ESCMID News

Invitation: Assembly of Members 2003

Professional
EU Conference 2003 in Rome on Antibiotic Resistance

Features
Infantile Paralysis: Will we Succeed in Eradicating Poliomyelitis?

Features
Immortal Music and Deadly Germs, Part 2
POLIO
The cover page of this issue shows an electron microscopic image of human poliovirus type 1 (image from F.P. Williams, US EPA). Poliovirus causes poliomyelitis (polio). It is a member of the enterovirus genus. Enteroviruses belong to the Picornaviridae family, which is one of the largest and most diverse of the viral families causing a wide range of different diseases. The viruses of this family share icosahedral structural symmetry and a genome of single-standard positive-sense RNA. Lacking a lipid envelope, they are resistant to ether, chloroform and ethanol. Infection usually occurs by the fecal-oral route. As their name indicates enteroviruses generally replicate in the intestinal tract. Poliovirus can spread from the intestine to the brain and spinal cord causing total paralysis in a matter of hours. One in 200 infections leads to irreversible paralysis (usually in the legs). Amongst the paralysed patients, 5%–10% die when their breathing muscles become immobilized.

Due to vaccination, the worldwide incidence of polio has been drastically reduced, from 350,000 cases in 1988 to approximately 483 in 2001. However in 2002 the fight against polio suffered a setback and the number of cases rose to just under 1500 with a five-fold increase in the number of cases in Nigeria and northern India. The CDC has postulated that polio will be “eradicated” by 2003 and has set 2005 as the deadline to certify all WHO regions as polio-free. However, the Technical Consultative Group (TCG) on poliomyelitis eradication notes that closing immunisation gaps in Egypt, India, and Nigeria requires urgent work if the 2003 mark is to be met. In addition, the current campaign has relied almost entirely on the live, attenuated Oral Poliovirus Vaccine (OPV). This virus is emitted by the vaccinated person into the environment, even in polio-free areas such as Europe. Evidence indicates that this virus can mutate back to a wild-type potentially paralytic virus needs urgent work if the 2003 mark is to be met. In addition, the current campaign has relied almost entirely on the live, attenuated Oral Poliovirus Vaccine (OPV). This virus is emitted by the vaccinated person into the environment, even in polio-free areas such as Europe. Evidence indicates that this virus can mutate back to a wild-type potentially paralytic virus attenuation and OPV-vaccinated individuals with compromised immune systems could play an important role as polio reservoirs as the incidence of AIDS around the world increases.

REFERENCES
1 TCG has “concerns” about India, Nigeria and Egypt – supplementary immunisation activity (SIA) of an increased incidence of AIDS around the world increases.

2 Dove AW, Racaniello, VR. The polio eradication effort: should vaccine eradication be next? Science 1997; 277 (5327): 779–780

Imprint

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

Editors and Editorial Office: Peter Schoch, Managing Director; Carl Erik Nord, Publication Committee President; Dianne White, Publication Assistant; Pamela A. Hunter, Medical Writer; Editorial Office: ESCMID Executive Office, PO Box 6, CH-4005 Basel, Switzerland. Email: info@escmid.org

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Dear Colleagues,

ESCMID is pleased to provide you with the first issue of ESCMID News for 2003, which should keep you up-to-date about the Society’s news and activities. Our retiring President, Professor Roger Finch, summarizes the successful achievements of our Society during his term of office for the past two years. ESCMID would like to welcome the newly elected country representatives in the European Council who will meet at the 13th ECCMID in Glasgow, May 2003.

The announcement of the ESCMID Awards and Fellowships for 2004 is given, which will hopefully motivate many of you to send nominations and applications to the ESCMID office. The section Membership Spotlight continues in this issue and gives an interesting portrait of an ESCMID member from the Czech Republic. This year a new ESCMID Study Group on Toxoplasmosis (ESGT) has been established and the inaugural meeting will be held during the 13th ECCMID. The presentation of the ESCMID Study Groups continues with a portrait of the European Helicobacter Study Group (EHSG). The 2nd ESCMID School of Clinical Microbiology and Infectious Diseases will take place in Utrecht, The Netherlands June 28–July 4, 2003. In April 2002 the new editor of our journal Clinical Microbiology and Infection, Dr Kevin Towner, will start his office. The transition of the editorship is described in this issue. President-elect Professor Marc Struelens and Marika Konings, Interel, express their views on a new and important project for our Society entitled The building of a European Public Affairs Programme. The next European Union conference with our Society will take place in Rome, November 28–30, 2003 with an overview given in this issue. A letter from Dr Michael Tibayrenc to the Editor of ESCMID News presents valuable comments to the readers on the question of creating a European Center for Infectious Disease Control. This issue is of current interest and will be discussed in a symposium at the 13th ECCMID.

The postgraduate courses are important activities of ESCMID and the announcements for several courses can be found in this newsletter. The incidence of poliomyelitis has fallen dramatically during the last 40 years as the result of mass vaccination campaigns, which is described in two articles. The second part of the review article on immortal music and deadly germs presents four world-known musicians’ and composers’ serious infections. Brief news items and forthcoming events in microbiology and infectious diseases are as usual reported in this newsletter.

From 2001–2003, I was chairing the ESCMID Publication Committee with responsibilities for ESCMID News and our journal Clinical Microbiology and Infection. It has been a pleasure to work with the ESCMID News editorial team, Peter Schoch, Dianne White and Pamela A. Hunter, and I want to thank them sincerely. I wish the ESCMID members and ESCMID News readers all the best and I am hoping to see you at the 13th ECCMID in Glasgow May 10–13, 2003.

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

The Annual ECCMID Conference is the most important event in the annual calendar. It is gratifying to hear from colleagues in Europe and beyond that ECCMID has become established as the premier European Congress in microbiology and infectious diseases. The programme in Glasgow is excellent and complimented by an increasing number of outstanding abstracts. We have continued our policy to make the congress as accessible as possible, especially to younger delegates and ESCMID members. New this year is a “European Network Corner” adjacent to the ESCMID booth, which I encourage you to attend. This will promote European scientific and educational initiatives and will allow delegates to meet with representatives of the Executive, the ESCMID Study Groups, Clinical Microbiology and Infection and other partners and organisations with whom we are collaborating. Do come along and “network”!

On the scientific front the Society has responded to the Framework 6 Research Initiative of the European Commission. Many members will be contributing to research proposals including a major Network of Excellence, which will embed many of the assets of the Society in supporting research and dissemination of knowledge focused on the control of antibiotic resistance in the context of lower respiratory tract infections. The outcome of this research proposal and others from our membership will be eagerly awaited. In the area of professional affairs it has been a very productive period. Firstly, through the UEMS and its sections on Infectious Diseases and Bio-pathology (which incorporates Clinical Microbiology) much progress has been made in defining a common training programme for the infection disciplines in Europe and in establishing a pan-European CME accreditation system. The European Boards of Accreditation in Infectious Diseases (EBAID) and Clinical Microbiology (EBACM) have been established. The Society’s support for UEMS has been strong; indeed the accreditation process will be run through our Basel Headquarters.

In defining a common training programme in infectious diseases the Society has responded to the Framework 6 Research Initiative of the European Commission. Many members will be contributing to research proposals including a major Network of Excellence, which will embed many of the assets of the Society in supporting research and dissemination of knowledge focused on the control of antibiotic resistance in the context of lower respiratory tract infections. The outcome of this research proposal and others from our membership will be eagerly awaited. In the area of professional affairs it has been a very productive period. Firstly, through the UEMS and its sections on Infectious Diseases and Bio-pathology (which incorporates Clinical Microbiology) much progress has been made in defining a common training programme for the infection disciplines in Europe and in establishing a pan-European CME accreditation system. The European Boards of Accreditation in Infectious Diseases (EBAID) and Clinical Microbiology (EBACM) have been established. The Society’s support for UEMS has been strong; indeed the accreditation process will be run through our Basel Headquarters.

To strengthen the involvement of the Society with the various EU activities in the field of communicable diseases a Task Force has been established under the leadership of Marc Struelens. Please read his article on the ESCMID initiative for a European Public Affairs Programme in this issue of ESCMID News.

Also under Professional Affairs, as detailed in the previous edition of ESCMID News, an important survey of the organisation of Clinical Microbiology in Europe has been conducted. Following this the Society has been able to make successful representation in support of the discipline in some Member States. This is important at a time when the public health needs for effective clinical microbiology are increasing substantially.

The Executive has also recognised its responsibilities to nurture the infection disciplines in Central and Eastern Europe, particularly as more and more countries achieve full membership in the EU. The Society has also responded to a request from colleagues in Russia to support their scientific, educational and professional needs. As a consequence I had the privilege to lead a successful delegation from the Executive to Moscow last December. This has led to a “Memorandum of Collaboration and Understanding” following discussions with the Russian Academy of Medical Sciences, and the Russian Ministry of Health.

Clinical Microbiology and Infection has made great progress under the leadership of Emilio Bouza and his team in Madrid. I am sure you will agree that the breadth and depth of research articles, reviews and supplements has been impressive, and gratifyingly complimented by an increasing array of high quality original articles. We are most appreciative and thank Emilio on your behalf. I am pleased to say that the task of identifying the next Editorial Team has been successful. The Publications Committee has recommended that two Editors be appointed, one with responsibility for the monthly edition of CMI and another with responsibility for Supplements. I am delighted that Kevin Towner and Carl Erik Nord respectively have been able to accept these positions. I am sure the membership will join me in wishing them every success during this next phase of the journal’s development.

The Society continues to develop its educational initiatives. Many of you will have enjoyed the reorganised web-site and the web-casts. Likewise, 2002 saw the first Summer School in
Lausanne. I am delighted that the next Summer School will take place in Utrecht (28 June – 4 July), and wish to thank the Faculty in advance for their support of this event. I encourage you to attend and to draw this to the attention of your colleagues. The Study Groups remain active and productive. The Society has established two new Study Groups on fungal disease and toxoplasmosis to be led by David Denning and Birgitta Evengård respectively. In addition, EUCAST, under the Chairmanship of Gunnar Kahlmeter, has established a Steering Committee drawn from the leading European national breakpoint and susceptibility testing committees. Considerable progress has been made in the journey towards achieving consensus. Furthermore, there is active dialogue between the NCCLS and European representatives, which one hopes will bring about international agreement in this important area of antimicrobial science.

ESCMID continues to collaborate with an ever-increasing number of European and international organisations. These include the American Society of Microbiology, the Federation of European Microbiological Societies, the Infectious Diseases Society of America, the International Society for Infectious Diseases, the International Society of Chemotherapy and most recently the European Societies of Laboratory Medicine. Likewise, at the request of the EMEA, nominated representatives have been provided to the CPMP Therapeutic Advisory Group for anti-infectives.

I am also pleased to announce that the Society will be jointly hosting a conference with the European Union in November on the Role of Research in Combating Antibiotic Resistance. This will be held in Rome, under the patronage of the Italian Ministries of Health and Research, when Italy holds the Presidency of the European Union. This will be the fourth major European conference dealing with antibiotic resistance and follows the earlier successful and influential meetings held in Copenhagen, Visby and Brussels.

In closing, I thank you for your support and wish Marc Struyven every success as the next President of this Society. I have every confidence that he will be well supported by the Executive and Membership, and that ESCMID will continue to be successful in its expanding repertoire of responsibilities.

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ESCMID is pleased to introduce the newly elected country representatives in the European Council for the office term 2003-2006. In accordance with the ESCMID Statutes the election was held at the end of 2002 in those countries with 5 or more ESCMID members. The European Council serves as an advisory board to the Executive Committee and includes, in addition to the elected country representatives, representatives of specialist societies involved in clinical microbiology and infectious diseases, and the chairpersons of the ESCMID study groups. The European Council convenes during the annual Society congress (ECCMID) with the ESCMID President as acting chair. Below is a list of the newly-elected country representatives.

