Volume 2, Issue 10

CIDS Newsletter

October 2015

CLINICAL INFECTIOUS DISEASES SOCIETY

Editor:
Dr Ram Gopalakrishnan

Associate Editors:
Dr Neha Gupta, Dr Ashwini Tayade, Dr Surabhi Madan

Design & format:
Dr Laxman G. Jessani

Editor's note

Dear CIDS members

Please mark your calendars for the following:

Our annual CIDSCON 2016 at Varanasi will be between August 26-28, 2016. Plans are afoot to have a combined session with ESCMID (European Society for Clinical Microbiology and Infectious Diseases) on 26th August.

The annual CIDS PG CME at Vellore will be between December 3-5.

CIDS members are encouraged to attend ICID in Hyderabad between March 2-5, 2016 where CIDS is a collaborating society.

CIDS members are planning to conduct CIDS endorsed regional CMEs at Hyderabad, Coimbatore and Nagpur in the next three months. This is an excellent way to project the value of our members, our society and the specialty of ID as a whole and I encourage all of you to do the same. Forms for endorsement are available with the secretary.

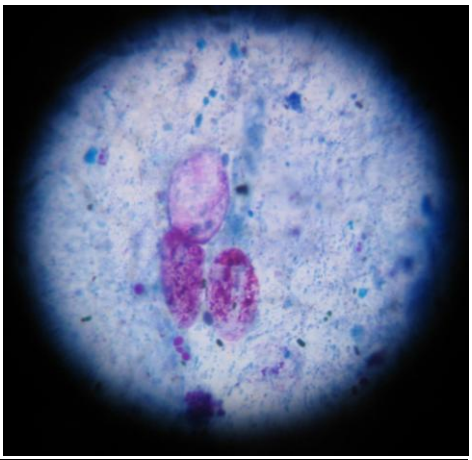
Sincerely

Ram Gopalakrishnan

Photo quiz

A 42- year- old gentleman with HIV-1 infection and a CD4 count of 100 cells/µl presented with loose stools of 5 days duration. He had 8-10 episodes/day, large quantity, watery with no blood, mucus and no fever. He had associated dyspeptic symptoms.
He was on AZT/3TC/EFV and on TMP/SMX 1DS prophylaxis. Patient has past history of chronic diarrhea for 3 years with partial relief with ciprofloxacin, metronidazole and nitazoxanide. Investigations revealed WBC- 5,200. Stool routine showed positive occult blood.
CRP was negative. CT scan did not show bowel wall thickening.

Stool Microscopy (Figure):



What will you start in this patient?

1) Metronidazole
2) Nitazoxanide
3) Paromomycin
4) Trimethoprim/ sulphamethoxazole (TMP/SMX)
5) Albendazole

News from the ID world

DM in Infectious Diseases introduced in India

AIIMS, New Delhi has announced two DM courses in Infectious Diseases:

-6 year course with 3 seats for MBBS candidates (http://aiimsexams.org/PDF/PGProspectusJANUARY2016Final.pdf).

-3 year course with 4 seats for candidates with M.D. in Medicine / Pediatrics / Microbiology (http://dm.aiimsexams.org/pdf/FinalProspectusDM-PHDProspectusJanuary2016.pdf)

Falling encephalitis rates in North India

The central government had announced an enhanced immunization drive against JEV earlier this year and this appears to be paying off. For instance, acute encephalitis syndrome (AES) rates in Uttar Pradesh have dropped from 3329 in 2014 to 1291 so far this year, and in Bihar from 1358 to 145.

Nobel prizes this year for antiparasitic therapies for neglected tropical diseases

(courtesy Dr Ashwini Tayade)

Three scientists were awarded the Nobel Prize in Physiology or Medicine for discovering "therapies that have revolutionized the treatment of some of the most devastating parasitic diseases," the Nobel committee`announced

William C Campbell and Satoshi Omura won for developing a new drug,Avermectin. A derivative of that drug, Ivermectin, has nearly eradicated river blindness (onchocerciasis) and radically reduced the incidence of lymphatic filariasis. They shared the USD 960 000 award with Tu Youyou, who discovered Artemisinin, a drug that has significantly reduced death rates from malaria.

