ESCMID NEWS
European Society of Clinical Microbiology and Infectious Diseases

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Aedes aegypti, the insect vector responsible for transmitting yellow and dengue fever

(see page 17)
Dear Colleagues

2004 began with further threats of potential pandemic disease: namely the rapid spread of H5N1 avian influenza among poultry flocks in South East Asia and its occasional spread to humans. The other has been the resurgence of sporadic cases of SARS, which to date have not resulted in epidemic clusters. Many countries have taken the opportunity to review their strategy and recommendations for the management of these infections and here ESCMID has played its part in relation to SARS. I refer you to a very helpful and practical set of recommendations for the hospital management and containment of SARS on the Society’s web site under “News & Current Issues”. However, these new threats pale into insignificance when the existing toll of morbidity and mortality from diarrhoeal diseases and vaccine-preventable infections in developing countries is considered.

The WHO campaign for the worldwide eradication of poliomyelitis has recently faltered as a result of the lack of co-operation by the Nigerian authorities. Hopefully, this can be rapidly resolved so that Africa can be made free from this tragic but preventable disease. The impact of these infections is greatest in the young, often in countries ravished by HIV, and therefore represents a double tragedy. The young are clearly the breadwinners and parents of tomorrow and without their survival the future economic wellbeing of these countries will be compromised. In contrast, many resource-rich countries now have a demographic imbalance between those in work and those who have retired, leading to serious concerns about wealth creation and the physical resources for health and social services for those who are retired or are unable to work. Simply importing skilled and non-skilled workers from resource poor countries cannot be the solution and is clearly becoming an increasingly sensitive political issue. Those professionally involved in the diagnosis, treatment and prevention of infection have seen a dramatic escalation in their workload. In Europe these specialist services can be broadly categorised as either laboratory based, clinically based or functioning within the public health arena. This triumvirate of expertise has provided the core skills necessary for maintaining public health in relation to infectious disease.

However, it is clear that many countries suffer from either an inadequacy of the numbers of trained specialists, or that these lack appropriate professional recognition. While much of the day-to-day management of common infections is in the sphere of the non-specialist in primary care or hospital practice, it is becoming recognised that the current complexity of resources for the appropriate management of infection requires a wider skill base. This topic, among others, was discussed at the ESCMID Workshop in Leuven on Progress Toward Meeting the Challenges in Clinical Microbiology and Infectious Diseases, which is the sequel to the workshop by the same name held in Birmingham, UK in 1999 and published in Clinical Microbiology and Infection (CMI 2000, 6 Suppl A). It is hoped that this second workshop not only identifies the current public health challenges and medical needs arising from the evolution of infectious diseases, but also identifies the most appropriate organisational models and communication networks for their management and prevention. Finally, the issues surrounding training in the specialist infection disciplines was also hotly discussed.

One additional challenging but professionally rewarding task of the Past President is to chair the Awards Committee. Here I wish to acknowledge the support I have received from my colleagues on the Awards Committee; namely Professors Jon Cohen, Herman Goossens and Jordi Vila. In addition to selecting and recommending the Annual ESCMID Award for Excellence in Clinical Microbiology and Infectious Diseases, there is the Young Investigator Award for Research in Clinical Microbiology and Infectious Diseases and a number of ESCMID Research Fellowships. This year, once again, we are delighted to be selecting the recipient of the AstraZeneca/ESCMID Turning the Tide of Resistance Research Grant. It will be a pleasure to welcome and congratulate the various awardees at the 14th ECCMID Meeting in May in Prague.
Message from the President

Marc Struelens

Dear Colleagues,

I hope that this issue of ESCMID News finds you enjoying the 14th European Congress of Clinical Microbiology and Infectious Diseases (ECCMID) held in Prague. The ECCMID is recognised as Europe’s premier congress in its field. It focuses on the implications of the latest research findings for the advancement of laboratory, clinical and public health practice in diagnosis, therapy and prevention of infection. This year’s superb Scientific Programme is composed of over a hundred oral sessions, including keynote lectures, state-of-the-art symposia, interactive sessions and meet-the-expert tutorials. Selected new data will be shared in 200 oral and 1500 poster presentations. The Scientific Programme has again been developed by the ECCMID Programme Committee under the outstanding leadership of Prof. Patrick Francioli, in association with the Organising Committee. We are most grateful to them and to Prof. Jarmila Jelinkova, President of the Congress, as well as to all the clinicians and scientists who are contributing to this programme.

The date and venue of this year’s ECCMID are of particular significance. The congress opens in Prague on a truly historical day for the unification of Europe: the Czech Republic and nine other countries from eastern and southern regions of the continent are joining the enlarged European Union. In the field of infectious diseases, the need for international co-operation has never been greater. Therefore, the broadest participation of colleagues from all parts of Europe and beyond in the Society’s activities is essential to address cohesively the challenges that we are facing. We also have a special responsibility of offering the best standards of continuing education to young scientists and clinicians. We are therefore particularly happy that attendance grants have allowed a record number of young colleagues to present their data at the 14th ECCMID and participate in ESCMID education courses this year.

To respond to the evolving needs of its membership, ESCMID has expanded its range of activities and is adapting its organisational modalities. The European Council will be discussing a new affiliation scheme as a basis for a renewed Council with the aim of strengthening our partnership with National Societies of Microbiology and Infectious Diseases. The plan for a single European Congress in the infection disciplines in co-operation with other international organisations will also be presented. The ESCMID General Assembly of Members will be held during the 14th ECCMID to review the Executive Committee’s activities and examine amendments to the Society’s Statutes meant to further democratic rule and rejuvenate leadership. Infectious disease control, diagnosis and management constitute an increasingly complex challenge for health care systems worldwide. At the same time, major advances in information technology, automation and molecular biology provide new tools. Constraints on health expenditure are prompting initiatives to review current practice with a view of cost-effectiveness. In response to these challenges, efforts are made across Europe to strengthen and harmonise the training of health professionals in this field and develop models for effective infectious disease management and prevention based on its diverse historical, social and cultural backgrounds. Many countries’ ageing workforce in the infection disciplines underlines the need for recruiting new talents to the field and offering young physicians an attractive and rewarding professional career track.

To critically review achievements made at national and European levels since these issues were first addressed in Birmingham five years ago, ESCMID organised its second workshop on the “Progress Towards Meeting the Challenges in Clinical Microbiology and Infectious Diseases” in Leuven, Belgium, on March 17–19, 2004. The meeting was very successful. Creative discussion by delegates from 28 countries followed stimulating presentations by a distinguished faculty with participation from the WHO, the European Union of Medical Specialties (UEMS) and the European Commission. Concrete recommendations will form the “ESCMID Declaration on Meeting the Challenges in Microbiology and Infection” to be published in Clinical Microbiology and Infection. You will find the meeting’s report by our Managing Director Peter Schoch on page 14 of this issue. Key messages that came across from this meeting were the need for ESCMID’s reinforced partnership with national and pan-European organisations in professional support for the infection disciplines and its role in advocacy campaigns to raise European citizens’ and policy makers’ awareness of the public health issue of infectious diseases. Another conclusion that was unanimously supported is the need for operational research to develop reliable indicators of performance for public health, laboratory and clinical services as well as professional and lifelong training programmes.

ESCMID has made a significant contribution to the debate on public health policy in the EU with the perspective of establishing a European Center for Disease Prevention and Control next year. I invite you to read the overview of the latest developments of this project by Peter Vanoverveld from the ESCMID Public Affairs Programme on page 12 in this issue. If the new European CDC is to be effective, all of us in the biomedical community will have to mobilise efforts aimed at strengthening our national public health capacity and fostering a new culture of open international co-operation and communication on infectious disease threats. ESCMID has resolutely engaged itself in that direction.

Marc Struelens
President, ESCMID
Invitation to the ESCMID Assembly of Members 2004

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 14th European Congress of Clinical Microbiology and Infectious Diseases in Prague.

Date and Time: Sunday, 2 May 2004, 12:15 h – 13:45 h
Location: Prague Congress Centre (PCC), Meeting Hall V (2nd Floor) Prague, Czech Republic

The Agenda reflects the wide range of activities in which the Society is involved and also features amendments to the Statutes, a renewed European Council and the adoption of new membership fees. The Executive Committee is counting on your attendance and is looking forward to meeting you in Prague.

