THE FEDERATION OF INFECTIOUS DISEASES SOCIETIES OF SOUTHERN AFRICA

# FIDSSA Quarterly

Volume 3 Issue 2 1st June 2012

**Special points of interest:**

- Lessons from an IPC outbreak
- The Accra Declaration
- Optimizing FNAB for mycobacterial culture
- Interpreting tests with an imperfect reference standard



## 2012 FIDSSA-GlaxoSmithKline Research Fellowships Request For Applications

fidssa federation of infectious diseases societies of southern africa

gsk GlaxoSmithKline

FIDSSA is delighted to announce a 2nd year of funding from GlaxoSmithKline by way of an unconditional educational grant, to finance the 2012 FIDSSA-GlaxoSmithKline Research Fellowships.

We will again be making 2 awards of R100,000 each. Funding for laboratory, clinical or public health research projects in the broad field of infectious diseases that FIDSSA represents will be considered. We encourage projects from all fields of infectious diseases, microbiology and infection prevention and control, especially those outside of the realm of HIV and tuberculosis. The awards are intended to support new research projects by junior investigators and applicants who have not previously received substantial funding (any award > R250,000) will be prioritised. Projects that are part of a larger funded project must clearly denote how the budget will be spent separate from the larger fund, and the project itself should be a discrete component of the larger project. Budget for salary support will not be considered, nor will travel or conference fees be supported by these fellowships, although successful applicants will be able to apply to FIDSSA for separate funding to present papers originating from the work at a national or international conference.

The following criteria apply to all applicants:

- Must be a full, paid up 'Ordinary' member of FIDSSA by the **closing date for applications on 31st July 2012.**
- Must be a citizen of one of the countries in the Southern African region (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) and must be undertaking the research project in Southern Africa. Applications to undertake periods of research outside of Southern Africa will not be considered.
- A fully completed application form downloadable from the FIDSSA website homepage (http://www.fidssa.co.za) or from Lea Lourens at info@fidssa.co.za must be returned to Lea Lourens at info@fidssa.co.za by the closing date (31st July 2012).
- Applications submitted after the closing date will not be accepted under any circumstances and incomplete applications will be returned to the applicant without review.
- Each award will be made as a once-off payment in full and the recipients will be announced by 15th September 2012, with an intended start date of 1st October 2012.
- Each recipient must undertake to provide a progress report at 6 months, and a final report at 12 months, which must include proof of how the budget was spent. Any publication arising from work funded by a FIDSSA-GlaxoSmithKline Fellowship, must acknowledge the funding in the manuscript.

## Hot topics in Infection Prevention and Control


To start with, a brief update and comment on an infection control issue in Cape Town, and some of the lessons that are being learned (or re-learned)

Recently, 3 patients at a Cape Town Hospital were identified as carrying a multi-resistant *Klebsiella pneumonia*, with the OXA-48 carbapenemase gene. As discussed in the May 2012 Case of the Month, one of the strategies that some are advocating for this organism is a "search and destroy" approach. The hospital embarked on a programme of screening all patients in the wards where the affected patients were, as well as screening all staff members. The screening identified 4 other patients, as well as a staff member (PCR positive but culture negative). Subsequently all high risk admissions (previous admission to the affected wards or admission to a private health care facility) were screened, and admitted to a "holding area" pending the result of the screening swab. This process has, at the time of writing, just started, but some important lessons have already come out (and some of these lessons are things we know, but seeing it happen in real life brings home how important they are):

1. Communicate with all stakeholders – there was a huge amount of panic particularly among health care workers, who started fearing for their own safety if they went into the same cubicle as one of the colonized patients.
2. Don't organize unusual / complicated screening and "holding area" procedures on a Friday afternoon – the poor sucker on call over the weekend is going to have to pick up the pieces of misunderstood policies.
3. Don't always rely on the heads of units to communicate policies to the rest of their department (which increases the pressure on the poor sucker on call over the weekend!)

