ESCMID
Invitation: Assembly of Members 2002

Education
ESCMID School of Clinical Microbiology and Infectious Diseases

Features
Global Public Health

Features
Nipah Virus: Cause of Concern in Southeastern Asia
HIV

The image on this issue's title page shows AIDS viruses leaving a T cell. This image also appears in the design of the renewed ESCMID Homepage that will go online in May 2002.

Since the beginning of the HIV epidemic in the 1970s, more than 25 million persons have died from AIDS. It is estimated that more than 40 million are currently living with HIV. The epidemic has spread to nearly every country on all continents. Today AIDS kills more people than any other infectious disease around the globe. While Africa is being hit the hardest, prevalence rates are rising to alarming levels elsewhere as well. Currently it is Eastern Europe which is experiencing the fastest increase in HIV infections. With more than 90% of new infections occurring in developing countries, HIV/AIDS not only poses a major threat to global public health, it also has detrimental effects on global development. The medical and human costs produced by AIDS are estimated by the UN to have reversed the social and economic development in twenty countries. The cost of AIDS therapies puts them out of reach for the vast majority of the people affected. Developing an affordable HIV vaccine to save human lives and prevent further economic and social damage is one of the greatest challenges facing humanity at the beginning of the 21st century.

http://www.iavi.org
http://www.unaids.org
http://www.iapac.org

Imprint

ESCMID News: Newsletter of the European Society of Clinical Microbiology and Infectious Diseases

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Dear Colleagues,

You have now the first issue of ESCMID News for 2002 in your hands. Our Newsletter is an important forum for the discussion of a broad range of issues in microbiology and infectious diseases across Europe. The Editorial Team is pleased to have the continuous support of our members. The European Congress of Clinical Microbiology and Infectious Diseases (ECCMID) is the premier annual European infection meeting at which the most important developments are presented, and we hope that you will attend the 12th ECCMID 2002 in Milan. The Statutes of ESCMID have now been revised and the new version is included in this issue. The presentation of the ESCMID Study Groups continues in this issue with a portrait of the European Study Group on Nosocomial Infections (ESGNI).

The postgraduate courses are popular activities of ESCMID and the announcements for the 19th and the 20th course can be found in this issue. The Nipah virus is a new member of the family paramyxovirus causing human encephalitis in Southeastern Asia. The virus is spread from bats to pigs and from pigs to humans. The emergence of this new viral agent in Malaysia is presented in this ESCMID News.

The issue of global public health is discussed in an article which illustrates various approaches in infection control and prevention. The first ESCMID School of Clinical Microbiology and Infectious Diseases will take place in Lausanne from 6–12 July 2002. During this one-week course most relevant topics in microbiology and infectious diseases will be covered. Thus, this programme is of particular interest to young MD’s at the end of their specialty training. Our Society recognises the threat of bioterrorism and has therefore decided to arrange a symposium on bioterrorism in Stockholm from 10–11 June 2002. The announcement can be found in the present ESCMID News. Brief news items and forthcoming events in microbiology and infectious diseases conclude this edition. The Editorial Team hopes that you will enjoy reading this newsletter.

Carl Erik Nord
Past President
President Publication Committee
Message from the President

Dear Colleagues,

We are now well into the New Year and have perhaps forgotten those few days of respite, which surrounds the festive season. The first few weeks of the year are an extremely busy period. They also have their professional rewards. In the past month clinically I have cared for three patients with cutaneous Leishmaniasis acquired in South America; introduced a new group of two hundred medical students to an intensive course that links the theory and practice of antimicrobial chemotherapy; advised Government on the management of viral haemorrhagic fevers and have had the satisfaction we all experience when a research manuscript is accepted for publication in a high impact journal. I quote these examples to illustrate the way in which our Society tries to balance its portfolio of activities to reflect those of its membership.

With regard to the first example, one is struck by the constantly changing dynamics between man and the world of microorganisms. South American Leishmaniasis has been relatively uncommon in the UK; historically our links were with other parts of the world. However, adventure tourism has opened up new diagnostic challenges and has also highlighted the relatively limited repertoire of interventions that are available to treat and prevent diseases which regularly affect the health and economies of resource-poor countries.

Teaching has undergone major changes in the past decade. Apart from the introduction of formal assessments of teaching quality, to ensure that it is effective with defined aims and objectives, there is now a tendency to move away from the conventional focus on imparting information (input), and to concentrate on the goals of education (output). In other words education content should be driven by what type of doctor or scientist we wish to produce, and how the skills and knowledge will be acquired. It is an innovative approach and likely to revolutionise teaching practice.

Professionals, in particular academics, have responsibilities not only to advance knowledge in their area of expertise, but to translate this to future generations and also ensure that society is provided with sound professional advice. In the world of Infectious Diseases such advice may well have public health impact. Increasingly, infectious challenges have an international dimension and yet there are limited formal mechanisms whereby good practice is shared and refined among countries. This may result in knowledge gaps or even duplication of effort and repetition of lessons learned.

Whilst informal networking has some advantages, I am sure there is a role for professional societies such as ESCMID to work with governments to ensure that public health issues are addressed in a more uniform manner.

The final example I quote was to illustrate the way in which the scientific method incrementally advances our knowledge and hopefully can also have translational benefit, either to address new or additional questions, or be linked to new interventions or practices for the benefit of mankind. The annual ECCMID and Clinical Microbiology and Infection are important vehicles for this activity.

The Society is in good shape and our Officers are working hard. The forthcoming ECCMID in Milan will be successful. There is an outstanding list of Keynote lectures. Our Study Groups will be reporting on their activities and progress. More than 1600 abstracts have been received and guarantee lively Poster and Free Paper sessions. The Scientific Programme is now available in draft form on the Society’s Website, which I encourage you to visit. The Society is also keen to maximise the outputs of its congresses. Not only will articles be published, but symposia will be presented in many journals including Clinical Microbiology and Infection, and again posters as presented will be made available on CD-ROM for delegates attending the conference.

In closing, the world of Microbiology and Infectious Diseases is very much alive. The Society is responding to the many calls in areas in which it has expertise. Do ensure that you participate and benefit from these various activities. Also, I would encourage you to contribute to the life of the Society. This will ensure that its goals of promoting excellence in science, teaching and professional activities for all those having responsibilities in the area of Microbiology and Infectious Diseases are sustained.

Best wishes

Roger Finch
President, ESCMID
Invitation to the ESCMID Assembly of Members 2002

Dear ESCMID Member

On behalf of the Executive Committee, I cordially invite you to the next regular Assembly of Members of the European Society of Clinical Microbiology and Infectious Diseases, which will be held during the 12th European Congress of Clinical Microbiology and Infectious Diseases in Milan.

Date and Time: Friday, 26 April 2002, 12:15 h – 13:45 h
Location: Sala Onore (Room B1), CISI Building, Fiera Milano, Largo Domodossola 1, I-20145 Milano, Italy (Sandwiches will be provided)

As you will note from the agenda below a number of important issues will be discussed. The Executive Committee counts on your attendance and looks forward to meeting you in Milan.

Agenda
1. Welcome (R. Finch)
2. President’s address and report (R. Finch)
4. Report of the Secretary General (S.R. Norrby)
5. ESCMID Awards (C.E. Nord)
6. Financial report of the Treasurer (A. Voss)
7. Acceptance of the accounts and formal approval (vote) (R. Finch)
8. Report of the Professional Affairs Officer, Clinical Microbiology (G. Cornaglia)
9. Report of the Professional Affairs Officer, Infectious Diseases (H. Giamarello)
10. Report of the Education Officer (C. Carbon)
11. Report of the Scientific Affairs Officer (R. Hakenbeck)
12. Proposal towards a single European Congress on Clinical Microbiology and Infectious Diseases (R. Finch)
13. Report of the Chairman of the Publication Committee (C.E. Nord)
14. Report of the CMI Editor-in-Chief (E. Bouza)
15. Report of the President of the 12th ECCMID 2002 (G. Schito)
16. Report of the ECCMID Programme Director (P. Francioli)
17. Endorsement of the Executive’s Performance (vote) (R. Finch)
18. Any other business

Announcement Concerning CMI:

Indexing and Impact Factor

Indexing: Blackwell informs us that they have now completed the conversion of files in order to make available all past issues of Clinical Microbiology and Infection (CMI) for inclusion in PubMed/IndexMedicus. We very much regret the delay caused by this lengthy process, however look forward to increased citations as a result of the enhanced visibility of our publications.

Impact Factor: CMI has been indexed since January 2000 by the Institute of Scientific Information (ISI), which is responsible for calculating Impact Factors that are listed in an annual Journal Citation Report (JCR). Since an Impact Factor is calculated according to citations during one year to articles published in the two previous years, there can be a delay of up to three and a half years to generate a rating. The 2002 edition of the JCR, which will appear in the summer of 2003, should list an Impact Factor for CMI for the first time.

Please see the next issue of the ESCMID News for an explanation of the process of calculating Impact Factors.

Judith Crane
CMI Managing Editor
The purpose of this study group is to carry out co-operative studies on various aspects of nosocomial infections. The group was set up in 1998 under its first chairman Professor Emilio Bouza. The current chairman is Dr Andreas Voss from the Department of Medical Microbiology, University Medical Center St. Radboud, Nijmegen. The Study Group has developed rapidly and now consists of over 90 members from 20 countries, including non-ESCMID members.

The Study Group has a Website (www.esgni.org) besides its pages within the Study Group Section of the ESCMID Website (www.escmid.org). Full details of the Study Group’s past activities can be found there as well as future plans. The annual reports of ESGNI are also to be found on the Website. The Study Group attempts to complement the work of other groups working in this area and to fill any gaps in the information currently available to microbiology and infectious diseases departments. The studies to date have been designed in each case as a pair of parallel studies, one concentrating on the laboratory aspects, including workload, incidence and aetiology, and the second concentrating on clinical aspects, including the underlying diseases, adequacy of treatment and other details of the patients. Each pair of studies has included a point prevalence survey, collecting information generated on a single day. The studies are designed around questionnaires sent to microbiology laboratories of a large number of European hospitals, initially to those with staff who are members of ESCMID. The questionnaires are available on the Website and thus to any hospital microbiologist or infectious disease clinician. The results of these studies are published both on the web site and in the Society’s journal Clinical Microbiology and Infection.

A notable feature of ESGNI is a Web-based data transfer system by which information from the various hospitals is sent to one centre. The questionnaires are filled in on-line and sent to the laboratory where the chairperson resides and where the results are collated and assessed. Up to and including 2001, this was in Madrid, but for future studies planned it will be in Nijmegen.