Yours sincerely,

Marc Struelens, President

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Agenda

1. Welcome (M. Struelens)
2. President’s address and report (M. Struelens)
3. Report of the Secretary General: proposal of a renewed European Council and affiliation scheme for European specialist societies (G. Cornaglia)
4. Revision of the Statutes (see below) (M. Struelens)
5. Proposal for new membership fees (see below) (M. Struelens)
6. Approval of the revised Statutes (vote) (M. Struelens)
7. Approval of the new membership fees (vote) (M. Struelens)
8. Presentation of the ESCMID Research Fellowships (R. Finch)
9. Financial report of the Treasurer (A. Voss)
10. Approval of the accounts (vote) (M. Struelens)
11. Report of the Education Officer (C. Carbon)
12. Report of the Professional Affairs Officer, Clinical Microbiology (E. Nagy)
13. Report of the Professional Affairs Officer, Infectious Diseases (R. Norrby)
14. Report of the Chair of the EU Task Force (M. Struelens)
15. Report of the Scientific Affairs Officer (J. Vila)
16. Report of the Chair of the Publication Committee (R. Finch)
17. Report of the President of the 14th ECCMID (J. Jelinkova)
18. Endorsement of the Executive’s performance (vote) (M. Struelens)
19. Any other business (M. Struelens)

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Ad 4: Revision of the Statutes

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

Statutes (Proposed amendments are printed in blue)

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

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

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

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

§ 3 Membership
The Society consists of individual full, associate, affiliated, corporate and honorary members from any country. All full members shall pay annual membership dues directly to the Society. Affiliat-
ed members are members of national scientific societies affiliated to ESCMID and their membership dues shall be paid annually by the affiliated society. Members of the ESCMID Study Groups who do not pay individual or affiliated membership dues are associate members of ESCMID. Corporate membership is open for companies and other organisations who wish to maintain closer ties with ESCMID. Membership is, subject to the approval of the Executive Committee, open to all who are interested in clinical microbiology and infectious diseases. The annual membership dues shall be proposed by the Executive Committee and approved by the Assembly of Members. Resignation from the Society must be made in writing no later than 30 November of a given year. Resignation shall be effective as of 31 December of said year. Membership expires on 30 June upon non-payment of dues.

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

Executive power of the Society is vested in the Executive Committee, which shall consist of the President, the President-elect, the Past President, the Secretary General, the Treasurer, and three additional members. The selection of candidates to be considered for election to the Executive Committee shall be made by a Nominating Committee. The members of the Executive Committee shall be elected by simple majority from among the individual full members of the Society in good standing by a secret ballot. They will be elected for a term of four years and may be re-elected once, whereafter at least four years must elapse before re-election can take place. If the President leaves office, then the President-elect shall become President and the Past President shall become President-elect.

The Executive Committee shall elect a President, a President-elect, a Treasurer and a Secretary General and appoint an ECCMID Programme Director, from either the elected members or the co-opted members of the Executive Committee. The maximum term in office shall be two years, with one year for the President, the President-elect and Past President.

The President, the Secretary General or the Treasurer shall represent the Society in legal matters and have executive powers within authorisation rendered by the Executive Committee. The Executive Committee shall adopt resolutions with the majority of its members present at the Executive Committee meeting; the President has the casting vote. The quorum shall consist of five members. The Executive Committee may appoint sub-committees for specific purposes.

The Executive Committee shall appoint a Managing Director to assist with the execution of its resolutions and to manage the administrative offices of the Society accordingly.

The European Council shall strengthen the cooperation and cohesion among the European specialist societies in the infection field and serve as an advisory board to the Executive Committee. Its constituent members are the European societies which signed an affiliation agreement with ESCMID. Each affiliated society is represented in the European Council by its President or a permanent nominee. Affiliation is subject to approval by the Executive Committee.

It will consist of elected representatives of European countries and of official representatives of associated European national societies, of the ESCMID study groups, and of other European societies involved in clinical microbiology and infectious diseases. The European Council shall meet during the annual congress of the Society. The President of the Society shall serve as chairperson. The Assembly of Members is the supreme body of the Society and shall hold Plenary Meetings. All full members of the Society in good standing shall be entitled to attend the Assembly of Members which is held during the annual congress of the Society (ECCMID). The President, upon resolution of the Executive Committee, shall notify members of the Society of an Assembly of Members and of its agenda by an announcement no later than four weeks prior to the date of the Assembly of Members. The Assembly of Members shall discuss the proposals of the Executive Committee and adopt resolutions by simple majority of the members present. Minutes shall be kept of the proceedings at the Assembly of Members, and such minutes shall be signed by the President, the Secretary General and the Managing Director.

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

§ 6 Amendments to the Statutes
Amendments to the Statutes can be proposed by a majority vote of the Executive Committee or by a written request signed by at least 50 members of the Society in good standing. Amendments to the Statutes can be made by ballot or at an Assembly of Members by resolution of a majority of members participating. In any matters concerning the interpretation of the Statutes, the decision shall rest with the Executive Committee, who will also resolve any matters concerning the Society that are not covered explicitly by the Statutes. The President of the Society has the right, upon legal advice and upon the advice of the Executive Committee, to make any amendments to the Statutes that are necessary for registration of the Society or for recognition of its non-profit status by the tax authorities. These amendments must be approved afterwards by the Assembly of Members.

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

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

§ 9 Dissolution
A resolution of two-thirds of the members of the Society shall be necessary to dissolve the Society. If the Society is dissolved, its funds shall be exclusively transferred to a public corporation or other recognised non-profit societies that support medical science and research.
Ad 5: Proposal for New Membership Fees

The revenues from members paying reduced membership fees are very low and even incur a deficit as they are only slightly above or below the CMI subscription fees for the two CMI editions (online and print & online, respectively). It is proposed to increase the fees for young and retired members from 2005 on to EUR 65 and EUR 37, respectively, as shown below. The regular rates of ESCMID membership shall remain unchanged.

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<tr>
<th>Membership</th>
<th>current membership fees (EUR)</th>
<th>new membership fees (EUR)</th>
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<tbody>
<tr>
<td>Individual full, regular rate</td>
<td>CMI print &amp; online 85</td>
<td>85 (unchanged)</td>
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<tr>
<td></td>
<td>CMI online</td>
<td>57</td>
</tr>
<tr>
<td>Individual full, reduced rate*</td>
<td>CMI print &amp; online 40</td>
<td>65</td>
</tr>
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<td>CMI online</td>
<td>33</td>
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* for young (≤ 35 years) and retired members

In the context of the new affiliation scheme for European specialist societies (item 3 of the Agenda) members of affiliated societies will be offered subscription to CMI for EUR 47 (online edition) or EUR 75 (print & online edition).

Announcement

Awards and Fellowships 2005

ESCMID Award for Excellence in Clinical Microbiology and Infectious Diseases 2005

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 2005 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 president of ESCMID at the 15th ECCMID 2005 in Copenhagen. 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 plenary lecture in their field of research of 45 min during the 15th 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:

1. A biographical sketch of the nominee (maximum two pages, plus an abstract of 150 words).
2. A summary and analysis of the nominee’s major contributions to research in the fields of clinical microbiology and/or infectious diseases.
3. A list of the major original publications in refereed journals.
4. 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).
5. In addition, two letters of support from individuals outside the nominating institution should be mailed directly or together with the nomination to the ESCMID Award Committee.

Seven copies of the nomination package must be received by 1 October 2004. 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 2005

The European Society of Clinical Microbiology and Infectious Diseases will sponsor in 2005 up to two ESCMID Young Investigator Awards for Research in Clinical Microbiology and Infectious Diseases to recognise 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 of the highest scientific level.

AWARDS
The awards of EUR 7500 each, which should be used to support further research, will be presented by the chairperson of the Award Committee at the 15th ECCMID in Copenhagen 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 1965 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 1 October 2004. They must be submitted in writing together with proof of the nominee’s age, and include a CV, a complete list of publications as well as up to five original papers published in 2002, 2003 or 2004 or accepted for publication. The nominations should describe the candidate, his/her career, his/her research interests and personal contributions to the various research projects he or she has been participating in. At least two additional supporting letters should be presented by individuals outside the nominating institution. Self-applications will not be considered. The complete postal and e-mail address, phone and fax number of the nominee must be included. 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 Taufkirchen / Germany
Phone + 49 89 612 6162
Fax + 49 89 612 8176
Email birgit.menzemer@escmid.org

ESCMID Research Fellowships 2005

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 15th ECCMID 2005 in Copenhagen. 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 1 October 2004. Applications must be submitted in writing together 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 and e-mail address, telephone and fax number and send four copies of all materials plus one colour photograph (on paper or electronically as tif, jpg or eps file) 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 Taufkirchen / Germany
Phone + 49 89 612 6162
Fax + 49 89 612 8176
Email birgit.menzemer@escmid.org
Meeting Report

The Resurgence of Streptococcal Diseases

During the annual congress of the Hungarian Society for Microbiology a one-day symposium, on the resurgence of streptococcal diseases was held in Balatonfüred, Hungary on 10 October 2003. The Semmelweis University of Budapest, Hungarian Society for Microbiology, and ESCMID organised this event within the framework of the ESCMID intervention plan for Eastern Europe to honour the great Hungarian scientist and clinician Ignác Semmelweis.

Levente Emődy (Pécs) gave the introductory lecture about the life and the important achievements of Semmelweis, who studied medicine in Budapest and Vienna and started his career as an obstetrician. Although post-surgical infections and puerperal sepsis were known to be transmitted from person to person even before Semmelweis's activity, he was the one who started a systematic analysis of the events and drew conclusions from scientifically-generated and statistically-evaluated data. Despite the fact that he was responsible for decreasing the obstetrical death rate from 18% to 1.2% through the introduction of hand washing with chlorinated solution before entering hospital wards, the hostile reaction of the narrow-minded local and international medical community overshadowed the enthusiasm of a few outstanding colleagues. Back in Budapest, the publication of his achievements in the Orvosi Hetilap (Weekly Medical Journal) did not reach the attention of the professional community. Semmelweis was indeed ahead of his time and only a few of his contemporaries could comprehend the significance of his findings. Even today infections caused by streptococci still continue to be a challenge to the management and therapy of patients.

