THE FEDERATION OF INFECTIOUS DISEASES SOCIETIES OF SOUTHERN AFRICA

fidssa federation of infectious diseases societies of southern africa

# FIDSSA Quarterly

Volume 1 Issue 2 1st September 2010

**Special points of interest:**

- New FIDSSA Administrator
- FIDSSA Conference 2011
- Restrictions on the use of the letters Cert ID(SA)
- Infection control news
- News on tigecycline

**Inside this issue:**



## Welcome to Lea Lourens, FIDSSA Administrator.

A big welcome to Lea Lourens who has taken over the role of FIDSSA administrator from e2 Solutions. Prior to joining us, Lea worked on the team at SASTM where she developed a wealth of experience. Lea will be concentrating on building the FIDSSA membership and improving service. There are a number of teething problems with transfer of databases etc, but hopefully, in time, FIDSSA members will enjoy a more personalized service, making renewal of membership easier and ensuring that the database is up-to-date so that you receive all FIDSSA communications timeously.

Lea can be contacted at 079 491 7109 or at info@fidssa.co.za

## FIDSSA 4-WARD 2011 - SAVE THE DATE!

The biennial FIDSSA conference will take place at the Elangeni Hotel, Durban from 8-11 September 2011. The local organizing committee of 'FIDSSA FOUR-WARD 2011' will be chaired by Prof Prashini Moodley from University of KwaZulu Natal with representatives from each of FIDSSA's 6 societies on the committee. The conference will once again be run by Sue McGuinness Communications and Event Management.


Further announcements will follow shortly.

Local Organizing Committee

Chair: Prof Prashini Moodley

IDSSA Prof Yunus Moosa

SASTM Dr Garth Brink

SASPID Prof Raziya Bobat

SASCM Prof Prashini Moodley

STDSSA Dr Yesholata Mahabeer

ICSSA Sr Sharmane Gavripersad

# State of the ID Nation

What is the difference between the President of the United States of America and the President of the Infectious Diseases Society of Southern Africa? Well, apart from charisma, good looks, intellect etc, Barack Obama has a budget. Not just any budget, but a whopping big budget. When Obama makes his State of the Nation address, he has money behind him to carry out his plans. I, or more accurately we, as a community of medical practitioners tackling the greatest burden of disease in this country on the other hand have diddly squat. These musings are brought into sharp focus today, as we are faced with dwindling resources from major funders such as PEPFAR-USAID who are cutting funds to South Africa, with an incomplete exit strategy in place from Government to fund what will be lost. Hardest hit, are secondary and tertiary level Infectious Diseases services.

We are faced with a paradox. Although South Africa has the most successful primary care HIV programme in the world in terms of rollout of antiretroviral therapy, the national and provincial departments of health are turning a blind eye to the need to support primary level patients by funding specialist HIV services at secondary and tertiary level hospitals. Modelling studies suggest that 15-20% of primary level HIV patients will require referral up to secondary level hospitals or clinics and 1-2% overall will need tertiary level care, either for a specialist opinion, investigation(s) or treatment with drugs not accessible outside of tertiary level institutions. In addition to service delivery, tertiary level hospitals are training centres for sub-specialists, registrars, interns, medical students and allied health professionals, the majority of whom will be employed at secondary or primary levels of care in the future, and thus support the HIV rollout and care programme directly.

Many arguments have been put forward against funding specialist Infectious Diseases services at higher levels of care. Apart from the obvious resource limitations, it is often said that infectious diseases as a whole is such a common problem in South Africa and as physicians have been dealing with infectious diseases patients for years without the aid of specialists in the field, there is really no need to build new "Empires" within tertiary centres and train doctors in the specialty. However, if this logic is applied, then there is no need for cardiology, pulmonology, neurology and all other specialities at tertiary level and these departments or "Empires" should be dismantled. Why is this not an option? Because in so doing, we would annihilate medical student and post-graduate education and sacrifice all those complex, sick patients who need something more than primary or secondary care. Furthermore, HIV has radically altered the burden of disease and composition of hospital admissions in South Africa, requiring physicians to manage a condition for which they have little or no training.

