

NEWSLETTER

Spring 2012

BIA
British Infection Association

At last Olympic year is upon us! I apologise to any readers who are already assiduously counting down the 5 months which remain until the *closing* ceremony and normal life, television, magazines, billboards and transport return. For those of us who are looking forward to the games, a nervous summer still awaits saturated with inevitable daily progress reports on each major athlete's training, progress, previous pharmacological history and injured metatarsals.

Infection is also on the Olympic news agenda with planning for the provision of healthcare services during the games ongoing for some time and the potential disruption that could result from the emergence of an infective threat high on the agenda given the large numbers of people visiting London from all corners of the globe. Enhanced surveillance measures have been introduced in hospitals local to the games and to protect the athletes themselves from more common infective foes, the British Olympic Association's chief medical officer has reportedly advised competitors not to shake hands with opponents at the games!

The 4 yearly Olympic cycle also provides an opportunity for reflection on the great achievements of games past. I'm sure that Usain Bolt's run in 2008 will seem as mythical to my children, too young at the time to appreciate it, as my father's recollections of the achievements of Bob Beamon forty years earlier did to me.

Professor Mike McKendrick was in the final stages of his registrar training when Allan Wells triumphed in the 100m at the Moscow games of 1980 and on page 3 he provides us with a fascinating insight into his long and distinguished career in Infectious Diseases after hanging up his stethoscope in February.

Also contained within this edition of the newsletter is an introduction to the new members of the BIA council and Tony Elston provides his first report as secretary of the Medical Microbiology and Virology Clinical Services committee.

This newsletter's "A Trivial Infection" takes the form of an infection control Sudoku challenge and can be found on page 9.



Albert Mifsud provides an update on training and manpower issues. I'm extremely grateful to him for the revisions and re-revisions which he has made to his piece in order to prevent it from being overtaken by events as proposals for joint training remain high on the agenda.

As we'll be reminded in the days which follow the opening ceremony on 27th July, it is

the end product of training which is all important and whichever training structure is adopted, it needs to produce the best infection specialists equipped to meet the challenges present at the time of the 32nd summer Olympiad in 2020 and long beyond.

Happy Easter!

Dave Partridge,

Newsletter Editor (david.partridge@sth.nhs.uk)

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In the News

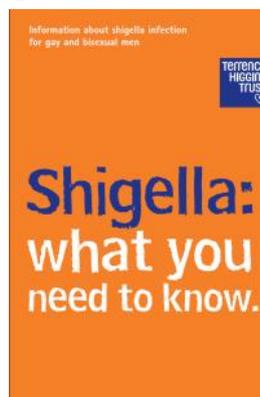
New guidance on provision of CMV negative blood products issued

The Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) has updated guidance on the provision of leucodepleted and/or cytomegalovirus (CMV) seronegative blood components to reduce the risk of transmitting CMV via transfusion. After reviewing the evidence, SaBTO concluded that the range of patients provided with CMV screened blood should be reduced with many groups receiving red cell and platelet components that have been leucodepleted as standard but not CMV screened. Pregnant women, intrauterine transfusions and neonates should, however, continue to be provided with CMV screened red blood cell and platelet components where required.

The Position Statement, together with a more detailed report, are published at <http://www.dh.gov.uk/health/2012/03/sabto/>.

Increase in Shigella infections in MSM

Aided by enhanced surveillance, introduced after 2 outbreaks in men who have sex with men (MSM) in 2011, the HPA detected 31 UK acquired cases of *Shigella flexneri* infection between September and December 2011. Of these cases, just under half were in men who reported having a casual male partner in the preceding week. HPA has raised awareness of the problem amongst at risk MSM and sexual health specialists through communication with the British Association for Sexual Health and HIV and a leaflet produced in conjunction with the Terence Higgins Trust. The HPA press release can be found via this link (<http://www.hpa.org.uk/NewsCentre/NationalPressReleases/2012PressReleases/120330RiseinUKShigellaadvice/>) and the full article is available at <http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20137>



Sports fans at risk in 2012

The Centers for Disease Control in the USA has warned potential visitors to the 2012 Olympics of the risk of measles acquisition amid fears that infections of sports fans in London could result in epidemics occurring following their return to the United States. A current measles outbreak on Merseyside has so far involved over 100 people resulting in 28 hospitalisa-

tions. Overall in 2011, there were 1086 laboratory confirmed cases of measles in England and Wales.