The first pair of studies (ESGNI-001 and ESGNI-002) looked at the prevalence and the aetiology of bloodstream infections in Europe in 1997 and compared results from EU and non-EU countries. The reason for setting up these studies was that although a great deal of information is available on a variety of aspects of nosocomial diseases, frequently this information comes from single institutions in a small number of countries. This can lead to bias as the institutions reporting such studies are often larger ones in the more developed countries, and it was felt that this may not reflect the broader picture. Increases in bloodstream infections have been related to the increase in more aggressive and invasive procedures now used, often on a more vulnerable population many of whom have underlying diseases.

Participants in these studies came from 112 hospitals in 28 countries. Eighty-four of the hospitals were in EU countries and 28 in non-EU countries. The results revealed that there was a significantly higher rate of blood samples collected for culture (255.9/1000) in EU countries than in non-EU countries (19.8/1000). In contrast, the number of cultures that were positive was lower in EU countries (13.4%) than in non-EU countries (19.1%). There was a significant difference between the proportions of nosocomial bloodstream infections in EU countries (68%) and in non-EU countries (86.5%). The aetiology of these infections confirmed recent trends with few anaerobes being isolated and the prevalent pathogens being Gram-positive. The commonest isolates were *S. aureus* in EU countries and *S. epidermidis* in non-EU countries. The prevalence of *Pseudomonas aeruginosa* was higher in the non-EU countries. (See Table 1) The major predisposing factor for bacteremia was the use of an intravenous catheter (71% overall). Other important factors were previous antibiotic use (9%), urinary catheter (37%), previous surgery (27%), intubation (24%) and the use of corticosteroids (21%). No major differences were seen between EU and non-EU countries. The second pair of studies (ESGNI-003 and ESGNI-004) were carried out in 1999 and looked at nosocomial urinary tract infections. The studies included more hospitals than the first pair of studies, with a total of 228 hospitals in 29 countries participating in ESGNI-003 and 141 hospitals from 25 countries in ESGNI-004. Whereas in the bloodstream infections the most commonly isolated organisms were Gram-positive, here the commonest isolates were Gram-negative (65.9%).

### Table 1: Bloodstream infection isolates – Data adapted from ESGNI-001 and ESGNI-002.

<table>
<thead>
<tr>
<th>EU Countries (total 232)</th>
<th>Non-EU Countries (total 71)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staphylococcus aureus 37 (15.9%)</td>
<td>Staphylococcus epidermidis 12 (16.9%)</td>
</tr>
<tr>
<td>Escherichia coli 37 (15.9%)</td>
<td>Staphylococcus aureus 9 (12.7%)</td>
</tr>
<tr>
<td>Staphylococcus epidermidis 21 (9.1%)</td>
<td>Pseudomonas aeruginosa 9 (12.7%)</td>
</tr>
<tr>
<td>Streptococcus pneumoniae 16 (6.9%)</td>
<td>Escherichia coli 7 (9.9%)</td>
</tr>
<tr>
<td>Coagulase –ve staphylococci 14 (6.0%)</td>
<td>Coagulase –ve staphylococci 7 (9.9%)</td>
</tr>
<tr>
<td>Enterococcus spp. 11 (4.7%)</td>
<td>Klебsiella pneumoniae 5 (7.0%)</td>
</tr>
<tr>
<td>Klебsiella pneumoniae 11 (4.7%)</td>
<td>Candida spp. 4 (5.6%)</td>
</tr>
<tr>
<td>Candida spp. 10 (4.3%)</td>
<td>Acinetobacter spp. 4 (5.6%)</td>
</tr>
<tr>
<td>Enterobacter spp. 10 (4.3%)</td>
<td>Enterococcus spp. 3 (4.2%)</td>
</tr>
<tr>
<td>Pseudomonas aeruginosa 7 (3.0%)</td>
<td>Enterobacter spp. 2 (2.8%)</td>
</tr>
<tr>
<td>Acinetobacter spp. 7 (3.0%)</td>
<td>Streptococcus pneumoniae 2 (2.8%)</td>
</tr>
<tr>
<td>Other 51 (22%)</td>
<td>Other 7 (9.9%)</td>
</tr>
</tbody>
</table>
commonest species isolated was *E. coli*, although, in agreement with other studies, enterococci and *Candida* species were common (second and third most frequently isolated species overall). There were more *Pseudomonas aeruginosa* isolates in non-EU countries overall. There were more *Enterococcus* spp. in non-EU countries (see Table 2). A high proportion of infections were catheter-associated, and in these patients, mortality was higher than in those where treatment was deemed to be adequate. The next pair of studies (ESGNI-005 and ESGNI-006) was designed to investigate vascular catheter-related bloodstream infections. Such devices represent one of the major advances in medical science, but they carry with them many complications and their use can lead to infection. The information regarding these studies was posted on the Website in September 2001 and ESGNI-005 was carried out on October 22, 2001, while ESGNI-006 took place between October 22 and 26, 2001. As before, the facility was available for participants to enter their data directly via the Website and currently these results are being compiled.

This dynamic Study Group has a future study planned to investigate antimicrobial susceptibility (ESGNI-007). Other plans include greater co-operation with other Study Groups within ESCMID, such as the meeting scheduled for April with ESGARS. In addition, there will be co-operation with groups outside ESCMID, such as the Hospital Infection Society (HIS), one of the earliest groups to investigate the problem of nosocomial infections. In 2003 a combined team from HIS and ESGNI will embark on a teaching tour of South America on the topic of hospital acquired infections and how to control them. Further plans include more combined CDC/SHEA/ESCMID training courses in hospital epidemiology. Details of all these future plans are available on the Website.

**REFERENCES**


**Corrigendum**

with reference to the article “Resistance to Antibiotics: What can be done?”, published in ESCMID News 2-2001: Our Newsletter featured an English translation of a German article by Dr. G. Eich. This German article was incorrectly published in the name of Dr. A.F. Widmer elsewhere. Dr. Widmer is thus not the author of the article published in ESCMID News as erroneously indicated.

We regret this incidence.

Pamela Hunter
Medical Writer
Statutes

European Society of Clinical Microbiology and Infectious Diseases (Non-Profit Society)

During its most recent meeting in Amsterdam in February 2002, the ESCMID Executive Committee agreed on a revision of the ESCMID Statutes. The version of the Statutes printed below allows readers to compare the old and new versions, as changes are indicated in colour. The revised Statutes will be up for approval by the ESCMID Membership during the Assembly of Members on 26 April 2002 at the 12th ECCMID in Milan.

§ 1 NAME AND REGISTERED OFFICE
The Society shall carry the name “European Society of Clinical Microbiology and Infectious Diseases” (abbreviation ESCMID). The registered office of the Society shall be located in Munich. The Society is registered in the Munich Register of Associations under VR 10956.

§ 2 OBJECTS OF THE SOCIETY
The Society shall devote itself to the promotion of research and education in diagnosis and therapy in the fields of clinical microbiology and infectious diseases. The fields of clinical microbiology and infectious diseases encompass the study of the following: the pathogens, pathogenesis, diagnosis, epidemiology, prevention and therapy of infectious diseases, including drug usage policy, infection control, and all other basic and clinical aspects of infection and immunity.

The Society shall strive to bring together persons who are active in the fields of clinical microbiology and infectious diseases in the European countries. The aims of the Society shall be realised by holding scientific congresses, by arranging exchange visits between members, by enhancing postgraduate education and teaching, by collaborating in research projects and in professional matters, by publishing various publications (journal, supplements, books, guidelines), by acting as a liaison between professional societies, governments or government agencies and the European Union, and any other activities related to these aims.

The Society shall pursue non-profit purposes exclusively and directly as defined in the paragraph “tax-privileged purposes” of the German Tax Act. The Society acts exclusively unselfishly and does not pursue economical purposes primarily. Funds of the Society shall be used only for purposes within the intentions of the Statutes. The members, relatives or business associates of the members shall receive neither allowances from the funds of the Society nor any other personal financial benefit. No person shall benefit from disproportionately high compensation or from the dispensation of funds for reasons incongruent with the objects of the Society.

§ 3 MEMBERSHIP
The Society consists of individual full, associate, affiliated and honorary members from any country. It also has corporate and institutional members.

All full members shall pay annual membership dues directly to the Society. Affiliated members are members of national scientific societies affiliated to ESCMID and their membership dues shall be paid annually by the affiliated society. Members of the ESCMID Study Groups who do not pay individual or affiliated membership dues are associate members of ESCMID. Membership is, subject to the approval of the Executive Committee, open to all who are interested in clinical microbiology and infectious diseases. All members shall pay the annual membership dues, the amount of which shall be proposed by the Executive Committee and approved by the Assembly of Members. Resignation from the Society must be made in writing no later than 30 November of a given year. Resignation shall be effective as of 31 December of said year. Membership expires on 30 June upon non-payment of dues.

§ 4 ORGANISATION
The Society will be organised by an Executive Committee, a European Council, and an Assembly of Members.

Executive power of the Society is vested in the Executive Committee, which shall consist of the President, the President-Elect, the Secretary General, the Treasurer, and three additional members. The selection of candidates to be considered for election to the Executive Committee shall be made by a Nominating Committee. The members of the Executive Committee shall be elected by simple majority from among the members of the Society by a secret ballot. They will be elected for a term of four years and may be re-elected once, whereafter at least four years must elapse before re-election can take place. The Past President, the Presidents of the annual Congress of the Society for the current year and the year preceding the Congress, the Editor-in-Chief of the Society’s journal and the Managing Director will be ex officio non-voting members of the Executive Committee. The Executive Committee may coopt up to two additional members: one from the European Council and one from the Society.

No more than two elected members of the Executive Committee shall come from the same country. The Executive Committee shall include at least two members representing the field of clinical microbiology and at least two members representing the field of infectious diseases.

The Executive Committee shall elect a President, a President-Elect, a Treasurer and a Secretary General and appoint an ECCMID Programme Director, from either the elected members or the coopted members of the Executive Committee. The maximum term in office shall be two years for the President and the President-Elect. The President, the Secretary General or the Treasurer shall represent the Society in legal matters and have executive powers within authorisation rendered by the Executive Committee. The Executive Committee shall adopt resolutions with the majority of its members present at the Executive Committee meeting; the President has the casting vote. The quorum shall
consist of five members. The Executive Committee may appoint subcommittees for specific purposes. The Executive Committee shall appoint a Managing Director to assist with the execution of its resolutions and to manage the administrative offices of the Society accordingly.