The other question that arises, is whether Infectious Diseases practice has indeed been so wonderful in years gone by as some would like to think? If this is so, why are we facing the silent epidemic of drug-resistant hospital acquired infections that we are? Why do malaria patients continue to die through lack of recognition of the diagnosis and appropriate treatment at primary and secondary hospitals and why is the level of basic knowledge in infection control in health care workers so poor, that nurses feel safer placing an XDR-TB patient in a side cubicle than a patient with H1N1 influenza? These are just a few examples of the reality, which is that overall management of infectious diseases in South Africa is poor and there is much work to be done to rectify the situation.

In order to start rectifying the problem, Government must be made aware of the disparity between the burden of Infectious Diseases and the amount of funding it receives for training and higher levels of care. In the Western Cape we have worked with the Provincial Department of Health to produce a document entitled *'Towards a comprehensive platform for the management of Infectious Diseases in the Western Cape'*. This has been accepted as an input document to plan for the future. It has taken 3 years to agree on its content and it is a first step, not the answer. The document will be posted on the FIDSSA website shortly and in the coming months IDSSA will be working with partners to start a situational analysis of secondary and tertiary level funding in other provinces in order to lobby government. One day, I hope that we will be able to say "Yes we can" and have a budget to back it up.

Marc Mendelson. The views expressed in this article are not necessarily shared by other members of IDSSA Exco.

## Yellow Fever Vaccination - Missing the point?

The World Cup has come and gone and as a result undoubtedly, from a public health perspective, many questions have arisen. Some of these questions bring to the fore problems in advice given to travellers to South Africa, and for South Africans visiting other countries where the risk of yellow fever infection is present.

The National Department of Health policy on yellow fever vaccine requirements, in accordance with the WHO recommendations, caused a minor furore for travellers transiting through Nairobi and those from Argentina and Chile. A flurry of emails appeared on the ISTM listserve, questioning the soundness of the policy. Queries from the National Travel Health Network and Centre (NaTHNaC) and Health Protection Scotland were received asking for confirmation as what was perceived to be an unnecessary policy and asking for advice. The policy as outlined by the DoH was confirmed.

The problem of assessing yellow fever infection risk to travellers continues. Ron Behrens, the director of the Travel Medicine Clinic at the London School of Tropical Medicine and Hygiene, has highlighted the extremely low risk to travellers to Kenya and questions the necessity of giving a vaccination when the risk is virtually non-existent. The last cases of yellow fever reported to the WHO from Kenya were three in 1995 and there have been no reported cases in travellers since 1990. Tanzania is even more interesting: no cases of yellow fever have been reported to the WHO and there have been no reported cases of yellow fever in travellers.

The travel health practitioner is clearly faced with a dilemma. One wonders what the outcome would be in the situation where a vaccine is given to a traveller to Tanzania and a severe vaccine adverse event results. Would the fact that policy was followed exonerate the practitioner despite there being little evidence on which to base the policy? One could argue that a waiver certificate could be issued to every traveller to Tanzania. What are the ethical and legal issues that arise in these situations? We are told that what we practice must be evidence based. If one then applies the current evidence, there would be no evidence to vaccinate a traveller to Tanzania against yellow fever. Yet we still apply a similar policy in this country: there is no reported polio in South Africa, yet the immunization against polio continues as part of the EPI. It is through immunization that the disease is not present so one could argue to refrain from yellow fever vaccination would result in the re-emergence of this infectious disease.

The proponents of the vaccine being administered state that one does not know what the traveller is going to do. Travel itineraries (or what one is told) are seldom followed and changes occur that could place the traveller at increased, but still low, risk.

