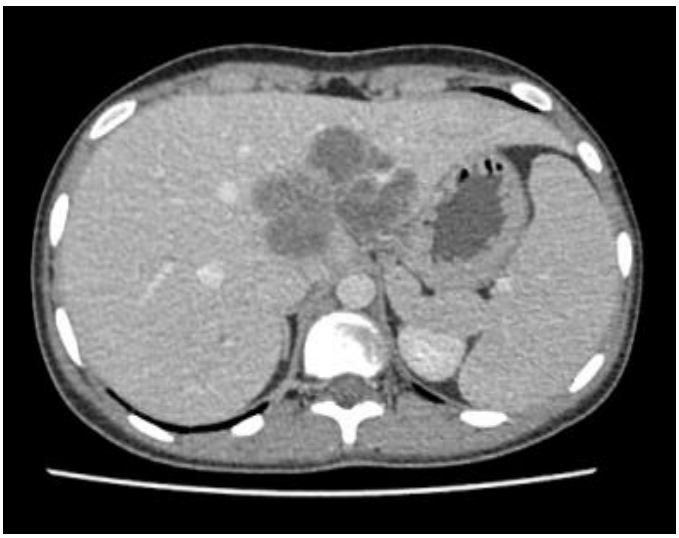
Photo quiz

A 15 year old school girl from Ranaghat, West Bengal presented with 3 month history of

- Fever intermittent, high grade(101-104)
- Dragging right hypochondriac pain radiating to the right shoulder
- loss of appetite
- weight loss of 9 kg and pruritus.

Her WBC count was 7100 (N39,L28,E29,M4).

CT abdomen is shown. It was read as showing well defined thick walled hypo-dense loculated lesions in segment II, III and IV of liver.



What is your diagnosis?

There isn't enough injectable "killed" vaccine available globally to replace the oral vaccine entirely. Also in some places it might difficult to give a shot to every child in a village: that is why the live oral vaccine containing strains of Type 1 and Type 3 polio will continue.

Tenofovir alafenamide approved in USA

The U.S. Food and Drug Administration issued approval for a fixed dose combination tablet of elvitegravir, cobicistat, emtricitabine and tenofovir alafenamide (TAF), as a complete regimen to treat HIV-1 in adults and children 12 years or older with no previous antiretroviral treatment or to replace treatment for virologically suppressed patients who have been on a stable regimen for six months or more with no treatment failure or resistance to individual components of the tablet.

TAF is expected to cause less nephrotoxicity and osteoporosis than tenofovir.

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Applications available for entrance exam for ID fellowship for 2016 from National Board of Examinations

http://www.natboard.edu.in/pdoof/fee/Notice%202015.pdf

The last date of submission of application forms is 7th December and the exam will be held on 17th January 2016. Please encourage all Internal Medicine postgraduates interested in ID to apply.

Snippets from the literature

Dengue vaccine: more questions than answers

N Engl J Med 2015; 373:1195-1206

A vaccine against dengue is a high public health priority and the most advanced candidate vaccine, called CYD-TDV, is progressing toward potential registration and review by the WHO in 2016. The safety and efficacy of CYD-TDV after the administration of three doses over a 12-month period was recently measured in two pediatric phase 3 trials in Latin America and Southeast Asia.

Updated results from the third and fourth years of surveillance after vaccination are now available.

Most eye-catching is the suggestion that CYD-TDV vaccination was associated with an elevated risk of hospitalization for dengue among children younger than 9 years of age (but most markedly, among those 2 to 5 years of age) when they were naturally infected in the third year after vaccination.

Partial, waning immunity is a particularly unwelcome outcome after vaccination. Live vaccines need to be sufficiently potent in their infectiousness and replicative capacity to initiate immunity in both unexposed recipients and those with partial immunity. Dengue human challenge studies might help in the selection of second-generation candidate vaccines.

Targeted approach to blood cultures for children with pneumonia

J Pediatr 2015 Oct 8

Blood cultures are positive in only a small percentage (well below 10%) of children with pneumonia. To compare clinical and cost outcomes of strategies of universal culturing of all patients versus targeted culturing of patients at high risk for bacteremia in this setting, researchers developed a decision-analysis model that incorporated the predicted rates of bacteremia in CAP (3.5%) and blood culture contamination (1.4%). They limited blood cultures to high risk patients: those who were immunocompromised, aged <6 months and unimmunized, or admitted to the intensive care unit or those having a central line, effusion or empyema, or a chronic medical condition. The risk for missing bacteremia in children for whom cultures were not obtained was very low (0.07 cases per 100 patients) in the targeted approach.

Using Mtb PCR to limit isolation

Clin Infect Dis 2015 Nov 1; 61:1365

In a retrospective analysis, 81% of hospitalized patients with culture-confirmed tuberculosis and at least three sputum samples had positive polymerase chain reaction results; 74% had positive smears.

The results suggest that if PCR results are negative, respiratory isolation can safely be discontinued.

Infliximab for steroid refractory HIV-TB IRIS

Clin Infect Dis 2015 Oct 15;

In three cases of steroid-refractory mycobacterial immune reconstitution inflammatory syndrome in HIV-infected patients, use of the TNF inhibitor infliximab appeared to be beneficial. No patient had a relapse of mycobacterial disease.