The European Council shall serve as an advisory board to the Executive Committee. It will consist of official representatives of affiliated European national societies, of the ESCMID study groups and working parties, and of other European societies involved in clinical microbiology and infectious diseases. The European Council shall meet during the annual congress of the Society. The President of the Society shall serve as chairperson.

The Assembly of Members is the supreme body of the Society and shall hold Plenary Meetings. All full members of the Society in good standing shall be entitled to attend the Assembly of Members which is held during the annual scientific congress of the Society (ECCMID) at least every two years. The President, upon resolution of the Executive Committee, shall notify members of the Society of an Assembly of Members and of its agenda by an announcement no later than four weeks prior to the date of the Assembly of Members. The Assembly of Members shall discuss the proposals of the Executive Committee and adopt resolutions by simple majority of the members present. Minutes shall be kept of the proceedings at the Assembly of Members, and such minutes shall be signed by the President, and the Secretary General and the Managing Director.

§ 5 MEANS OF COMMUNICATION
The official publications of the Society are Clinical Microbiology and Infection and the newsletter ESCMID News. The Society will also use other means of communication as appropriate, including its website.

§ 6 AMENDMENTS TO THE STATUTES
Amendments to the Statutes can be made by ballot or at an Assembly of Members by resolution of a majority of members participating. In any matters concerning the interpretation of the Statutes, the decision shall rest with the Executive Committee, who will also resolve any matters concerning the Society that are not covered explicitly by the Statutes. The President of the Society has the right, upon legal advice and upon the advice of the Executive Committee, to make any amendments to the Statutes that are necessary for registration of the Society or for recognition of its non-profit status by the tax authorities. These amendments must be approved afterwards by the Assembly of Members.

§ 7 LANGUAGE
The language of the Society and its publications is English. The English version of the Statutes shall be determinative in all cases. The Society shall be subject to the laws of the country in which the Society has its registered office.

§ 8 BYLAWS
Administrative details of function and practice of the Society shall be fixed in the Bylaws, which the Executive Committee is entitled to set forth.

§ 9 DISSOLUTION
A resolution of two-thirds of the members of the Society shall be necessary to dissolve the Society. If the Society is dissolved, its funds shall be exclusively transferred to a public corporation or other recognised non-profit societies that support medical science and research.

Erratum with reference to the article “Infections in Pictorial Art” by Prof Anna-Stina Malmborg, published in ESCMID News 3-2001:
The ESCMID News editorial team regrets that a confusion of illustrations resulted in an incorrect picture being printed along with Prof Malmborg’s article. Instead of Nicolas Pussin’s “The Plague of Asdod” his “Abduction of the Sabine Women” was featured. We are now including the correct illustration for our readers’ reference.
ESCMID Scholarships 2001

The individuals mentioned below were awarded an ESCMID attendance grant for one of the two postgraduate courses in 2001 or they were awarded travel grants and/or free registration to attend the 11th ECCMID in Instanbul.

Postgraduate Education Courses

Alcaide, María del Mar
Alvarez García, Patricia
Bagrade, Linda
Bedenkov, Alexandre
Cárdaba Arranz, Mario
Cepeda, Jorge
Dumpis, Uga
Galkin, Dmitry
Griskieviciene, Jolanta
Grošdanovski, Krsto
Holemans, Xavier
Murcia, Spain
Pontefreda, Spain
Riga, Latvia
Smolensk, Russia
Valladolid, Spain
Riga, Latvia
Riga, Latvia
Smolensk, Russia
Vilnius, Lithuania
Skopje, Macedonia
Charleroi, Belgium
Jursa, Joanna
Kargaltseva, Irina
Keuleyan, Emma
Markovska, Rumyana
Matulionyte, Raimonda
Mazzariol, Annarita
Pietuszko, Slawomir
Rjabkova, Elena
Tambic Andresevic, Arjana
Veréb, Ilona
Wareham, David
Szczecin, Poland
St. Petersburg, Russia
Sofia, Bulgaria
Sofia, Bulgaria
Vilnius, Lithuania
Verona, Italy
Warsaw, Poland
Smolensk, Russia
Zagreb, Croatia
Szeged, Hungary
London, UK

11th ECCMID 2001 Istanbul

Abbate, Isabella
Afeltra, Javier
Augustynowycz, Ewa
Babela, Robert
Balotescu, Carmen
Blanco Ramos, José
Celik, Ilhami
Christova, Iva
Cieslik, Anna
Djukic-Ivancevic, Boba
Dominquez, José
Dumitruc, Irina M.
Duncan, John
Elviss, Nicola C.
Esen, Saban
Gizynski, Krzysztof
Golkhoeva, Eliza
Hadzi-Petruseva, Ivanka
Hristea, Adriana
Ilhendyane, Nahla
Keys, Carrina
Rome, Italy
Nijmegen, The Netherlands
Warsaw, Poland
Trnava, Slovak Republic
Bucharest, Romania
Lardero, Spain
Elazig, Turkey
Sofia, Bulgaria
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Samsun, Turkey
Gdansk, Poland
Sofia, Bulgaria
Skopje, Macedonia
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Huddinge, Sweden
London, UK
Khryanin, Alex
Komarnicka, Jolanta
Kovacivova, Gabriela
Letferova, Victoria
Manuel, Rohini
Meletiadis, Joseph
Mihaylova, Sashka
Neal, Shona
Paciorek, Jaroslav
Pancer, Katarzyna
Paul, Malgorzata
Rajendram, Dunstan
Revathi, G.
Rui, Joaquín
Rusanova, Marina
Rybak, Bartosz
Stefanovic, Anna
Thulin, Pontus
Vitale, Roxana
Yakovenko, Lyudmyla
Zivanovic, Dragana
Novosibirsk, Russia
Gdansk, Poland
Trencin, Slovak Republic
Sofia, Bulgaria
Southampton, UK
Nijmegen, The Netherlands
Pleven, Bulgaria
London, UK
Warsaw, Poland
Warsaw, Poland
Posnan, Poland
London, UK
Nairobi, Kenya
Barcelona, Spain
Moscow, Russia
Gdansk, Poland
Vilnius, Lithuania
Huddinge, Sweden
Nijmegen, The Netherlands
Kyiv, Ukraine
Belgrade, Yugoslavia
We are looking forward to seeing you at the 12th European Congress of Clinical Microbiology and Infectious Diseases
Milan/Italy, April 24–27, 2002

http://www.escmid.org/eccmid2002
European Symposium on

BIOTERRORISM

June 10–11, 2002 in Stockholm · Sweden

INVITED SPEAKERS

John G Bartlett, USA
Edward Eitzen, USA
Alasdair M Geddes, UK
Alexandr Leonidovich Ginsburg, Russia
Maria Rita Gismondo, Italy
John-Erik Stig Hansen, Denmark
Anders Johansson, Sweden
Stefan Kaufmann, Germany
Michael Osterholm, USA
Herbert Schmitz, Germany
Mathias Uhlén, Sweden
Britta Wahren, Sweden

MORE INFORMATION

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E-mail stocon@stocon.se · Internet www.stocon.se/bioterrorism2002

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F Elgh, I Engstrand, C E Nord, S R Norrby, I Å Pellborn

ORGANISED BY

European Society of Clinical Microbiology and Infectious Diseases (ESCMID)
Karolinska Institutet
Swedish Institute for Infectious Disease Control

SMITTSSKYDDSINSTITUTET
Swedish Institute for Infectious Disease Control
Announcement

1st ESCMID School of Clinical Microbiology and Infectious Diseases

Lausanne, Switzerland, July 6 –12, 2002

A one-week course dedicated to postgraduate and continuous medical education. The programme covers most of the relevant topics in clinical microbiology and infectious diseases, thus being of particular interest to young MD’s at the end of their specialty training. By providing short reviews and well-selected case studies, the ESCMID School helps the students in preparing for their examination.

Organised by the ESCMID Education Committee

Under the auspices of the University of Lausanne, Faculty of Medicine

ESCMID SCHOOL 2002 MAIN CHAPTERS
- Antimicrobial chemotherapy and immunisation
- Micro-organisms and infection pathogenesis
- Major clinical syndromes: diagnostic and management strategies
- Immunocompromised hosts
- Epidemiology; public health

FACULTY
Currently confirmed faculty include Martin Altwegg, Jacques Bille, Thierry Calandra, Claude Carbon, Teresa Coque, Francis Drubniewski, Jean-Yves Fagon, Matthew Falagas, Roxana Filip, Maria R. Gismondo, Philippe Hauser, Andy Ian M. Hoepelman, Luis Martinez-Martinez, Pascal Meylan, Philippe Moreillon, Patricia Munoz, Roland Nau, Guy Tran Van Nhieu, Piero Oliaro, Giuseppe Pantaleo, Geoffrey M. Scott, Philippe Sudre, Amalio Telenti, Paul Verveij, Bengt Wretlind, Giorgio Zanetti

VENUE
University of Lausanne, Faculty of Medicine (next to the CHUV (Centre Hospitalier Universitaire Vaudois))

TUITION
The tuition fee for participation is EUR 1000 for ESCMID members and EUR 1300 for non-members. The tuition fee covers the course, bed and breakfast in the Ecole Hôtelière de Lausanne, lunch at the CHUV, a 7-day public transportation ticket for Lausanne and the social event on Thursday evening.

APPLICATION
In order to apply for the ESCMID School 2002, please register via the internet at www.akm.ch/ESCMIDschool2002

In addition we request to send a short application letter (explaining your professional situation and motivation for attending the school), a brief CV and a description of a case study / problem (see below) as electronic copies.

Applications are accepted until May 20, 2002. The successful candidates will be selected by the ESCMID Education Committee and notified by May 31, 2002, at the latest. The earlier you register the better the chances of being accepted.

CASE STUDY / PROBLEM TO BE PRESENTED BY THE PARTICIPANTS
Each participant is requested to submit a case or problem when applying for the ESCMID School. Some of the cases / problems will be selected for presentation and discussion in working groups or in plenary sessions. The case / problem should be based on the experience of the applicant, be of practical relevance and have educational value. Its description should not exceed 2500 characters.

CME ACCREDITATION
European CME accreditation is being sought.

FURTHER INFORMATION
For more detailed information about the organisation of the ESCMID School, the educational programme and the submission of a case study please consult www.akm.ch/ESCMIDSchool2002

From early June onwards, this site will also feature educational material accessible to registered participants only.

INCENTIVE
All participants of the 1st ESCMID School for Clinical Microbiology and Infectious Diseases will be awarded a free 2-year ESCMID membership, including subscription to CMI.