WHO panel changes 2 strains in Southern Hemisphere flu vaccine

(courtesy Dr Ashwini Tayade)

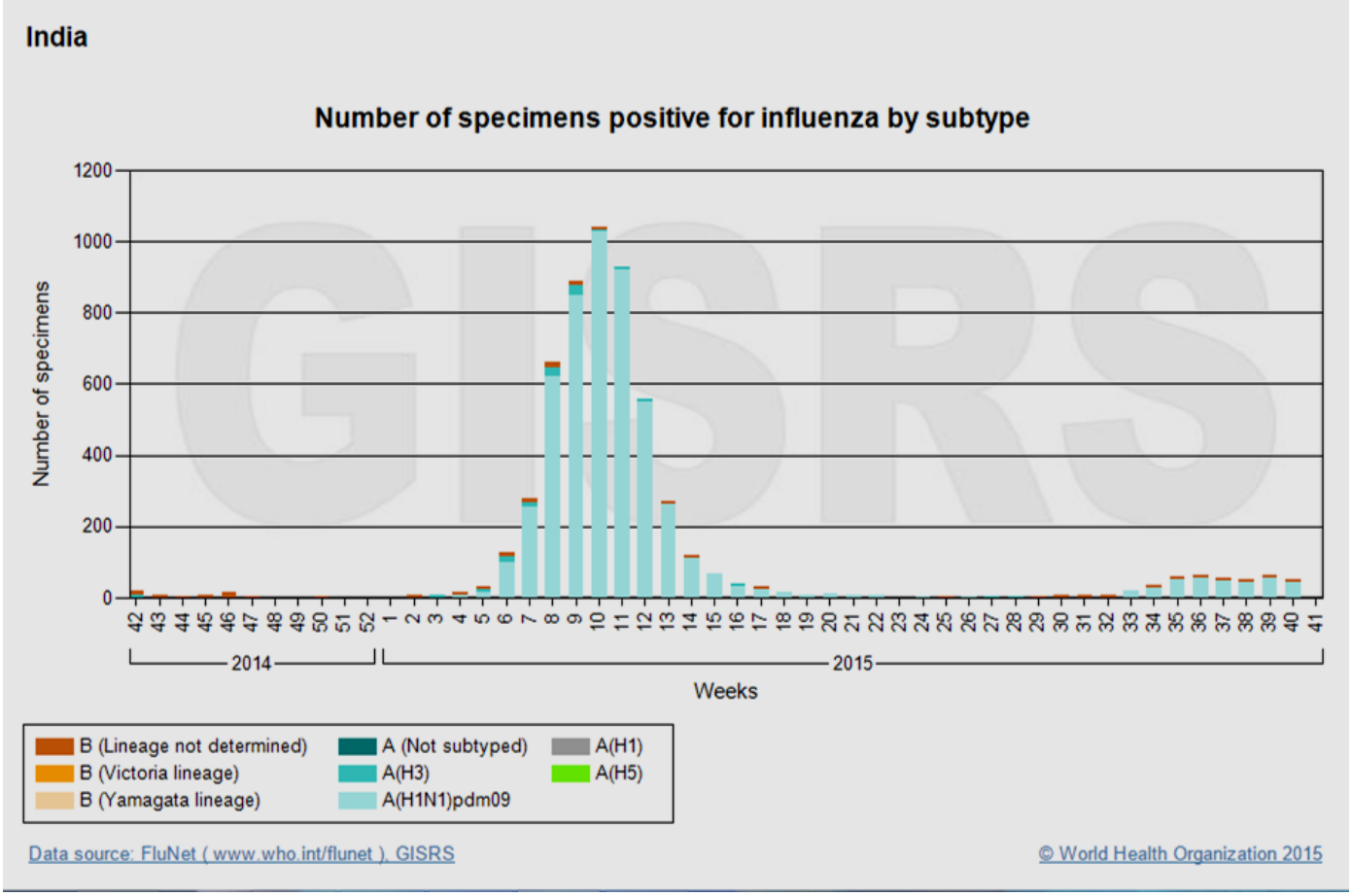
A World Health Organization (WHO) expert committee has recommended changes for 2 of 3 strains in the trivalent versions of influenza vaccines for the Southern Hemisphere next year [2015-16] because of changes in circulating strains. An expert committee meeting recommended swapping out the A/H3N2 and B strains in trivalent influenza vaccines. For quadrivalent formulations, the group recommended adding the influenza B Yamagata lineage component that wasincluded in its previous trivalent recommendation for both hemispheres. The A/H1N1 strain would remain the same.