Edward L. Kaplan (Minneapolis) discussed the current epidemiology of group A streptococcal infections and the accompanying resurgence of these infections and their sequelae. Modern molecular techniques are needed to carry out longitudinal studies on group A streptococci, in which there is a constant shift in the prevalence of the M-types among strains isolated from the same or different regions. Curtis Gemmel (Glasgow) discussed the effects of sub-MIC concentrations of different antibiotics on the expression of several virulence factors of streptococci, rendering them more susceptible to phagocytosis. Giuseppe Cornaglia (Verona) and Roland Leclerq (Caen) discussed the changing susceptibility of streptococci to different antimicrobial agents of known resistance mechanisms with special emphasis on the epidemiology of penicillin resistant S. pneumoniae and of macrolide-resistant streptococci and enterococci. Ferenc Rozgonyi (Budapest) and Judit Szabó (Debrecen) summarised the resistance data of streptococci and enterococci isolated from patients of two Hungarian hospitals, namely the Semmelweis University Hospitals in Budapest and the University Hospitals in Debrecen, respectively. Elisabeth Nagy (Szeged), presented on the pathogenesis, antibiotic resistance and clinical significance of the anaerobic streptococci, showing how the changing taxonomy of these pathogens and the determination of their real role in mixed infections do represent a real challenge for both clinicians and microbiologists. Pentti Huovinen (Turku) provided a Finnish example of how antibiotic usage may influence resistance levels of S. pyogenes and S. pneumoniae. A similar phenomenon was reported by Ildikó Sánta (Miskolc) to occur in Hungary, where the increasing resistance of S. agalactiae to macrolides and clindamycin was observed to parallel the increasing usage of these antibiotics for vaginal infections due to Chlamydia and Mycoplasma. André Brysikier (Romainville) discussed new therapeutic options, such as linezolid, telithromycin or new streptogramins for combating antibiotic-resistant streptococci.

A separate section of the meeting dealt with: the problem of invasive pneumococcal diseases, the clinical meaning of penicillin, and macrolide-resistant S. pneumoniae strains isolated from either invasive infections or the upper respiratory tract. The members of the faculty were Javier Garau (Barcelona), Sebastian Amyes (Edinburgh), Jarmila Jelinková (Prague) and Orsolya Dobai (Budapest). They discussed the resistance data reported from Hungary and several other countries. According to a multicenter study performed between 1999 and 2002, 40% of the Hungarian S. pneumoniae isolates showed an intermediate susceptibility to penicillin, while the incidence of high-level penicillin-resistant strains was less than 2% and that of minocycline resistance approached 40%. The importance of different typing methods, such as serotyping and genotyping was also addressed, in relation to the spread of some extremely penicillin-resistant S. pneumoniae clones throughout Europe.
Mechanisms of Antimicrobial Resistance: A Practical Approach

28th ESCMID Postgraduate Education Course
Palma de Mallorca, Spain, June 20–26, 2004

This course is organised in cooperation with the Spanish Society of Infectious Diseases and Clinical Microbiology, Spanish Society for Chemotherapy, and the Group for the Study of the Antimicrobial Action and Resistance. The objective is to provide participants with updated background information and a practical approach to the study of clinically relevant mechanisms of antimicrobial resistance. This 5th edition of the workshop will focus on Gram-negative bacteria expressing extended spectrum beta-lactamases, with altered outer membrane permeability, mutations in QRDR of gyrases, and expressing active efflux.

For further information please contact: Dr Sebastian Alberti, Phone +34 9711 73353, Email salberti@hsd.es or consult the ESCMID website (www.escmid.org), Courses & Workshops.

ESCMID/SHEA Training Course in Hospital Epidemiology

30th ESCMID Postgraduate Education Course
Freiburg, Germany, October 17–20, 2004

This intensive training programme is aimed at those who have responsibility for hospital epidemiology and infection control programmes. It is organised by the ESCMID Study Group of Nosocomial Infections (ESGNI) and the Society for Healthcare Epidemiology of America (SHEA). The course is taught by renowned experts from the US and Europe, dedicated to continuous quality improvement in infection control and the application of epidemiology within the hospital setting. The course offers an advanced module in addition to the basic module.

For further information please contact: Dr Markus Dettenkofer
Email markus.dettenkofer@uniklinik-freiburg.de or consult the websites at www.hosp-epi-course.org or www.escmid.org

Antimicrobial Therapy in the 21st Century
ESCMID Symposium

Stockholm, Sweden, June 1–2, 2004

Antimicrobial resistance has resulted in a continuous need for new therapeutic alternatives. However, there are very few new anti-infective drugs against bacteria, viruses and fungi. Reasons are the increasing costs of new drug development and their being reserved for special patients. As a result the economic return is so small that some pharmaceutical companies have decided to leave the field of infectious diseases. The ultimate threat is that we may end up with patients who cannot be treated due to lack of effective drugs. These problems will be addressed in the symposium, which is of interest to those involved in drug discovery and development, regulatory agencies and treating patients.

For further information please contact: Stockholm Convention Bureau, Phone +46 8 5465 1500, Email stocon@stocon.se or consult the ESCMID website (www.escmid.org), ECCMIDs & Conferences.
On 12–14 December 2003 the 26th ESCMID Postgraduate Education Course on “Role of Clinical Microbiology in the Management of Community-Acquired Infections” was held in Smolensk, one of the most ancient Russian cities, 400 kilometers from Moscow. This event, the first of its kind to be held in Russia, was jointly organised by the ESCMID Study Group on Antimicrobial Resistance Surveillance (ESGARS) and the Interregional Association for Clinical Microbiology and Antimicrobial Chemotherapy (IACMAC), and co-organised by the Russian and Italian Chapters of the Alliance for the Prudent Use of Antibiotics (APUA).

Despite the severity of the Russian winter, this scientific event was attended by more than 30 young scientists from Russia, Belarus, Latvia, Estonia, Romania, Turkey, the Netherlands and Ukraine. The course reviewed how to effectively investigate community-acquired infections (CAIs) by means of routine testing, how to report the microbiological findings to clinicians and how to use them efficiently as a rational basis for clinical treatment. Special attention was paid to the role of various antibiotics in managing CAIs and to how monitor antibiotic resistance in most important pathogens.

All participants were provided with the basic, integrated elements necessary for understanding the need to perform microbiology tests in CAI, as well as the need for correct identification and reporting. The clinical issues debated included management of patients with upper and lower respiratory tract infections, UTI, diphtheria, fungal diseases and infections caused by MRSA.

The programme mainly consisted of interactive sessions, and formal lectures were always followed by lively and highly involving discussions. Several clinical cases, prepared and discussed by the participants themselves, proved of great interest.

According to a specific policy, shared by ESGARS and IACMAC and aimed at encouraging the newer generation of scientists that is rapidly emerging in Europe, the faculty included some young scientists that had participated in previous ESCMID Postgraduate Education Courses on similar topics. Lectures were delivered by G. Cornaglia (Verona, Italy), R. Canton (Madrid, Spain), G. Bahar (Ankara, Turkey), L. Stratchounski (Smolensk, Russia), A. Dekhnich (Smolensk, Russia), N. Klimko (St. Petersburg, Russia), and I. Smolenov (Moscow, Russia). The course represented an excellent opportunity for meeting fellow researchers and establishing sound contacts and networks for the future.

The next ESCMID Postgraduate Education Course in Russia will focus on ICU infections and will be held in Sochi, on 8–9 October 2004. The leaflet with information about the course will be distributed during the 14th ECCMID in Prague.

Maxin Pimkin,
Smolensk, Russia
EUCAST Report

EUCAST, the European Committee on Antimicrobial Susceptibility Testing, is convened by ESCMID and the national breakpoint committees in Europe. All final and discussion documents referred to below, are available on the EUCAST website at www.eucast.org. EUCAST’s view on the process of harmonising breakpoints for existing antimicrobials, for defining breakpoints for new antimicrobials and for setting epidemiological cut-off values were described in the Journal of Antimicrobial Chemotherapy (JAC 52:145–148, 2003) and are further developed in a document available on the website.

EUCAST AT 14TH ECCMID IN PRAGUE, MAY 2004
- The annual EUCAST General Committee meeting will be held, as usual, during the ECCMID.
- This year’s EUCAST symposium is entitled “Susceptibility testing and its role in therapy and epidemiology”.
- There is also a symposium on “Antimicrobial susceptibility testing of difficult organisms (fungi, mycobacteria, chlamydia, mycoplasma and viruses)

The time and place of all three activities will be announced in the ECCMID programme.