### Newly Elected Country Representatives

- **Austria** Allerberger, Franz
- **Belgium** Glupczynski, Youri
- **Bosnia-Herzegovina** Janic, Spomenka
- **Croatia** Skrlin, Jasenka
- **Czech Republic** Jindrak, Vlastimil
- **Denmark** Bruun, Brita
- **Finland** Huovinen, Pentti
- **France** Leclercq, Roland
- **Germany** Shah, Pramod
- **Greece** Malamou-Ladas, Eleni
- **Hungary** Rozgonyi, Ferenc
- **Ireland** Humphreys, Hilary
- **Israel** Block, Colin
- **Italy** Marchetti, Daniela
- **Latvia** Zilevica, Aija
- **Lithuania** Ambrozaitis, Arvydas
- **Luxembourg** Brouart, Pol
- **Netherlands** Meis, Jacques
- **Norway** Harthug, Stig
- **Poland** Dzierzanowska, Danuta
- **Portugal** Marques, Maria T.
- **Romania** Rebedea, Iliea
- **Russian Federation** Firsov, Alexander
- **Serbia-Montenegro** Svaoric-Vlahovic, Milena
- **Slovak Republic** Kazar, Jan
- **Slovenia** Koren, Srecko
- **Spain** Martinez-Martinez, Luis
- **Sweden** Kahlmeter, Gunnar
- **Switzerland** Bille, Jacques
- **Turkey** Akova, Murat
- **UK** Read, Robert C.
The European Helicobacter Study Group (EHSG)

The European Helicobacter Study Group (EHSG) was set up in 1987 in Copenhagen, Denmark, making it one of the oldest established of the ESCMID Study Groups. The current President of the group is Professor Torkel Wadström, Lund, Sweden and President of the group is Professor CMID Study Groups. The current one of the oldest established of the ES- is more common in the develop- pylori in the stomachs of other mammals. pylori in the stomach is a contribut- ing the presence of this organism in the gastric mucosa and they help to explain why the pathogenic potential of H. pylori was accepted so reluctantly by much of the medical community. Although well over half of the world’s population is estimated to be infected by H. pylori relatively few of these individuals develop overt disease, while most gastric ulcers and cancers are associated with the presence of H. pylori. It is now known that the organism can colonise the stomach for many years, causing inflammation. In this respect it is similar to the syphilis spirochete and the leprosy bacillus, both of which produce a low-grade persistent infection. The persistent inflammation is thought to induce changes in the gastric mucosa leading to an increased turnover of cells. Cytokine production is induced by the inflammation and this damages the epithelial layer. Further evidence of the pathogenic role of the bacterium is afforded by the beneficial effects of antibacterial agents in the treatment of ulcers. It is clear from the above why the EHSG is a multidisciplinary group since studies on both the organism and the disease process are complex and involve many different scientific and medical disciplines. A major function of the Study Group has been in organising scientific meetings and educational meetings. Each year since its inception, the EHSG has held an international workshop, the first one being held in Bordeaux, France, in 1988 and the most recent one being held in Athens, Greece, in September 2002. The 16th workshop will be held in Stockholm, Sweden, in September 2003. The programme of the recent workshop illustrates admirably the range of topics covered, including as it does, microbiological subjects (metabolism, physiology, molecular genetics, virulence factors), epidemiology, inflammation and host response, gastritis, neoplastic diseases, ulcer diseases, paediatrics, animal models, digestive pathophysiology and clinical management. Details of the next and previous workshops can be found on the EHSG web page at www.helicobacter.org. In addition, the EHSG has held symposia at all ECCMIDs since 1989. A workshop was held in Prague in 1992 for scientists from Central and Eastern European countries. This field is always expanding and the EHSG is now examining the possibility of Helicobacter colonisation being involved in hepatobiliary disease. Various Helicobacter species have been shown to cause infection and inflammation of the liver and the bile duct in rodents, and in humans Helicobacter species may be implicated in a range of hepatobiliary diseases, including chronic cholecystitis, primary sclerosing cholangitis, gall bladder carcinoma and primary hepatic carcinoma. Some recent studies have indicated a positive link between the presence of Helicobacter species and liver carcinoma (1) or biliary cirrhosis (2) in humans. In these studies the presence of Helicobacter 16S rDNA was determined using PCR. The infecting species were found to be very closely related to H. pylori, but not identical.

A combination of bismuth, a proton pump inhibitor or an H2 antagonist, with at least two antibacterial agents (clarithromycin, metronidazole, tetracycline or amoxycillin) has been used to treat ulcers where H. pylori is sus-
expected or shown to be present. Resistance to some of the antibacterial agents used has now emerged in *H. pylori*, most noticeably to the macrolide clarithromycin, where resistance in vitro has been shown to reduce the effectiveness of the drug considerably. Resistance has also been noted to metronidazole, although this has a less marked impact on therapy. Resistance to amoxycillin is currently rare. In recognition of the importance of this area, the EHSG has carried out a European survey of resistance to antimicrobials among *H. pylori* isolates (3), the results of which were reported in 2001 and another study is planned. Those wishing to participate are invited to contact the secretary.

Another important aspect of the EHSG has been in producing guidelines and consensus papers. Examples are the guidelines published as the Maastricht 2002 consensus reports (4, 5), which considered the management of *H. pylori* infections. The first report (4) was published in 1997 and this was updated in 2000 to reflect progress and new insights into therapy (5). The reports are the culmination of meetings between specialists and experts from around the world, representatives from the national gastroenterology societies and general practitioners from Europe. In the second report the urea breath test or a stool antigen test is recommended for diagnosis and the case for eradicating *H. pylori* is made strongly for all patients with peptic ulcer, atrophic gastritis, low-grade gastric mucosa-associated lymphoid tissue lymphoma and for patients who are relatives of gastric cancer patients. Summaries of both reports can be found on the web site, which also has useful guidelines for the planning of clinical trials. Another example is the consensus statement emerging from the European Paediatric Task Force (6); this has had a major impact on the practices of doctors.

A major clinical study on the risk factors for atrophic chronic gastritis (the Eurohepygast Study) has recently been completed and the results are being published (7). In this study particular emphasis was placed on disease markers and premalignant conditions (atrophy and dysplasia). This was a three-year, multicentre, cohort study, which took place in 27 European centres. Patients included were aged between 20 and 75 and were attending outpatient gastroenterology clinics for non-ulcer dyspepsia. The main inclusion criterion was the presence of chronic gastritis demonstrated by biopsy. In addition, none of the patients had received ulcer treatment (antibacterials for *H. pylori*, bismuth compounds, proton pump inhibitors or non-steroidal anti-inflammatory drugs). This Study Group clearly is very successful and includes most of the leading experts in the world.

Pamela Hunter
Medical Writer

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**REFERENCES**

1. Detection of Helicobacter species in the liver of patients with and without primary liver carcinoma. Avenaud, Marais & Monteiro et al., Cancer 2000; 89: 1431

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**A Call for Clinical & Laboratory Guidelines**

ESCMID would like to take this opportunity to remind you that we welcome submissions of clinical and laboratory guidelines on a national or European level for publication on the ESCMID website. It is our goal to establish our homepage as a platform for the dissemination of relevant guidelines related to the diagnosis and management of infectious diseases. Please send contributions for publication to: info@escmid.org.
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 13th European Congress of Clinical Microbiology and Infectious Diseases in Glasgow.

Date and Time: Monday, 12 May 2003, 17:45 h – 19:00 h
Location: Room Carron, Scottish Exhibition and Conference Centre (SECC), Glasgow, Scotland, UK

The Agenda reflects the wide range of activities in which the Society is involved and also features the inauguration of Marc Struelens as the new ESCMID President. The Executive Committee is counting on your attendance and is looking forward to meeting you in Glasgow.

Yours sincerely,

Roger Finch, President

Agenda

1 Welcome (R. Finch)
2 President’s address and report (R. Finch)
3 Report of the Secretary General (S.R. Norrby)
4 Presentation of the ESCMID Research Fellowships (C. E. Nord)
5 Financial report of the Treasurer (A. Voss)
6 Acceptance of the accounts and formal approval (vote) (R. Finch)
7 Report of the Professional Affairs Officer, Clinical Microbiology (G. Cornaglia)
8 Report of the Professional Affairs Officer, Infectious Diseases (H. Giamarellou)
9 Report of the Chair of the EU Task Force (M. Struelens)
10 Report of the Scientific Affairs Officer (R. Hakenbeck)
11 Report of the Education Officer (C. Carbon)
12 Report of the Chair of the Publication Committee (C. E. Nord, R. Finch)
13 Report of the President of the 13th ECCMID (I. Gould)
14 Endorsement of the Executive’s Performance (vote) (R. Finch)
15 Any other business (R. Finch)
16 Inauguration of the new President (R. Finch, M. Struelens)

Announcements Concerning Clinical Microbiology and Infection (CMI)

• Emilio Bouza and the Deputy Editors in Madrid are retiring from active duty in April. Their formal term of office will end in December 2003.

• Kevin Towner, Nottingham, will handle the editorial affairs from April onwards and assume the role of Editor-in-Chief in January 2004.

• Carl Erik Nord has been appointed as Supplements Editor and is currently overseeing projects from Stockholm.

• A permanent Editorial Office has been established in Paris. Submissions and correspondence concerning CMI should be directed there as from April 1, 2003.

Judith Crane
CMI Editorial Office
39 Quai de Grenelle
75015 Paris, France

Phone: +33 1 47 64 11 59
Email: judith.crane@escmid.org

The new web-based system for online submission will go into effect in the summer of 2003. Please check the Blackwell and ESCMID websites (www.blackwell-science.com/clm and www.escmid.org) for updates and detailed submission instructions. When operational, the journal website will be: http://cmi.manuscriptcentral.com.

ESCMID Executive Committee
Manuscript submission on the Web

From 1 June 2003, Clinical Microbiology and Infection will accept manuscripts submitted online. Online submission will facilitate the editorial process and you will receive a decision on your paper sooner. You will need your files in an electronic format, an Internet connection, and a user ID and password for the site. To begin a new submission go to http://cmi.manuscriptcentral.com and Create a new account.

1. Log on to http://cmi.manuscriptcentral.com
   - Log on with your user ID and password. Click Author Centre and then Submit First Draft of a New Manuscript.

2. Choose manuscript category
   - Choose your article category from the drop-down list. Click Save and Continue to proceed.

3. Input affiliations
   - Add the institutional affiliations (a single affiliation can be used for several authors, so you only need enter each institution once).

4. Input all authors
   - Add the names of all contributing authors, choosing up to three affiliations for each. Only the corresponding author's e-mail address is needed.

5. Title, abstract & keywords
   - Copy and paste these from your document. Use the Character Palette to add Greek and other symbols.

6. Reviewer suggestions
   - Optional: choose up to four reviewers to suggest and/or two to exclude. Please note that the Editors are not obliged to accept your suggestions.

7. Cover letter
   - Either type directly or copy and paste your cover letter. The cover letter can also be uploaded with your manuscript files.

8. Upload files using the File Manager
   - Use the Browse button to select a file. Choose a designation from the list and whether it will be seen by reviewers. Click Upload to add your file. Repeat until all files are uploaded.

9. View ‘proof’
   - You must check the ‘proofs’ before submission. This will show you what Editors and reviewers will see. You can go back and replace incorrect files.

10. Submit
    - Click Submit once you are satisfied. An automatic confirmation with your manuscript number will follow. The progress of your submission can be tracked at http://cmi.manuscriptcentral.com

Don't forget to submit your revisions online. Log on to your Author Centre and locate the manuscript to be revised. Click View comments/respond to reply to reviewers and then click the manuscript title to submit your revised files.

From 1 April until 1 June 2003, please send submissions to the permanent Editorial Office in Paris.
Judith Crane, CMI Editorial Office, 39 Quai de Grenelle, 75015 Paris, France
Telephone +33 1 47 64 11 59, e-mail judith.crane@escmid.org / cmi@escmid.org
ESCMID Award for Excellence in Clinical Microbiology and Infectious Diseases 2004

The European Society of Clinical Microbiology and Infectious Diseases will present the ESCMID Award for Excellence in Clinical Microbiology and Infectious Diseases in the year 2004 to honour a senior scientist for his/her overall achievements in these fields.

PURPOSE
The purpose of this award is to recognise and reward an outstanding contribution to progress in clinical microbiology and/or infectious diseases.

AWARD
The award of EUR 10,000 will be presented by the ESCMID president at the 14th ECCMID 2004 in Prague. The recipient will be honoured at the occasion of a 45-min lecture to be given by the awardee. The name of the recipient will be published in the Final Programme, ESCMID News, Clinical Microbiology and Infection (CMI) and on ESCMID’s website.

ELIGIBILITY CRITERIA
Nominees for the award must be senior scientists who are professionally active and prepared to give a 45-min plenary lecture in their field of research during the 14th ECCMID. Members of the ESCMID Executive Committee or the ESCMID European Council are ineligible until 5 years after resignation.

NOMINATION PROCEDURE
All medical schools and institutions active in the fields of clinical microbiology and infectious diseases in Europe, ESCMID’s European Council, ESCMID members as well as ESCMID committees and study groups are asked to nominate candidates for the award. Each nomination should include:
- A biographical sketch of the nominee (maximum two pages, plus an abstract of 150 words).
- A summary and analysis of the nominee’s major contributions to research in the fields of clinical microbiology and/or infectious diseases.
- A list of the major original publications in refereed journals.
- The complete postal and e-mail address, phone and fax number, and a colour photograph of the nominee (on paper or electronically as tif, jpg or eps file).
- In addition, two letters of support from individuals outside the nominating institution should be mailed directly or with the nomination to the ESCMID Award Committee.