The Food Standards Agency has also launched a "Play It Safe" campaign (complete with Twitter feed @playitsafefood) aimed at minimising the risk of food-borne illness from the estimated 14 million meals served at Olympic sites during the games.

Meanwhile the Sun has reported that at least 1 in 5 Ukrainian commercial sex workers (not the term used in the currant bun) are infected with HIV potentially placing fans playing away at this summer's European championships at risk. The full story complete with in depth interviews and photographs can be found at [this link](#).



BIA Grant award scheme application deadlines

Details of awards offered by the BIA can be found via the following link: <http://www.britishinfection.org/drupal/content/british-infection-association-grants>.

Applications are encouraged for the following approaching deadlines:

Barnett Christie Lecture - 14th September 2012

BIA Clinical Exchange award - 15th June 2012

BIA Research Project Priming Grants - 15th June 2012

BIA Travel Awards - 15th June and 26th October 2012



HIS Mike Emerson Young Investigator's Award

Applications are also invited for this award, which has been established for trainees who are medical graduates, nurses, clinical scientists or biomedical scientists. The criteria for this award include scientific merit, the stage of the career of the applicant and whether the individual is likely to receive funding from other sources.

The grant will be available for a sum up to £10,000 and the closing date for all applications is 31st August 2012.

“Smallpox to swine flu”

Brief reflections on 35 years

in Infectious Diseases

Professor Mike McKendrick recently retired after 31 years in his post as lead consultant in the Department of Infection and Tropical Medicine at the Royal Hallamshire Hospital Sheffield. He is a former president of the British Infection Society and has been heavily involved in the development of Infectious Diseases training both nationally and on a European level. The newsletter wishes Mike a long and happy retirement but added to his 'to-do' list by asking for his reflections on the many changes and developments which have occurred during his career.



The article in February New England J Med perhaps sums it up – ‘The Perpetual Challenge of Infectious Diseases’.

Where to start? Clinically, the challenges of polio, diphtheria and tetanus in the UK were largely controlled when starting as senior registrar in 1977 at East Birmingham Hospital but we forget ‘old diseases’ at our peril – over 30 years in Sheffield we have had one case of polio (vaccine strain in young man left paraplegic) and a handful with diphtheria and tetanus, thankfully

all with good outcome. Smallpox has gone – the last case in Birmingham in 1978 - but will smallpox, anthrax, tularaemia and others ever be used as bioterrorist tools? Nationally we invested many weeks in smallpox preparation and training after 9/11 though this spotlight has now dimmed.

In 1981 when appointed consultant at Lodge Moor Hospital (400 beds) and medical superintendent of Hallwood Hospital (on 4 hour standby for smallpox) I had 2 adult ID and 2 general medical wards and a children’s ward - 84 acute beds, 1800 annual admissions. Manpower was limited - 2 PRHOs, 2 first year SHOs (=FY 2), no ID registrar; on call every other night and weekend with an associate specialist. Communication was easier and usually face to face as computers were not yet on the scene. The ‘fever hospitals’ have, quite rightly, been superseded by ID departments in teaching hospitals. A single story building with face to face meeting with management, porters, labs, switchboard operators etc has some communication advantages, and certainly supports multidisciplinary working! These were interesting and enjoyable, but challenging times, for example waiting for surgical support for the young hypotensive lady with severe diarrhoea who had a ruptured ectopic pregnancy and preparing for bedside tracheostomy for a young man with stridor from acute epiglottitis – thankfully both survived but they underlined the importance of ID being within a general hospital.