WHO recommends the following for trivalent vaccines:

- for H1N1, a A/California/7/2009-like virus
- for H3N2, an A/Hong Hong/4801/2014-like virus
- for B, Brisbane/60/2008-like virus (belonging to the Victoria lineage)

For quadrivalent vaccines that contain a 2nd B strain, the agency recommended adding Phuket/3073/2013-like virus, a Yamagata lineage virus that was the B component of trivalent vaccines for the Southern Hemisphere's current season and is the B component of trivalent vaccines for the Northern Hemisphere's upcoming season.

Just when we started vaccinating patients with the new Northern Hemisphere vaccine, the Southern Hemisphere vaccine composition for next year has changed!



Nontuberculous Mycobacterium Infections Associated with Heater-Cooler Devices

(provided by Dr Surabhi Madan)

http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm466963.htm

On Oct 15 2015, US FDA announced a **Safety Communication** to heighten awareness about infections associated with heater-cooler devices and steps health care providers and health facilities can take to mitigate risks to patients. Heater-cooler devices are used during cardiothoracic surgeries, as well as other medical and surgical procedures to warm or cool a patient to optimize medical care and improve patient outcomes.

Snippets from the literature

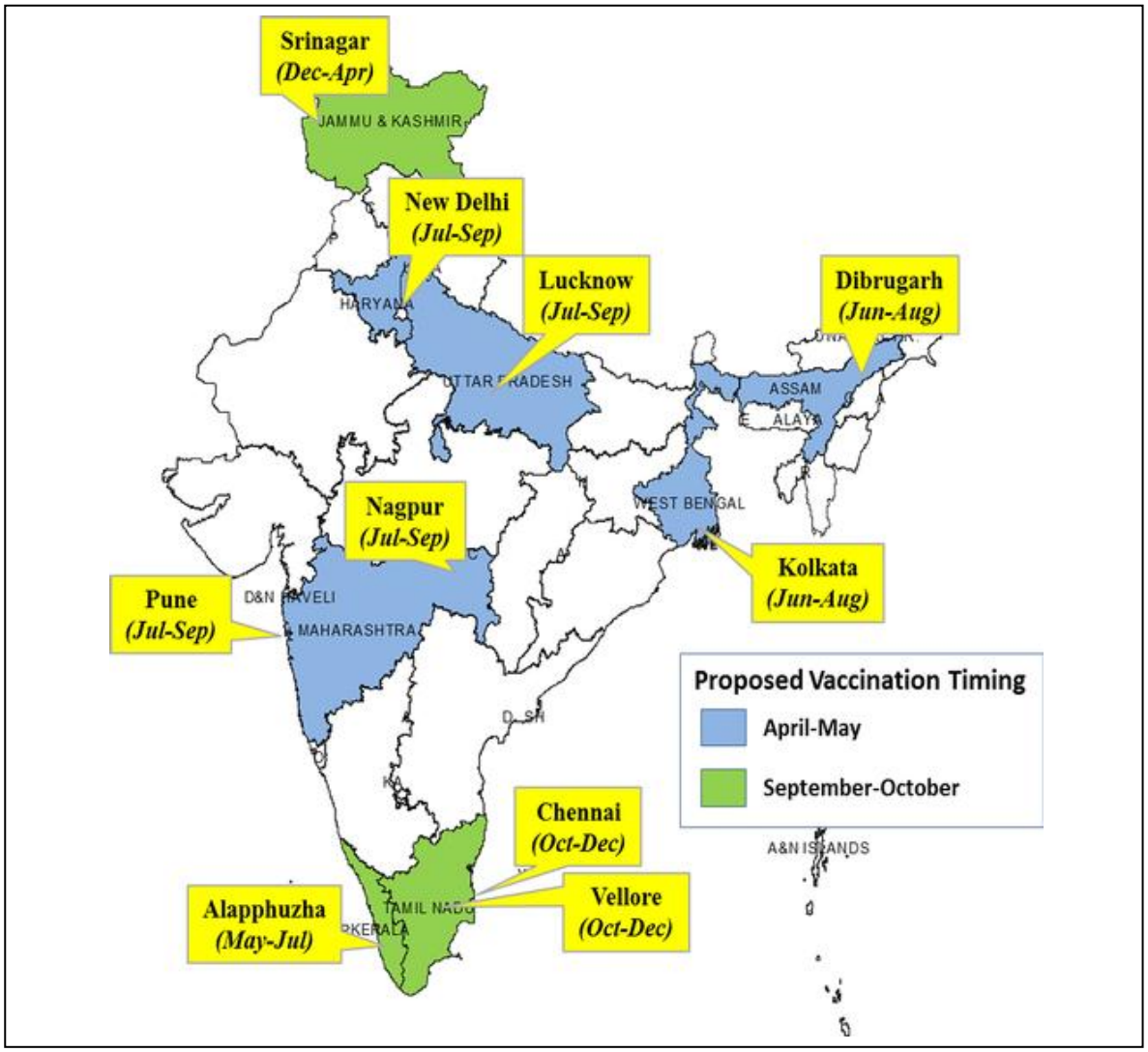
Dynamics of Influenza Seasonality at Sub-Regional Levels in India and Implications for Vaccination Timing