CONTACTS
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Call for cooperation with a Population Genetic Study of *E. cloacae*

*E. cloacae* has become an increasingly important nosocomial pathogen. But what is identified as *E. cloacae* in clinical microbiology laboratories represents a very heterogeneous cluster. The species *Enterobacter hormaechei*, *Enterobacter asburiae*, *Enterobacter dissolvens* and *Enterobacter cloacae* sensu strictu, all belong to this cluster. Some genetic groups share more homology with *Yersinia* species and some with *E. coli*. Fitness and virulence factors are not randomly distributed between the genetic groups. In order to get a better understanding of the reasons for the increasing number of outbreaks with strains of the nomen-species *E. cloacae*, more studies of its epidemiology and virulence properties are needed. Before these studies can take off, representative population genetic studies are essential.

For this purpose, we started the collection of strains belonging to the *E. cloacae*-cluster, i.e. strains that have been identified as *E. asburiae*, *E. dissolvens*, *E. cloacae* or *E. hormaechei* in different areas of Europe. They have been either recovered from clinical samples or from the environment (water, soil, animals).

We would be very thankful, if you could send us up to ten of such strains from your laboratory. If you mail or fax us a short message, we will send you all transport materials. The study results and a detailed characterisation of your strains will be transmitted to you once the study is completed.

Andreas Roggenkamp, PhD, MD, and Harald Hoffmann, MD

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**EDUCATION**

**19th ESCMID Postgraduate Education Course**

**Mechanisms of Antimicrobial Resistance – A Practical Approach**

Palma de Mallorca, Spain, June 16 – 22, 2002

Organised by the Laboratory of Microbiology, University of Balearic Islands
Supported by ESCMID, SEIMC, and SEQ

For further information please contact: Dr. Vicente Javier Benedí, Dept. of Microbiología, Universidad de las Islas Baleares, Carretera de Valldemosa, KM 7.5, 07071 Palma de Mallorca, Spain. Phone: +34 971 173353, E-mail: vjbenedi@uib.es
Public health is neither a new concern, nor one that is easily circumscribed. The term is an administrative category which does not lend itself to easy definition, and the parties to be held responsible are similarly difficult to determine. The US Institute of Medicine proposed that the mission of public health is “fulfilling society’s interests in assuring conditions in which people can be healthy” – a statement which encompasses almost all aspects of life and provides little direction. Establishing a clear definition is difficult in part because public health manifests as a negative. When at its best, all is well and no one thinks about the health of the public.

While responsibilities are obvious for some professionals, as is the success of their efforts, this is not always the case for public health workers. When food and water are safe, when children are immunised, when air is breathable and water are safe, when children are healthy, contributions to the imprecise definition are continually re-evaluated, as are the questions of scope and priority. Although the context of infectious disease during the time of Ovid, who witnessed the transition from BC to AD, differed in many ways from the world that is ever more complex and interdependent, the idea that the health of every nation depends on the health of all others “is not an empty wishful thinking and inaccurate data (blood samples collected periodically from pregnant women who present randomly at maternity clinics throughout the country). Nearly 40 percent of the women presenting themselves for HIV counselling and testing at one clinic have tested positive, according to epidemiologist Nancy S. Padian from the University of California at San Francisco who is working in collaboration with the University of Zimbabwe in an attempt to prevent the spread of HIV. In Africa the virus is transmitted largely through heterosexual sex and from mother to newborn. Sexual customs, in conjunction with family politics, present the greatest challenge. In an article in the Journal of Infectious Diseases, Janneke van de Wijgert reported the correlation between commonly-used sexual practices and susceptibility to sexually transmitted infections such as HIV.

People could learn a lot from the mosquitoes — it’s their introduction of disease. They don’t discriminate. People could learn a lot from the mosquitoes.

Disease doesn’t discriminate — people do.

Emergence – Eradication – Re-emergence: Some believe vaccination will break the chain.

People could learn a lot from the mosquitoes — it’s their introduction of disease. They don’t discriminate. People could learn a lot from the mosquitoes.
ONE SCENARIO: ERADICATION VERSUS MANAGEMENT

In the late 1930s at Geigy, Switzerland, in an effort to find a protection against mosquitos for woolens, Paul Müller discovered, in an accidental way linked to its potency in small amounts and its long half-life, a new insecticide called dichloro-diphenyl-trichloro-ethane (DDT).

Geigy sent the ‘miracle powder’ to its New York Office in 1942 where it was ignored until another chemist translated the claims and passed it on to the Department of Agri- culture, which passed it on to the Military who was desperate to protect its troops against insect-borne disease. Typhus was responsible for the death of millions during and following the First World War and was still present throughout the war zones during the Second World War. More problematic still was malaria. In a situation where ten out of seventeen thousand American Marines were incapacitated by symptoms of malaria, an entire division was pushed from combat and sent to Melbourne to recuperate. According to General MacArthur, two thirds of his troops were ill with malaria at any one point during the early stages of the war.

The impact that the early success of DDT had in the realm of public health cannot be overstated. In the 1940s malaria existed throughout Europe, Asia, the Caribbean and the southern United States. In India alone, malaria was responsible for eight hundred thousand deaths annually. In 1948 Müller won the Nobel prize for his work with DDT, and during the next twenty years his discovery became the focal point of the most ambitious public-health campaign in history.

With the publication of “Silent Spring” by Rachel Carson in 1962, however, the environmental consequences of DDT and its unusual persistence and toxicity became public knowledge. What is considered deplorable about DDT today— that it kills everything it touches and continues to do so for a long time—is precisely what made it welcome at the time when thousands were afflicted and combating malaria meant spending incredible amounts of time in stagnant swamps. What was considered a lifesaver for a long period, between the end of the Second World War and the 1960s, has now become a symbol of all that is dangerous about humanity’s attempts to interfere with nature. The great moral of the twentieth century may be that benefits are inevitably set off by risks. Even the most effective efforts, made with the best intentions, can have consequences that are seemingly perverse, but in fact are natural. In 2001, at the Stockholm Convention on Persistent Organic Pollutants, more than ninety countries signed a treaty, placing DDT on a restricted-use list and proposing that it be phased out entirely.

During the years when anti-malaria war- riors were considered heroes, they fell into two camps. Those who maintained that the enemy was the malaria parasite, the protozoan that mosquitoes pick up from the blood of an infected person and transmit to others, believed that the best way to inter- rupt the chain of infection was to treat the sick with anti-malarial drugs, killing the protozoan so that there was nothing to transmit. The second group maintained that the mosquito was the actual enemy and elimination of the carriers would eliminate the problem.

Among the latter group was Fred Soper, who received a doctorate from the Johns Hopkins School of Public Health and spent most of his career working for the Rockefeller Foundation, which functioned as the world’s unofficial public-health directorate before the establishment of the United Na- tions and the World Health Organisation. Soper differed from his predecessor who believed that in order to fight malaria one had to think like a mosquito, a notion and turn of speech that is currently very popular. Soper believed that fighting malaria had very little to do with science or biology, and he raised the killing of mosquitoes to an art through discipline. His method was to mo- tivate and organise the mosquito-killing teams that went door to door and stream to stream, and his goal was complete eradica- tion. Schedules were maintained to the minute, co-workers were expected to cross- check each other’s work, and consequences severe when something was out of line. Soper often quoted Louis Pasteur’s state- ment that “it is within the power of man to rid himself of every parasitic disease” and he maintained that the responsibility of the public health professional is to make an ob- ligation out of what is possible. Soper’s technique was effective, even be- fore the ‘miracle’ of DDT. In 1938, faced with the worst malaria epidemic in the Americas, he set out to eradicate gambia, the variety of mosquito most capable of transmitting malaria because 95% of the time it bites hu- mans rather than animals. Working with the local dictator, who made it illegal to re- fuse entrance to one of Soper’s team, his tar- get was eighteen thousand square miles, the entire area of colonised Brazil. Using diesel oil and an arsenic-based mixture, Soper ac- complished the seemingly impossible task within twenty-two months.

Later, with DDT at his disposal, Soper be- lieved it was necessary to kill only those mosquitoes directly connected to the spread of malaria, only those who had just picked up the parasite from an infected per- son and were about to infect another. Ac- cording to his calculations, this could be achieved by spraying 80% of the homes in infected areas. Training institutes were opened during the late 1950s and DDT was shipped worldwide by the ton. By 1960 six- ty-six nations were involved in the eradica- tion project, and the results were dramatic. Malaria was eradicated in Taiwan, much of the Caribbean, the Balkans, parts of north- ern Africa, the northern regions of Australia and much of the South Pacific. In India, where malaria infected an estimated seven- ty five million and killed eight hundred thousand yearly, fatalities dropped to zero by the early 1960s. Between 1945 and 1965 DDT saved millions of lives worldwide, perhaps more than any other man-made drug or chemical before or since.

What DDT could not accomplish was com- plete eradication. At the same time, DDT lost its efficacy in areas where spraying had been the heaviest and resistance began to emerge. In 1969 the WHO formally aban- doned global eradication, and currently re- commends treatment through the health- care system, through elimination of the par- asite. Unfortunately many anti-malarial drugs are no longer effective and outbreaks have occurred in India, Sri Lanka, Brazil and South Korea, among other places, dur- ing the past thirty years.

According to Andrew Spielman, senior in- vestigator in tropical disease at the Harvard School of Public Health, Soper fell into the category of public health professionals with a medical approach. His method resembled that of medical professionals, who deal with individuals at a given moment in time, for whom the goal is complete elimination of the condition within the shortest period possible. There is a fundamental difference between public health professionals who share Soper’s desire to achieve complete resolution of an immediate situation and those who favour Spielman’s approach, which he describes as the epidemiological perspective. Epidemiologists deal with populations of individuals rather than one single individual, and with populations over time rather than at a given moment. For them the goal is management or con- tainment as opposed to cure or eradication. It has become acceptable to believe that tru- ly effective control of epidemics must wait until a global public health infrastructure has been created, encompassing even de- veloping countries. There may still be a place, however, for people like Fred Soper who are unwilling to wait, who will aim high and make an obligation out of what they believe is possible.
transmitted infections. Countless studies have reported the difficulty, and questioned the appropriateness, of combating local customs. Lynd Francis, founder of an AIDS support group called The Centre, estimates that 60 percent of her clients use traditional treatments for the relief of AIDS symptoms. One traditional healer, who “hears what she is supposed to do in dreams,” distributes red bark powder to be sprinkled on porridge to control the symptoms of AIDS to as many as twenty clients daily.

The one thing clear about public health is that it involves more than curative medicine. An editorial in a recent issue of The Lancet Infectious Diseases, with reference to AIDS, maintains that it is “a social, economic and developmental disease that needs to be treated from all sections of society”. Because certain countries have been tardy in acknowledging the spread of the disease, experts are now insisting that these countries take immediate action before “the devastating potential of this disease will be allowed to run its course”.