Seven copies of the nomination package must be received by 21 November 2003. The recipient of the award will be asked for a manuscript on the research field to which she/he mostly contributed for publication in CMI.

SELECTION PROCEDURE
The recipient will be determined by the ESCMID Award Committee. No correspondence beyond that necessary for the nomination will be accepted. Self-applications will not be considered.

Please send your nomination to:
ESCMID Award Committee
Hainbuchenstrasse 65
D-82024 Taufkirchen / Germany
Phone +49 89 612 6162
Fax +49 89 612 8176
Email birgit.menzemer@escmid.org
ESCMID Young Investigator Award for Research in Clinical Microbiology and Infectious Diseases 2004

The European Society of Clinical Microbiology and Infectious Diseases will sponsor in 2004 up to two ESCMID Young Investigator Awards for Research in Clinical Microbiology and Infectious Diseases to recognize outstanding research by younger colleagues in these fields.

PURPOSE
The purpose of these awards is to acknowledge excellence in research, and to stimulate further research at the highest scientific level.

AWARDS
The awards of EUR 7500 each, which should be used to support further research, will be presented by the ESCMID president at the 14th ECCMID in Prague on the occasion of a 20-min lecture to be given by the awardees on topics of their main field of research. In addition, the awardees are expected to write a review paper reflecting their field(s) of research for publication in Clinical Microbiology and Infection (CMI). The names of the recipients will be published in the Final Programme, ESCMID News, CMI and on ESCMID’s website.

ELIGIBILITY CRITERIA
Nominees for the award should be born on 1 January 1964 or after. Appropriate research may be based on laboratory investigations, clinical studies, experimental animal studies, or a combination thereof. Nominees must have been employed in a European laboratory or hospital or have a future appointment in one. Members of the ESCMID Executive Committee or the ESCMID European Council are ineligible.

NOMINATION PROCEDURE
Nominations must be received no later than 21 November 2003. They must be submitted in writing together with proof of the nominee’s age, and include a CV, a complete list of publications, and two supporting letters, including a specific description of the applicant’s present research and/or infectious diseases. Seven copies of all materials plus one colour photograph (on paper or electronically as tif, jpg or eps files) must be sent to the ESCMID Award Committee, who will select the recipients. No correspondence beyond that necessary for the nomination will be accepted.

Please send your nomination to:
ESCMID Award Committee
Hainbuchenstrasse 65
D-82024 Taukirchen / Germany
Phone + 49 89 612 6162
Fax + 49 89 612 8176
Email birgit.menzemer@escmid.org

ESCMID Research Fellowships 2003

The European Society of Clinical Microbiology and Infectious Diseases will sponsor the ESCMID Research Fellowships to support further research of young Society members in the fields of clinical microbiology and/or infectious diseases.

PURPOSE
The purpose of these awards is to encourage young investigators and to promote the development of research in the fields of clinical microbiology and/or infectious diseases.

FELLOWSHIPS
Up to five fellowships, each consisting of a cash award of EUR 5000 will be presented by the president of ESCMID at the Assembly of Members taking place during the 14th ECCMID 2004 in Prague. The names of the recipients will be published in the Final Programme, Clinical Microbiology and Infection (CMI), ESCMID News and on ESCMID’s website.

ELIGIBILITY CRITERIA
Awards will be made on the basis of a detailed research plan to be part of the application. Eligible individuals should not be more than five years beyond their training as post-doctoral students or fellows. Appropriate research may be based on laboratory investigations, clinical studies, experimental animal studies, or a combination thereof. Research must be carried out in a European research laboratory or department. If there are collaborators, applicants must make clear their personal role in planning, undertaking and supporting the planned project. Members of the ESCMID Executive Committee or European Council are ineligible.

APPLICATION PROCEDURE
The deadline for submission is 21 November 2003. Applications must be submitted in writing with a CV, a list of publications, and two supporting letters, including a specific description of the applicant’s present research and a detailed research plan. Applicants must include their complete postal address, phone and fax number and send four copies of all materials plus one colour photograph (on paper or electronically as tif, jpg or eps files) to the ESCMID Award Committee, who will select the fellows. No correspondence beyond that necessary for the application will be accepted.

Please send your application to:
ESCMID Award Committee
Hainbuchenstrasse 65
D-82024 Taukirchen / Germany
Phone + 49 89 612 6162
Fax + 49 89 612 8176
Email birgit.menzemer@escmid.org
AstraZeneca / ESCMID Research Grant 2003

Turning the Tide of Resistance

The European Society of Clinical Microbiology and Infectious Diseases (ESCMID) and AstraZeneca are proud to announce the recipient of the USD 50,000 research grant for research in the field of antibiotic resistance. The grant was announced under the logo Turning the Tide of Resistance during 12th ECCMID 2002 in Milan. The recipient selected by the ESCMID Award Committee is:

Dr Alex van Belkum
Erasmus University Medical Center
Rotterdam, The Netherlands

He was selected for his project on:
Phylogenetic Background and Virulence Profiles of Fluoroquinolone-resistant Escherichia coli Isolates from Two Human Populations in Java, Indonesia

We would like to congratulate him on this success.

ESCMID Award Committee

Escherichia coli were first described in 1885 by the Austrian physician Theodor Escherich. They are widespread in nature as well as being useful inhabitants of the human intestine. Some E. coli strains have been adapted so completely to laboratory conditions that they have lost their ability to live in the human gut. Other strains have acquired virulence factors which render them pathogenic, especially if extra-intestinal. Combined with fluoroquinolone-resistance genes they have become a serious health problem in several countries. Alex van Belkum is investigating the genetics of such E. coli strains from Java, Indonesia, and the Netherlands as a basis for improved strategies to prevent their further spread.

Member Spot

Michal Holub

Michal Holub, MD, is a board certified infectious diseases (ID) specialist who works as an assistant professor of infectious diseases in First Faculty of Medicine of Charles University in Prague, Czech Republic. In the March 2003 issue of CMI the article: “Lymphocyte subset numbers depend on bacterial origin of sepsis”, was published under his name.

OF WHAT DOES YOUR DAILY WORK MAINLY CONSIST?
My daily work consists of teaching medical students (lectures and bedside training) and conducting scientific work in the cell immunology laboratory. Also, I have clinical duties in the ward and clinic with infectious patients.

WHAT PART OF YOUR WORK DO YOU MOST ENJOY?
I mostly enjoy the scientific part of my work, especially when we have interesting results that have to be explained.

WHO HAS INFLUENCED YOU THE MOST PROFESSIONALLY AND WHY?
Since I have decided to do science after obtaining my clinical degree, I have been recently very much influenced by my mentor Dr. David A. Lawrence from the Wadsworth center (Albany, NY, USA), where I was doing my laboratory training in infectious diseases. He has showed me holistic principles of medical science.

WHAT WOULD YOU ALSO LIKE TO DO IF YOU HAD NOT HAD THE CHANCE TO ENTER YOUR CURRENT PROFESSION?
If I could not have entered my current occupation, I would have been a writer. Unfortunately, I spent part of my life in a country with a communist regime,
which taught me an important lesson
about conscience and the role of writers.

OUTSIDE OF YOUR OWN
SPECIALITY WHAT DO YOU THINK
IS THE MOST EXCITING FIELD
OF SCIENCE AT THE MOMENT?
I am excited by advances in molecular
and cell biology. I think that these two
fields will bring us novel treatment for
many fatal diseases like cancer and
HIV/AIDS.

WHAT DID YOU ALWAYS WANT
TO KNOW?
From my adulthood on I have been
questing ethical principles of life.

WHAT IS THE PASSION OF YOUR
LIFE APART FROM YOUR PARTNER?
I am enjoying learning new things. The
two years that I spent working and living
in the USA was an excellent opportunity
to train this flexibility.

IF YOU COULD CHANGE ONE
THING IN THE WORLD, WHAT
WOULD IT BE?
In the last decade, I was shocked by the
violence resulting from war conflicts and
by war crimes against civilians such as
those that occurred in Rwanda or Yu-
goslavia. If I could do something to make
the world less violent, I would do it.

WHAT WAS THE WORST/MOST
MEMORABLE COMMENT YOU
EVER RECEIVED FROM A
REFEREE?
I had one memorable comment regard-
ing an experimental model of endotoxin-
induced sepsis and acute lung injury.
The referee surprised me by a detailed
knowledge of flow cytometric analysis
of intracellular cytokines of alveolar
macrophages in mice.

WHAT IS THE ONE THING ABOUT
SCIENCE THAT YOU WISH THE
PUBLIC UNDERSTOOD BETTER?
The public could be sometimes more pa-
tient while waiting for concrete results. I
would like people to understand better
that science takes time although this
pressure is healthy for shifting science to
practical aspects.

Dr Martin Wood died unexpected-
ly last December. He was 57 years
of age and was in the final year of his
Presidency of the British Society for
Antimicrobial Chemotherapy - a Soci-
ety to which he had given loyal serv-
vice for more than 20 years. As Presi-
dent of the BSAC he will be remem-
bered for his energy and skill in pro-
moting its aims and objectives both
nationally and internationally. Prior
to this he had been an outstanding Ed-
itor-in-Chief of the Journal of Anti-
microbial Chemotherapy for the period
1995-2000. During that time the Jour-
nal grew in stature to its pre-eminence
as the leading European journal in its
field. He was particularly keen to sup-
port manuscript submissions in the
area of antiviral chemotherapy, which
was an area professionally and scien-
tifically close to his heart.

As a Consultant in Infectious Diseases
he was highly respected for his knowl-
edge, wisdom and advice, which he
willingly gave to individuals, profes-
sional societies, governments and in-
dustry. He was a good lecturer and his
talents were widely sought. He could
prove tenacious in arguing a particular
point where his opinions were careful-
lly martialled and admirable for their
sound basis. This characteristic was
also brought to good effect in his doc-
toring where he practised the art as
well as the science of medicine for the
benefit of his patients.

As Senior Clinical Lecturer his re-
search and publications output was
prodigious and often in cutting edge
journals. In particular, he was an au-
thority on the management of herpes
virus infections. He was co-author of
‘Neurological Infections’ and an ‘Atlas
of Infectious Diseases’, which were
both well received.

On a personal note he was always
good company, witty and entertain-
ing. He will certainly be missed, but
his legacy lives on. His contribution to
ESCMID’s European Council was ap-
preciated. On behalf of the member-
ship and Executive every sympathy
has been transmitted to the BSAC and
to his wife Stephanie and their sons, as
they come to terms with this tragic and
unexpected loss.

Roger Finch
President

Martin Wood – a tribute
New ESCMID Study Group on Toxoplasmosis

ESCMID is pleased to announce the establishment of the ESCMID Study Group on Toxoplasmosis (ESGT), which will hold its inaugural meeting during the 13th ECCMID, Glasgow, May 12, 12:15-13:30, Orkney Suite, Moat House Hotel. This meeting will be led by the Steering Committee Chairperson, Birgitta Evengard.

Toxoplasma gondii has a worldwide distribution and causes chronic infection in more than a billion persons. Much knowledge has been gained on the biology of Toxoplasma gondii, however both the laboratory-based doctor and the clinician are still lacking much necessary information regarding its effects on persons with an impaired immunodefense. In immunocompromised patients, toxoplasmosis is usually a result of reactivation of latent infections but it can also be transmitted through blood or blood products and transplanted organs. Immunocompromised patients may have serious sequelae. To our knowledge the brain is most frequently affected and specific treatment is indicated in these patients. Initially the activities of the group will be focused on toxoplasmosis in immunocompromised patients. There will be a focus on outputs, e.g. a Europe-wide recommendation on diagnostic strategies for investigation of toxoplasmosis in the immunosuppressed and immunocompromised patients. At a later stage, developing recommendations for treatment would be a possible goal for the group. Initiatives to improve diagnosis, e.g. a Europe-wide quality assurance scheme for PCR, would be welcomed and supported. If you are interested in becoming involved with the new study group, please contact Birgitta Evengard (birgitta.evengard@labmed.ki.se) or attend the above mentioned inaugural meeting.