I thought that it would be interesting to go through the postings on the OSHA website (http://blogs.hcpro.com/osha/) and compile a short summary of some of the more interesting or useful posts there. While this is a US-based site, many of the issues are relevant in South Africa as well, and sometimes its fun to see that others face the same problems we do.

•The FDA issued a warning, April 18, to healthcare facilities using Other-Sonic Generic Ultrasound Transmission Gel. The agency has found that some lots sold in 250 milliliter (mL) bottles and 5 liter (l) dispensing containers are contaminated with the bacteria *Pseudomonas aeruginosa* and *Klebsiella oxytoca.* While this particular product might not be used in SA, its worth remembering that these gels can become contaminated and serve as a source of transmission of various organisms

•Among all U.S. workers, 30% report not getting enough sleep, and workers on night shift usually reported the most sleep deprivation, according to the CDC. The report, published in *Morbidity and Mortality Weekly Report*, found a high prevalence (52.3%) of short sleep duration reported by night shift workers in the health-care industries. Nearly 30% of regular daytime shift healthcare workers and 36.6% in other shift categories, such as regular evening shifts and rotating shifts, reported short sleep duration (averaging less than 6 hours per 24-hour period). It's probably not a great surprise that healthcare workers are often sleep deprived. But it is important - in addition to adverse health effects such as cardiovascular disease or obesity, insufficient sleep duration is associated with decreased workplace safety and impaired job performance.

•There is clear evidence that *Clostridium difficile* (*C.difficile*), a difficult-to-control and treat bacterial infection, is increasing, especially in non-hospital settings, according to Mayo clinic researchers in a study presented at Digestive Diseases Week, 2012. The study found that the incidence of C. difficile infection (CDI) in children between 2004 and 2009 was more than 12 times higher than between 1991–1997. Also, 75 percent of those cases were community-acquired C. difficile, which means that the patient had not been in a hospital for at least four weeks prior to contracting the infection. From an infection control perspective it should be remembered that C. difficile

can be contracted from contaminated surfaces and spread from person to person. Alcohol based hand rubs are not effective against *C. difficile*, and washing hands with soap and water after patient contact is preferred. Patients should also be on contact precautions.

- Acute care hospitals have lower rates of methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections when having a board certified infection prevention director. The study by Pogorzelska *et al*, (Am J Infect Control 2012; 40: 96), analyzed data from 203 California hospitals to determine if there is an association between structure and practices of their programs, and frequency of infections caused by antibiotic-resistant bacteria, and is one of the first studies to find a link between patient care practices, infrastructure elements, and rates of healthcare-associated infections. This should strengthen the argument for instituting a standardized curriculum for training infection control, and ensuring that hospitals are adequately staffed by appropriately trained IPCPs.
- A study shows that contact -precautions may cause patient delirium. A study in the -January issue of *Infection Control and Hospital -Epidemiology* indicated that patients moved to isolation during a hospital stay are nearly twice as likely to develop -delirium. Patients beginning their stay in -isolation do not share this increased risk. The authors do comment that patients who are put on contact precautions may be sicker to start with, making them predisposed to delirium to begin with. So while contact precautions still need to be applied when appropriate, remember that like most medical interventions, may have adverse effects that people should be aware of.

And finally - should vaccinations against influenza be mandatory for healthcare workers?

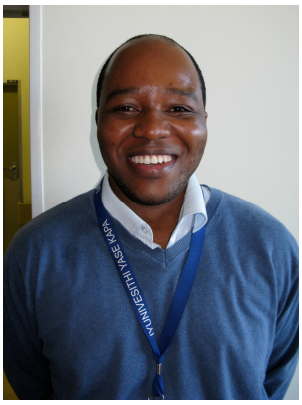
A debate is currently raging about whether the decision to get a flu shot should be made by a nurse, or by his or her employer. In Massachusetts, one in five employees at acute care hospitals declined to be vaccinated last Autumn. Organizations such as the American Hospital Association and American Academy of Family Physicians support mandatory flu vaccines for healthcare workers, with exceptions in the case of health or religious opposition. But nurses have provided some of the most vocal opposition to such mandates; just read some of the individual comments and the summary of public comments about the issue.