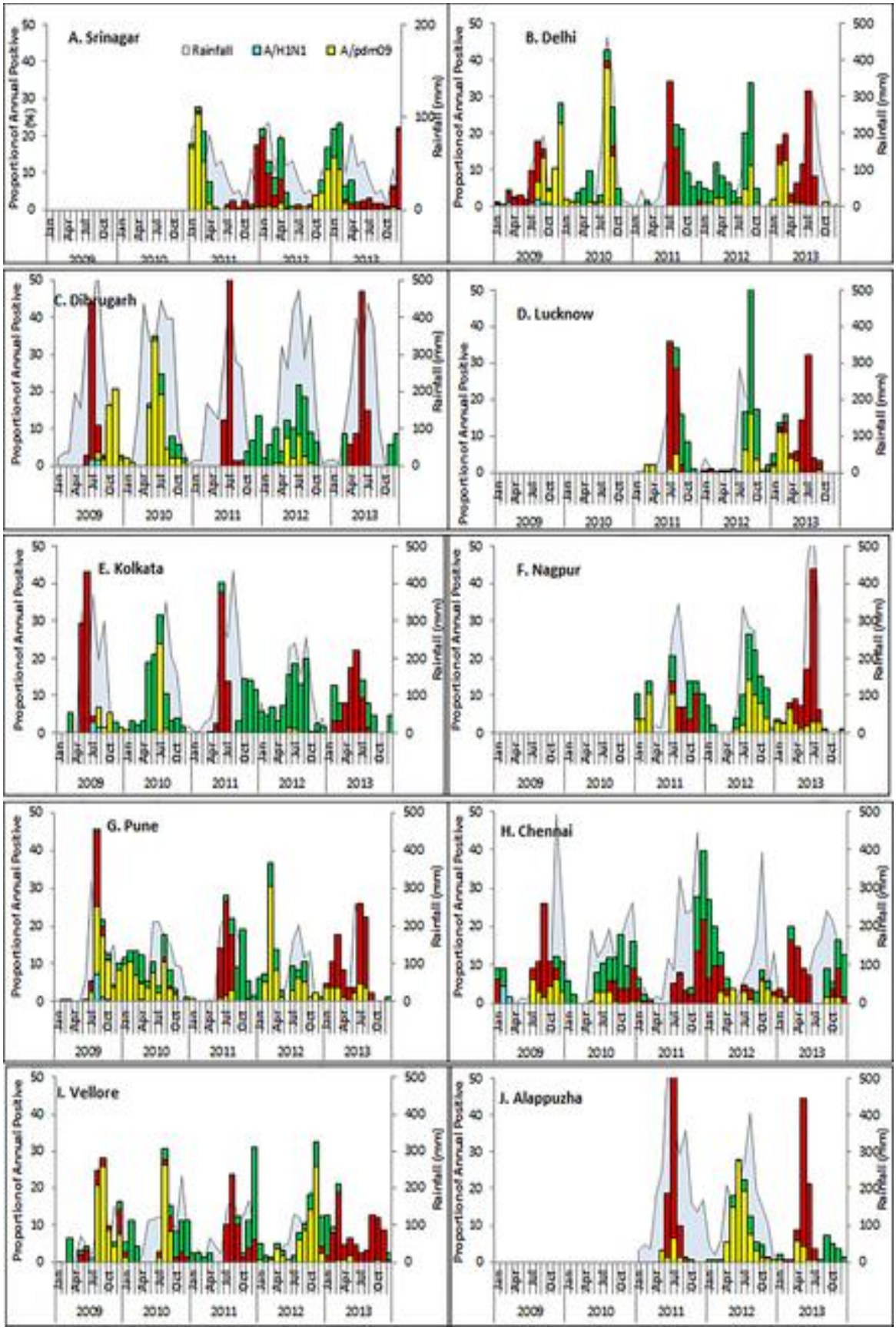
(courtesy Dr OC Abraham)