Just after starting, a tank respirator was delivered (DH sent a new one to all ID units) - thankfully never used – I wonder if this was the result of a policy decision taken 15 years previously? – Perhaps some things never change! AIDS and HIV had not yet appeared. Viral research and therapeutics were in their infancy – no molecular tests, the only ‘targeted’ antiviral was aciclovir. The joy of progressing from ‘dying from AIDS’ to ‘living with HIV’ is easy to understand and perhaps the silver lining on the HIV cloud has been the fantastic development of laboratory tests, links of organisms with ‘new’ diseases and the profusion of new antivirals now spilling over into hepatitis and other areas?

As an SHO I remember plunging a long needle into a patient’s liver at the bedside seeking the pus that my consultant believed was there supported by a very primitive and grainy ultrasonic scan. It was an anxious time for the operator but he was right - pus drained, amoebic abscess diagnosed, the patient recovered and I published my first case report. A common ward round discussion then was when to do an exploratory laparotomy when investigating the patient with PUO. The wonderful advances in CT, PET and MRI makes this just of historical interest. Similarly most patients who died in hospital had a post mortem; the visual experience of seeing adrenal glands totally replaced by caseous material (only other organ involved with the TB was the lung), of multiple abscesses in the kidneys of a young patient with pyelonephritis etc. leave a powerful image not enjoyed by current generation of doctors.

Training in the 70’s was more ‘apprenticeship’ – small number of consultants in busy departments with high patient throughput. Today training is very structured; however there is no short cut to clinical experience. The most valuable MDT remains the weekly radiology meeting and we had these even as an SHO. Being a single handed physician for 14 years I am a strong believer that patient care is optimised by keeping closely involved in patients’ care - just as important today with consultant expansion though perhaps more challenging to achieve. The links between ID and Microbiology/virology over the last 20 years have been to the benefit of each discipline with successful introduction of joint training. I still believe that the Joint Colleges Committee’s agreed goal for specialists trained in Microbiology and in Infectious Diseases to be in each general hospital is a desirable and achievable objective.

The Societies have evolved. Memories from the Scottish Scandinavian meeting of the British Society for the Study of Infection (BSSI) at St Andrews in about 1980 are strong - Bill Jamieson reciting ‘Ode to a Haggis’ at the dinner caused much amusement to our Scandinavian friends! The international links are now across Europe through UEMS with international clinical meetings, observership scheme (via ESCMID), a common European curriculum and perhaps common assessment based on SSE. The Clinical Infection Society, started in the 1980s by clinicians who wanted more science, research and debate, culminated in merger with BSSI in 1990s to form the British Infection Society (BIS). The union of the BIS with the Association of Medical Microbiologists (AMM) to form the BIA must be used to further strengthen the voice for infection. It is though important, in my view that the ‘infection’ speciality continues to recognise and respect and support their differences as well as rejoicing in the large areas of overlap and success of joint training.

Training in Birmingham with Alasdair Geddes demonstrated the value and pleasure of ‘clinical’ research. This does not challenge laboratory based research but that is not the formula for all. Despite the NHS erecting sizeable barriers to small scale clinical research I believe that all clinicians can and should be involved with this and every trainees CV should have entries under ‘publications and case reports’. The description of an unusual case and writing up series is not difficult. Establishing databases, for example for the newly appointed specialist, can be inexpensive yet provide a basis for analysis and study for future generations.

Thirty five years in infectious diseases has flown by. I hope that all who are now starting out will get something of the pleasure I have enjoyed in a constantly changing yet challenging patient and service focussed speciality.