The Resurgence of Streptococcal Infections
Remembering Ignaz Semmelweis

In the light of our Society’s commitment to the development of the infection disciplines in the Central and Eastern European countries, ESCMID has granted its patronage to the Semmelweis University of Budapest, Hungary, for organising a one-day meeting on “The resurgence of streptococcal infections”, to be held on October 10, 2003 in Balatonfüred, which coincides with the International Congress of the Hungarian Society for Microbiology. The meeting will be held to remember and honour the great Hungarian scientist Ignaz P. Semmelweis and his pioneering studies on childbed fever, and will celebrate the 55th anniversary of the local Institute of Medical Microbiology and the 50th anniversary of the Hungarian Society for Microbiology.

For further information please contact:
Ferenc Rozgonyi, Semmelweis University, Institute of Medical Microbiology, PO Box 370, H-1445, Budapest, Hungary, Phone/fax +36 1 210 2959, E-mail rozfer@net.sote.hu

Giuseppe Cornaglia, Dipartimento di Patologia, Università degli Studi di Verona, Strada Le Grazie, 8 37134 Verona, Italy, Phone +39 45 8027196, Fax +39 45 584606, Email giuseppe.cornaglia@univr.it
Training Course in Hospital Epidemiology

25th ESCMID Postgraduate Education Course

Antalya, Turkey, November 5–9, 2003

This course is co-organised by the Society for Healthcare Epidemiology of America (SHEA) and the ESCMID Study Group on Nosocomial Infections (ESGNI).

The course comes in a basic and an advance module. The objectives of both modules are similar, albeit at different levels of depth: to get an overview of the major techniques and methods used in hospital epidemiology and resistance surveillance, to be able to manage and control nosocomial pathogens and resistant diseases in the healthcare setting and to discuss recent surveillance data.

For further information please consult the ESCMID website (www.escmig.org), Courses & Workshops or www.hosp-epi-course.org

The Role of Clinical Microbiology in Managing Community-Acquired Infections

26th ESCMID Postgraduate Education Course

Smolensk, Russia, December 12–14, 2003

Jointly organised by:
ESCMID Study Group on Antimicrobial Resistance Surveillance (ESGARS) and the Interregional Association for Clinical Microbiology and Antimicrobial Chemotherapy (IACMAC)
Supported by: Alliance for the Prudent Use of Antibiotics (APUA), Russian and Italian Chapters

For further information, please contact:
Dimitry Galkin, MD or Olga Stetsiouk, MD, Institute of Antimicrobial Chemotherapy (IAC), Smolensk State Medical Academy, PO Box 5, Smolensk 214019, Russia
Phone +7-812-611327 or +7-812-611301, Fax +7-812-611294, Email galkin@antibiotic.ru or see the ESCMID website at www.escmid.org, Courses & Workshops
Dear Colleagues

It is with great pleasure that we invite you to Scotland for the 13th European Congress of Clinical Microbiology and Infectious Diseases (ECCMID). The ECCMID has rightly secured its place as the premier scientific congress in its field and we are confident that Glasgow will maintain this scientific excellence while giving you the opportunity to sample the renowned Scottish hospitality, marvellous scenery and a European city of culture.

The scientific and organising committees have put together a truly exciting and innovative programme which reflects the latest advances in basic sciences, clinical microbiology, diagnostics, infectious diseases, antimicrobial chemotherapy, infection control and epidemiology. In addition, we are planning several innovations in the way data is presented at ECCMID including poster walks, a European network corner, educational updates and literature reviews.

On the cultural side, Glasgow has famously developed from a major industrial city and sea-port of the British Empire into a modern European city of cultural significance and a major shopping hub (second only to London). Yet it has retained most of its impressive Victorian architecture and has many fascinating historical sites as well as numerous art galleries and museums. While Scottish weather is not always ideal, May is the driest month and spring will be in the air.

We are confident that ECCMID in Glasgow will be scientifically, culturally and socially rewarding and that you will return home with new ideas, new friendships, rekindled old friendships and a determination to return to Scotland in the future to further experience its renowned hospitality.

We are looking forward to welcoming you in Scotland,

Dr. I. Gould
President 13th ECCMID

Prof. R. G. Finch
President of ESCMID
ESCMID Initiative for a European Public Affairs Programme

Infectious disease threats are high on the political agenda. As the Severe Acute Respiratory Syndrome (SARS) spreads across the globe, there are increasing public expectations about European capacity to prevent and control communicable disease epidemics and tackle the erosion of therapeutic options by antimicrobial drug resistance. The ever-increasing influence and decision-making power of the European Union in the field of health has led to a gradual shift of focus from a national to a European level when it comes to influencing legislative and policy processes. With the increased competence of the European Commission in the field of health resulting from the Amsterdam Treaty, and the current discussions on the European Convention which might further extend this competence, it is imperative for European organisations with interests in the field of health to engage in dialogue with key decision-makers in the EU institutions in order to make their voices heard. More specifically, the different initiatives undertaken by the European Union in the field of infectious diseases and antibiotic resistance, such as the Network on Communicable Diseases and the Council resolution on the prudent use of antimicrobial agents in human medicine, have demonstrated the need for ESCMID to engage in an active partnership with key EU decision-makers to contribute to these developments and ensure the input of ESCMID and its members in any future initiatives.

To this end ESCMID has decided to embark on a public affairs campaign and establish a dedicated EU Task Force. In partnership with Interel, a leading Public Affairs company based in Brussels, a strategic plan was developed outlining the priority areas and objectives of the campaign. As the European Union is a complex web with responsibilities and issues spread amongst a variety of different bodies and directorate-generals, the first step in identifying the opportunities for ESCMID was to carry out an extensive Community Audit. On the basis of this audit, the following strategic priorities have been identified:

– Building trust and relationships through an EU meeting programme, which addresses issues such as a European Centre for Disease Control, recognition of professional qualifications, and 6th Framework Programme for research
– Identifying opportunities for funding and participation in the new Health Action Programme and the 6th Framework Programme
– EU representation and monitoring.

Even at this early stage of the implementation of the Public Affairs programme, the EU Task Force feels strongly that the initial results can already be felt. ESCMID’s contacts with key EU decision-makers are constantly expanding and deepening. For example, ESCMID has taken a constructive stance and is actively involved in the discussions on the creation of the European Centre for Disease Control and is also aiming to actively participate in the development of a proposal for such a centre. Furthermore, ESCMID and DG Research will co-organise a conference on Antibiotic Resistance Research, which will be held under the auspices of the Italian Presidency in November of this year. Other outreach activities are being undertaken in the area of the recognition of professional qualifications and education. An International Workshop will be organised next year to review progress in

Treatment Failure in HIV-Infected Patients Receiving Antiretroviral Therapy

23rd ESCMID Postgraduate Education Course

Enghien-les-Bains, France, September 4–6, 2003

This course is offered to MD specialists in infectious diseases (or in the process of graduating) who would like to acquire expertise in the evaluation and clinical management of HIV infection.

For further information please contact:
Karine Grange, Nex&co M Santé RP Congrès,
27–29 rue des Poissonniers, 92522 Neuilly sur Seine Cedex, France
Phone +33 1 46 43 33 35, Fax +33 1 46 43 33 34,
Email Nexcom1.rpcongres@wanadoo.fr

or see the ESCMID website at www.escmid.org, Courses & Workshops.
education and training in the field of clinical microbiology and infectious disease as well as models for the management of infection. A healthy and prosperous Europe will be built as much by initiatives from its citizens as by complex multicountry political negotiations. ESCMID endeavours to foster the role of professionals in leading the development of the best healthcare practice and scientific guidance of disease prevention and treatment strategies. In order to keep all ESCMID members informed of the developments and opportunities on the EU level, we are planning to dedicate a special section of the ESCMID website to the public affairs programme, which will allow for your input and feedback with the hope that you will benefit from this new programme.

Marika Konings
Interel
Marc Struelens
ESCMID President-elect

ESCMID and EU DG Research to co-organise a Conference in Rome, November 2003

European Conference on Antimicrobial Resistance

Invitational EU Conferences have been organised during several EU presidencies to discuss the problem of antimicrobial resistance, namely:

- The Microbial Threat (Copenhagen, Denmark, 9–10 September 1998)
- European Conference on Antibiotic Use in Europe (Brussels, Belgium, 15–17 November 2001)

A new “European Conference on the Role of Research in Combating Antimicrobial Resistance” is now planned during the Italian EU Presidency from November 28–30, 2003 in Rome. The conference will be co-organised as a joint initiative between the European Commission (DG RTD) and ESCMID under the patronage of the Italian Government and will be officially announced at the 13th ECCMID in May 2003 in Glasgow.

DG RTD and ESCMID will directly invite up to about 70 participants, including executive officers, chairpersons of Study Groups involved in the field, leading experts, recipients of recent ESCMID awards and active members from Western and Eastern Europe; DG RTD will also invite Member States and Associated States to appoint up to 2–3 delegates to participate (at their own cost); individual applications for attendance (maximum of 70-80); tentative registration fee: 900 EUR for non-profit organisations; 1400 EUR for commercial companies) will be also possible. The conference will focus on the problem of anti-bacterial resistance and human health, addressing both basic and clinical research. Its main objectives will be:

1. to clarify the state of research and its priorities in fields where discussion is particularly needed, namely: microbial ecology, mechanisms of resistance, genomics and new molecular targets for antibiotics;
2. to identify the areas which are most suitable for research in Europe (at the EU level as well as at the national level) and most likely to impact the problem of resistance in human bacterial pathogens;
3. to stimulate partnership building across public/private/government for future research initiatives;
4. to identify ways to overcome bottlenecks in European research, such as decreasing industrial incentives for R&D into new antibiotics, to discuss IPR issues and implementation of research results into clinical practice;
5. to increase the visibility of antibiotic research among scientists, clinicians, politicians and the general public;
6. to contribute to the establishment of a European Research Area (ERA) in this field.

Further information about the scientific programme and registration will be published on the ESCMID website at www.escmid.org.
Infantile Paralysis: Will we Succeed in Eradicating Poliomyelitis?

Someone who has driven a car through the cities of Nairobi, Manila or Caracas is familiar with the shocking images, beggars with matchstick-thin arms and legs at traffic lights asking for handouts. They lean on handmade wooden crutches or sit in primitively constructed wheelchairs, and frequently their extremities are twisted in such a way that they can only creep forward. The handicapped wear thick supports from old car tires under their knees and elbows. In younger years they had all fallen victim to a plague, which has accompanied mankind since biblical times, poliomyelitis.

In 1988 the General Assembly of the World Health Organization (WHO) decided to exterminate polio and to wipe out all traces of the pathogen from the face of the earth. This would prevent children from becoming severely crippled for life as a result of the disease. The circumstances for this ambitious undertaking were good. As was also the case for smallpox, there was an excellent vaccine. In addition the poliovirus has a specific relationship to its host: it can strike only humans. An animal reservoir, in which the pathogen can survive, as for example with the influenza virus, is not known.

Indeed, the extermination campaign turned into a success story. Several billion children were vaccinated (575 million in the year 2001 alone) and the number of polio cases dropped in the course of a decade from 350,000 to approximately 2000: a decrease of approximately 95%. In 1994 the American continents were declared to be polio-free zones and six years later the Pacific area as well as Eastern Asia. Originally polio was found in 125 countries. By the year 2000, it occurred in only 20 states.

According to the recent report from the Polio Eradication Initiative, there are at present only ten countries where there is a risk of contracting polio. Five of these are categorised as high transmission-risk countries (India, Afghanistan, Pakistan, Niger and Nigeria) and five as low transmission-risk (Ethiopia, Somalia, Sudan, Egypt and Angola). In the past years wild-type viruses from endemic areas were imported to Bulgaria, Georgia, Mauritania and Zambia. However, a renewed spreading of these wild-type viruses could be prevented by mass vaccination.

The ambitious goal to eradicate poliomyelitis by the turn of the century was not met. Approximately 540 cases were reported to the WHO in 2001. The Polio Eradication Initiative has thereupon set December 31, 2005 as a deadline for the extermination of the pathogen.

Despite such impressive reports of success, two of the following examples show that it is not “smooth sailing”. In March 2000, a 13-year-old Roma girl in the city of Burgas, Bulgaria contracted a case of acute flaccid paralysis (AFP). Four weeks later and 70 kilometres to the west another Roma child got sick, likewise with indications of acute poliomyelitis. Four weeks later another case of polio appeared in Burgas.

None of the affected children was vaccinated. Because poliomyelitis had not been encountered in Bulgaria since 1991, the health authorities were extremely alarmed. Laboratory tests showed that in the three cases the so-called wild poliovirus type 1 was responsible for the illness. A gene sequencing of the isolate revealed a real phenomenon: the virus from the three Roma children was almost identical to a polio strain, which was identified one year previously in the Indian federal state of Uttar Pradesh. How did the pathogen get to Eastern Europe from Northern India?