This is a common problem in India and we have one more option, though further studies are needed.

Long-acting injectable HIV treatment shows promise in early study (provided by Dr Surabhi Madan)

CROI 2015 updated Nov 2015

HIV treatment that doesn't depend on daily dosing seemed to move a little closer with an announcement that early findings show an injected combination of two antiretroviral medicines (rilpivirine and cabotegravir) given monthly or every two months effective in controlling HIV among people whose virus was already suppressed. The findings come from the first 32 weeks of the LATTE 2 study that involved more than 300 adults in the U.S., Europe and Canada.

Patients getting injections every month had viral suppression of 94 percent after 32 weeks, while the suppression rate was 95 percent for those receiving treatment every eight weeks. By comparison, patients on tablets had a suppression rate of 91 percent.

The study will continue for another 64 weeks to assess longer term outcomes.

Guideline watch

WHO updates HIV treatment guidelines on when to start ART

WHO now recommends treatment for all HIV infected persons based on data from the recent START and TEMPRANO trials, with priority given for persons with CD4<350 or Stage 3/4 disease. PREP is also recommended for all eligible persons.

Recommendation 1: When to start ART among people living with HIV			
Target population	**Specific recommendation**	**Strength of the recommendation**	**Quality of the evidence**
Adults[a] (>19 years)	ART should be initiated in all adults living with HIV at any CD4 cell count	*Strong*	*Moderate* NEW
	As a priority, ART should be initiated in all adults with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and individuals with CD4 count ≤350 cells/mm³	*Strong*	*Moderate*
Pregnant and breastfeeding women	ART should be initiated in all pregnant and breastfeeding women living with HIV at any CD4 cell count and continued lifelong	*Strong*	*Moderate* UPDATED
Adolescents (10–19 years old)	ART should be initiated in all adolescents living with HIV at any CD4 cell count	*Conditional*	*Low* NEW
	As a priority, ART should be initiated in all adolescents with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and individuals with CD4 count ≤350 cells/mm³	*Strong*	*Moderate*
Children (1 to <10 years old)	ART should be initiated in all children 1 to <10 years old living with HIV at any CD4 cell count	*Conditional*	*Low* NEW
	As a priority, ART should be initiated among all children <2 years old and those with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and individuals with CD4% <25% (if <5 years old) or CD4 count ≤350 cells/mm³ (if ≥5 years old)	*Strong*	*Moderate*
Children (<1 year old)	ART should be initiated in all children living with HIV younger than 1 year old at any CD4 cell count	*Strong*	*Moderate*

AHA guidelines on infective endocarditis updated (courtesy Dr Neha Gupta and Dr Surabhi Madan)

Circulation. 2015;132:00-00. DOI: 10.1161/CIR.0000000000000296.

Upcoming ID conferences and CME programs

CIDS CME for postgraduates
Dec 3-5, CMC, Vellore
Contact secretary@cidsindia.org or www.cidsindia.org

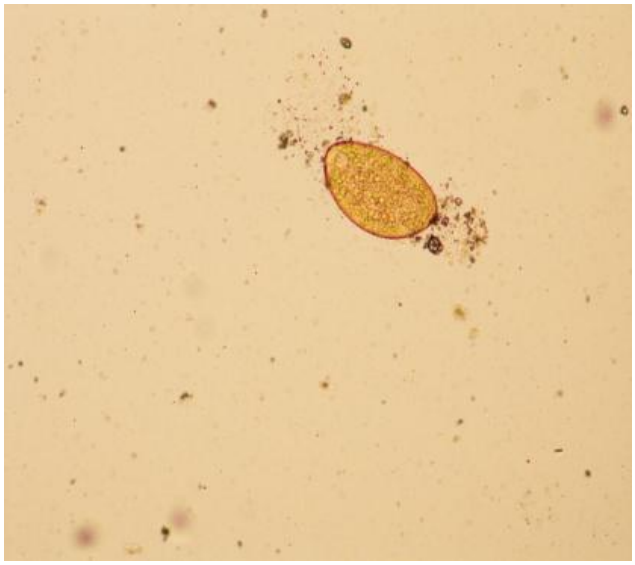
CIDS endorsed ID CME
Dec 19, Coimbatore
Contact Dr A Murali muralimd2000@yahoo.com