To assist the travel health practitioner, the issue of risk assessment for yellow fever infection and the ethical issues that arise will be addressed at the SASTM Congress in Cape Town in October (see page 8). Watch this space for further news – better still, attend the Congress!

Garth Brink

---

## Erratum: Grandfathering and the Cert ID(SA)

In the last issue of the FIDSSA Quarterly, we congratulated the paediatricians and physicians that had been recognized as Infectious Diseases sub-specialists by the HPSCA. In so doing, we mistakenly congratulated them on attaining Cert ID(SA).

According to the HPCSA, the Cert ID(SA) qualification is only to be used by those who have successfully taken and passed the Cert ID(SA) examination, be it Cert ID(SA) Paeds or Cert ID(SA) Phys. Practitioners that have been grandfathered, but have not actually sat the examination are **not allowed to use the letters Cert ID (SA)** after their name. They may denote themselves as Infectious Diseases Specialists in correspondence or on documents and their HPCSA certificate will denote their sub-specialty as Infectious Diseases. It is just the letters that you are not allowed to use.

Congratulations to Dr Halima Dawood, whose appeal to the HPCSA was delayed, but who has now been recognized by the HPCSA as an Infectious Diseases Specialist!

## New African Paediatric Society


# Towards the formation of an African Society for Paediatric Infectious Diseases (AFPIDS)

The International Paediatric Association Conference held in the Sandton Convention Center, 4th to 9th August 2010, was attended by approximately 4000 delegates from many countries. It was an ideal setting for African delegates to meet and consider launching an African society.

A meeting was co-hosted by SASPID (Southern African Paediatric Infectious Diseases Society) and NISPID (Nigerian Society for Paediatric Infectious Diseases). The meeting was sponsored by a special grant from the World Society for Paediatric Infectious Diseases. Prof. Kike Osinusi, President of NISPID briefly outlined the history and functioning of NISPID. Thereafter, Mark Cotton briefly described the history and activities of SASPID

The meeting was attended by 100 delegates from 15 countries, all of whom enthusiastically supported establishing an African society of Paediatric Infectious Diseases. Specialists of African origin, but working elsewhere also supported the process. We were fortunate to have delegates from the African Immunodeficiency Society attend the meeting, through Prof Brian Eley.

A single representative from each country was nominated to join a steering committee and work towards organizing a launch of the Society within the next 12 months.

The most overwhelming need of attendees is training and accreditation. All countries share these concerns. There is also a need for guidelines. Here SASPID has already made a contribution through publishing guidelines for management of Tuberculosis in children and participation in guidelines for URTI and Community Acquired pneumonia. Guidelines for management of urinary tract infections are expected by December 2012. Delegates were also made aware of the FIDSSA website and the open access of the Southern African Journal of Epidemiology and Infectious Diseases.

Mark Cotton (President, SASPID)
Shabir Madhi (Vice President, SASPID; President WSPID)

## Website Watch; What's new on www.fidssa.co.za?

fidssa federation of infectious diseases societies of southern africa

**Case of the Month**: Since the inaugural FIDSSA Quarterly newsletter, case of the month has gone live on www.fidssa.co.za. With 4 cases posted so far. Visitors gain access to the case via the link on the website's homepage. Cases are presented, questions asked and detailed answers follow. FIDSSA members can then earn 3 CPD points by logging in and answering the MCQs attached to the case. Successfully earned points are automatically recorded on your CPD profile. September's Case of the Month is not for the faint-hearted, but is a corker of a case and one that I would encourage all of you to view!

**New Funding Resources page:** continuing in our attempts to make the FIDSSA website a relevant and useful resource, we have added a new page under the Links tab, entitled 'Funding Resources'. Here, users will find direct links to the leading funding bodies, such as NIH extramural grants, The Wellcome Trust and the Bill and Melinda Gates Foundation.