Although the nurses' union National Nurses United "maintains the position that every RN should be vaccinated against the flu," it opposes vaccine mandates, saying that such programs "engender distrust and resistance among employees; offer a disincentive to providing vaccination education to employees, and raise ethical and legal questions about the personal employment rights of employees." In its written policy provided to HealthLeaders Media, the American Nurses Association "urges all registered nurses to get vaccinated every year to protect themselves, their families, and the patients they serve." However, it "does not support mandatory influenza vaccination requirements for healthcare workers unless they adhere to certain guidelines to ensure they are fair, equitable and nondiscriminatory."

Voluntary measures don't seem to work as well. According to the CDC, "during the 2010-2011 influenza season, coverage for influenza vaccination among healthcare workers was estimated at 63.5%." However, "coverage was 98.1% among healthcare workers who had an employer requirement for vaccination."

As far as I know, influenza vaccination is not mandatory in any health care setting in South Africa, but is offered by many centres. It would be interesting to get people's feedback and experiences with staff influenza vaccination. Is it well taken up or not; if not why not; and has anyone tried to make it mandatory?

## Congratulations to 2 new ID specialists!



Heartfelt congratulations go to Dr Sipho Dlamini and Dr Tom Boyles who passed their Cert ID(SA)Phys examinations in May.

In a sane world, Sipho and Tom would be embraced by a health system that understands the value of having ID-trained specialists working at tertiary and secondary hospitals, supporting primary care and addressing the needs of patients and the health system alike. Sadly, we are not living in a sane world. Thus due to the lack of expansion of infectious diseases posts in South Africa, neither of these outstanding physicians have an ID post to go into. While South Africa continues to ignore the need to expand posts for ID physicians and paediatricians in the face of the overwhelming burden of infectious diseases, the population will continue to be poorly served.

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## Fool's gold; how to interpret a test with an imperfect reference standard

Tom Boyles, Division of Infectious Diseases and HIV Medicine, UCT

It has been said that epidemiologists see the world through a 2x2 table. I suspect that many would like to but unfortunately things are rarely so simple when it comes to assessing new tests. Once a 2x2 table is populated we can determine all the sensitivities, specificities, predictive values and likelihood ratios we like but it is easy to underestimate the difficulties this sometimes presents. To populate the first column we must define a group of patients who unequivocally have the condition and for the second column a group who unequivocally don't have the condition. This may be fairly easy for pregnancy if you take women with an ultrasound scan showing an image of a baby with a beating heart in her uterus and another group with an ultrasound scan showing no evidence of either a uterus or a baby. If the pregnancy test also gives unambiguous results we would be able to populate the table and easily evaluate the pregnancy test.

| | Disease | No Disease |
|---|---|---|
| Test Positive | A | B |
| Test Negative | C | D |

We immediately run into problems however if it is difficult to decide who does or doesn't have the condition. Take a new test for pulmonary tuberculosis as an example. We might take 2 sputum samples from each patient and put all patients with at least 1 positive result in the 'disease' column. We might put all patients with 2 negative cultures in the 'no disease' column and populate the table from there. In doing this we would be defining our reference standard (sometimes called Gold standard) in terms of these culture results. However, we also know that is possible to die from pulmonary tuberculosis despite having 2 negative MTB cultures which is an admission that the reference standard is imperfect. We can get along fairly well in evaluating tests if we can agree on reasonable reference standards but must acknowledge the introduction of errors if the reference standard is known to be imperfect.