CONSTITUTIONAL AMENDMENTS
The EUCAST Steering Committee wishes to suggest a number of changes to the EUCAST constitution. They are all designed to improve our channels for dissemination of information and for consultation. The EUCAST General Committee will, in addition to national representatives, have one representative each from ISC and FESCI. Instead of having representatives from the pharmaceutical industry and manufacturers of media and devices for susceptibility testing, these groups will be offered communication channels with EUCAST through an email network whereby each representative will have exactly the same information and opportunity to comment on Steering Committee proposals as the EUCAST General Committee. The amended constitution will clarify how EUCAST is funded and will stipulate that members of the Steering Committee will declare any significant involvement with industry.

EUCAST “AUTHORITY”
Since the question of the authority of the EUCAST has been raised a few times it is important to point out that EUCAST has no legal standing. Similar to the NCCLS and the European national breakpoint committees, EUCAST consists of scientists that are entrusted with the task of giving national recommendations on questions related to antimicrobial susceptibility testing. These scientists, altogether numbering almost 100 on the participating national committees, have now agreed to work jointly towards harmonisation of their recommendations. The effort has been recognised by DG Sanco in the form of joint financing of EUCAST activities, and by EMEA in the form of a formalised collaboration.

REFERENCE METHODOLOGY
The EUCAST recommendations for broth microdilution MIC determination were published as a Discussion Document inserted in CMI during 2003. It is also available on the EUCAST website. A reference method based on this document is now being taken through CEN and in a joint project between CEN and ISO will eventually appear as an ISO-document. Arne Rodloff is chairing the CEN-committee and James Jorgensen is chairing the ISO-committee.

HARMONISED NOMENCLATURE FOR DESCRIBING S, I AND R-BREAKPOINTS
The six national breakpoint committees on the EUCAST Steering Committee have agreed to a common nomenclature for describing S, I and R-breakpoints. The recommended way of expressing the breakpoints is ≤ (less than or equal to) X mg/L and R> (more than) Y mg/L. In tables the breakpoints are given as e.g. 0.5/0.5 interpreted as ≤0.5 and R>0.5 mg/L.

DEFINITIONS OF CLINICAL BREAKPOINTS AND EPIDEMIOLOGICAL CUT-OFF VALUES
New definitions of clinical breakpoints and epidemiological cut-off values are available on the EUCAST website for comment. They were accepted by all six national breakpoint committees on the EUCAST Steering Committee meeting in 2003.

PROCEDURE FOR SETTING BREAKPOINTS AND COLLABORATION WITH EMEA
A document which describes the procedure for harmonising breakpoints for existing antimicrobials and for defining breakpoints for new antimicrobials is available on the EUCAST website for comment. The European Agency for the Evaluation of Medicinal Products (EMEA) and EUCAST are, at the moment, developing procedures by which the expertise of EUCAST can be fully utilised in the process of determining breakpoints for new drugs. The CPMP committee has voted in favour of such a joint procedure.

EUROPEAN CLINICAL BREAKPOINTS
Tentative EUCAST harmonised MIC breakpoints have been given to four classes of existing antimicrobials: fluoroquinolones, aminoglycosides, glycopeptides and oxazolidinones. Tables are available on the EUCAST website.

A corresponding process has been started for cephalosporins, carbapenems and aztreonam. Our hope is to conclude the process for these agents during 2004 and to liaise with NCCLS in doing so.

WILD TYPE MIC DISTRIBUTIONS AND EPIDEMIOLOGICAL CUT-OFF VALUES
Tables and graphs of MIC distributions of bacteria without resistance mechanisms are available on the EUCAST website. Each graph also con-
tains the EUCAST clinical breakpoints, when defined, and the epidemiological cut-off value for that drug-species combination. For drugs that have been addressed by EUCAST species specific epidemiological cut-off values are shown in tables.

**FUNDING**

EUCAST is funded by ESCMID and the National breakpoint committees in France, Germany, Norway, Sweden, the Netherlands and the UK. Recently EUCAST has been granted co-funding for 3 years by DG-Sanco of the European Commission.

**LIAISON WITH OTHER GROUPS**

EUCAST continues to liaise with ESCMID study groups, EMEA, and EARSS (the European Antimicrobial Resistance Surveillance System), and we value the bi-annual opportunity to liaise with NCCLS. On several occasions during 2003 we have had in-depth discussions with pharmaceutical companies and with industry involved in the development of devices and media for susceptibility testing.

_Gunnar Kahlmeter_

Chairman, EUCAST Steering Committee

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**ESCMID and bioMérieux Award 2005 for Advances in Clinical Microbiology**

The European Society of Clinical Microbiology and Infectious Diseases (ESCMID) is pleased to announce an award of EUR 10'000 sponsored by bioMérieux to recognise excellence and/or major contributions to progress in clinical microbiology by young scientists from Central and Eastern Europe.

The award expresses the shared mission of ESCMID and bioMérieux to advance laboratory practice of clinical and diagnostic microbiology across Europe.

**Application**

Nominations of Central and Eastern European scientists born in 1964 or later are to be submitted in writing. They must contain a description of the nominee’s career, his/her postal and email address, place and date of birth, list of publications, research interests and major contributions to the development of clinical microbiology. Two supporting letters from outside the nominating institution must be included. Self-applications will not be considered. Seven copies of all materials, plus one colour photograph (on paper or electronically as tif, jpg or eps file) must be sent to the ESCMID Award Committee.

The selection of the recipient will be made by the ESCMID Award Committee. Members of the ESCMID Executive Committee are ineligible. No correspondence beyond that necessary for the application will be accepted.

The deadline for submission is October 1, 2004. Applicants will be notified of the decision by March 15, 2005. The Award will be granted at 15th ECCMID 2005 in Copenhagen.

Please send your application to: ESCMID Executive Office P.O. Box 6, Clarastrasse 57 CH-4005 Basel, Switzerland Phone +41 61 686 77 99 Email peter.schoch@escmid.org

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**Europe to Establish Centre for Disease Prevention and Control**

Over the last 2 years, the public has become keenly aware of the threat of emerging infectious diseases with the global spread of severe acute respiratory syndrome (SARS), the continuing threat of bio-terrorism, the proliferation of West Nile virus, and the discovery of human cases of monkey pox in the United States. At the same time, an old foe has again reared its head, reminding us that our worst nightmare may not be a new one. In 2003, highly pathogenic strains of avian influenza virus again crossed the species barrier from birds to humans and caused fatal illnesses. Luckily, the worst-case scenarios of the start of the next pandemic did not come about in the 2004 avian influenza virus scares. However, the year’s events eliminated any remaining doubts that international advance planning is necessary to tackle the threat of communicable diseases.

**LEGISLATIVE AND INFRASTRUCTURE CHANGE**

It seems we are now much better equipped with technologies and reagents to rapidly identify and respond to disease outbreaks than we were a few years ago. The most promising means of accelerating the response time e.g. to pandemic influenza is the use of plasmid-based reverse genetic systems to construct influenza virions and vaccines. On the other hand, legislation is being enacted to translate scientific advances into real public health benefits. Though at times European policy makers seemed to be struggling to keep pace with scientific progress, a few weeks ago an important step was made to equip Europe with the necessary means to prevent and control the spread of communicable diseases. Members of the European Parliament and Member State governments agreed on setting up the European Centre for Disease Prevention and Control.
FROM A NETWORK TO THE CENTRE
Since 1999, the European Commission has managed a Communicable Diseases Network. The network is currently based on ad hoc cooperation between Member States within the legal framework of EU legislation, i.e. Decision 2119/98.

Following the aforementioned disease scares there was broad agreement that these structures needed substantial reinforcement if the EU is to be in a position to control communicable diseases effectively. In 2000 and 2001, external evaluations of the Network highlighted how the functioning of existing structures could be improved and reviewed options for a more effective response capacity at the EU level. In 2002, Member States’ key epidemiologists gave their view on the future of the surveillance of communicable diseases at the European level and favored the creation of an EU-level Centre. This position was re-emphasized during a Workshop on Communicable Disease Surveillance in the European Parliament in November 2002. Marc Struelens attended the Workshop on behalf of ESCMID, during which he had the opportunity to briefly introduce ESCMID’s views regarding a European Centre to Commission and Parliament officials.

EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL
Following up on the 2002 recommendations, in summer 2003 the European Commission presented the proposal to set up a European Centre for Disease Prevention and Control (ECDC). In the wake of the SARS pandemic, David Byrne, European Commissioner for health and consumer protection, made the creation of the Centre one of his political priorities.

To this end, ESCMID drafted a position paper on the subject matter (ESCMID News 3-2003, p. 18-20) and distributed it to Member State government representatives, Parliament, and Commission officials in an attempt to emphasize the importance of centrally-managed research and training and the potential benefits from the inclusion of non-governmental expertise such as ESCMID, to help succeed with the Centre’s ambitious objectives.

Public concern regarding Europe’s preparedness to cope with an outbreak on the continent added urgency, convincing Member State governments and Members of the European Parliament to tackle the proposal in a fast-track procedure. Taking into account part of ESCMID’s suggestions, the European Parliament with the support of Member States gave the go-ahead for establishing the European Centre for Disease Prevention and Control on the 10th of February this year.