Most critical in countries where the population is either uninformed or unable to come forward for testing, and where the social stigma and discrimination against afflicted individuals extends even to the public health workers who provide care and instruction, is the need for political commitment and leadership.

Public health not only involves other sectors than that of organised medicine, it is often antagonistic to physicians - because its policies may contradict schemes that prioritise individual health over the good of the public. Judged according to such key indicators of public health as life expectancy, infant mortality and death due to infectious disease, the contribution of vaccines and antibiotics is relatively small as compared to social and governmental programmes.

The majority of deaths among children and young adults in Africa and South Asia are due to infectious diseases.

The biggest killers of the poor

[Diagram of the biggest killers of the poor]

Upcoming issues of CMI will feature a new Public Health Section. The section will begin with an article entitled “Antimicrobial Resistance – from Pathogen to Disease Surveillance”. Shortly following will be a series of articles on the subject of Bioterrorism.
Affordable treatment has become so interconnected with the politics of public health that few officials dare to say publicly what many of them believe: that prevention makes far more sense than treatment, especially in the case of AIDS. Making expensive drugs affordable has not eliminated the fact that these drugs are toxic and difficult to take. During the past five years, the treatment for AIDS has become increasingly complex in order to match the ‘genius’ of the virus which learns quickly to evade the effects of a single drug. The collection of drugs that comprise the therapeutic cocktail used in highly active antiretroviral therapy (HAART) requires constant monitoring and frequent fine-tuning and must be taken for life.

As one health care professional explains, the general level of poverty in some countries makes useless even affordable drugs. Drugs must be distributed, must be taken by the expiration date, must be stored with refrigeration, must be taken with water. In a country where tens of millions of people do not even have access to clean drinking water, and where securing a minimum of food is a daily priority, the likelihood of being able to comply with, and complete, a complicated drug regime is questionable.

As everyone is now aware, failure to complete a full course of treatment contributes to the development of resistance, as does indiscriminate use. One recent study based in San Francisco where, unlike in India, the medical facilities are sophisticated, the personnel are highly experienced and the patients are motivated, predicts that by 2005 nearly half of all HIV patients in the city will fail to respond to the drugs they are using currently. The inevitable development of resistant variants is one reason some health care professionals advocate prevention rather than treatment.

Public health officials, however, often differ in their priorities, as does public opinion. Martha Ainsworth, a World Bank economist, maintains that “at all stages of an epidemic, politicians find reasons not to invest in prevention”. In countries like India or Russia, where tens of thousands of people are dying of tuberculosis each year, it is difficult to find support for the allocation of scarce resources to AIDS, when it takes years for the infection to manifest as illness. Later, when the situation reaches epidemic proportions, treatment for the millions of people affected becomes a priority. It is much less controversial to treat individuals who are visibly ill than to take preventive measures which involve changing sexual habits and social mores.

In a just world, as described by Prasada Rao, director of the Indian AIDS programme, a decision between treatment and prevention would not be necessary. In the absence of that ideal, he advocates a prevention model. Citing the Brazilian government’s decision to pay for antiretroviral drugs, Rao believes there is serious injustice in spending three hundred million dollars yearly to treat one hundred thousand people. Pointing out that vaccines are among the world’s most effective health interventions, because a standard package of inexpensive vaccines can realistically be distributed to three-quarters of the children in the world, Rao believes that what is needed is a vaccine for AIDS.

There is little incentive, however, for companies to invest in the development of vaccines. Development programs are hampered by market forces and liability issues. Michael Kremer, a Harvard economist, points out that “despite recent scientific advances which have increased the feasibility of developing malaria, tuberculosis and AIDS vaccines, global Research and Development on these vaccines is woefully inadequate”. Most pharmaceutical companies believe that they will find it difficult to sell enough vaccine to recover the cost of their research. Although vaccine development would benefit the public globally, no single country has sufficient incentive to invest. In response to this irony, Kremer advocates a global system that would allow countries to buy vaccine in advance. The investment in research would thus be justified by the existence of a guaranteed market. When asked whether it made sense to focus heavily on treatment rather than prevention, Yusuf Hamied responded, “I make drugs. I can only do what I do.” From a global perspective, capturing the attention of the international pharmaceutical industry and the political leaders of the world is not a slight achievement. Hamied also pointed out that he considered himself a businessman rather than a revolutionary. However, his profits were such that he could afford to make drugs affordable, or as Fred Soper would have understood it, he made an obligation out of what he was capable of doing.

A global public health infrastructure, in order to be successful according to Garrett, must include not just the essential elements of disease control and surveillance that are functioning in wealthy pockets of the globe, but must also create global partnerships in order to intervene in the treatment and prevention of epidemic infectious diseases. Above all, it must address the global challenge: how to adapt public health strategy in order to control environments and modify behaviours in a constantly changing world.

A sound public health system is vital to societal stability. The reverse is true also, and herein lies the challenge. Much of society in many parts of the world is both unstable and unhealthy. Because disease not only persists but evolves, action on the part of the global community is called for; long delays in coping will surely contribute to the problem.

RESOURCES

The Lancet Infectious Diseases, The Leading Edge, October 2001


The New Yorker, Annals of Medicine by Michael Specter, 17 December 2001

Betrayal of Trust: the Collapse of Global Public Health by Laurie Garrett, Hyperion, 2000

Mosquito: a Natural History of Our Most Persistent and Deadly Foe by Andrew Spielman and Michael D’Antonio, Hyperion, 2001

Confronting AIDS by Martha Ainsworth and Mead Over, World Bank, 1998


Judith Crane
CMI Managing Editor
The Nipah Virus
A Cause for Concern in Southeastern Asia

The catastrophe began in September 1998 in the Federal State of Perak, Northern Malaysia. Lai Mai, a pig breeder, suddenly became sick with high fever and headache. He seemed disoriented, and soon seizures also set in. He was admitted to the intensive care unit of the University Hospital of Kuala Lumpur two days later, but by then the patient was already in a state of deep coma without reflexes. The clinical picture of an encephalitis was corroborated by extreme tachycardia accompanied by hypotension. Despite intensive care treatment, the patient died on the sixth day of the disease. The diagnosis of encephalitis was confirmed by the autopsy. The cause was assumed to be a Japanese encephalitis (JE) infection, a flavivirus infection frequent in Southeast Asia during the rainy season. By the end of December, thirteen more farmers had shared the fate of Lai Mai. By the end of the year the disease had spread out to within 60 km of the capital. Although several Malaysian scientists had publicly expressed their doubts, the Ministry of Health stuck to the opinion that the disease was one of the JE epidemics typical for the season. Since JE is transmitted by mosquitoes, with pigs as a reservoir, the preconceived notion of the highest health authority of the country was to have dramatic consequences for the handling of the epidemic. While new cases of encephalitis were reported week after week, tens of thousands of pig breeding farms were spread with pesticides, entire villages were evacuated, nearly 100,000 people were vaccinated against the JE virus, and the pig population was decimated by unprecedented mass killings (the Malaysian army shot an average of 35,000 pigs a day).

These draconian measures had little effect, however. By the end of March 1999, a total of 105 people had died of infectious encephalitis. A further 160 persons had survived the disease (indicating a lethality of 40 percent) - but in 15 percent of them residual damage remained. Approximately 1.1 million pigs had been killed, numerous pig breeding farms looked like after a bomb attack, as they had been razed to the ground by the army, the market for pork meat had collapsed and the entire meat industry, a pillar of the Malaysian economy with its 670 million Dollar yearly turnover, was in ruins.

As if this outcome had not been tragic enough, the health authorities meanwhile had realised that one was dealing with a disease that was in fact caused by a previously unknown pathogen. Encephalitis was not caused by the JE virus, but by a different virus called Nipah virus after a patient from the village Sungai Negah, from whose cerebrospinal fluid it had first been isolated. The Nipah virus is a member of the family paramyxovirus – a diverse group of viruses including mumps, measles, parainfluenza and Newcastle disease virus. A new member of the group, the so-called Hendra virus, was discovered in 1994 in Northern Australia. At the time, 14 racehorses succumbed to pneumonia. Simultaneously, a stablehand and a horse trainer became ill as well as the pathologist who later carried out the autopsy of the animals. Two of the three human victims died.

The genome of the new Nipah virus has recently been sequenced, showing it to be closely related to the Hendra virus: the N, C, P, V, M, F and G genes of the two pathogens are identical to a degree of about 82%. The protein structure even shows 92% similarity and the start/stop signals on the viral RNA are strictly identical.

Since the Hendra virus normally occurs in fruit-eating bats, it was reasonable to assume a similar animal reservoir for the Nipah virus. A study by M. Y. Johara and his colleagues at the Veterinary Research Institute in Ipoh, Malaysia, confirmed this hypothesis. Neutralizing antibodies against Nipah virus were found in 21 of 324 bats examined. In 20 cases, the bats were of the fruit-eating type (Pteropus hypomelanus > Pteropus vampyrus > Eonycteris spelaea > Cynopterus brachyotis), whereas one was an insectivorous Scotophilus kuhlii. Furthermore, infectious Nipah virus was also detected in the urine of some of the bats.

For the first time, a plausible chain of infection could thus be established: flying foxes’ are often dwelling in fruit trees in the direct vicinity of pig stables, and in Malaysia these are normally located right next to farm houses. Some pigs could thus have been infected by bat excrements. But since the saliva of the bats also contains infectious virus, another possibility is that remains of fruits eaten by bats could have fallen into a barn and then been eaten by pigs. Finally, since pigs are omnivores, they could also have devoured bats unable to fly because of injuries and become infected via their blood.

As has now become evident, Nipah virus causes an acute infection of the respiratory tract in pigs, with a characteristic ‘barking cough’ (Malaysian farmers call it the ‘one-mile cough’, because the animals can be heard coughing from far away). Humans probably get infected via airborne droplets exhaled by coughing.
The neighbouring tissue – of brain or vasculitis leads to platelet adhesion and lary system of the CNS. The resulting lial cells, with a preference for the capil-

view. It mainly infects vascular endothe-

The new pathogen is also somewhat un-

breeding, transport and slaughtering

it is now clear in retrospect why the ma-

of so far (no seroconversion has ever

man-to-human transmission is known

ed for other domestic animals such as
cats, dogs or horses, and since no hu-

man-to-human transmission is known

of close contact with sick pigs. Animal experiments have now confirmed that such aerosol infection is possible.