Major problems occur when there is no reference standard or the standard is disputed. To take a controversial example; if there is no agreed reference standard for diagnosing chronic Lyme disease then it is not possible to populate the beloved 2x2 table and therefore impossible to evaluate any test for the condition. Any estimation of the sensitivity or specificity of a new test would be meaningless without an agreed reference standard.

A less controversial but equally puzzling example relating to the diagnosis of leptospirosis has recently been described and fortunately the authors have supplied a method for approaching the conundrum[1]. In attempting to evaluate a new rapid test for leptospirosis the authors chose an accepted reference standard of either a positive leptospira culture or positive microscopic agglutination test [MAT] as indicating presence of disease and a negative result for both tests as indicating absence of the disease. However they began to doubt the validity of this choice when a number of patients who fitted the clinical picture for leptospirosis were found to be negative on both reference tests but positive on the new rapid tests. Rather than accept these as false positives they sought an alternative way of analysing the data and finally reanalysed data from 4 similar trials.

The method is known as a Bayesian latent class model and random effects meta-analysis[2]. While the details may be for the enthusiast a summary is that a mathematical model is created that includes the results of several different tests for the same disease. None of the tests is assumed to be 100% sensitive or specific [the definition of a Gold standard] and data from real studies are combined in the model which estimates the true sensitivities and specificities of each test.

Results showed that in the standard model the combination of culture plus MAT was assumed to have 100% sensitivity and specificity but the Bayesian model suggested that the true figures were around 55% and 99% respectively. In evaluating the new rapid test the standard model suggested sensitivity of 88% and specificity of 70% whereas the Bayesian model suggested figures of 86% and 96% respectively. As a result the model suggests that the rapid test performs better than originally anticipated with a specificity of 96% rather than 70%.

The problem of uncertain, disputed or impractical reference standards is common when evaluating new tests of infectious diseases; pulmonary tuberculosis, neurosyphillis and pneumocystis pneumonia are just three examples. The Bayesian approach is not novel but may be a powerful tool in evaluating diagnostic tests where accepted reference standards are lacking.

1. Limmathurotsakul D, Turner EL, Wuthiekanun V, et al. Fool's Gold: Why Imperfect Reference Tests Are Undermining the Evaluation of Novel Diagnostics: A Reevaluation of 5 Diagnostic Tests for Leptospirosis. Clin Infect Dis 2012.
2. Joseph L, Gyorkos TW, Coupal L. Bayesian estimation of disease prevalence and the parameters of diagnostic tests in the absence of a gold standard. Am J Epidemiol 1995;141:263-72.

## The Accra Declaration

South African Society of Travel Medicine

*Dr David Hyams (Current President of SASTM) and Mrs Arvinda Sooka (Representing the Enteric Disease Unit of the NICD) attended the first meeting of **IDEA: I**nitiative against **D**iarrhoeal and **E**nteric disease in **A**frica in Ghana from the 23-25th of April this year. The following Declaration was issued highlighting what the initiative is all about and invites any relevant stakeholders to become part of this initiative:*

**The ACCRA Declaration: ACCRA, Ghana, April 27th 2012**

**The Initiative against Diarrhoeal and Enteric diseases in Africa (IDEA) consolidates its organization and confirms its commitment in the fight against cholera.**

Since its launch in Dakar in November 20111, IDEA is a unified, independent and multidisciplinary group of scientific, medical and public health professionals from cholera-prone countries in Africa and Asia2. Its mission is to participate and to contribute to effective enteric diseases and cholera control through a multi-sectorial approach based on its expertise, collection, analysis and dissemination of evidence-based data and by establishing linkages with national and international stakeholders involved in the fight against enteric diseases.

Representatives from 10 English- and French-speaking African countries3 met in Accra, Ghana from 23 to 27 April 2012 and considered that the epidemiology situation is still alarming despite positive trends in some countries thanks to continuous efforts to curb the disease. Cholera is still a real threat in many countries, resulting in a heavy, individual, humanitarian, public health and socio-economic burden.