The legal document still requires rubber-stamping by the Council of Ministers, however, the agenda for setting up the Centre has been set. It shall start to operate in the spring of 2005 in Stockholm, Sweden and will be fully developed after 3–5 years. The communicable diseases within the Centre’s scope are to include influenza; poliomyelitis; HIV infection; hepatitis; foodborne and waterborne diseases such as botulism and salmonella; typhus; yellow fever; cholera; malaria; Creutzfeld-Jakob disease; legionnaire’s disease; tuberculosis; and viral haemorrhagic fevers such as Ebola.

EU CONTRIBUTION TO NATIONAL HEALTH SERVICES
Following the agreement reached on February 10th, John Bowis, British Conservative Member of the European Parliament, who steered the legislation through the Assembly, explained that the Centre’s resources would supplement, rather than replace national capacity reacting to health threats. To this end, it would strengthen the informal ad hoc cooperation that now exists under the Communicable Diseases Network. “This demonstrates the positive contribution the EU can make by sharing good practice, research and expertise. We cannot afford to be complacent. The Centre will allow the EU to be proactive and not just reactive,” he said.

Though ESCMID hoped to see the Centre take a more central role in research and education of experts, ESCMID’s expertise and concerns were taken into consideration. The Commission in a letter dated 16th of February confirmed to the Society that its contributions were well received and that it hoped ESCMID would further contribute to the ECDC. A decision on this will have to be taken by the management of the ECDC, but the Commission highlighted their support to include ESCMID in the advisory panel to the ECDC.

On a day-to-day working basis, the Centre will tap into the expertise that already exists in national public health institutes. It will take over management of today’s Disease Network and become closely involved in monitoring and planning activities against bioterrorist attacks. To this end, it will act as an early warning system, issuing scientific opinions, providing technical assistance both inside and outside the EU, preparing measures against health emergencies, and supporting national public health institutes. General public disease information, which is important for citizens, will be posted on a dedicated website of the Centre.

NEXT STEPS – INTERNATIONAL COOPERATION
The door has been left open for a possible extension of the Centre’s responsibilities after its first three years of work. This might include monitoring a range of health measures, including drug resistant diseases and hospital infections, which pose an increasing problem for hospitals, the National Health Services and, not in the least, individuals.

One of the first tasks of the Centre will be to establish clear working arrangements with the WHO. In 2001, the WHO initiated the development of a Global Agenda for Influenza Surveillance and Control. Its four main objectives are to strengthen influenza surveillance, improve knowledge of the disease burden, increase vaccine use, and accelerate pandemic preparedness. In May 2002, this agenda was adopted. Likewise, the WHO adopted in 2001 its Global Strategy for Containment of Antimicrobial Resistance, while in the same year the European Commission issued the Community Strategy against Antimicrobial Resistance. Both strategies focus on the same key areas: surveillance, prevention, research and product development, and international cooperation. Part of this strategy is the “Council Recommendation on the Prudent Use of Antimicrobial Agents in Human Medicine” that lists priority public health actions to contain resistance. In the different areas of communicable disease and antibiotic resistance containment, it is now the task of the EU Centre to solidify international cooperation and progress from talking about prevention and control to taking action.

Peter Vanoverveld
Interel
PROFESSIONAL

Meeting Report

ESCMID Workshop on Progress towards Meeting the Challenges in Clinical Microbiology and Infectious Diseases

The public health challenges from the threats of emerging infectious diseases in Europe in the early 21st century and their implications for healthcare services were discussed during a 2-day workshop in Leuven, Belgium. The workshop was organised by ESCMID and the Belgian Society for Clinical Microbiology and Infectious Diseases and took place on 17–19 March, 2004. Seventy delegates representing 28 countries, including participants and contributors from the WHO, European Commission and UEMS attended the workshop.

The purpose of the workshop was to review the preparedness of Europe to respond to the threats of spreading resistance, bioterrorism and emerging infections, to critically review progress in the organisation of infection diagnosis, treatment and prevention in the member states and to come up with recommendations directed at improving the current situation.

The input given by various keynote lecturers was later reflected and discussed in three working groups, which focussed on the following topics:

i) Public health challenges for infectious disease surveillance, alert and response systems

ii) Professional needs and models for health care services (microbiology and infectious disease departments, hospital infection control)

iii) Specialist training and continuing medical education in the infection disciplines.

The conclusions of the working groups, as presented by rapporteurs, can be summarised as follows:

PUBLIC HEALTH CHALLENGES

The main purpose of surveillance systems for infectious diseases is to detect and analyse emerging threats and to monitor the burden of disease. This can only be obtained by the clear definition of the objectives and public health gains achieved by use of surveillance information, which is often lacking.

An effective monitoring system for nosocomial infections must be built on routine laboratory data and active surveillance to provide information useful for infection control interventions. The determination of attributable burden of disease should be complemented by specific studies on length of hospitalisation and loss of life days associated with nosocomial infection.

Efforts should be made to make data on benchmarking of quality of care concerning hospital-acquired infections publicly available without destroying trust between practitioners, surveillance administrators and health policy makers.

In view of the changing demands on microbiologists and infectious disease physicians caused by rapidly-emerging new organisms in the community and the hospital setting there is a clear need for improved training at all professional levels. This refers to standardised molecular diagnostic techniques, epidemiological thinking, population awareness and communication channels including responsible liaison with the public media.

To efficiently develop early warning and response preparedness, scenario-guided emergency models must be developed with action plans defining clearly the role of each player in the response system (laboratory microbiologist, community- and hospital infectious disease physician, field and hospital epidemiologist, public health specialist, etc).

The diversity of current surveillance approaches and response systems across Europe does not ensure efficient use of available personnel and financial resources. As a first step an inventory and comparison of the various systems should be made, followed by their critical assessment and the identification of gaps. The data should be used to develop a strategy for an internationally integrated and concerted approach towards an effective surveillance, alert and re-
sponse system with proper resources and dedicated coordination. The promotion of public health, the reaction to health threats and disease prevention are at present still in the hands of national authorities. It remains to be assessed whether and how the national public health agencies, systems and contingency plans can provide the basis for an effective and coherent international intervention system. The planned European CDC and European Community health programme must be able to respond to specific health needs of any member state by integrating national centres with central facilities. To be apt to its mission the European CDC should develop its own laboratory and field epidemiology resources. It should be provided with the appropriate resources, competence and management structure to overcome bureaucracy and national political sensitivities. ESCMID has many roles as the leading European organisation in the infection field. It should assist interaction between academia, health care, regulatory and public health agencies, national and European organisations, industry and the media. The Society should be a partner in defining the health targets, developing models of best practice, informing the professional and public communities about the threat by infectious diseases, fostering professionalism and providing training opportunities. ESCMID tries to bridge the infectious disease service line from bed to community and drive the cultural change and awareness needed among professionals, politicians and the public to tackle the immediate threat of emerging diseases.

NEEDS IN THE HEALTH CARE SYSTEMS AND INFECTION MANAGEMENT MODELS

Within Europe, a variety of specialist services and organisational models have developed for diagnostic laboratories, clinical services and public health programmes. This diversity causes major problems in building integrated and international surveillance and alert and response systems, which can be addressed in part by standardisation of methods, accreditation and quality assurance. On the other hand, awareness of the threat by emerging infectious diseases, including drug resistant microorganisms, is rising, which seems to translate into increasing support for the improvement of professional services, closer collaboration and the convergence of expertise in Europe. Technological advances in diagnosis and communication as well as access to more robust data provide novel opportunities for improved patient management, cost-benefit analyses and better integration of infection specialists. Meanwhile the technological developments in molecular diagnostics and automation as well as the increasing health care costs drive the centralisation of laboratory services, which have a negative impact on the quality of samples and reduces the necessary interactions between microbiologists and clinicians.

The opinion seems to prevail that the clinical microbiologist should participate in clinical ward rounds and provide advice on diagnostic and therapeutic issues. In addition, clinical microbiologists have a definite role to play in infection control, drugs & therapeutics, antibiotic policy and biosafety committees. This reflects the notion that the expertise of microbiologists, infectious disease and infection control specialists must be better integrated in a manner that varies according to the specific needs and historical background of different health care facilities.

Many European countries suffer from an ageing workforce and shortage of infection specialists, which might undermine the current efforts to improve disease management and public health in this field. Measures need to be discussed to enhance career options for young physicians and recruit new talents in the infection disciplines. There were, however, conflicting views on:

a) the microbiologist’s managerial responsibilities for running the laboratory,

b) the question as to what degree expensive equipment and core facilities should be shared with other disciplines in laboratory medicine, and

c) how many clinical microbiologists a 1000-bed hospital should optimally have.

It was suggested to establish a working party to investigate the current arrangements in Europe and come up with recommendations and a blueprint for the optimal organisation of health care services in the infection field while taking into account the diverse historical, cultural and economic backgrounds of different countries.