Since only some isolated cases of infec-
tion with Nipah virus have been report-
ed for other domestic animals such as
cats, dogs or horses, and since no hu-

man-to-human transmission is known

of so far (no seroconversion has ever

been observed in the personnel of neuro-

logical intensive care units, for instance),
it is now clear in retrospect why the ma-

ority of patients were male and of Chi-

nese descent: in Muslim Malaysia, pigs are kept exclusively by the Chinese, and breeding, transport and slaughtering are tasks traditionally reserved for men.

The new pathogen is also somewhat un-

usual from a microbiological point of view. It mainly infects vascular endothe-
lial cells, with a preference for the capil-

lary system of the CNS. The resulting vasculitis leads to platelet adhesion and finally to the formation of a thrombus. The neighbouring tissue – of brain or other organs – develops hypoxemia and rapid infarction.

But another reason why Nipah virus is an extremely dangerous pathogen is its distinctive ability to also infect neurones directly, causing cell death within a very short time.

Dangerous as the Nipah virus is once it has penetrated the body, it is also very easy to eliminate in the outside world. Because the viral RNA is protected only by a thin lipid coat, common detergents or even soap are enough to inactivate the germ. Simple measures of hygiene dur-

ing pig breeding and transport thus af-

ford sufficient protection against infec-
tion with the Nipah virus.

In order to avoid a disaster similar to the one of 1999, the Malaysian ministry of health has now set up a sophisticated monitoring system. In the areas at risk, sows are now regularly checked for the presence of antibodies against Nipah virus (sows remain in a breeding station for a longer time than either piglets or boars and are therefore ideal indicators for the transmission of germs from their natural reservoir to the pig population).

If seroconversion is detected in one of these so-called sentinel pigs, all animals are checked as well as the farmers hand-
lng them.

The system was put to the test in the summer of 2000. At the end of July, a con-

rol in Sarawak revealed antibodies in some sows that had still been seroneg-

ative in the previous month. Infection with Nipah virus must therefore have occurred in the meantime. Simultane-

ously, anti-Nipah IgM antibodies were found in four farm workers. This led the authorities to put 5100 pigs to death without delay.

Four species of paramyxovirus trans-
mittted by fruit bats have been discov-
dered in Australia and in Malaysia in the past few years. Since these animals lead a migratory life, future discoveries of Ni-

pah virus, or of other germs of the paramyxovirus family, in different loca-
tions in Southeast Asia are not unlikely. Our conclusion from the short but dra-
matic history of the discovery of the Nipah virus and its relatives is that they might well have some more surprises in store for us.

Hermann Feldmeier

JAPANESE ENCEPHALITIS

With a total of 50,000 cases and approximately 10,000 deaths, Japanese encephalitis is one of the major infectious diseases of Southeastern and Eastern Asia. Being a vector-trans-
mittted disease, the number of cases fluctuates strongly during the course of the year, with a maximum during the rainy season.

An infection with Japanese encephalitis virus (JEV) typically starts with a fever and a headache. This is followed by other encephalitis symptoms. Clinically, an infection with the JEV cannot be distinguished from an infection with Nipah virus.

The vaccines against JEV presently used (JEV grown on mouse brain and inactivated by formaldehyde) have an efficacy of over 90%. However, to achieve a reliable protective effect, the vaccine must be administered three times within a month.

Prophylactic vaccination is recommended for travelers to the affected regions during the rainy season, especially if sojourns in rural areas with pig breeding are planned. No vaccines against JEV are produced in Europe, but they can be imported from manufacturers in Asia.
News in Brief

Prions and Transmissible Spongiform Encephalopathies

**BSE CONTINUES TO SPREAD IN EUROPE**
The first confirmed case of BSE in Austria was reported on 6 December 2001. The case was a 70 months old cow that had not shown any clinical signs of disease but was tested under the routine testing scheme using immunocytochemistry and rapid tests. The rest of the herd had to be culled.

Detailed tests in Finland at the farm where a case of BSE was found have not revealed the source of the infection. The protein concentrate used as feed was of plant origin but the possibility of some contamination with meat and bone meal is being examined.

_Eurosurveillance Weekly, 20 December 2001_

**VARIANT CJD – FIRST CASE IN ITALY**
The first case of vCJD has been reported in Italy. The patient, a young Sicilian woman, is alive and the case was diagnosed using various clinical tests and tonsillar biopsy. Italy banned the feeding of mammalian protein to ruminants in 1984. The prevalence of BSE in 2001 was 1.03/10,000. Surveillance for CJD became mandatory in 2002. It is reported that the patient is to receive quinacrine.

There are suggestions that illicit importation of cattle in the early 1990s could have brought BSE into Sicily. The farmer owning cattle identified as having BSE in 1994 is believed to have had links with the Mafia. A former trade union official has spoken out about the illegal trade and the poor veterinary control. Since 1999 veterinary services have improved and the Government has assured the public that the current safety measures are good.

_Eurosurveillance Weekly, 7 February 2002; Reuters_

**SHOULD QUINACRINE BE USED FOR THE TREATMENT OF vCJD?**
A letter in the _BMJ_ considers the ethics of using quinacrine for patients with vCJD. The Department of Health in the UK is planning a clinical trial which would include patients taking a placebo. The authors point out that the side effects of quinacrine are both well known and relatively mild, whereas vCJD is invariably fatal. They thus suggest that it is not ethical to set up such a trial but that all patients with probable or possible vCJD should be offered quinacrine.

_D. Braunholtz & J. Harris BMJ 2002; 324: 239_

**HIV and AIDS**

**THE SEARCH FOR AN HIV VACCINE**
A paper published in the _BMJ_ on 26 January 2002 considers whether the development of a vaccine to protect against HIV is likely. The authors are from the Medical Research Council of South Africa and conclude that an effective and affordable vaccine is likely in 7-10 years. Nevertheless, they point out that political problems are as great as the scientific and technical problems. Sufficient investment is required in the countries bearing the greatest burden, i.e. the poorest countries. They suggest that equitable public-private partnerships will provide the best strategy.

_M.W. Makgoba et al. BMJ 2002; 324: 211_

**HIV VACCINE – THE PROBLEMS AND THE SUCCESSES**
An article published in The Lancet on 19 January 2002 summarises two recent papers, both published in Nature, that illustrate the ups and downs of finding a vaccine for HIV. In one paper, plasmid DNA vectors were used in monkeys allowing the identification of a promising candidate vector (Ad5) (Nature 2002; 425: 331). In contrast another paper revealed that a rhesus monkey vaccinated previously had shown breakthrough after 24 weeks with detectable viral load. The animal died of AIDS by week 52 (Nature 2002; 415: 335).

_Lancet 2002; 359: 235_

**INTERMITTENT DRUG THERAPY USED FOR HIV**
A pilot study of the cyclic use of HIV drugs, 7 days on, 7 days off, has been found to reduce the adverse side effects inherent in HAART, but is still efficacious. Larger studies are planned to confirm these findings.

_National Institute of Health News Release, 3 December 2001_

**INFECTION DISEASES AND OUTBREAKS**

**LEGIONNAIRES’ DISEASE IN NORWAY AND LONDON**
The final report of the first ever reported outbreak of Legionnaires’ disease in Norway revealed that 26 cases were confirmed with an additional two probable cases. Seven patients, aged between 43 and 94 years (average age 81), died. The outbreak occurred in Stavanger, on the west coast of Norway between July and September 2001. The outbreak was traced to a water cooling tower at a hotel.

_Commun Dis Rep CDR Wkly, 22 November 2001; Eurosurveillance Weekly, 22 November 2001_

Cooling towers on an industrial site are also implicated as the probable source of four cases of Legionella pneumophila between August and November 2001 in west London. The disease was confirmed in the four men by the detection of urinary antigen.

_Commun Dis Rep CDR Wkly, 24 January 2002_

**VACCINATION AGAINST PNEUMOCOCCUS AND MENINGOCOCCUS**
The Health Council (Gezondheidsraad) in the Netherlands has recommended universal vaccination against Group C meningococcus and pneumococcus. Initially the vaccinations will be given separately, the meningococcus vaccine in two injections at 5 and 6 months. The pneumococcus vaccine will be given in three injections at 2, 3, and 4 months but not until a combined vaccine against diphtheria, tetanus, pertussis, polio and Haemophilus influenzae type B is available (2002-2003), reducing the numbers of injections required by infants. A combined vaccine of meningococcus and pneumococcus is expected to be available by 2005.

_Eurosurveillance Weekly, January 2002_
MENINGOCOCCAL MENINGITIS
An EU enhanced surveillance system has revealed eight patients with meningitis caused by Neisseria meningitidis serogroup W135 between October and December 2001. There was one case in France, two in Germany, one of whom was fatal, and five in the UK, one of whom was fatal. The surveillance was in response to an epidemic in 2000 among pilgrims returning from the haj pilgrimage to Mecca. Only one of the eight patients had any known link to the haj pilgrimage.

_Eurosurveillance Weekly_, January 2002

PERTUSSIS
There have been reports from a number of countries of a resurgence of pertussis, even where the population has a high level of vaccination. Older adults are likely to have low levels of protection and may carry pertussis and infect young infants. The International Consensus Group on Pertussis Immunization has called for a review of vaccination policies and recommends regular booster vaccinations for all adolescents and adults. The new acellular vaccines are safer than the old whole cell vaccines, making such a policy feasible, at least for adults likely to come into contact with infants.

_Pharmaceutical Times Webcast_, 15 January 2002

MEASLES AND MMR VACCINATION
A measles outbreak has been reported from Jutland in Denmark. Between December and early February measles was confirmed in 19 children, ten of whom were younger than two years and were unvaccinated. A further five patients were unvaccinated and two had received only one dose of MMR. Although Denmark normally has a high coverage of the first dose of MMR vaccine, the percentage of children having the second dose by 15 months of age has been reported to be below the WHO 95% target.

_Eurosurveillance Weekly_, 7 February 2002

Claims by a UK doctor (Andrew Wakefield) that the MMR vaccine is linked to autism and bowel disease and the controversy these have caused have led to a drop in the take-up of the vaccine in certain areas in the UK, falling overall to only 84.2%. The controversy has been fuelled by large scale media coverage, leading to the Chief Medical Officer in the UK attempting to allay fears and assuring parents that the vaccine is safe. Several cases of measles have been reported in south London and in the Gateshead and South Tyneside area. The UK Government has refused to allow free vaccination with separate vaccines but their use has increased dramatically in the last year and it is reported that supplies of these separate vaccines are now very limited.