IDEA members reiterated their commitment and are willing to share information, analyze relevant issues, raise disease awareness and suggest or support appropriate measures to improve disease control and prevention when required. IDEA members acknowledge the efforts conducted by the international community to improve the management, control and prevention of cholera, including the introduction of vaccination, whilst regretting the under representation of African countries in such initiatives.

IDEA members are calling for a more active involvement of decision-makers and politicians through better awareness and understanding of this issue and its actual impact, as well as for an increased partnership and collaboration between countries and international organizations. Within the coming year, IDEA is going to implement a plan of action focusing on some priority areas such as the assessment of the actual medical, public health, socio-economic and cultural burden of cholera; the identification of the needs for operational research efforts; and the best advocacy approaches to improve awareness of decision-makers and field actors to allocate necessary resources to support cholera and enteric diseases management, control and prevention.

IDEA will then attempt to make proposals for global and integrated national management plans that will fill the gaps to the current situation and meet the needs for an effective control of cholera and other enteric diseases.

1 La Déclaration de Dakar, 10 November 2011
2 The Chiang Mai Declaration, 1 December 2011
3 Benin, Cameroun, Côte d'Ivoire, Kenya, Mali, South Africa, Uganda, Senegal, Zambia and Zimbabwe (Democratic Republic of Congo, Ghana, Madagascar, Mozambique, Tanzania were invited but not able to attend)

*IDEA is supported by an unrestricted educational grant from Sanofi Pasteur*

## Improving access to mycobacterial culture and specimen from fine needle aspiration biopsy (FNAB) specimens


Colleen Wright. NHLS Port Elizabeth and Faculty of Health Sciences, NMMU, Port Elizabeth

Fine-needle aspiration biopsy (FNAB) is a useful modality for obtaining confirmation of mycobacterial disease in children and adults. In endemic areas, 5-10% of children have tuberculous adenitis associated with pulmonary disease. Extrapulmonary tuberculosis (EPTB) occurs in 10-30% of children with TB, with tuberculous lymphadenitis the commonest clinical manifestation.[1]

A recent retrospective study of mycobacterial lymphadenitis in children from an endemic area of South Africa showed FNAB to be superior in yield and mean time to diagnosis than respiratory specimens such as gastric aspirates or induced sputum.[2] However, to be effective in the control of mycobacterial disease, FNAB needs to rely not only on cytomorphology and identification of the organism on light microscopy, but to enable culture, speciation and sensitivity testing.

Bedside inoculation of commercial liquid media systems such as mycobacterial growth indicator tubes (MGIT: Becton Dickinson, Sparks, Maryland, USA) has proved to be an effective means of obtaining mycobacterial culture

from residue remaining in the needle and syringe. However this is too costly for routine use, which led to the development of a TB transport bottle by pathologists/scientists within the NHLS and Stellenbosch University, now available through NHLS laboratories.[3] For standardisation purposes it has initially been manufactured by the media division at the NHLS Greenpoint laboratory.

The TB transport bottle contains Middlebrook's medium, is stable at room temperature and does not require removal of the cap at inoculation minimising the risk of contamination. The residue of material remaining in the needle and syringe after preparation of the smears is rinsed into the bottle and submitted for culture. If pus is aspirated, only 1 to 2 drops should be inoculated into the bottle to prevent overwhelming the culture medium.
The amount of Middlebrook's in the bottle has been carefully calculated to enable this bottle to be used as a multipurpose medium for submission of material from FNAB for the Xpert MTB/RIF test.

A recent study looking at 50 patients with suspected mycobacterial lymphadenitis who underwent FNAB and in whom a specimen was submitted for Xpert MTB/RIF using the transport medium, showed this technique to have a sensitivity of 96.7% with a specificity of 88.9%.[4]
A recent study looking at 50 patients with suspected mycobacterial lymphadenitis who underwent FNAB and in whom a specimen was submitted for Xpert MTB/RIF using the transport medium, showed this technique to have a sensitivity of 96.7% with a specificity of 88.9%.[4] This superb outcome combined with an extremely rapid turnaround time has led to consideration of the possibility that FNAB specimens may be fast tracked directly to Xpert MTB/RIF, particularly in high-risk groups. These would include paediatric specimens and patients awaiting commencement of antiretroviral therapy.