It is conceivable that members of another Roma family were infected by the poliovirus on a journey through India and brought the virus into Bulgaria. Since Roma children frequently “slip through the cracks” of national vaccination campaigns, it was only a question of time, until an unprotected child was infected with the pathogen from Uttar Pradesh.

A second event also caused the WHO’s plan to come unhinged. Suddenly and unexpectedly 2000 children and adolescents on the island of Hispaniola acquired AFP in July 2000. Within a few months many dozen cases in the Dominican Republic as well as in the neighbouring country of Haiti amassed. Stool tests, which were carried out by virologists in the Center for Disease Control in Atlanta, USA, showed that the virus was 98% identical to the virus, with which the island’s population had been vaccinated in 1998.

Figure 1. Children being immunized in New Delhi streets
Source: Marcel Crozet/OMS
The presumed explanation: in at least one vaccinated person, most likely someone with a compromised immune system, the vaccine virus mutated and thereby regained its virulence, which had been “debred” through many years of undergoing cell cultures. Since the Dominican Republic and Haitian governments had been vaccinating fewer persons from year to year due to the costs, a generation was growing up, in which only the minority was protected from polio (characteristically the cases of vaccine-associated poliomyelitis occurred in exactly those municipalities where the rate of mass vaccination totalled less than 40%). One person releasing the mutated viruses undetected over a period of several months was sufficient to bring the fatal cycle back on course. A similar course of events in the Philippines proves that this rather improbable seeming process is not an isolated case.

Geneva estimate the cost of eradicating the poliovirus worldwide by 2005 to be approximately a billion US dollars. National monitoring of poliomyelitis also needs to be optimised, since again and again there are difficulties determining in the ten problem countries which cases of AFP are caused by poliovirus and which have another neurological cause.

Hermann Feldmeier

Box 1
The poliovirus is a faecal-orally transferred entero-virus, which typically strikes the intestinal-tract mucosa. In 2% of the cases this affliction leads to diarrhoea and in only 0.2–0.5% the virus enters the central nervous system and causes paralysis. That means, for every case of polio there are 200 to 500 persons, who are overlooked, because the infection takes its course in the absence of the typical symptoms. The carrier excretes poliovirus with the stool, which can lead to the infection of dozens of other persons under poor sanitary conditions. If the immune system is compromised, as is often the case in developing countries, then the pathogens are often excreted for many years through the intestinal tract.

Box 2
When is a country officially polio-free? Countries must fulfil three criteria to be certified by the WHO as free of poliomyelitis:
1. All cases of flaccid paralysis in persons under 15 years of age (which can have very different etiologies) must be reported to the WHO in Geneva.
2. Within two weeks of initial reporting two stool samples must be sent to a reference laboratory for each case of flaccid paralysis.
3. Over a period of at least three years the stool samples must be completely absent of wild-type poliovirus.

Box 3
The problems of surveillance faced by poor countries in eradicating poliomyelitis are best demonstrated by looking at India. In the year 2000, 8103 cases of acute flaccid paralysis (AFP) were reported. Only AFP cases in which wild poliovirus can be isolated from a stool sample are classified as confirmed poliomyelitis. Of 8103 cases, 265 fell into this category. For 6280 cases of AFP, two stool samples were available and found negative. These cases can be discarded as non-polio-AFP. However, 1558 cases without adequate stool-samples remained. Follow-up examination of these patients showed no residual weakness in 559 cases, and were also discarded as non-polio-AFP. 999 cases remained which had to be individually analysed by a national expert committee. Of these, 362 were considered compatible poliomyelitis cases rendering the total number to 637. This indicates that the existing surveillance system correctly identified only about 40% of the true poliomyelitis cases occurring in India.
Postscript on Post Polio Syndrome

A ll epidemics of global proportion leave in their wake a set of circumstances that manifest in different ways, at different moments. Although the recognition of a psychological impact is often long-delayed, and social or political repercussions evolve over time to become a part of history, debilitating physical consequences rarely appear after such a prolonged absence of symptoms as those that afflict the survivors of paralytic poliomyelitis. While much of the world considers polio a disease of the past and the WHO is speaking in terms of eradication, many individuals who were infected with the poliovirus decades ago are now encountering a complex of specific symptoms known as post polio syndrome (PPS).

The prevalence of PPS is reported differently, but all sources agree that a great number of individuals are affected – several claiming as many as fifty percent of polio survivors, a population estimated at 1.6 million during the 1990s. A report from Norway in 2001 stated that a total of 23,000 cases of acute poliomyelitis were registered in that country during the course of the twentieth century and gave an estimate of as many as 10,000 survivors afflicted with PPS at that time. In 2002, statistics from Germany indicated that 80,000 survivors were still living forty years after the last epidemics in Germany, forty to seventy percent of whom have developed PPS.

Because the syndrome is difficult to diagnose and validate, these figures most likely represent an underestimation of the actual prevalence of PPS. It generally manifests after a period of functional and neurological stability of at least fifteen years beyond the initial episode of poliomyelitis. The onset is not obvious, even to the one afflicted, and has been described as insidious – as though the symptoms have been lying in wait since the acute phase. The slowly progressive nature of the phenomenon also contributes to the difficulty in diagnosis, as does the occurrence of periods of stability which vary in length from three to ten years. Finally, and frequently only after the exclusion of other medical, neurological, orthopaedic or psychiatric diseases that may account for the new symptoms, each symptom requires several differential diagnoses. The cluster of symptoms includes new muscle weakness, excessive fatigue and intense pain in muscles and joints resulting in decreased endurance and diminished function. Less commonly these symptoms include cold intolerance and atrophy in the limbs, the bulbar or the respiratory muscles, leading to difficulty with breathing or swallowing. The symptoms can be categorized as either neuromuscular symptoms, presumably caused by progressive deterioration of motor neurons, or musculoskeletal symptoms, caused by prolonged overuse of the muscles affected during the episode of paralysis. The combination of motor unit remodelling and direct mechanical damage results in the increased weakening of individual muscles. When several muscles are affected, and the postural limb strategies used by the patient are no longer able to compensate for the loss of muscle strength, generalised weakness results and becomes apparent clinically.

Although there is now agreement among researchers concerning degenerative changes within motor units, there continues to be speculation about the mechanism(s) responsible for triggering these changes. A favoured theory to explain the onset of PPS is related to the death of individual nerve terminals in the motor units that remain after the initial attack of polio. This deterioration of individual nerve terminals might be an outcome of the recovery process from the acute polio attack. During the recovery process, an effort to compensate for the loss of motor neurons, surviving neurons sprout new endings to restore function to muscles. This results in large motor units that may add stress to the cell body. As a result of this rejuvination, the individual may have normal-functioning muscles for some time. But after a number of years, the motor neurons with excessive sprouting may not be able to maintain the metabolic demands of all their new sprouts, and a slow deterioration of individual terminals may result.

The NIH clinical description in 1995 defines the “evolution of a subclinically ongoing motor neuron dysfunction...clinically manifested as PPS when the well-compensated re-innervating process crosses a critical threshold beyond which the remaining motor neurons cannot maintain the innervation to all the muscle fibres within their motor unit territory”. However, other theories to explain the triggering mechanisms for motor unit degeneration have been proposed. These include: scarring within the spinal cord that decreases blood supply to motor nerve cells; environmental toxins that damage polio-involved motor nerve cells at exposure levels lower than those which affect normal cells; an immunological abnormality that may be triggered by re-exposure to live polio virus or by reactivity to persistent viral fragments in the spinal cord; and the implication of yet unknown infectious microorganisms.

In light of the uncertainties that still exist, the continuing interest in PPS as a topic of research is not surprising, nor are the numerous articles that aim to ‘educate the practitioner’. Many authors maintain that it is the patients themselves who are in the best position to educate professionals about the symptoms they are experiencing. A concurrent branch of research focuses on these symptoms and the changes in lifestyle necessitated by them. The scope of such studies is broad, ranging from coping techniques, as addressed in a recent study from Sweden, to work-place accommodation, as addressed by a study done in Japan. To some extent, such studies are the result of a quest on the part of polio survivors to maintain the quality of life they have enjoyed since their original bout with the virus. They have survived an epidemic and now, living in its wake, they have established an extensive support system among themselves. Characteristic of such groups, they see themselves as survivors rather than victims. Their refusal to accept misdiagnoses from the medical community has led to the establishment of PPS as a clinical entity and the questions they pose continue to challenge the research community.

Judith Crane
Letter to the Editor

The European Centre for Infectious Diseases: a project for Europe’s needs and historical mission

Sir- I read with great interest your forum article: “Surveillance in Europe: a need for a European Centre?”. In the framework of this debate, I have argued that current European action in disease research and control rather lacks coordination – like an orchestra with no conductor (1–6). The cure for this distressing situation is to create a centralized institution similar to the US Centers for Disease Control and Prevention (CDC). This proposal has been named: “European Centre for Infectious Diseases” (ECID; see http://cepm.mpl.ird.fr/ecid/index.htm). It has a scientific board of more than 30 renowned scientists, with a steering committee that includes Santiago Mas Coma (University of Valencia, Spain), Jean-Claude Pifferetti (Istituto Cantonale di Microbiologia, Bellinzona, Switzerland), Marc Struelens (Erasmus Hospital, Brussels, Belgium) and myself.

This proposal has created abundant commentaries (7–12). It has been opposed by arguments preferring a more virtual concept, that is to say: a better use of existing structures through electronic networking (13, 14). But the two concepts are not incompatible. Even if the solution of a centre with bricks and mortar is retained, it would be complemented by outstations and corresponding centres connected through the internet (3–6).

Until recently, the ECID concept seemed to be “politically dead” (15), since the European Parliament had opted for the network concept (16, 17). However, the bioterrorism threat has turned minds in a different direction. The concept of a centralized structure is now more accepted (18), including by the European Commissioner for Health, David Byrne (19). But even if these latest proposals go in the right direction, I consider that they will not be an adequate response to the threats of bioterrorism or, more particularly, major epidemics. They merely propose a “slim” central structure of disease surveillance (similar to the French Institut National de Veille sanitaire, but at a European scale) to coordinate the various surveillance networks already operating. This is wise, since the concept of networks with no head is nonsense. But limiting our ambitions to such a shy project would make us miss a unique historical opportunity to found a much more visible and efficient structure. The ECID project includes not only global surveillance (respecting national sovereignties), but also ambitious research programmes and training activities. The USA has immense ambitions for biomedical research, especially in relation to infectious diseases. The budgets of the National Institutes of Health and of the CDC have been recently boosted toward reaching these goals. By comparison, not only is the European effort much more limited, but also research activities in Europe are currently split into hundreds of national structures with limited interaction, or even worse, unwelcome rivalries. Each nation cannot afford separately the vast investments demanded by powerful new technologies (20). If we want to reach critical sizes matching the US approach, this can be achieved only through a parallel European structure.

We have to do for communicable diseases what has been achieved for particle physics by CERN (European Centre for Particle Physics) – although programmes on infectious diseases will always remain much less costly than particle physics. In order not to compete with the national structures (subsidiarity principle), the scientific programmes of disease research and surveillance should go in two main directions: (I) holistic, multidisciplinary programmes (20) relying on costly megatechnologies (massive sequencing, satellite detection, bioinformatics), that are difficult to afford at the national levels (e.g. the massive efforts to sequence the genome of many pathogens). Such studies currently remain typological and concern only one strain, whereas European collaboration could give these programmes the populational dimension they lack. Similarly, an infectious disease-oriented Human Genome Diversity Programme (IDHGDP) could be launched to comple-
ment the general HGDP recently started (21). (II) At the other extreme, the ECID could be a refuge for vanishing savoir-faire that is essential in studying the epidemiology of infectious diseases, but currently neglected by young, ambitious scientists, for the reason that they do not generate high impact factors. I am speaking for an example of medical entomology. We risk having a complete generation of “molecular idiots” unable to distinguish a mosquito from a phlebotomine sandfly without the help of a molecular probe.

A further dimension not fully considered by the recent proposals (18, 19) is to develop privileged links with medical professionals and scientists from developing countries (22). “Microbes ignore borders” (1) – so if we want to control infectious diseases in Europe, we have to do it in the endemic regions, because massive human migrations from these areas will undoubtedly be a growing phenomenon of the 21st century.

Lastly, the ECID will be the ideal place to develop specialized training activities to give rise to a new generation of epidemiologists inured to the more modern technologies thanks to daily interaction with researchers. The very recipe of a successful centre will be continuous cross-fertilization between research, surveillance/control and training – three activities that are too often separated. And considerable economies could be obtained by sharing in the three activities facilities such as conference rooms, computers, etc.