_BBC on-line News_, January 2002

Research into the link between measles virus and the bowel disorder, ileocolonic lymphonodular hyperplasia (ILH), has revealed that intestinal tissue in a high percentage (75/91) of patients with ILH was positive for the measles virus. The paper is not yet published but, because of the interest in the topic and because part of the findings were broadcast on the BBC television, it has been released early on the Web together with statements from the lead author, Prof. O’Leary from Dublin, and from the editors of Molecualr Pathology. One of the authors is Dr Wakefield, but Prof. O’Leary stressed that the role of MMR was not investigated and the strain of measles detected has not been compared with that contained in MMR. The editors state that ‘any link with MMR is not justified, and was not intended by the study authors’.

_www.molpath.com_, _V. Uhlinmalm et al._

A highly relevant population study investigating the relationship between autism and the use of the MMR vaccine has been published early on the Web version of the BMJ. The study was carried out at the Royal Free Hospital and the Public Health Laboratory Service in the UK. The study investigated 473 autistic children born over a 20 year period (1979 to 1998). MMR was introduced in 1988 but no differences could be seen in the proportion of children with bowel symptoms or developmental regression before or after the introduction of the vaccine. The conclusions of the authors are that their data provide no support for an MMR-associated ‘new variant’ form of autism.

_Taylor et al. BMJ online_, 7 February 2002

UN WARNS THAT BRITISH FEARS OVER MMR COULD SPREAD TO OTHER COUNTRIES
A medical officer for the World Health Organisation has expressed his concern that the publicity around the MMR vaccine in the UK might spread doubts in other countries as to its safety. Measles still kills approximately 800,000 children every year worldwide. The WHO says that claims that the vaccine could cause autism or bowel disease are without scientific merit and that there is no reason to administer the vaccine separately. Such an approach would result in children being not fully protected for longer periods of time.

DIPHTHERIA CASES REPORTED IN FINLAND AND UK
A 3 months old unvaccinated infant died in south east Finland in November 2001 from diphtheria. The disease was confirmed by the isolation of a toxigenic strain of _Corynebacterium diphtheriae var mitis_. Typing revealed that the strain was related to those currently circulating in Russia. A sister of the patient was found to be an asymptomatic carrier, and the family had been in close contact with people who had recently visited Russia, where the incidence of diphtheria is increasing. Previous recent cases of diphtheria in Finland were all found to have links with Russia.

In January a toxigenic strain of _C. diphtheriae var mitis_ was isolated from a throat swab from a 11 year old boy in north-west England. The family had returned from Israel a few days prior to the child developing a sore throat. No other symptoms of diphtheria were evident and he has received a course of azithromycin. Swabs taken from the family and close contacts have proved negative but all have received prophylactic courses of azithromycin. All the family had been vaccinated, and have now been given booster doses.


ANTHRAX
The structure and mode of action of one of the toxins of anthrax, the edema factor (OF), has been revealed in a recent paper in Nature. OF is an adenyl cyclase which binds to calmodulin,
changing its conformation. Calmodulin regulates the levels of cyclic AMP within mammalian cells but, when bound to OF, is unable to modulate cyclic AMP, leading to a build-up in the mammalian cell. OF adenyl cyclase has no homology with mammalian adenyl cyclases. The structure of all three anthrax toxins are now known, although knowledge of how the toxins interact is still inadequate.


The Federal Bureau of Investigation (FBI) is still trying to find the source of the anthrax spores released deliberately last year in the US. It is reported to be investigating government and contract laboratories, as the powder containing the spores had many characteristics in common with that being used by the US military programme. The Ames strain was used and the concentration of spores in the powder was very high, meaning that considerable technical knowledge would be required to produce such a powder. An expert in biological weapons, Dr. Rosenberg, has claimed that a government insider or a contact of an insider is the most likely suspect.

The genome of two variants of the Ames strain of anthrax has apparently been decoded by scientists at the Institute for Genomic Research, but the results are not being released at the request of the FBI. It was knowledge of part of the genome that allowed ‘fingerprinting’ of the strain used in the attack to be linked to the Ames strain. New York Times, 2 November, 2 December, 3 December 2002

PHAGE THERAPY RESURFACES

Bacteriophages (phages) were one of the earliest known ways of killing bacteria, but interest in their potential for therapy waned following the advent of antibacterials. The spread of strains of pathogenic bacteria with resistance to many antibacterials has led to a renewed interest in this field. These viruses are specific to bacteria and have no harmful effects on humans.

A phage of Enterococcus faecium has been shown to be able to protect mice infected with a lethal dose of vancomycin resistant E. faecium (VRE). Workers at the National Institutes of Health and Exponential Biotherapies (US) injected a phage suspension intraperitoneally into mice 45 min after infection with a strain of VRE and protected all animals from death.

B. Biswas et al. Inf & Immun 2002; 70: 204

When phages infect bacteria, after they have killed the bacterial cell, they escape by producing lytic enzymes. A group at the Rockefeller University (US) used a spray containing a purified pneumococcal phage enzyme to eliminate Streptococcus pneumoniae from the nasopharyngeal area of mice. The enzyme was able to kill 15 common serotypes of pneumococcus in vitro in a few seconds but had no effect on microorganisms normally found in the oro-pharynx. The authors suggest that this offers a safe method of eliminating carriage of drug-resistant strains in humans.

J.M. Loeffler et al. Science; 2001

CYSTIC FIBROSIS AND PSEUDOMONAS AERUGINOSA

Work published from the University of Tübingen (Germany) and groups in biological weapons, Dr. Rosenberg, has claimed that a government insider or a contact of an insider is the most likely suspect.

The genome of two variants of the Ames strain of anthrax has apparently been decoded by scientists at the Institute for Genomic Research, but the results are not being released at the request of the FBI. It was knowledge of part of the genome that allowed ‘fingerprinting’ of the strain used in the attack to be linked to the Ames strain.

New York Times, 2 November, 2 December, 3 December 2002

NEW SUBTYPE OF INFLUENZA IDENTIFIED

A new subtype of influenza virus A (H1N2) has been identified in Egypt, Israel and the UK. The WHO considered this at a recent meeting to decide the composition of the influenza vaccine for the northern hemisphere for 2002-2003. The new subtype appears to have arisen by a reassortment of the common type A strains, as it contains a haemagglutinin component similar to that in H1N1 strains and a neuraminidase component similar to that in H3N2 strains. It is thought that those vaccinated with the current vaccine should have good immunity to this new subtype.

Eurosurveillance Weekly, 7 February 2002

NEW APPROVALS

The FDA has approved Merck’s er tapenem (Invanz®) for moderate to severe adult bacterial infections, including those caused by Gram-negative and Gram-positive aerobes and anaerobes.

Gilead announced on 7 February 2002 that they had gained approval from the European Medicines Evaluation Agency for the use of Viread® in combination with other anti-retroviral agents in patients with HIV who have early virological failure. Viread, or tenofovir disproxil fumarate, is the first nucleotide reverse transcriptase inhibitor and is available as a once daily tablet.

GLAXO SMITHKLINE AND MERCK COMMENCE TRIALS ON HIV VACCINE

GSK announced that they are to commence Phase 1 safety and immunogenicity trials on an HIV vaccine in several centres in the US. Previous tests in rhesus monkeys gave promising results. Merck are also commencing Phase I studies on two versions of their candidate vaccines.

ACAMBIS TO PRODUCE SMALLPOX VACCINE IN US

Acambis, a biotechnology company based in Cambridge, UK, announced on 28 November 2001 that its American subsidiary, Acambis Inc., has been awarded a second contract from the CDC to make smallpox vaccine in the US. They are the only company to gain such a contract and this will result in them producing 209 million doses of smallpox vaccine in 2002. Acambis is funded by its major shareholder Baxter to reactivate its facility in Massachusetts to manufacture the smallpox vaccine. Acambis make a range of antibacterial and antiviral vaccines.

BIOSEARCH ITALIA ANNOUNCES CONTINUED DEVELOPMENT OF DALBAVANCIN

Dalbavancin (VRC 3950) is a glycopeptide antibacterial, an analogue of vancomycin, discovered by Biosearch
Italia and licensed to Versicor. It has recently entered Phase II studies. Results on Phase I studies released at ICAAC in Chicago in December by Versicor showed that dosing daily (up to 1000 mg doses) or once weekly were both well tolerated. Once weekly dosing provided blood levels adequate to treat staphylococcal infections.

EU LILLY AND VERTEX SELECT HEPATITIS C LEAD COMPOUND
A new class of protease inhibitors designed to inhibit the hepatitis C (HCV) protease (C NS3-4A) has been announced by Eli Lilly and their biotechnology partner, Vertex. The compound (LY 570310, VX-950) is currently undergoing preclinical studies and it is anticipated that Phase I studies will commence in 2003. Vertex said that the HCV protease, which is essential for viral replication, has a flat activity site. This, and the problems in getting HCV to replicate under laboratory conditions, has made finding an inhibitor difficult. The lead announced is the first compound to inhibit HCV protease.

ADEFOVIR DIPIVOXIL EFFECTIVE AGAINST HEPATITIS B INFECTIONS IN CLINICAL TRIALS
Adeovir dipivoxil (Gilead Sciences) is currently undergoing Phase III clinical trials for the treatment of lamivudine-resistant chronic hepatitis B infections. Results in post-transplant patients with once daily dosage have proved promising. Filing in the US and Europe is anticipated for 2002.

ANTI-DEPRESSION DRUGS HAVE ANTFUNGAL ACTIVITY
Recent studies from the University of Innsbruck (Austria) have demonstrated antifungal activity on the part of selective serotonin re-uptake inhibitors (SSRIs). Sertraline and fluoxetine were the most active SSRIs tested, with activity against Aspergillus fumigatus, A. flavus, A. terreus and Candida parapsilosis.


LINEZOLID AND THROMBOCYTOPENIA
Thrombocytopenia (platelet count of <100,000/mm³) was observed in 6/19 patients receiving the oxazolidinone linezolid for >10 days. In nine of the patients the platelet count was decreased by at least 30%, the median duration of therapy in these patients being 19.1 days (range 10–42). The platelet count continued to fall after linezolid therapy was discontinued, recovering after 4–13 days. In eight patients who received linezolid for a median of 7.7 days (range 5–11) there was no significant fall in the platelet count.

Attassi et al. CID 2002; 34: 695

FRENCH HEALTHCARE SYSTEM
Two royal decrees were approved in December 2001 allowing health services to be transferred from central government to regions. This paved the way for a complete decentralisation of the healthcare system in January 2002 and necessitated the payment of 10.2 billion Euros to regions.