SPECIALIST TRAINING AND CONTINUING MEDICAL EDUCATION IN THE INFECTION DISCIPLINES

The current core training programme developed by the respective UEMS Sections for Infectious Diseases and Medical Biopathology, Microbiology Commission, are quite general with the specifics left to the national authorities. This flexible approach is considered adequate in view of the disparity of European medical health care systems. Core competence must be comprehensive and apply to all types of infections, including HIV, hepatitis, tuberculosis, and sexually transmitted diseases. To warrant free movement of specialists and similar quality of care across Europe, core curricula should be similar in all member states. The implementation and validation of training programmes vary considerably between EU member states. Research into assessment methodology for specialty training and competence (recertification is encouraged. While validation of training centres is supported, it is probably too early for European board examinations. Infection Control should have its own curriculum. In countries where Infection Control is not recognised as a specialty, the curriculum should be included with that of Microbiology and/or Infectious Diseases, depending on which specialty has the responsibility for Infection Control.

A core curriculum for a single specialty of infection should be developed to better integrate all infection disciplines.
After a common training it should allow various degrees of subspecialisation in Medical Microbiology, Infectious Diseases, Paediatric Infectious Diseases and Infection Control. Training in Infectious Diseases should always be based on Internal Medicine. Discussions within UEMS on a single specialty should be initiated.

Adherence to European recommendations must be aimed for while validation of training programmes should remain national.

It should be possible to collect CME/CPD credits at the national and international level. To simplify and harmonise CME accreditation the UEMS Specialist Sections should be empowered to accredit European and international events.

In the closing session, Marc Struelens, ESCMID President, summarised the main conclusions by saying that

i) there should be closer working between infection disciplines and public health

ii) models and performance indicators for health care services need to be developed to better integrate infection specialists while respecting the subsidiarity principle

iii) an international surveillance, alert and response system needs to be implemented and put to test

iv) the European CDC is to be supported and enabled to assume a leading role in tackling the global threats from infectious diseases

v) ESCMID should expand and evaluate its educational activities to meet the needs of professionals in the infection service line

vi) ESCMID should facilitate interaction of key players to form professional policies in the infection field

vii) cooperation between the European Commission, WHO, UEMS, the national specialist societies and ESCMID must be fostered

viii) awareness and communication needs to be improved and targeted for the medical profession, policy makers and the general public.

A more detailed and comprehensive position paper on these professional issues will appear in one of the forthcoming issues of Clinical Microbiology and Infection under the title ESCMID Declaration on Meeting the Challenges in Microbiology and Infection.

Peter Schoch
ESCMID Managing Director
The microbiologists at the Oswaldo Cruz Institute in Rio de Janeiro will not forget the 12th of January 2000 anytime soon. On this day they isolated a pathogen which was almost already classified as a relict in southern Brazil. The yellow fever virus was found in the blood of a 24-year-old woman who had spent New Year’s in a national park in the federal state of Goiás in central Brazil. The last reported case was in 1942 in the city of the Sugar Loaf.

Since the woman had suffered nearly one week from the then-unidentified illness, and *Aedes aegypti*, the insect vector, is ubiquitous in the megalopolis, alarm bells went off with the health authorities. All inhabitants residing within 300 meters were immediately inoculated against yellow fever. In the meantime an additional 50 persons had become stricken by yellow fever in central Brazil leading to the organisation of a national vaccination campaign. In the following six months 17 million Brazilians were inoculated. Actually, there had been plans to vaccinate the entire population (about 35 million people) in the regions bordering the state of Goiás. However, an unforeseen event destroyed the Brazilian health minister’s plan. Within a few weeks two persons (a five-year-old child and a 22-year-old woman) fell ill with yellow fever from the vaccination virus. Both died. Hence, authorities aborted the vaccination campaign.

Brazilian infection specialists have not yet been successful in assigning the present epidemic to one of the known epidemiologic patterns. In Brazil, as in the rest of South America, there are two types of yellow fever. In the original sylvan cycle the yellow fever virus circulates between *Haemagogus* mosquitoes and various kinds of monkeys. People become infected only if they enter the forest to hunt or collect or clear wood. Because these activities are mainly male-dominated, this kind of yellow fever is more prevalent in men than in women.

In contrast an urban cycle is characterised by virus spread through the mosquito species, *Aedes*, “all-over-the-world” mosquitoes, which in the meantime habitat almost all Brazilian cities as well as rural areas. These culicidae have a doubly bad reputation, since they also carry the dengue virus. The yellow fever epidemics that afflicted almost all large cities in Africa south of the Sahara and in Central and South America in the 19th and 20th centuries, started with interurban transmission of the yellow fever virus. Both varieties of yellow fever are crucially affected by the special ability of the pathogen to be transmitted transovarially. One mosquito generation passes the virus onto the next, from a female mosquito to her eggs and from them to pupae and adults. Hence, in contrast to the dengue virus, which is also a flavivirus, the yellow fever virus can survive without a human or monkey ‘stopover’.

The consequence of this vertical transmission is that the yellow fever virus can also survive long dry periods, during which the insect population drastically decreases. The mosquito eggs can ‘hibernate’ in miniscule water reservoirs and the first blood meal of a young mosquito har-
Box 1

Yellow fever vaccine – antiquated, but tested million fold

In 1927 the yellow fever virus was first isolated: the decisive prerequisite for the development of a vaccine. Independently, English scientists with a yellow fever strain from Ghana and French researchers with a strain from Senegal tried to breed avirulent variants. The yellow fever vaccine went into the annals of medicine history in 1945 as 17D vaccine. Since then roughly 400–500 million persons have been inoculated, 150 million alone in the last four years. The vaccine is considered unusually reliable and safe. Just 10 days after inoculation sufficient antibodies have been produced to protect the person against yellow fever. Protection lasts at least 10 years, in individual cases even 45 years. For approximately 2.3 million inoculations between 1960 and 1995 in Germany, only 20 unexpected and transient side effects were reported.

It is unclear why the vaccine can induce lethal yellow fever in individual cases and why the serious incidents have been building up in the past years. None of the seven deceased of the recent case series had a relevant immune deficiency. However it was remarkable that in at least one person, viable inoculation virus was recovered from autopsy material 12 days after vaccination. Usually the viremic phase ends a few days after inoculation with the vaccination virus.

Box 2

Yellow fever in Rio

At the beginning of the 20th century yellow fever was a feared mass illness in Rio de Janeiro. Around the turn of the century year for year several hundred persons got sick. In 1901 at the beginning of the last large epidemic there were well over 1,000. The death rate was over 50%. Yellow fever was so common that it seemed the ideal place to study the etiology of the illness to the yellow fever researchers of the Pasteur Institute. Between 1901 and 1905 the French researchers inoculated dozens of volunteers and came to the conclusion that yellow fever is an infection, which is not bacterial and is transferred illness to the yellow fever researchers of the Pasteur Institute. Between 1901 and 1905 the French researchers inoculated dozens of volunteers and came to the conclusion that yellow fever is an infection, which is not bacterial and is transferred by mosquitoes.

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under patronage of WHO and UNICEF, did not have enough available vaccine, vaccine was brought in from various sources (due to the urgent situation even Niger, Ghana and Nigeria made their own vaccine supplies available). The resulting time delays slowed down mass inoculation in the country’s interior, so that the epidemic could progress further. In order to avoid such calamities in the future, there is only one alternative: inhabitants of risk areas must be inoculated as a preventative measure, optimally in conjunction with childhood inoculation. Yet, there is the hitch that the presently available 17D vaccine can cause severe adverse events in individual cases.

Recently, one and four deaths were reported after yellow fever inoculation in the USA and Australia, respectively. These cases involved older persons with different underlying illnesses. Nevertheless, experts evaluated the incidents and came to the conclusion that the yellow fever vaccine is one of the safest (Box 1).

In the meantime molecular biologists have almost completely analysed the genome of the yellow fever virus. Thus, which RNA sections encode which proteins is exactly known. Additionally, because the attenuated yellow fever virus currently used in vaccines induces protective immunity with just one injection for at least 10 years, it suggests itself to combine genetic components of the yellow fever virus with those from other flaviviruses for which there is so far no reliable inoculation. Researchers at the American company, Acambis, in Cambridge, Massachusetts already developed a hybrid virus, which protects against Japanese Encephalitis in an animal model. Work is also being undertaken on a chimeric vaccine against West Nile virus. This has been worrying the American east coast population for the past three years.

Hermann Feldmeier

**Box 3**

**Yellow fever in Asia?**

In principle yellow fever is not a tropical illness. In the 18th and 19th century there were about 50 epidemics in North American cities (in Philadelphia alone 20 and in New York 15). Only due to cold winters, which kill the majority of the mosquito vectors, did the illness not become endemic.

Also today the risk of outbreaks is imminent in areas where *Aedes aegypti* is commonly found in the local mosquito population. Therefore the International Health Regulations of 1969 planned that all international air- and seaports must be kept free of mosquito larvae and adult mosquitoes.

Data from India show, however, a precarious development: larval premises index between 1964 and 2000 rose in the harbour cities of Chennai from 0 to 23% and in Bombay from 0 to 12%. Additionally, the number of *Aedes aegypti* larvae at international airports climbed precariously; for example in Delhi from 0 to 61% between 1977 and 2000. Just one arriving traveler in the early phases of the infection with no present clinical symptoms could thus set off an outbreak on the Indian subcontinent.