I do not buy the argument that it would be difficult to staff such a structure (23). Was CERN difficult to staff? In addition to existing European expertise, a huge human resource could be made available from Eastern Europe, not only the candidate countries, but also the former USSR. These countries constitute an immense reservoir of expertise that is underemployed due to their national economical difficulties. The ECID could be an opportunity to make available from Eastern Europe, instead of crossing our arms expecting that we honor this historical commitment to give rise to a new generation of young, ambitious scientists, for the very same reasons.

Infectious diseases are not a video-game. The difference between an efficient structure and too shy a project is simply thousands or tens of thousands of human lives. This is the very responsibility that must face supporters of money savings and of limited projects. Twenty-five countries, among the richest in the world, can afford the ECID. Our partners from the South are expecting that we honor this historical mission, instead of crossing our arms in front of the disasters called tuberculosis, AIDS and malaria that are devastating their countries, without speaking of sleeping sickness, meningitis and others.

Since the initial proposal (1-3), six precious years have been wasted. I believe more in the threat of major epidemics than in bioterrorism, although the latter must not be neglected. But when major epidemics are considered, all the ingredients for a disaster such as the Justinian plague are here: climatic changes, massive migrations, antibiotic and insecticide resistance. Mad cow and foot-and-mouth disease are only warning coughs. When the “big one” comes, it will be too late to build the ECID.

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The following is the second part of the article printed in ESCMID News 3-2002.

ALEXANDER SKRIABIN
At the age of 23 Alexander Skriabin (Fig. 5) suffered from severe tendon inflammation of the right hand due to complete overexertion as a pianist. He was desperate. He thought that his life as a pianist and therefore also as a composer would soon come to an end. That is why he composed deeply grieving, touching, painful music for the left hand which moves to tears. Yet fate had mercy on him and the inflammation subsided so that he was able to create the great work we can refer to today. He was one of the first to break through the walls of tonality and dissolve the major-minor principle during his life as an artist. Like no one else he prepared the ground for modern music. He is perhaps the greatest musical innovator and visionary around the turn of the century.

Alexander Skriabin was born on December 25th, 1871 – thus on Christmas Day. He died around Easter in April 1915 and this is why many people see a parallel between Skriabin as a human being and a divine one, a Messiah, in the same way he regarded himself later on. Skriabin was fascinated by Chopin who at first became his ideal for musical harmony and composition. He composed in a possessed manner and, similar to Chopin, mainly for piano.

The possibilities this instrument provided, however, were not sufficient for him and around the turn of the century he became eager to turn to orchestra. In 1903–1904 he composed his 5th Symphony better known as “Prometheus”. This work is particularly instructive for a characterization of the world of ideas and the musical idiom of Skriabin. At that time Skriabin frequented symbolist circles – he was a member of the Moscow Society of Philosophy – and he read Nietzsche and Schopenhauer. We can comprehend his world of ideas by reading his diaries. He wrote: “If I stopped realizing, i.e. if I brought my activity to an end, everything would disappear for me. It actually follows from this that I am the origin of all experience, the creator of the world. Everything is created by me…” Later on Skriabin noted down: “I am God”. Finally Skriabin had in mind to unite music, colours, dancing movements, perhaps also taste, odours, feeling, touching into a superhuman, divine work of art, which he called “Mysterium”. Of course, only a god-like individual would be able to accomplish this enormous task of a unified work of art – that is, Skriabin himself. Skriabin, however, came to realize more and more that he could only present drafts of his superworks, since he did not feel well, he was in poor health. Having a natural hypochondriac disposition, he was always afraid of infections. On March 21st, 1914, Skriabin wrote to his wife Tatyana Schloetzer from a concert tour in London: “Money fell on this letter. …It is infected… Take the paper at the ends! …The fourth page is infected most…”. At the beginning of April, 1915 Skriabin suffered from an abscess on the right side of the upper lip. He had a temperature but still gave a piano recital in Moscow on the 2nd of April which was to be his last concert. Skriabin was confined to bed, his family was with him. The Moscow specialists dared a further cut into the lip but no pus came to light to the surprise of all people present. Skriabin’s blood was already poisoned and on April 27th, 1915 he died of severe sepsis (Table 6). The funeral procession comprised thousands of people, Sergei Rachmaninow was among the pallbearers. At the gravesite Rachmaninow decided to start a concert tour to all large Russian cities in the following winter and to play exclusively Skriabin piano compositions.

Table 6
Composers Suffering from Fatal Bacterial Sepsis

<table>
<thead>
<tr>
<th>Composer</th>
<th>Date of Birth</th>
<th>Date of Death</th>
<th>Location of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jean Baptiste Lully</td>
<td>28.11.1632</td>
<td>22.03.1687</td>
<td>Florence</td>
</tr>
<tr>
<td>Anton Franz J. Eberl</td>
<td>13.06.1765</td>
<td>11.03.1807</td>
<td>Vienna</td>
</tr>
<tr>
<td>Gioacchino Rossini</td>
<td>29.02.1792</td>
<td>13.11.1868</td>
<td>Pesaro (I)</td>
</tr>
<tr>
<td>Georges Bizet</td>
<td>25.10.1838</td>
<td>03.06.1875</td>
<td>Bougival (Paris)</td>
</tr>
<tr>
<td>Gustav Mahler</td>
<td>07.07.1860</td>
<td>18.05.1911</td>
<td>Kalischt (Kalisch)</td>
</tr>
<tr>
<td>Alexander Skrjabin</td>
<td>06.01.1872</td>
<td>27.04.1915</td>
<td>Moscow</td>
</tr>
<tr>
<td>Ottorino Respighi</td>
<td>09.07.1879</td>
<td>18.04.1936</td>
<td>Bologna</td>
</tr>
<tr>
<td>Alban Berg</td>
<td>09.02.1885</td>
<td>24.12.1935</td>
<td>Vienna</td>
</tr>
</tbody>
</table>
ALBAN BERG

When Skrjabin died in 1915, a composer in Vienna was working on an opera, called "Wozzeck". It represented a key piece of work for the new music and was based on Georg Büchner's drama fragment, "Woyzeck", which tells the story of a haunted person. This great composer is Alban Berg (Fig. 6).

GUSTAV MAHLER

Among Alban Berg’s models we find the idol of the whole musical youth in Vienna of that time: Gustav Mahler (Fig. 7). Mahler was the first to make the right pronunciation of his name. Mahler is known for his symphonies, which he never finished. He died of scarlet fever during the summer holidays in Maiernigg at the "Wörthersee". Mahler and his wife were shocked. Mother Alma complained of heartache and a doctor was called, who, however, could not find anything particular and only prescribed rest. More driven by coquetry than by acute complaints, Mahler asked the physician to examine him as well. The doctor diagnosed a clear heart condition. This diagnosis came as a bombshell to Mahler, news from which he would actually never recover.

Mahlers's illustrious career is beginning to become a thing of the past. However, it is still a superb one. He was nominated chief director of the Royal Opera in Vienna – a position to dream of. A meteoric advancement as a conductor, in the beginning less than a composer, was granted to him and he fast became an international celebrity. In 1901 at the age of 41, Mahler, always the centre of attention in Viennese social life, met the beautiful Alma, daughter of the landscape painter Emil Jakob Schindler and his junior of 20 years. He married her on March 9th, 1902 in Vienna.

Right from the start the marriage was overshadowed by Mahler’s unstable state of health. The holiday months were problematic as well. Mahler used them to compose from dawn to dusk. His immensely demanding task as a chief conductor in Vienna took all his time from morning to night and allowed no time for composing during the usual working-day. On July 5th, 1907 his beloved elder daughter Maria died of scarlet fever during the summer holidays in Maiernigg at the "Wörthersee". Mahler and his wife were shocked. Mother Alma complained of heartache and a doctor was called, who, however, could not find anything particular and only prescribed rest. More driven by coquetry than by acute complaints, Mahler asked the physician to examine him as well. The doctor diagnosed a clear heart condition. This diagnosis came as a bombshell to Mahler, news from which he would actually never recover.

In 1907, Mahler retired from his high position in Vienna after nerve-racking disputes and intrigues and accepted an engagement as chief conductor of the Metropolitan Opera in New York. There he composed drafts of a 10th symphony, which he never finished. In fact, Mahler was severely and chronically ill and in New York on February 20th, 1911, he was attacked by fever with a sore and coated throat accompanied by a circulatory collapse. His family practitioner, Dr. Fraenkel, contacted the New York doctor Emanuel Lipman of the Mount Sinai Hospital, who was the first to make the right diagnosis.
diagnosis of Endocarditis lenta, i.e. inflammation of the heart valves from streptococci. Lipman informed Mahler of this diagnosis and the hopeless prognosis. Nevertheless, a last hope came from some of the famous bacteriologists in Paris such as the Nobel prize winner, Ilja Metchnikov or the well-known infectious disease doctor, Fernand Widal. Therefore, the family returned to Europe by ship in April, 1911. They went to Paris to see Metchnikov or Widal but did not reach the famous scientists due to the Easter holidays. Instead they consulted an assistant at the Institut Pasteur, Dr. André Chantemesse. Chantemesse took a blood sample and Alma Mahler wrote about the circumstances of this examination in her memoirs: “Chantemesse, the famous bacteriologist, now made a pure culture with Mahler’s blood – oh, doctors! After a few days he appeared – beaming – with a microscope. Should a wonder have happened? He adjusted the microscope on the table, “Look, Mme. Mahler, I myself have never seen streptococci developed so fabulously. Look at these strings – they are algae.” He wanted to explain, to shine! But I could not hear anything. Almost fainting with pain I left him. My mother also suffered severely from this shock.” Mahler wanted to die in Vienna, to where he was brought with the Orient Express. He was suffering and tormented. Finally, he received morphine and on the evening of May 18th, 1911, died of severe bacterial sepsis after a long agonizing death. He died during a thunderstorm as did Beethoven 84 years earlier.

In 1913 Arnold Schönberg delivered a commemorative speech on Gustav Mahler in Prague in the course of which he also talked about Mahler’s last works. He said about Mahler’s 10th symphony: “What his Tenth was meant to say to us, we will know as little about it as in the case of Beethoven and Bruckner. It seems as if the Ninth is the limit. The one who wants to go beyond has to leave. It looks like the Tenth could tell us something that we shall not yet know, for what we are, is not yet mature. Those who wrote a Ninth were too closely connected to the other world. Maybe the mysteries of this world would be solved if somebody who knows about them wrote the Tenth. And that is probably not intended to be.”

OTTORINO RESPIGHI AND CONCLUSION

During the era of the big epidemics, such as the plague, and up until the end of the 19th century, doctors and scientists had no idea of the aethiopathogenesis of an infection, not to mention how a septic disease was caused or even could be healed. Clinical science and medical microscopic research had advanced far, of course still needing to develop further. However, they were not enough popularized and supported. Today research is undoubtedly better promoted but certainly not yet to a sufficient degree. This could have fatal consequences as we have to learn in the coming years, since infectious diseases will certainly return and sepsis continues to represent one of the most common causes of death of patients in intensive care units. That is why we equally need, more than ever, a most intensive and widely diversified research on infections to develop new strategies for prevention and therapy. Due to the development of resistances, rapid spread of infectious agents, tourism, dramatic urbanization and other factors, infectious diseases will certainly return to our latitudes. Then, doctors and scientists have to lay their cards on the table. The degree of doctors’ and scientists’ helplessness against infectious diseases as was present at the time the plague, cholera and syphilis reigned, must never resurface again.

It is interesting to note that parallel to the development of antibiotics and the preliminary end of infectious diseases, classical music reached an almost inaccessible, artificial impasse where it could hardly be judged whether a composer was an artist or a charlatan. In the thirties the one who already realized that music was developing into a dead end is the composer with whom I would like to end my excursion – I am referring to Ottorino Respighi (Fig. 8). On July 9th, 1879 Ottorino Respighi was born in Bologna. In December, 1900, he joined the St. Petersburg theatre orchestra where he took lessons with Rimski-Korsakov and Max Bruch. The basic character of Respighi’s creative work consists of the attempt to create a balance between tradition and progress, similar to Alban Berg but nearly always in a tonal and completely other way. His masterly talent for orchestration and the brilliant colouring of his arrangements was unique. In the last months of the year 1935 Respighi’s thoughts revolved around his last work, an opera entitled “Lucrece” (based on Shakespeare’s “The rape of Lucrece”). He worked feverishly, struggling against a chronic unexplainable fatigue. This was probably connected to a slowly increasing bacterial infection which haunted him more and more towards the end of 1935. In January 1936 Endocarditis lenta was finally diagnosed and Strepriococcus viridans bacteria were isolated from his blood. Ottorino Respighi’s wife Elsa had to lie to her husband, following the advice of the family doctor: she told him that he was only suffering from a harmless Escherichia coli infection with no threatening consequences. In March, Respighi had written the last notes of his opera “Lucrece”, but the hour of his death was inexorably approaching. During his last days, Respighi was still supplied with sulfonamides from Berlin since Gerhard Domagk had just published the discovery of “Pronitosil”. However, the therapy had no effect, probably above all because the sepsis had already progressed too far. On April 18th, 1936, at 6 o’clock in the morning Respighi died of septic shock and with him one of music’s masters. The last minutes of his agony were accompanied by rain and storm, thunder and lightning as in the case of Beethoven and Mahler, but when Respighi closed his eyes forever, a nightingale was singing.