BMJ 2002; 324: 68

NEW GENERIC LAW IN GERMANY CAUSES CONTROVERSY
On 1 February 2002, the Bundesrat (Federal Council) approved a package designed to reduce expenditure on drugs. A component of this package regarding the prescription of generic drugs has caused controversy. Doctors would be required to prescribe a generic drug and the pharmacist would then select a product in the lowest price category. An appropriate transport with qualified ambulance staff is lacking. Dutch MPs have reacted angrily to this situation.

BMJ 2002; 324: 259

EU’S ‘6TH FRAMEWORK’ CRITICISED
The health component of the draft of the EU’s sixth framework programme
for research has been criticised as having far too much emphasis on genomics and biotechnology to the detriment of individual diseases. French MEP Gérard Caudron has said that “Genomic research...by its exploratory nature may not always lead to effective results. The classic approaches must not be overlooked.” He has suggested an approximate 50/50 split in the allocation between genomic and specific disease research.

Pharma Business Daily, 14 November 2001

FISHMEAL FEED FROM GERMANY CONTAMINATED WITH CHLORAMPHENICOL
Officials in Lower Saxony (Germany) are trying to trace the source of chloramphenicol-contaminated fishmeal feed. The consignment contains fish ingredients from the Netherlands and batches have also been sent to Austria, Denmark, Poland, Romania and the Czech Republic. Chloramphenicol is totally prohibited in foods.

Reuters, 22 January 2002

NEW PROJECT ON ANTIBIOTIC USE (ESAC) FUNDED BY EU
A new group, European Surveillance of Antibiotic Consumption (ESAC) has been set up by the EU in November 2001. Major differences in the consumption of antibiotics had been noted between European countries, leading to the setting up of ESAC. Currently 25 countries have joined and collaborators are being sought in other countries.

www.uia.ac.be/esac/

Miscellaneous

FBI ASKS FOR LIST OF ASM MEMBERS
As part of their investigations into the source of the anthrax used in recent attacks, The Federal Bureau of Investigation (FBI) in the US has requested the names and addresses of 43,000 members of the American Society for Microbiology (ASM). A report in The Scientist says that many American scientists are concerned about new acts passed recently in the US which could be used to limit the sharing and releasing of information; the cornerstone of scientific research. The associate dean at Johns Hopkins University’s School of Public Health believes that “Science has gone from a very mildly regulated industry to one of the most regulated.” Dr Brenda Wilson, a microbiologist from the University of Illinois says “What frightens scientists most is that we’re being threatened by people making decisions who don’t know what we do, how we do it, or why we do it.”

ARE REGULATIONS FROM THE FDA MAKING IT IMPOSSIBLE TO PROGRESS ANTIBACTERIALS?
A recent letter in the Journal of Clinical Infectious Diseases suggests that a new FDA proposal for Phase III clinical trials on antibacterial agents has made it extremely difficult for the pharmaceutical industry to progress compounds. The authors even say that this has probably contributed to the recent withdrawals of Eli Lilly and Bristol-Myers Squibb from antibacterial discovery research. FDA has asked that when designing equivalence studies the target of 10% delta should be used for the lower limit of confidence interval. The authors calculate that this seemingly minor change results in unacceptably large numbers of patients needing to be enrolled for trials. European regulatory authorities are apparently taking a similar stance. Such an approach is likely to discourage more companies from continuing in antibacterial research.

D.M. Shales & R.C. Moellering. CID 2002; 34: 420

Pamela Hunter, Medical Writer

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Dept. of Pathology (Microbiology Section)
University of Verona
Strada Le Grazie 8
I – 37134 Verona, Italy
Phone: +39-045-802 7196
Fax: +39-045-584 606
E-mail: giussepe.cornaglia@univr.it

6–12 July 2002
1st ESCMID School of Clinical Microbiology and Infectious Diseases, Lausanne, Switzerland

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Phone: +41-61-686 77 11
Fax: +41-61-686 77 88
E-mail: info@akm.ch
Internet: www.akm.ch/ESCMIDSchool2002

25–28 August 2002
20th ESCMID Postgraduate Education Course: Training in Hospital Epidemiology, Stein am Rhein, Switzerland

Contact:
Dr Christian Ruef
Division of Infectious Disease and Hospital Epidemiology
Universitätsspital, HAL 14 C
CH-8901 Zürich
Switzerland
Phone: +41 1 255 5731
E-mail: spitalhygiene@dim.usz.ch

10–13 May 2003
13th European Congress of Clinical Microbiology and Infectious Diseases (ECCMID), Glasgow, UK

Contact:
AKM Congress Service
Phone: +41-61-686 77 11
Fax: +41-61-686 77 88
E-mail: info@akm.ch
Internet: www.eccmid.org/eccmid2002

14th European Congress of Clinical Microbiology and Infectious Diseases (ECCMID), Prague, Czech Republic

Contact:
AKM Congress Service
Phone: +41-61-686 77 11
Fax: +41-61-686 77 88
E-mail: info@akm.ch

2-5 May 2005
15th European Congress of Clinical Microbiology and Infectious Diseases (ECCMID), Copenhagen, Denmark

Contact:
AKM Congress Service
Phone: +41-61-686 77 11
Fax: +41-61-686 77 88
E-mail: info@akm.ch

In co-operation with ESCMID

3–5 June 2002
4th World Congress on Tuberculosis
Washington, DC, USA
Contact:
NIAID/NIH
Internet: www.niaid.nih.gov/dmid/tuberculosis/fbccongress

17–18 June 2002
5th IACMAC International Conference: Antimicrobial Therapy, Moscow, Russia
Contact:
Dmitry Galkin
Phone: +7-812-611-301

Other events:

22–24 April 2002
HPC, Bacteria in Drinking Water – Public Health Implications?, Geneva, Switzerland
Contact:
Bob Tanner
NSF International
Phone: +1-32-2-771 3654
Internet: www.nsf.org/conference/hpc

3–6 November 2002
4th International Symposium on Perspectives in Clinical Microbiology and Infections, Venice, Italy
Contact:
EAC srl
Phone: +39-025-990-2320
E-mail: eacsrl@tin.it
Internet: www.eac.it

4–7 May 2002
4th European Congress of Chemotherapy and Infection (ECC), Paris, France
Contact:
Congrex Sweden
Phone: +46-8-459 6600
Internet: www.congrex.com/ecc-4

4–7 July 2002
5th International Workshop on Pathogenesis and Host Response in Helicobacter Infections, Helsingor, Denmark
Contact:
Karen A. Krogfelt
Phone: +4-532-683-745
E-mail: kakk@ssi.dk

7–12 July 2002
XIVth International Conference on AIDS, Barcelona, Spain
Contact:
Conference Secretariat
Phone: +34-93-254 0554
Internet: www.aids2002.com
### CALENDAR

#### 24–27 July 2002
6th International Meeting on Molecular Epidemiology and Evolutionary Genetics in Infectious Diseases (MEEGID-VI), Paris, France

**Contact:**
Altafi A. Lai  
E-mail: aal1@cdc.gov  
Internet: http://cepm.mpl.ird.fr

#### 27 July–1 August 2002
The World of the Microbes – Joint Meeting of the Divisions of the International Union of Microbiological Societies, Paris, France

**Contact:**
ICU/JCD Conseil  
Phone: +33 (0) 1 40 64 2000  
Internet: www.lums-paris-2002.com

#### 18–22 August 2002
14th IEA World Congress of Epidemiology, Montréal, Canada

**Contact:**
Events International  
Phone: +1-514-286-0855  
E-mail: info@eventsintl.com

#### 28–30 September 2002
42nd Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), San Diego, CA, USA

**Contact:**
ASM Conferences  
Phone: +1-202-942 9248  
Internet: www.asmusa.org

#### 15–18 September 2002
5th International Conference of the Hospital Infection Society (HIS), Edinburgh, UK

**Contact:**
HIS 2002 c/o Concorde Services LTD.  
Phone: +44-141-331 0123  
Internet: www.his2002.co.uk

#### 28–30 September 2002
42nd Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), San Diego, CA, USA

**Contact:**
ASM Conferences  
Phone: +1-202-942 9248  
Internet: www.asmusa.org

#### 1–5 December 2002
8th Western Pacific Congress of Chemotherapy and Infectious Diseases, Perth, Australia

**Contact:**
International Convention Management Services (ICMS)  
Phone: +61-3-9682 0244  
E-mail: wpcidd@icms.com.au

#### 6–8 April 2003
13th Annual Scientific Meeting of SHEA, Arlington, VA, USA

**Contact:**
SHEA Meetings Department  
Phone: +1-856-423 7222  
Internet: www.shea-online.org

#### 14–17 September 2003
43rd Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), Chicago, IL, USA

**Contact:**
ASM Conferences  
Phone: +1-202-942 9248  
Internet: www.asmusa.org

#### 28 September–1 October 2003
8th Congress of the Eastern Mediterranean Confederation of Medical Mycology, The Netherlands

**Contact:**
Congress Care  
Phone: +31-73-683-1238  
Internet: www.nlccm-temcm.org

#### 16–19 October 2003
3rd International Meeting on Antimicrobial Chemotherapy in Clinical Practice (ACCP), Santa Margherita, Portofino, Italy

**Contact:**
Matteo Bassetti  
Phone: +39-010-555-2668  
E-mail: mattb@tin.it

#### 26–29 October 2003
9th European Conference on Clinical Aspects and Treatment of HIV Infection, Warsaw, Poland

**Contact:**
K.I.T. GmbH  
Phone: +49-30-24-60-30  
Internet: www.eacs-conference2003.com

#### 30 November–5 December 2003
40th World General Assembly of the International Union Against Sexually Transmitted Infections (IUSTI), Punta del Este, Uruguay

**Contact:**
Dr. Ross Phillpot c/o IUSTI  
Phone: +61-882-324 511  
Internet: www.iusti.org

#### 3–5 December 2003
6th International Epidemiological Association Scientific Meeting in the Eastern Mediterranean Region, Ahwaz, Iran

**Contact:**
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Phone: +98-611-336-3312

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**Contact:**
Steven Talboom, K.I.T. GmbH  
Phone: +49-30-24603-301  
E-mail: tropical2002@kit.de

**Contact:**
Kenes International  
Phone: +1-22-908-0488  
E-mail: www.kenes.com/wspid

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**Contact:**
Diman van Rossum  
Phone: +31-73-683-1238  
Internet: www.nlccm-temcm.org

**Contact:**
K.I.T. GmbH  
Phone: +49-30-24-60-30  
Internet: www.eacs-conference2003.com

**Contact:**
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Phone: +61-882-324 511  
Internet: www.iusti.org