Professor Mike McKendrick



Clinical Services Committee (Microbiology) report

The main agenda item for the CSC remains the transformation of pathology services, though the introduction of meaningful KPIs has been running a close second. The wide geographical representation on the committee enables a snapshot of how pathology services are grappling with QUIP across the country. It appears that 20% can be saved in a variety of ways ranging from demand management, private public partnerships, happy collaborations and mergers through to shotgun marriages. One consequence of this as yet unrealised natural experiment is that precedent for any proposed change to services is bound to have been in place somewhere else for some time, such is the variation in past and current practice across the country. This discussion has so far been rather focussed on England but the committee is aware that similar, perhaps less extreme measures are gathering momentum in Scotland. KPIs for pathology, and specifically microbiology, have generated almost as much discussion, both at the committee and more widely. This remains a live issue and will be one of the main topics for the Speciality Advisory Committee of the college; a consultation on current proposals has recently run with a clear opportunity for the BIA to try and strike a balance between the various prevailing opinions. Three such proposals have been to encourage departments to set up systems, reflected in job plans, to enable urgent clinical advice to be available within 30 minutes

and to encourage attendance of microbiologists at MDTs.

The committee has also been updated about developments in education and infection control. The joint working party looking at infection training has done a stock taking exercise and recognised three areas where progress needs to be made. It is apparent that the current CCT specialities will remain in place initially with any potential for convergence developing later. The logistics of delivering the ID component of the proposed training scheme requires considerable work and finally how trainees will be assessed and progress also needs to be developed. In infection control new guidance has been published for the management of Norovirus (http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1317131647275). NICE has published an (aspirational) Quality Improvement guide for healthcare acquired infections in secondary care (<http://www.nice.org.uk/aboutnice/whatwedo/aboutpublichealthguidance/healthcare-associated-infections/qualityimprovementguide.jsp>). The work on a national competency passport for Infection Prevention and Control continues. Andrew Swann has stood down as the chair of the committee which warmly thanked him for his wise, balanced and determined chairmanship through a series of contentious issues; we wish him well and I hope that I can do the job at least half as well.

Tony Elston

Clinical Services Secretary (Microbiology)

Launch of National Endocarditis Database

A national endocarditis database project – National Endocarditis Epidemiology, Management and Outcomes study has been launched.

The initial aims of the project are to:

1. establish an online system for data collection and a network of interested cardiologists, infection specialists (microbiologists and infectious diseases physicians), cardiac surgeons and pharmacists to collaborate on this and related projects;
2. estimate the incidence of infective endocarditis in England (and ultimately the UK and Ireland) and to describe trends in incidence over time (e.g. of emerging problems such as pacemaker associated endocarditis);

3. analyse the prevalence of cardiac and other (e.g. dental) risk factors for development of endocarditis;

4. examine the organisms causing endocarditis and describe trends and variation;

5. analyse trends and variation in antimicrobial therapy and surgery for endocarditis and allow benchmarking;

describe the outcome, including survival and allow benchmarking.

Ethical approval has currently been granted for England and Wales. If there is sufficient interest, we would like to expand the project to include Scotland, Northern Ireland and The Republic of Ireland.

Please visit www.neemo.leedsth.nhs.uk to register or find more information or contact Dr Jonathan Sandoe (jonathan.sandoe@leedsth.nhs.uk).



Training and Manpower

The last few months has seen significant changes in the development of infection training.

As you know, in 2007 the RCPATH and RCP established a Joint Infection Working Party under the auspices of the Academy of Medical Royal Colleges with a brief to explore the development of unified training in the three specialties of infection: medical microbiology, medical virology and infectious diseases, leading to a single CCT. A draft curriculum was published for consultation in 2010. In this curriculum, trainees are recruited from Core Medical Training, CMT, (or equivalent) with possession of MRCP, into a programme comprising a period of common training (referred to as Common Infection Training, CIT) followed by a selection of modular training drawn from the three specialties, including healthcare associated infection.