PLoS ONE 10(5): e0124122.
doi:10.1371/journal.pone.0124122

Patients in ten cities presenting with influenza like illness in out-patient departments of dispensaries/hospitals and hospitalized patients with severe acute respiratory infections were enrolled from 2009 to 2013. Of the 44,127 ILI/SARI cases, 6,193 (14.0%) were positive for influenza virus. Peaks of influenza were observed during July-September coinciding with monsoon in cities Delhi and Lucknow (north), Pune (west), Allaphuza (southwest), Nagpur (central), Kolkata (east) and Dibrugarh (northeast), whereas Chennai and Vellore (southeast) revealed peaks in October-November, coinciding with the monsoon months in these cities. In Srinagar (Northern most city at 34°N latitude) influenza circulation peaked in January-March in winter months.

The patterns of circulating strains varied over the years: whereas A/H1N1pdm09 and type B co-circulated in 2009 and 2010, H3N2 was the predominant circulating strain in 2011, followed by circulation of A/H1N1pdm09 and influenza B in 2012 and return of A/H3N2 in 2013. Antigenic analysis revealed that most circulating viruses were close to vaccine selected viral strains.





This paper greatly helps with deciding when to suspect influenza clinically. The authors also suggest that while cities with temperate seasonality will benefit from vaccination in September-October, cities with peaks in the monsoon season in July-September will benefit from vaccination in April-May.

Crimean-Congo hemorrhagic fever: widespread in India?

Emerg Infect Dis. 2015
Oct. http://dx.doi.org/10.3201/eid2110.141961

The authors of this study conducted a cross-sectional serosurvey of Crimean- Congo hemorrhagic fever)CCHF) among livestock in 22 states and 1 union territory of India. A total of 5,636 samples from bovines, sheep and goats were screened for CCHF virus IgG. IgG was detected in 354 samples, indicating that this virus is widespread in this country.

Figure: Gray shading, seropositivity in bovines; black dots, seropositivity in sheep/goats; white, serum samples not available screening.

It appears that we need to suspect CCHF in patients from any part of India with hemorrhagic fever who have a history of contact with livestock or tick exposure.

Mixed malaria: commoner than we think

Emerg Infect Dis. 2015
Oct. http://dx.doi.org/10.3201/eid2110.150678

In 8 malaria-endemic states in India, mixed *Plasmodium* spp infections were detected by PCR in 17.4% (265/1521) of blood samples that microscopy had shown to contain only P. falciparum. PCR showed mixed infections with *P. falciparum* and *P. vivax* in 239 (16%) samples; *P. falciparum* and *P. malariae* in 19 (1%) samples; *P. falciparum* and *P. ovale* in 6 (0.4%) samples; and *P. falciparum*, *P. malariae*, and *P. ovale* in 1 (0.1%) sample.

The authors suggest that the quality of microscopy must be improved because use of PCR for detection of malaria parasites is limited in rural areas.