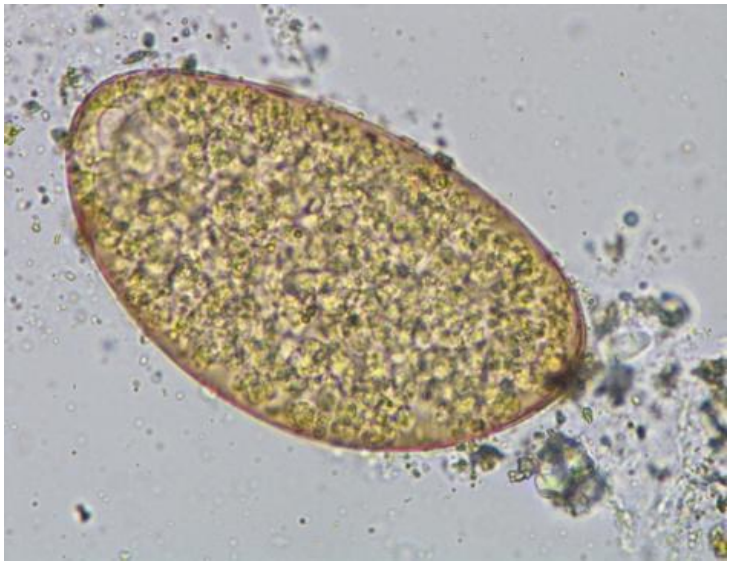
CIDS endorsed ID CME
Jan 23-24, Nagpur
Contact Dr Ashwini Tayade drashwini.tayade@gmail.com

Chennai ART symposium (CART)
Jan 23-24, 2016, Chennai
ttps://www.yrgcare.in/cart/cart_welcome.htm

17th International Congress on Infectious Diseases (ICID)
March 2-5, 2016, Hyderabad
http://www.isid.org/icid/

Answer to photo quiz





Biliary aspirate showed mature eggs of Fasciola hepatica.

Hepatic fascioliasis is acquired by consumption of metacercariae on water plants such as watercress, and causes liver lesions with eosinophilia. If eggs are absent in stool, biliary aspirate can demonstrate the worms or the eggs.

Diagnosis: Hepatic fascioliasis.

(case provided by Dr Madhumita R)

Registration fee

A fee of Rs. 1500/ should be paid as demand draft for confirming the registration along with completed application form. 21st November 2015 will be the last date for receipt of registration forms. Number of registrations is restricted and the selection will be on first-come first-served basis.

Payment Details

Payment should be made by Demand Draft in favour of "Clinical Infectious Diseases Society" payable at Vellore.

Application process

Please download the application form from www.cidsindia.org and send it to the address below after completion along with the demand draft. Your registration can be confirmed if you email a scanned copy of your completed application form and DD to secretary@cidsindia.org

Accommodation

Reservation for accommodation can be made subjected to the availability. Please visit our website for details.

Address for correspondence

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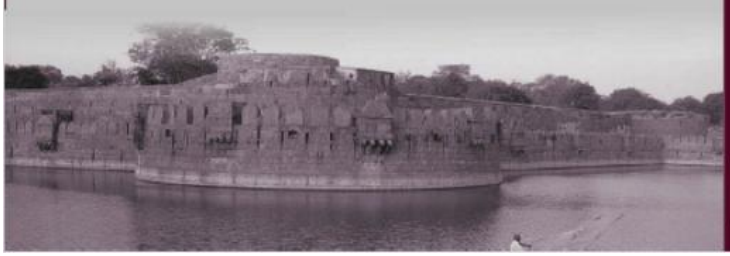
Infectious Diseases Training & Research Centre
Christian Medical College
Vellore- 632004.

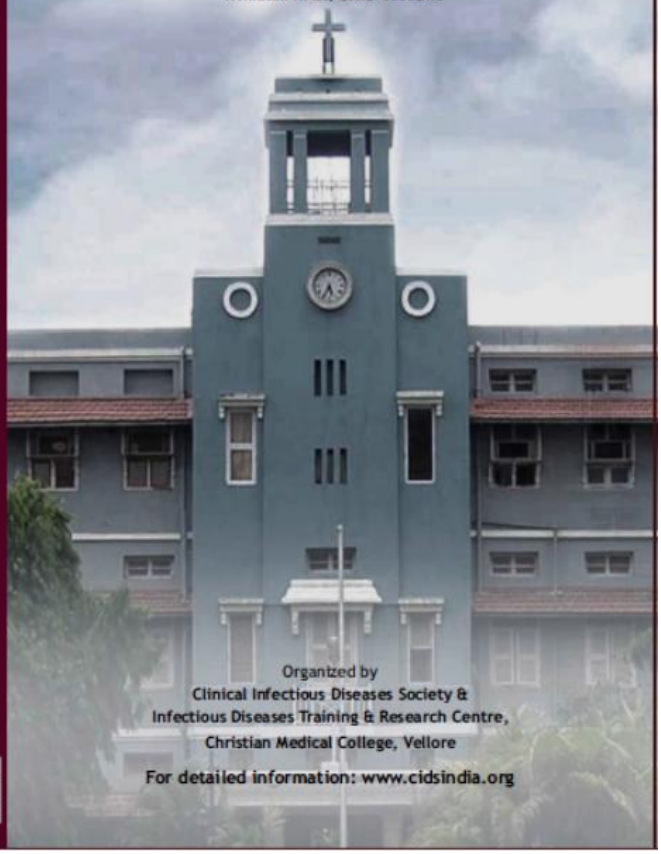
Phone: 0416-2282804
Email: secretary@cidsindia.org
Website: www.cidsindia.org



INFECTIOUS DISEASES CME FOR POSTGRADUATES

3 – 5 December, 2015

WHEELER HALL, CMC VELLORE



Organized by
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Christian Medical College, Vellore

For detailed information: www.cidsindia.org