1. Marais BJ, Gie RP, Schaaf HS, Hesseling AC, Enarson DA, Beyers N. 2006. The spectrum of childhood tuberculosis in a highly endemic area. Int J Tuberc Lung Dis. 10:732-738.
2. Wright CA, Hesseling A, Bamford C, Burgess SM, Warren RM, Marais BJ. 2009. Fine-needle aspiration biopsy: a first-line diagnostic procedure in paediatric tuberculosis suspects with peripheral lymphadenopathy. Int J Tuberc Lung Dis 13(11):1373-1379.
3. Wright CA, Bamford C, Prince Y, Vermaak A, Hoek KGP, Marais BJ, Warren RM. 2010. Mycobacterial transport medium for routine culture of fine needle aspiration biopsies. Arch Dis Child 95(1):48-50.
4. Ligthelm LJ, Nicol MP, K.G.P H, Jacobson R, van Helden PD, Marais BJ, Warren RM, Wright CA. 2011. Xpert® MTB/RIF for the rapid diagnosis of tuberculous lymphadenitis from Fine Needle Aspiration biopsy specimens. J Clin Microbiol in press.

## Is haematospermia due to a sexually transmitted infection?


The first reaction of most men when they notice blood in their semen (haematospermia) is that of shock with thoughts of prostate cancer or death. Haematospermia is quite common in sexually active men but may also happen in young boys who are not yet sexually active and older men who have 'hung up their boots'. There are many causes including inflammation of the prostate gland, infection, blockage or trauma anywhere in the male reproductive system. In most cases, haematospermia is idiopathic and resolves by itself in a few days.

The vessels and structures in the male reproductive system are very delicate. As the testes, seminal vesicles (the tubes that distribute semen from the testicles), urethra, prostate gland, epididymis (a segment of the spermatic ducts that serves to store, mature and transport sperm), and the perineum are weak tissues, any impact or strain can cause a small blood vessel to break and result in haematospermia. For example, "exhausted love making" can cause haematospermia. Without sufficient semen in the seminal vesicles, the mucous membranes strain on ejaculation. Just like when one blows one's nose too often or too hard, the delicate mucous membranes can rupture and bleed. Although haematospermia is quite common, its incidence is impossible to determine, as most semen is ejaculated intravaginally.

Haematospermia is most commonly a result of a prostate-gland biopsy that may persist for 3-4 weeks. Likewise, as a result of a vasectomy. In schistosomiasis-endemic countries, haematospermia is a common sign in young boys and men who have repeated exposure to inland waterways. A proper exposure history should be taken and investigations for schistosome ova in sperm and urine should be performed. Other conditions that have been reported to be associated with hematospermia are:

- Benign or malignant tumors of the prostate, bladder, testes or seminal vesicles.
- STIs such as chlamydia, herpes trichomoniasis and cytomegalovirus
- Prostatitis, epididymitis and urethritis
- Calculi (stones) in the seminal vesicles or prostate.
- Ejaculation-duct obstructions
- Metastatic cancers in the genitourinary system
- Cysts, hemorrhage in the seminal vesicles.

Should haematospermia persist, a number of diagnostic tests may be performed after a thorough clinical history clinical history and physical examination. This should include urinalysis and cultures to identify any STI or other infections. Ultrasound or MRI may reveal tumours, and semen analysis is recommended.

For a single episode of haematospermia, the patient should be reassured and no investigation is necessary, if otherwise well. Only persistent haematospermia needs further investigation. If infection is the cause of haematospermia, which is uncommon, antibiotic therapy will be necessary. Surgery may be required for obstruction. Most cases of recurrent idiopathic haematospermia resolve with time.