Upcoming ID conferences and CME programs

8th Annual Conference of AIDS Society of India
October 30-Nov 1, Mumbai
http://www.asi-asicon.com/

CIDS endorsed ID CME
Nov 7-8, NIMS, Hyderabad
Contact Dr Subbalaxmi (cmecidshyd@gmail.com)

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

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

Co-trimoxazole. Stool microscopy reveals large oval oocysts of Cystoisospora belli.
Infection is acquired by the consumption of oocysts, after which the parasite invades intestinal epithelial cells. Acute infections can begin abruptly with fever, abdominal pain and watery nonbloody diarrhea and can last for weeks or months. Eosinophilia, which is not found in other enteric protozoan infections, may be detectable.
The diagnosis (Figure) is usually made by detection of the large (~25-µm) oocysts in stool by modified acid-fast staining. If repeated stool examinations are unrevealing, sampling of duodenal contents by aspiration or small-bowel biopsy (often with electron-microscopic examination) may be necessary.
TMP/SMX is the drug of choice. Other drugs effective are ciprofloxacin, metronidazole and nitazoxanide.

Diagnosis:

Intestinal cystoisosporiasis.

(case provided by Dr Neha Gupta)

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

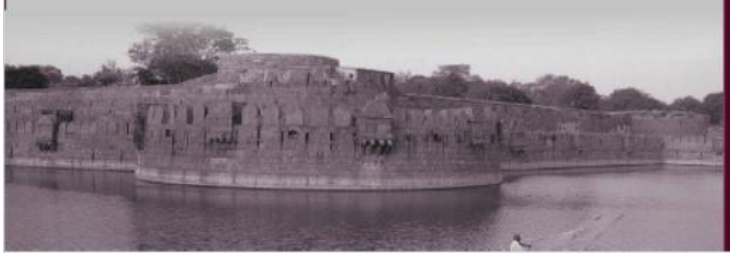
Accommodation

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

Address for correspondence

ID CME for Postgraduates
Infectious Diseases Training & Research Centre
Christian Medical College
Vellore- 632004.

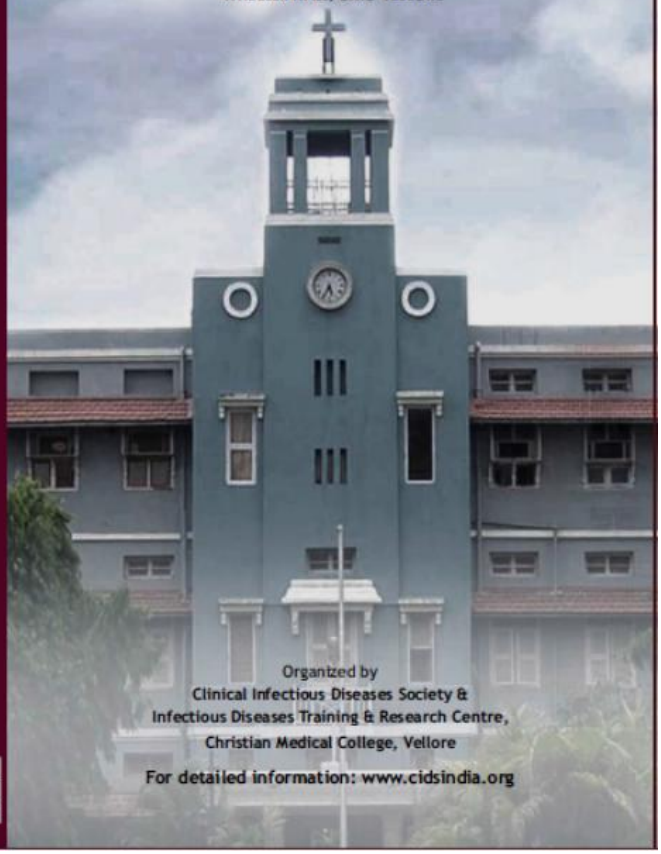
Phone: 0416-2282804
Email: secretary@cidsindia.org
Website: www.cidsindia.org



INFECTIOUS DISEASES CME FOR POSTGRADUATES

3 – 5 December, 2015

WHEELER HALL, CMC VELLORE



Organized by
Clinical Infectious Diseases Society &
Infectious Diseases Training & Research Centre,
Christian Medical College, Vellore

For detailed information: www.cidsindia.org

CIDS