Aedes aegypti mosquito, the insect vector responsible for transmitting yellow and dengue fever

"I am soon going to get out of here. Life got terrible since ECCMID and ESCMID got so popular in Europe."
News in Brief

**Infectious Diseases and Outbreaks**

**YERSINIA OUTBREAK TRACED TO LETTUCE**
A detailed epidemiological and environmental study carried out in Finland has revealed the first documented evidence of human infection with *Yersinia pseudotuberculosis* being acquired from eating contaminated iceberg lettuce. The organism was found in irrigation water and soil from farms providing lettuce eaten by affected people. The assumption is that the environmental contamination originated from the faeces of roe deer.

*Tauxe J Infect Dis 2004; 189: 761*

**SALMONELLA OUTBREAK IN US CAUSED BY RAW GROUND BEEF**
Dozens of cases of salmonellosis in north-eastern states have been linked with the consumption of raw or cooked ground beef. Studies are ongoing to determine the source of the beef. CDC has not yet commented on the outbreak although the US Department of Agriculture has issued a public health warning about eating raw or undercooked ground beef.

*Reuters January 30, 2004*

**NEW COMMUNITY-ACQUIRED MRSA STRAIN IDENTIFIED IN GERMANY**
Community acquired strains of MRSA isolated in Germany during the second half of 2002 were found to have the determinant for Panton-Valentine leukocidin (PVL) and to be resistant to fusidic acid. This pattern is different from nosocomial-acquired strains but corresponds to the pattern seen in strains isolated from other European countries. These strains have been isolated from geographically distinct hospitals in Germany, indicating that they may already be widely disseminated.

*Eurosurveillance Monthly 2004; 9: 1*

**LOW RATE OF TRANSMISSION OF MRSA IN DUTCH HOSPITALS**
A study in 16 nursing homes across four regions of the Netherlands has shown a low rate of prevalence of MRSA. Nasal swabs were collected from 1218 residents and MRSA was isolated from only 8 (0.7%). The isolates proved to be indistinguishable from each other and from MRSA isolates in local hospitals. Previous studies have shown a low rate of prevalence of MRSA in Dutch hospitals, possibly a consequence of the restrained use of antibacterials in the Netherlands.

*Eurosurveillance Weekly 2003; 7 (51), December 18*

**OUTBREAK OF LEGIONNAIRE’S DISEASE IN NORTHERN FRANCE**
24 cases of legionnaire’s disease have been reported in northern France during November and December 2003. Most patients (19/24) are men and the mean age of all patients is 71 years. Three patients have died. All patients live in or have visited the same area and an environmental source is being sought. One local factory has been closed to allow disinfection of its cooling tower.

*Eurosurveillance Weekly 2003; 7 (51), December 18*

**Resistance**

**ANTIBIOTIC RESISTANCE IN THE MEDITERRANEAN REGION (ARMED PROJECT)**
The levels of resistance to antibiotics in the Mediterranean parts of Europe have been shown previously to be higher than in western and northern parts of the continent but no systematic analysis of the situation in these countries has been carried out. A project (ARMed), funded by the EC’s Directorate General for Research has been set up to assess the occurrence of resistance and its determinants in the European and adjacent Mediterranean countries, including Cyprus, Egypt, Jordan, Morocco, Tunisia and Turkey.

*Eurosurveillance Weekly 2004; 8 (7), February 12*

**MRSA SHOWN TO HAVE INDUCIBLE RESISTANCE TO CLINDAMYCIN**
A clindamycin-susceptible, erythromycin-resistant strain of MRSA causing a scalp infection in a child developed resistance to clindamycin following therapy with clindamycin. The original strain was shown to have inducible resistance to clindamycin in vitro. A survey carried out in the same hospital revealed a substantial number of *S. aureus* strains with inducible resistance to clindamycin.

*Silery et al. Clin Infect Dis 2003; 37: 1257*

**Viral Infections**

**HUMAN DEATH ASSOCIATED WITH RACCOON RABIES**
The first human death associated with raccoon rabies was reported by CDC in late 2003. The patient, a 25-year-old man from Virginia, did not report an animal bite but lived in an area in which raccoon rabies is endemic. CDC reports that in the majority of human rabies cases in the US no history of animal bites is recorded.

*MMWR 2003; 52: 1102*

**HUMAN METAPNEUMOVIRUS IS A MAJOR CAUSE OF INFECTION IN CHILDREN**
A recent report claims that the recently discovered (2001) human metapneumovirus is a major cause of respiratory tract infections in children. This virus may account for a number of previously undiagnosed infections. In the present study the authors tested over 200 nasal washings collected from children with a respiratory tract infection of unknown origin over a 25-year period and found that 20% showed the presence of metapneumovirus. The virus probably accounts for 12% of all respiratory infections in children.

*Williams et al. NEJM 2004; 350: 443*

**SARS**

**IS SARS A HYBRID VIRUS?**
Scientists from the University of Toronto believe that the SARS coronavirus may have its origins in a hybridisation between a mammalian and an avian corona virus. A gene controlling the production of the “spike” protein...
which is part of the virus coat appears to be a hybrid with characteristics of both mammalian and avian coronavirus.


**INTERFERON–ALPHA SHOWS PROTECTIVE EFFECT AGAINST SARS IN MONKEYS**

A group in the Erasmus Medical Centre, Rotterdam have shown that pegylated interferon-alpha administered to macaque monkeys gave considerable protection from subsequent infection with SARS virus. Compared with control-infected animals, there were very few virus particles in the throat and far fewer in the lungs. Pegylated interferon alpha is used to treat hepatitis C infections in humans.


**LABORATORY WORKER IN TAIWAN CONTRACTS SARS**

In December 2003 a research worker from the P4 laboratory in the National Defense University, Taipei, Taiwan became ill with a fever. The presence of the SARS corona virus was confirmed from samples of blood, sputum and a throat swab in late December. The patient became ill on his return from a visit to Singapore, but the health authorities in Taiwan suspect that he became infected in Taiwan while working on the coronavirus. The Taiwan health authorities are checking all known contacts from Taiwan and the Singapore Ministry of Health is tracing the contacts in Singapore. This is the second case of laboratory-acquired SARS, the previous one being a medical student in Singapore.

_Eurosurveillance Weekly 2003; 7 (51), December 18_

**SARS CASES SEEN AGAIN IN CHINA**

A new case of SARS was confirmed in late December 2003 in a man in Guangdong province in China. Two other suspected cases from the same area have been confirmed as having the SARS virus. All have recovered and have been discharged. All known contacts have remained well. The source of the infection in these three patients is not known and it is not clear whether there is a link between them and contact with animals.

WHO CSR 2004 January 27. Update 4

**CHEMICAL DECONTAMINATING FOAM MAY KILL SARS VIRUS**

A chemical foam formulation developed to decontaminate chemical and biological warfare agents has been tested for its efficacy against a bovine coronavirus. The work was carried out by a team from Sandia National Laboratories and Kansas State University who have developed a range of compounds for decontaminating surfaces. Preliminary tests with bovine coronavirus, used as a surrogate for SARS virus, showed that DF-200 foam was able to inactivate the virus in less than a minute. It is planned to test it against SARS and avian influenza.


**WEST NILE VIRUS (WNV)**

A group from the National Museum of Natural History, Washington, DC has suggested that hybrid mosquitoes may have influenced the spread of WNV in the US. They have found that over 40% of the _Culex pipiens_ examined in the US are genetic hybrids of two distinct types. In Europe the types differ, one of which bites birds and hibernates over the winter and one of which bites mammals year round. The ability of the American hybrid mosquitoes to bite both birds and mammals may have contributed to the rapid spread of the virus throughout the continent.

_Fonseca et al. Science 2004; 303: 1535_

CDC reports that at November 25 the total number of human cases of WNV in 2003 was 8,567 in 46 states with an approximately equal distribution between the sexes. There have been 199 human deaths and 11,350 dead birds recorded from 45 states. In addition 4,146 horses, 30 dogs, 17 squirrels and one cat were infected.

_MMWR Weekly 2003; 52: 1160_

**AVIAN INFLUENZA**

In December, 2003, in Korea 19,000 chickens died out of a flock of 24,000 birds. It was confirmed that the outbreak was caused by highly pathogenic avian influenza virus H5N1. Later in December avian influenza spread to other chicken and duck farms in Korea and by January similar outbreaks were reported from Vietnam, the first time that highly pathogenic avian influenza had been detected in this country. During January, 13 children in Vietnam contracted a severe respiratory disease, 7 of whom died. Samples from two of these fatal cases and the mother of one of the children were confirmed as having the H5N1 virus.

In spite of stringent measures taken to restrict the spread of the disease, Japan, Thailand, Cambodia and China also reported outbreaks of the H5N1 virus in chicken farms during January. In Pakistan an outbreak of avian influenza was found to be caused by the H5N7 subtype. Nearly 2 million hens have either died or been killed as a control measure in Pakistan.