**Recommended further reading**:

*1.Andrology Australia August 2007*. E-mail:info@andrololologyaustralia.org
2. Venereophobia in the male . 1951 Norwich by H.L Rogerson

Contribution: Frans Radebe, Centre for HIV & STIs, NICD.

## SASPID News

We have 2 very exciting & pivotal meetings planned, linked to upcoming conferences:

**1. SASPID parallel session at Bana Pele conference 25th August 2012**

SASPID have organized a parallel session on August 25th 2012 from 10h30 to 12h30 at the Bana Pele (Children First) conference through the South African Paediatric Association (SAPA), held every 2 years. The conference will take place at the Ranch, Polokwane from August 22nd to 26th, 2012 (www.paediatrician.co.za)

Provisional Program chairs – Shabir Madhi (Wits & NICHD) & Mark Cotton (SU)

Nicolette du Plessis (UP): "Meningococcal outbreak" - Description and management of the outbreak
Theunis Avenant (UP)– "Outbreak investigation" An approach to outbreak investigation in general
Julie Morrison (SU) – Case presentation: TB and HIV prophylaxis in setting of resistance to HIV and M.tb
Brian Eley (RCCH, UCT) – TB diagnosis – what is up and coming 20 mins
Lee Fairlie (Wits)– ARV & HIV update New drugs – New guidelines 20 mins
Raziya Bobat (KZN)– Infant feeding – new guidelines for HIV prevention
Adrian Brink (Microbiologist– antibiotic stewardship in the era of ESBLs and carbapenem resistance.

The SASPID **AGM** will be held on the afternoon of the 25th August 2012 when elections for office bearers will be held. Please attend and help to plan for our future. The **Agenda** will include a summary of the 1st 4 years, elections and plans for the future.

**2. Foundation meeting for African Society for Paediatric Infectious Diseases AfPIDS): Thursday November 8th 2012**

This meeting is linked to the International Vaccinology Conference for Africa 9 – 11 November 2012 at the Blue Lagoon Hotel, Cape Town (www.vacfa.com) organized through U.C.T. and NICHD. The mission is to protect African children, families and communities from the threat of infectious diseases.

AfPIDS plans to adopt a constitution and develop a program to increase capacity for excellence in Paediatric Infectious Diseases in Africa.

Please plan to attend both the AfPIDS meeting as well as the conference. Please RSVP to Natasha Samuels (samuels@sun.ac.za) if you plan to attend.

## Local Conferences









SASTM's conference, Travel Health Africa - The Past, Present and Future will be held at the Sandton Convention Centre 13-16 September, with David Shlim and Pat Schlagenhauf as its international invited faculty. Both are internationally renowned speakers and leaders in the field of Travel Medicine.

If it's a Paediatric refresher you need to update you on the latest in Paeds practice including Infectious Diseases, then UCT Faculty of Health Sciences is hosting the GP Paediatric Update 2012 at the Upper East Side Hotel in Cape Town from 5-6 October.

From the 9-11 November, the International African Vaccinology conference takes place in Cape Town, hosted by the Vaccines for Africa initiative (VACFA)), University of Cape Town and jointly organized by UCT and the National Institute for Communicable Diseases (NICD).

The first South African HIV Clinicians Society Conference comes to Cape Town from 25-28 November. With Prof Gary Maartens chairing this inaugural conference and a host of international speakers such as Prof Brian Gazzard and Prof Tom Harrison joining the best of Southern Africa's HIV talent, this is a conference not to be missed.

Last, but not least, the 4th Infection Control Africa Network meeting returns to Cape Town from 27-29 November, with Prof Shaheen Mehtar at the helm, this is sure to be a great event.

Watch this space in the next edition of FIDSSA Quarterly for what will hopefully be a major conference announcement for ID in South Africa!