**Antimicrobial prescribing**: two new guidelines have been added to the list of resources under the Guidelines tab on the home page. The Western Cape Academic Hospitals Antimicrobial Recommendations 2010 is a pdf version of the popular pocket handbook known to all Western Province practitioners. Edited by Steve Oliver and Elizabeth Wasserman with contributors from University of Cape Town and University of Stellenbosch, this is an excellent resource for the general practitioner and hospital doctor alike. Joining these recommendations are the Appropriate Use of Tigecycline guidelines written by Adrian Brink and colleagues that were published in the June edition of the SAMJ. These are important guidelines, summarizing not only the appropriate use of the drug, but its inappropriate use too. For more of interest concerning tigecycline, see page 6 of this newsletter.

## Infection Control News

Infection Control Society of Southern Africa

It seems like only yesterday that I wrote something for the first newsletter, and my first reaction on being reminded that another contribution was due was to wonder what on earth to write about. However, after not too much thought I realised that things are happening all the time – sometimes when you're in the middle you don't realise as acutely that things are changing.

Much work has gone into improving the FIDSSA website, and the ICSSA site is also going to be undergoing changes. We have sections on the site for "Resources" and "News and Events", and while Lesley, Joy and I will do what we can to keep these updated, we also need feedback from you as to what you want to have available on the site. If you have any resources or events that you want publicised please let one of us know (and we will also set up a link on the site for you to post suggestions directly).

The Free State chapter has had to unfortunately cut down the number of meetings being held for logistical reasons, and have started their own eMICI newsletter (Multidisciplinary Infection Control Indaba), and this will be available on the ICSSA website as well. Tygerberg Hospital is hosting an Infection Control Day on the 2nd Nov (contact Yolanda Gouws at yolandag@sun.ac.za), and the IPCAN / IFIC congress will be held at Spier at the end of August.

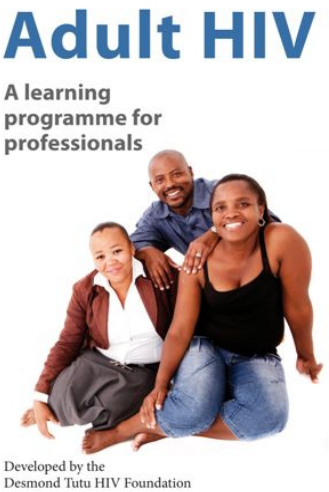
A brief update on the Best Care… Always campaign. As I mentioned in the last letter, a workshop had been held in Gauteng as well as an information session in the Free State during May 2010 . Future plans for Free State BCA: The ten pilot hospitals (1 Academic, 5 Regional and 4 District) will be meeting on 26 August 2010 for a follow-up workshop. Each team will give a short presentation on the implementation of the bundles at their facility and challenges they experienced. The FS Standard Compliance Sub-Directorate will assess progress, provide support and carry out assessments at said hospitals during the next six months. Dr Victor Litlhakanyana will be arranging a meeting with the Free State Department of Health's doctors to inform them of the Best Care... Always Campaign and to lobby for their support in implementing the care bundles.

Plans are underway to organise something similar in Cape Town, and a national strategic planning session is planned for September. For those not yet involved, please visit the website (www.bestcare.org.za)

As always, if you want to contact ICSSA for any reason (complaints, praise, suggestions, donations of money…) please feel free to contact either Joy Cleghorn (joy.cleghorn@lifehealthcare.co.za), Lesley Devenish (Lesley.Devenish@netcare.co.za) or myself (Andrew.whitelaw@uct.ac.za)

---

## Book Review - Adult HIV; A learning programme for professionals




There are now an increasing number of local and international books on HIV Medicine which act as comprehensive reference texts. In contrast to these, *Adult HIV; A learning programme for professionals* is aimed more at giving the target audience, doctors and nurses working at primary level clinics and family practitioners, the skills with which to manage HIV patients from pre-testing to antiretroviral therapy and beyond. In so doing, it de-centralizes training, taking the teaching course to the practitioner rather than vice-versa. Part of a successful series of HIV-related publications from EBW Healthcare, this book developed by the Desmond Tutu HIV Foundation in Cape Town, uses a question and answer format to bring out the important issues in HIV management. The format guides the reader through each step in the management process and transfers the skills necessary for a comprehensive approach to HIV care. Unlike many textbooks, there is a strong emphasis on the social issues surrounding HIV care, helping the practitioner to ensure patients are retained in care once they start on antiretroviral therapy.