The disease continued to spread in February, with more cases occurring in humans. Avian influenza (H5N7) outbreaks are confirmed in two farms in Delaware, USA. Laboratory studies indicate that there are significant differences between the current outbreak strain of virus and the viruses causing the outbreaks in Hong Kong in 1997 and 2003, indicating that the virus has mutated. The WHO is accelerating work on developing a vaccine. The virus isolated from infected humans is shown to be resistant to amantadine and rimantadine. By mid-February the total number of human cases is 25 in Thailand and Vietnam, 19 of which have been fatal.

_WHO. H5N1 influenza: a chronology of key events_

Cats have been found to be infected with avian influenza in Thailand but this is not thought to have major implications as the cats do not excrete large numbers of virus and remain healthy.

_WHO. Avian Influenza. Update 28. February 28, 2004_

An emergency meeting between officials from FAO, OIE and WHO was held at the end of February in Bangkok to discuss avian influenza. It has been estimated that over 100 million birds have been killed or have died in Asia over the last two months. Various features pertaining to the ways in which poultry are kept and their economic importance make rapid control and long term prevention of recurrence difficult.

_WHO. Avian Influenza. Update 31. March 2, 2004_
HIV and AIDS

CO-INFECTION WITH GB VIRUS C PROLONGS LIFE OF HIV PATIENTS
GB virus C (GBV-C) is a non-pathogenic virus which has been shown to inhibit the replication of HIV in vitro. Previous studies have indicated that in those co-infected with GBV-C and HIV there may be a prolongation of life. The current study assessed the duration of viraemia with GBV-C in HIV-positive men and showed a significant prolongation of survival in those with a prolonged viraemia but not in those with transient viraemia.

Williams et al. NEJM 2004; 350: 981

Vaccines

PROMISING RESULTS ON SARS VACCINE
A trial adenoviral-based vaccine for SARS has shown promising results in rhesus macaque monkeys. Six monkeys were inoculated, all of whom developed antibodies and produced immune macrophages. Some corona viruses can replicate inside macrophages and thus worsen the disease. It has not yet been established whether the SARS virus can do this. This vaccine contains three genes from the SARS virus contained within a non-virulent virus. The authors emphasise that challenge tests are required in a clinically-relevant SARS disease animal model to confirm the value of this vaccine.


VALUE OF POST-EXPOSURE MEASLES VACCINATION QUERIED
Post-exposure vaccination to protect susceptible contacts against measles in an outbreak has been advocated, but recent results in the UK have cast doubt on the wisdom of this approach. Following a case of measles in a 17-month old child attending a nursery, four of the six previously unvaccinated contacts were vaccinated but all contracted the disease within 3 days.

Eurosurveillance Weekly 2004; 8 (8), February 19

ALUMINIUM-CONTAINING DTP VACCINES APPEAR SAFE
There have been concerns in some quarters over the safety of aluminium salts used as adjuvants in some vaccines, including DTP, hepatitis A and B, H. influenzae and pneumococcus vaccines. A systematic review with a meta-analysis of studies using DTP vaccines containing aluminium were compared with those without aluminium or with lower levels of aluminium. The only significant effect of aluminium was on local pain at the injection site in older children and more erythema and induration at the injection site in young children. The authors conclude that there is no evidence of any long term adverse events from the use of aluminium-containing vaccines.


New Chemotherapeutic Agents

ANTIMICROBIAL PEPTIDE SHOWS ACTIVITY IN PARASITIC INFECTIONS
A group of Spanish workers from Barcelona has shown that a peptide is...
safe and active in the treatment of leishmaniasis in dogs. This preliminary study used 8 dogs infected with *Leishmania infantum* and in all dogs the parasitic load was decreased. The peptide was an acylated synthetic cecropin A-melatin hybrid.

Albenola et al. Antimicro Ag Chemother 2004; 48: 641

New Fusion Inhibitor Shows Activity Against Respiratory Syncytial Virus (RSV)

A new compound has been shown to have activity against RSV in infected mice as well as a range of laboratory and clinical isolates. The compound inhibits the fusion of lipid membranes during early virus entry and late stage syncytium and is active by the oral route.

Cianci et al. Antimicro Ag Chemother 2004; 48: 413

Industry and Drugs

Yamanouchi and Fujisawa to Merge

After previous denials, Yamanouchi has confirmed that it is to buy Fujisawa. The company will be the largest Japanese pharmaceutical company.

www.yamanouchi.co.jp and www.fujisawa.com

Pfizer Stops Development of DK-507K

Development of the in-licensed Daiichi compound DK-507K has been discontinued. Pfizer announced that the results of Phase I studies were disappointing. DK-507K is a fluoroquinolone with greater activity in vitro than most quinolones currently available or in development. It had also shown promising activity in animal models.

www.pfizer.com

New Antifungal Drugs Criticised by UK Journal

The journal Drugs and Therapeutic Bulletin has criticised the promotional claims for two new antifungal drugs, Pfizer’s voriconazole and Merck’s caspofungin. Both companies claimed that their new compounds show advantages relative to amphotericin B in patients with invasive aspergillosis, but the Bulletin states that the evidence for these claims is unconvincing.

Drug Ther Bull 2004; 42: 5

Primaquine Shown to Be Useful Prophylactic Agent Against Malaria

Recent clinical trials on the use of primaquine have shown it to be safe, well-tolerated and effective in preventing malaria. The trials were conducted in Indonesia, Kenya and Columbia against *Plasmodium falciparum* and *P. vivax*. The advantage of using primaquine is that it can be taken immediately on entering a malarious area and for only 3 days after leaving the area.


Moxifloxacin Shown to Have Promising Activity Against Human Tuberculosis

The 8-methoxy fluoroquinolone, moxifloxacin (Bayer) has proved to have activity equal to that of rifampicin but slightly less than that of isoniazid in a Phase II study. The drugs were given for 5 days of monotherapy before switching to conventional four-drug therapy. The authors recommend a larger scale clinical trial with moxifloxacin.

Gillespie et al. Am J Respir Crit Care Med 2003; 168: 1342

European Matters

**European Centre for Disease Prevention and Control (ECDC)**

The proposed ECDC has now received a favourable vote from the European Parliament on February 10. Various amendments were made to the original proposal made by the European Commission in September 2003. This still has to be endorsed by the European Council, which is anticipated for March or April. It is hoped that the ECDC will begin functioning in 2005 and that it will reinforce the current communications between the various member states with regard to surveillance and the tracking and handling of outbreaks of infectious diseases. Stockholm, Sweden will be the location for the new ECDC. A budget of almost 48 million Euros is allocated for 2005–2007.

Eurosurveillance Weekly 2004; 8 (10), March 4 and Lancet 2004; 363 (9409)

**Scientific Community Has Doubts About the Planned European Research Council**

The proposed European Research Council (ERC) is to be set up within the Framework Programme and it is this that has caused concern among many European scientists. They fear that the ERC will become entangled in the bureaucracy and politics of the EU. Bodies such as the UK Royal Society and the UK Biochemical Society have expressed these views.

The Scientist. January 23, 2004

**Germany’s New Charging System Has Mixed Results**

Health reforms were introduced in Germany in January 2004. These changes included charges for seeing a doctor. There are criticisms that the new scheme has caused confusion for both patients and doctors. It is too early to determine whether there will be a reduction in the number of patients visiting doctors. The additional time spent on administration of collecting fees has led to delays in patients being seen.

Pamela Hunter
Medical Writer

The Academy for Infection Management: Interactive learning at ECCMID 2004

The Academy for Infection Management (AIM) is a global educational initiative that was launched to gain a wider acceptance of the concept of using appropriate antibiotics early in nosocomial infections. AIM is led by a panel of multinational, multidisciplinary experts who have produced a series of educational resource materials that are freely available on the AIM website, www.infectionacademy.org. The AIM faculty will run a series of stimulating interactive case history-based sessions, called the “Academy in Action”, at the 14th ECCMID in Prague, Czech Republic, during 1–4 May. The sessions will provide an excellent forum for discussion and learning. AIM is supported by an educational grant from AstraZeneca.
Forthcoming Events

More detailed information about ESCMID courses and conferences as well as general information about other events can be found on the ESCMID website at www.escmid.org under Courses & Workshops, ECCMIDs & Conferences, or Calendar of Events, respectively.

ESCMID events

1-4 April 2004
14th European Congress of Clinical Microbiology and Infectious Diseases (ECCMID)
Place: Nice, France
Contact: AKM Congress Service
Phone: +41 61 686 77 11
Email: info@akm.ch

Supported by ESCMID

15-18 May 2004
EWGU session
Place: Chamonix, France
Contact:
Email: jetienne@univ-lyon1.fr
Internet: http://www.invs.sante.fr/agenda/ewgul.2004/

23-26 June 2004
6th International Workshop on Pathogenesis and Host Response in Helicobacter Infections
Place: Helsingør, Denmark
Contact: ESGPIHI and EHS
Internet: www.helpatim.dk
or www.helicobacter.org

Imprint

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