Figure 8. Ottorino Respighi

Ernst Th. Rietschel
News in Brief

Infectious Diseases and Outbreaks

DISRUPTION OF QUORUM SENSING AS POSSIBLE DRUG LEAD
A series of agonists to the quorum-sensing, autoinducers for *Pseudomonas aeruginosa* were constructed and from these, antagonists were prepared. These antagonists were shown to inhibit quorum sensing in *P. aeruginosa*. Quorum sensing is a first step to the formation of biofilms and to the production of virulence factors in vivo. The authors suggest that such an approach could provide novel drug leads.


INHIBITOR OF CHOLERA TOXIN-INDUCED FLUID LOSS FOUND
Fluid loss in cholera victims causes dehydration and is a major cause of death in children in the developing world. A group studying the protein controlling transmembrane conductance in cystic fibrosis (CFTR) has discovered that inhibitors of this protein also inhibit fluid secretion in the small intestine of mice. The inhibitors were all 2-thioxo-4-thiazolidinones.


LACTOBACILLI MAY PROTECT AGAINST GONORRHOEA
Four species of lactobacilli commonly found in the vagina were tested for their ability to inhibit the growth of the gonococcus. All four species were inhibitory at an acidic pH but two were also able to inhibit gonococcal growth at a neutral pH. There was evidence that the inhibitory lactobacilli produced hydrogen peroxide.

St Amant et al. Infect Immuun 2002; 70: 7169

PERTUSSIS OUTBREAK AMONG ADULTS
In spite of vaccination of children, cases of pertussis continue to increase in the US, especially in adults. An outbreak in adults at an oil refinery in Illinois between August and October 2002 was reported by the CDC recently. It is thought that adults may act as a reservoir for pertussis as the efficacy of the vaccine declines after a decade or more. Pertussis is frequently overlooked as a possible cause of persistent cough in adults and left untreated; these individuals can transmit the infections to infants.

MMWR 2003; 52: 1

Viral Infections

AVIAN INFLUENZA OUTBREAK IN HONG KONG
Authorities in Hong Kong have confirmed that a child and her father have both died from avian influenza, strain A (H5N1). Members of the family travelled to China in January and on return, the son became ill, but subsequently recovered. His sister and father have both since died. The WHO is monitoring the situation in Hong Kong and China. These cases follow reports in January of an outbreak of avian influenza in two chicken farms in Hong Kong. Although the strain was influenza A type H5, it was not H5N1. Control measures were instituted; these included the slaughter of approximately 15,000 chickens, disinfection of the units and halting of imports of chicken from China.

WHO Epidemiological Bulletin, Jan and Feb 2003 (www.who.int/csr/don)

WEST NILE VIRUS
CDC updated the epidemiological data regarding the spread of West Nile Virus (WNV) in the US during 2002. The virus has now been isolated in 44 states in contrast to 29 states in 2001. The total number of human cases (median age 55 years) was 3,398, 69% of whom had meningoencephalitis and 21% fever. The number of cases peaked in August. The number of deaths was 201, with a median age of 78 years (range 24 to 99). As before, a large number of birds were found to be infected, mostly crows and blue jays. In addition there were over 9000 horses found to be infected. A range of mosquito species proved to be infected, 55% were species of *Culex*, but infection was also found in seven new species, including *Aedes aegypti* and *Anopheles wulkeri*.

MMWR 2002; 51: 1129

Mice lacking B cells were found to be extremely sensitive to infection with WNV, developing serious brain and spinal cord infection. This could explain the susceptibility of older humans to the disease.


A fourth person has been shown to be positive for WNV after receiving a transplant from a car crash victim. The CDC believes that this suggests that the virus can be transmitted via transplants.

Medscape. Nov 26, 2002

OUTBREAK OF EBOLA IN THE REPUBLIC OF CONGO
An epidemic in the Congo has been confirmed as being caused by Ebola haemorrhagic fever. As of February 18th, 2003 there were 79 confirmed cases and 59 deaths. The government has requested the assistance of the WHO.

Eurosurveillance Weekly 2003; 7(8): 1

INCREASING NUMBERS OF MEASLES CASES IN IRELAND
Between late November 2002 and early February 2003, 234 clinical cases of measles were reported in the Republic of Ireland. This represents a substantial increase when compared with the same period over the previous four years (below 50 cases in 2001/2002). The majority of cases were in children between 1 and 4 years of age and a large number had not been vaccinated or had only received one dose of MMR vaccine. The uptake of the MMR vaccine had been low and this is attributed to the adverse publicity surrounding the use of the vaccine.

Eurosurveillance Weekly 2003; 7(8): 1

Vaccines

DISAPPOINTING RESULTS FOR AIDS VACCINE
Results released on February 24th, 2003 by VaxGen revealed that the Phase III clinical trial of their vaccine AIDSVAX did not offer protection from HIV. The vaccines incorporate non-infectious proteins from the surface of the HIV and are designed to raise antibodies against the virus. There was a slight indication of some protection seen in a small sub-population of ethnic minorities and blacks, but the President of the International AIDS Vaccine Initiative said that the numbers in these groups were too few to show significance.

Press release from VaxGen, Feb 24, 2003
H. PYLORI VACCINE APPROVED
The FDA has approved an investigational new drug application for a vaccine to prevent *Helicobacter pylori* infections (January 28th, 2003). Helivax is an inactivated, multivalent, whole cell vaccine produced by Antex Biologics Inc. Phase I safety and immunogenicity trials gave promising results and the company now plans to carry out Phase II studies in the US. Prophylactic and therapeutic studies are planned.

MERCURY IN VACCINES
Thiomersal (ethyl mercury) is commonly used as a preservative in vaccines and there has been concern expressed as to its safety for infants and children. Levels of mercury were measured in blood, urine and stools of infants aged 6 months and below who had received vaccines containing thiomersal. The results indicated that ethyl mercury was rapidly excreted into the stools, with little being detected in the urine samples. Pichichero et al. Lancet 2002; 360: 1711

RISKS FROM SMALLPOX VACCINE
The CDC started shipping smallpox vaccine to some US states on January 22nd, 2003 as the first stage of a federal move to vaccinate half a million health care workers. The vaccine is offered on a voluntary basis and in the second phase an additional 10 million volunteers could be vaccinated. In response to these plans articles in the US press have highlighted the risks from receiving the vaccine. It has been estimated that for every million people vaccinated, between 14 and 52 may have serious side effects and 1 or 2 could die. A spokesman from the Office of Public Health Emergency Preparedness predicts that when reports of adverse effects become more widely known, demand will decrease sharply. JAMA 2003; 289: 685, USA Today Dec 15, 2002

PENTOSAN POLYSULPHATE TO BE USED IN vCJD PATIENTS
In the UK, following a High Court action, the drug pentosan polysulphate is to be given to a teenager suffering from vCJD. The drug is normally administered orally for the treatment of bladder pain and cystitis, but experimental studies on scrapie in mice in Japan and the UK have shown it to produce similar results. Angeles, all associated with the community-acquired infections. Resistance
MRSA infections are commonly associated with hospitals and institutions, with community-acquired infections being more rare. Three outbreaks in Los Angeles, all associated with the com-
munity are reported by the CDC. A predominant strain, with a similar antimicrobial susceptibility pattern, has been identified in all three episodes. A shared characteristic is resistance to fluoroquinolones.

**European Matters**

**THE EU’s 6TH FRAMEWORK PROGRAMME HAS BEEN LAUNCHED**
The 6th Framework Programme was launched in November 2002 with urging from the EU Commissioner for Research, Philippe Busquin for scientists to “think European”. All applicants will need to consider trans-European co-operation. There will be 17.5 billion Euros available between 2003 and 2006. One of the aims of the EU is to establish a network of integrated, co-ordinated, research projects; this is termed the European Research Area.

*The Scientist. Jan 13, 2003*

**TOWARDS A EUROPEAN RESEARCH COUNCIL**
The institution of a European Research Council (ERC) was proposed by the European Science Foundation (ESF) at a meeting held in Paris in February and attended by representatives of various eminent scientific bodies. The aim is to prevent the drain of talent to the US and to fund long-term basic research. Some thought that the ERC should be complementary to the 6th Framework Programme, but should not need short-term aims for funding.

*The Scientist Feb 20, 2003, www euroscience.org/

**A CLINICAL TRIALS REGISTER FOR EUROPE**

In an editorial in the BMJ comments were made on the need for a register of clinical trials in Europe, something that has long been discussed, but still has not materialised. There are some local initiatives, for example in the UK, the Netherlands and Germany, but nothing overall. The European Science Foundation suggested in 2001 that all members should register controlled trials on the web. A meeting was held in Frankfurt in November 2002 to discuss progress, if any, and to try and move forward. The European Commission refused funding earlier in 2002, meaning that little progress has been possible.

*BMJ 2002; 325: 1314*

**THE DROP IN NEW DRUG APPLICATIONS CONTINUES**
The dramatic fall in new drug submissions is affecting the financial stability of the European Medicines Evaluation Agency (EMEA). The EMEA is funded by the fees it gets for evaluating potential new drugs. In October 2002, the EMEA announced that it was cutting its budget by 5 million Euros. There were 58 new submissions in 2001 but only 31 in 2002.

*Pharmafile.com Dec 30, 2002*

**LACK OF PROGRESS IN PHARMACEUTICAL REFORM BY EU**
The European Federation of Pharmaceutical Industries and Associations (EFPIA) is concerned about the lack of progress made by the EU in finalising legislation regarding reforms on pharmaceutical regulation. The EFPIA has pointed out that finalisation needs to be made before enlargement of the EU in 2004. The delay is apparently caused by the inability of the member states’ health ministers and the European Parliament to agree on proposed reforms with the EC.

*Pharmafocus Feb 5, 2003*

**PROBLEMS WITH GERMANY’S HEALTH CARE SYSTEM**
Germany’s health care system is suffering from a lack of funding, which is particularly marked for hospitals. The German government has capped the annual increase in budgets to 0.8% and this has resulted in one hospital in East Germany taking the unprecedented step of stopping all patient care except for emergency treatment.

*BMJ 2003; 326: 11*

**BELGIUM HOSPITALS TO TREAT UK PATIENTS**
The Belgian health authorities have signed an agreement with the UK to allow patients from the UK to be treated in Belgian hospitals. The system will keep bureaucracy to a minimum and will ensure that patients from the UK do not take precedence over Belgian patients.

*BMJ 2003; 326: 304*

**COMPANIES AND DRUGS**

**COPEGUS PRICE TO BE REDUCED**
The FDA has approved the use of Copegus (ribavirin) with Pegasys for hepatitis C. The drug has just been launched in the UK following approval by the Medicines Control Agency. Roche has settled its patent infringement dispute with ICN Pharmaceuticals and Ribapharm and has now announced that the price of Copegus will be less than that of the rival product from Ribapharm.

**PFIZER AND PHARMACIA MERGER STILL NOT APPROVED IN THE EU**
The EU has delayed the proposed merger between Pfizer and Pharmacia as antitrust officials requested additional information.

**GENERIC FORMS OF AUGMENTIN MARKETED**
Gliaxo SmithKline has lost patent protection for Augmentin in most countries but is still filing lawsuits in an attempt to prevent the flood of generic forms being marketed. Geneva Pharmaceuticals (part of Novartis), Teva (an Israeli firm), and Ranbaxy Pharmaceuticals (an Indian firm) all have generic products. The latest to enter this lucrative market is Lek, a Slovenian firm owned by Novartis.

**EXCERPTS FROM BMJ**

**PATIENTS**

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*BMJ 2003; 326: 304*

**THE EMEA ANNOUNCED IN OCTOBER 2002 IT WAS CUTTING ITS BUDGET BY 5 MILLION EUROS**

The dramatic fall in new drug submissions is affecting the financial stability of the European Medicines Evaluation Agency (EMEA). The EMEA is funded by the fees it gets for evaluating potential new drugs. In October 2002, the EMEA announced that it was cutting its budget by 5 million Euros. There were 58 new submissions in 2001 but only 31 in 2002.