This book is highly recommended for the non-HIV specialist that needs to acquire the skills to manage HIV patients in the community in a safe and effective manner.

Copies of the book can be ordered at http://ebwhealthcare.com/content/section/7/32/ retailing at R100.

## Tigecycline

Tigecycline is a new antibiotic that has recently been licensed in South Africa. It belongs to the glycylcycline class of antibiotics. Tigecycline acts by inhibiting protein translation, thereby exerting a bacteriostatic effect. It has a broad-spectrum of activity; however, it is important to note that certain bacteria, such as *Pseudomonas aeruginosa* and *Proteus spp*., are inherently resistant to the antibiotic. In addition, acquired resistance has been detected in *Acinetobacter baumannii*, *Burkholderia cepacia* and *Stenotrophomonas maltophilia*. Drug efflux pumps have been implicated as the major resistance determinants.

Antimicrobial susceptibility testing is therefore important. To date, only the FDA and EUCAST have breakpoints for tigecycline. Interpretation of breakpoints can be difficult as these differ between the EUCAST and FDA recommendations whilst breakpoints do not exist for certain bacteria for which there is poor correlation between MIC values, Pk/Pd data and clinical outcomes. Controversy exists as to which criteria are more accurate. Various methods may be used to test tigecycline susceptibility. These include disk diffusion, Etests, automated susceptibility testing, and broth microdilution. Each method is associated with its own technical problems. Important factors to consider when testing are the manganese content of the media, especially when using Etests, and the use of fresh media (< 12 hours) for Etests and broth microdilution. Clinical microbiologists need to be aware of these issues, whilst clinicians need to be aware of the potential limitations of antimicrobial susceptibility testing for tigecycline.

Please refer to the SASCM Technical Note on Tigecycline for a detailed description of tigecycline susceptibility testing (www.fidssa.co.za)

## Conference Watch


The **5th South African HIV Drug Resistance Workshop** takes place at the Free State School of Medicine, Bloemfontein from 27-29 October. The workshop involves theoretical lectures and practical sessions on the usage and interpretation of HIV-1 drug resistance genotyping in the management of HIV patients on anti-retroviral treatment. It is targeted at clinicians, clinical virologists, nurses and researchers. Registration is FREE OF CHARGE. Contact Anthea.Van.Blerk@mrc.ac.za Closing date for registration 15th September 2010

SASTM

With Cape Town being voted the best destination in Africa for the 3rd consecutive year and as one Soccer World Cup fan said 'You don't want to go anywhere else when you get here. You've found your spot on the planet'. SASTM agrees and has organized a wonderful practical and academic congress to be run at the Cape Town International Convention Centre from Friday 15TH to Sunday 17th October.

The Theme of the conference is" **Travel Health Africa – Research and Reality**". A host of both international speakers and local experts have been assembled to present the latest disease research and its relevance to both travel and working in Africa. The President-elect of ISTM, Ms Genasi will be covering the Yellow Fever controversy -assessing the risk. Ethics in travel medicine will be presented by Professor Solly Benatar.

One of the most important practical sessions to be run by the top local specialists bringing one up to date with 'chronic diseases optimizing treatment before travel' will cover cardiovascular, epilepsy, respiratory and diabetes.

This conference is geared to bringing all health care professionals up to date with all aspects of travel medicine and the relevant infectious diseases. SASTM extends a warm welcome to all FIDSSA members to register on line at www.sastm.org.za

International Speakers

Prof David Durrheim

Ms Fiona Genasi