*Pharmafile.com Dec 30, 2002*

**PROBLEMS WITH GERMANY’S HEALTH CARE SYSTEM**
Germany’s health care system is suffering from a lack of funding, which is particularly marked for hospitals. The German government has capped the annual increase in budgets to 0.8% and this has resulted in one hospital in East Germany taking the unprecedented step of stopping all patient care except for emergency treatment.

*BMJ 2003; 326: 11*

**BELGIUM HOSPITALS TO TREAT UK PATIENTS**
The Belgian health authorities have signed an agreement with the UK to allow patients from the UK to be treated in Belgian hospitals. The system will keep bureaucracy to a minimum and will ensure that patients from the UK do not take precedence over Belgian patients.

*BMJ 2003; 326: 304*
The Benefits of Full ESCMID Membership

### Scientific Information
- Subscription to the monthly *Clinical Microbiology and Infection (CMI)*, the official ESCMID journal, in print or online

### Professional Information
- Subscription to the quarterly ESCMID *News* informing about educational events, study groups and professional issues across Europe

### Discounts at ECCMIDs, ESCMID Schools and Other Educational Events

### Eligibility for ESCMID Research Fellowships

### Access to ESCMID Member-only Webpages

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**Membership Fees and Terms**

- **Membership with Print and Online Edition of CMI:**
  - EUR 82 for one year
  - EUR 148 for two years

- **Membership with Online Edition of CMI:**
  - EUR 55 for one year
  - EUR 100 for two years

- **Reduced-rate Membership (up to 35 years of age or retired) with Print and Online Edition of CMI:**
  - EUR 37 for one year
  - EUR 68 for two years

- **Reduced-rate Membership (up to 35 years of age or retired) with Online Edition of CMI:**
  - EUR 31 for one year
  - EUR 56 for two years

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**Fax (e.g. +41-61-686 7798)**

**Email**

**Birth Date (dd.mm.yy)**

**Specialty:**

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**Reduced-rate membership:**

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- **Third party (name) has transferred EUR:**

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- **to Deutsche Apotheker- und Ärztebank,**
  - 80323 München, Germany, account no. 000 236 2368, bank code 700 906 06

- **Bank cheque/draft is enclosed**

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- **American Express**
- **Diners Club**

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**New Membership Registration** **or Membership Renewal**

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**Join ESCMID or renew your membership online at www.escmid.org**

or return the completed application form and payment to ESCMID, P.O. Box 1131, D-82018 Taufkirchen, Germany,

Fax +49-89-612 8176

Phone +49-89-612 6162
Forthcoming events:

ESCMID events:

- **4–6 September 2003**
  - 23rd ESCMID Postgraduate Education Course: Treatment Failure in HIV-Infected Patients Receiving Antiretroviral Therapy
  - Location: Enghien-les-Bains, France
  - Contact: Karine Grange
    - Phone: +33 1 46 43 33 35
    - Email: nexcom.1rpcongres@wanadoo.fr
    - Internet: www.escmid.org

- **5–9 November 2003**
  - 25th ESCMID Postgraduate Education Course: Training Course in Hospital Epidemiology
  - Location: Antalya, Turkey
  - Contact: Serhat Ünal
    - Email: sunal@hacettepe.edu.tr
    - Internet: www.escmid.org

- **12–14 December 2003**
  - 26th ESCMID Postgraduate Education Course: The Role of Clinical Microbiology in the Management of Patients with Community-Acquired Infections
  - Location: Smolensk, Russia
  - Contact: Dimitry Galkin or Olga Stetsiouk
    - Phone: +7 812 611301 or +7 0812 611327
    - Email: iacmac@fond-merieux.ru
    - Internet: www.escmid.org

- **17–19 March 2004**
  - ESCMID Workshop on Progress Toward Meeting the Challenges in Clinical Microbiology and Infectious Diseases
  - Location: Leuven, Belgium
  - Contact: Marc Stuelens
    - Email: marc.stuelens@ulb.ac.be

- **1–4 May 2004**
  - 14th European Congress of Clinical Microbiology and Infectious Diseases (ECCMID)
  - Location: Prague, Czech Republic
  - Contact: AKM Congress Service
    - Phone: +41 61 686 77 11
    - Email: info@akm.ch

Other events:

- **2–5 April 2005**
  - 15th European Congress of Clinical Microbiology and Infectious Diseases (ECCMID), Copenhagen, Denmark
  - Contact: AKM Congress Service
    - Phone: +41 61 686 77 11
    - Email: info@akm.ch

- **1–4 April 2006**
  - 16th European Congress of Clinical Microbiology and Infectious Diseases (ECCMID), Nice, France
  - Contact: AKM Congress Service
    - Phone: +41 61 686 77 11
    - Email: info@akm.ch

In co-operation with ESCMID:

- **27–30 August 2003**
  - 6th International Meeting on Microbial Epidemiological Markers
  - Location: Les Diablerets, Switzerland
  - Contact: IMMEM 6
    - Phone: +41 61 686 77 11
    - Email: info@akm.ch
    - Internet: www.asmsua.org/mtgsrc/immem6general.htm

- **10 October 2003**
  - The Resurgence of Streptococcal Infections – Remembering Ignaz Semmelweis
  - Location: Budapest, Hungary
  - Contact: Ferenc Rozgonyi
    - Phone: +36 1 210 2959
    - Email: rozfer@net.sote.hu

- **28–30 November 2003**
  - European Conference on the Role of Research in Combating Antibiotic Resistance
  - Location: Rome, Italy
  - Co-organised by the European Commission and ESCMID
    - Internet: www.escmid.org
  - Contact: Giuseppe Cornaglia
    - Email: giuseppe.cornaglia@univr.it

- **29–30 May 2003**
  - International Conference on Modern Concepts in Microbial and Viral Infections
  - Location: Harapan Kita Cardiovascular Center
  - Contact: Secretariat National Cardiovascular Center
    - Phone: +62 21 568 4093
    - Email: pharmapro@cbn.net.id

- **16–18 May 2003**
  - International Congress on Pharmacokinetic/Pharmacodynamic, Bali, Indonesia
  - Contact: Secretariat National Cardiovascular Center
    - Phone: +62 21 568 4093
    - Email: pharmapro@cbn.net.id

- **18–21 May 2003**
  - Medical Virology Congress of Africa, Berg-en-Dal, South Africa
  - Contact: Barbara Lillienfeld
    - Phone: +011 803 8461
    - Email: fppeople@icon.co.za

- **18–22 May 2003**
  - American Society for Microbiology General Meeting, Washington, DC, USA
  - Contact: ASM
    - Phone: +1 202 942 9356
    - Internet: www.asmsua.org/mtgsrc/generalmeeting.htm

- **25–29 May 2003**
  - ISHAM 2003, San Antonio, TX, USA
  - Contact: Imedex
    - Phone: +1 770 751 7332
    - Internet: www.imedex.com

- **26 May–6 June 2003**
  - 4th Advanced Vaccinology Course 2003, Les Pensières, Veyrier-du-Lac, France
  - Contact: Betty Dodel
    - Phone: +33 4 7240 7972
    - Email: betty.dodel@fond-merieux.org
    - Internet: www.fond-merieux.org

- **30 May–4 June 2003**
  - IMAB-NATO Conference on Risk Infections Applied for Biomedical Terrorism, Varna, Bulgaria
    - Contact: Professor Dr. Krasimirl Metodiev
    - Phone: +359-52-634107
    - Email: kr.metod@mail.vega.bg

- **7–10 June 2003**
  - 23rd International Congress of Chemotherapy (ICC), Durban, South Africa
    - Contact: ICC Secretarial c/o Congrex Holland bv
      - Phone: +31 20 5040 200
      - Internet: www.congrex.nl/icc2003

- **23–25 June 2003**
  - International Conference on Toxoplasmosis, Copenhagen, Denmark
    - Contact: ICS A/S Copenhagen
      - Phone: +45 3946 0500
      - Fax: +45 3946 0515
      - Internet: www.toxo2003.ics.dk/organisers.htm

- **23–25 June 2003**
  - 2003 Annual Conference on Antimicrobial Resistance, Bethesda, Maryland, USA
    - Contact: National Foundation for Infectious Diseases
      - Phone: +1 301 656 003 Ext. 19
      - Email: resistance@nfid.org
      - Internet: www.nfid.org/conferences

- **26 – 28 June 2003**
  - 7th International Symposium on Modern Concepts in Endocarditis and Cardiovascular Infections, Chamonix Mont Blanc, France
    - Contact: Congress Center
      - Phone: +33 4 50 53 75 50
      - Email: iscvid7@chamonix.org
      - Internet: www.iscvid7.chamonix.org
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| 29 June–1 July 2003 | Infection and Immunity in Children 2003, Oxford, UK |              | University Department of Paediatrics  
Phone: +44 1865 22 1074  
Email:julia.bremble@paediatrics.ox.ac.uk  
Internet: www.bpa1ig.org/meetings2003.html |
| 29 June–3 July 2003 | 1st European Congress of Microbiology, Ljubljana, Slovenia |              | FEMS Central Office  
Phone: +31 15 278 5604  
Internet: www.fems-microbiology.org/congress2003.htm |
| 4 – 7 July 2003 | Central European Symposium on Antimicrobial Resistance, Brijuni, Croatia |              | Croatian Microbiological Society  
Phone: +385 1 23 90 204  
Email: hmd@hmd-cms.hr  
Internet: www.hmd-cms.hr |
Phone: +33 1 40 64 20 50  
Internet: www.iasconferences.org |
| 14 – 17 September 2003 | 43rd Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), Chicago, IL, USA |              | ASM Conferences  
Phone: +1 202 942 9248  
Internet: www.asmsusa.org |
| 15 – 17 September 2003 | Brucellosis 2003 International Research Conference, Pamplona, Spain |              | Phone: +34 948 425600  
Email: brucellosis2003@unav.es  
Internet: www.unav.es/brucellosis2003 |
| 20–24 September 2003 | Salmonella: Epidemiology, Pathogenesis and Vaccine Development, Sardinia, Italy |              | ASM  
Email: info@asmsusa.org  
Internet: mtgsrch/salmonella.htm |
| 28 September–1 October 2003 | 55th DGHM – Congress of the DGHM, Dresden, Germany |              | Prof. Dr. E. Jacobs  
Phone: +49 351 458 6550  
Email: enno.jacobs@mail-box.tu-dresden.de  
Internet: www.dghm.de/red/veranstaltungen |
| 28 September–1 October 2003 | 9th Congress of the European Confederation of Medical Mycology and 7th TIFI, Amsterdam, The Netherlands |              | Congress Care  
Phone: +31 73 683 1238  
Internet: www.ecmm-tifi2003.org |
| 9–12 November 2003 | 4th Congress of the International Federation of Infection Control, St. Julians, Malta |              | Infection Control Unit  
Phone: +356 21 235 447  
Email: infection.control@gov.mt  
Internet: www.gov.mt/info/medical-mycology/ |
Phone: +49 030 24 63 240  
Email: info@kit.de  
Internet: www.kit.de |
| 16–19 October 2003 | Brucellosis 2003 International Research Conference, Pamplona, Spain |              | Progetti di Congress Studio srl  
Phone: +39 02 319 6951  
Email: info@congress-studio.it  
Internet: www.acci.org |
| 20–24 October 2003 | 5th European Congress of Chemotherapy and Infection, Rhodes, Greece |              | Congrex Sweden AB  
Phone: +46 8 459 64 00  
Email: ecc5@congress.se  
Internet: www.congress.se/ecc5/ |
Phone: +49 030 24 60 30  
Email: info@k.t.de  
Internet: www.congress.se/ecc5/ |
| 9–12 November 2003 | 4th Congress of the International Federation of Infection Control, St. Julians, Malta |              | Infection Control Unit  
Phone: +356 21 235 447  
Email: infection.control@gov.mt  
Internet: www.gov.mt/info/medical-mycology/ |
Phone: +49 030 24 63 240  
Email: info@kit.de  
Internet: www.kit.de |
| 10–12 May 2004 | Vième Congrès National de la Société Française de Microbiologie, Bordeaux-Lac, France |              | Société Française de Microbiologie  
Phone: +33 (1) 45 68 81 79  
Email: cmurphy@pasteur.fr  
Internet: www.jsfmc.org |
Phone: +1 415 647 1020  
Email: info@asmusa.org  
Internet: www.asmusa.org |