In the Autumn of 2010, the BIA undertook a very extensive consultation exercise among our membership in which some 70 members participated. The BSAC supported the BIA response. The consultation response is available on our website: <http://www.britishinfection.org/drupal/sites/default/files/BIA%20comments%20on%20Infection%20Training%20draft%20curriculum%20101106%20final.doc>

There was overwhelming support for the concept for unifying the initial training of all infection specialists (CIT). However, although a majority of respondents from both ID and MM/V were in favour of a merged curriculum leading to a single CCT, the views were more mixed. Furthermore, it was recognised that there was no agreement over the nature of the work of the respective infection specialists of the future.

Following this, an amended curriculum was proposed that addressed the principal concerns expressed by respondents, but leading to a single CCT. A survey of trainees was undertaken by the BIA and a summary was published in the Summer 2011 Newsletter (http://www.britishinfection.org/drupal/sites/default/files/summer%20newsletter%202011_0.pdf). The response rate was around 25%, and most respondents were not supportive of the curriculum as proposed (in particular the proposal that training would be undertaken by specialists outside the three main infection specialties) and a clear majority did not favour a single CCT.

In part due to the slow rate of progress, in the summer of 2011, the sponsoring Royal Colleges decided to wind up the Academy Infection Working Group and a new working group, co-chaired by training chairmen from the RCPATH and JRCTB, was set up with a small nominated membership. A summary of the options was presented at the trainees' day prior to FIS 2011 and a copy was sent to BIA Council and other interested bodies but, unlike the deliberations of the Academy's Working Party that were transparently published on their website, this summary has not been formally published. Strangely, even the membership of the group has not been stated. (For your interest, I was able to locate the summary statement on the web using a search engine: http://www.rcpath.org/NR/rdonlyres/272A75A5-A122-4918-BAA9-16BC3841EA2E/0/08_ID_Joint_Training_statement_for_22Feb2012_SAC_MM.pdf, accessed 18/03/11).

The BIA considered this paper at its Council meeting in January. We recognised that infectious diseases, microbiology and virology now face considerable changes and uncertainties, such that there would be considerable advantages to consolidation of training. However, we were also very aware that after some 5 years of deliberations, there was no tangible outcome to the Academy's working group, and we feared that the significant benefits of

recruitment from CMT and joint CIT run the risk of being lost. We therefore decided to formally support immediate introduction of this model of training, as an intermediate step to the eventual complete consolidation of training into a single CCT specialty. The letter may be accessed on our website: [Letter to Presidents of Royal Colleges Feb 2012.doc](#)

In this letter, we noted with some surprise that the option of widening the currently successful and highly popular training programme leading to dual CCTs in ID with MM/MV was not included as a third option. (We believe that this option can be readily introduced and should address the bulk of the concerns expressed, with the exception of facilitating certification in combined infection with G(IM).)

We have also offered to participate in the group. This would enable communication with the profession and to represent colleagues.

I believe that the future of infectious diseases, medical microbiology and medical virology is threatened and greater flexibility in training would put trainees in a better position to cope with future uncertainties, ideally as a single CCT in infection (*without* specified sub-specialties, as is broadly the case with the current dual CCT in ID/MM or MV).

Some of my reasons include:

- the drive towards centralised laboratories, whether run within the health service or independently, with infection specialists becoming, by necessity, more remote from either the laboratories or the hospital and community that they serve;
- the Modernising Scientific Careers programme to train clinical scientists, who will be expected to manage laboratories;
- the central commissioning of Infectious Diseases services through the National Commissioning Group;
- the ongoing development of Acute Medicine as the principal mono-specialty training pathway for acute and general physicians; and
- the current economic climate, that is generally believed will appertain for at least a decade, that will constrain, if not reverse, the considerable growth of new consultant posts that have been created in recent years in all the infection specialties.

Manpower projections are a cause for some concern. It would appear that the significant but modest expansion in both ID and MMV consultant positions has largely been driven by the prominence given to the imposition of targets in HCAI and the success of ID physicians in participation in acute medical rotas. These drivers are unlikely to continue to lead to ongoing expansion, and several of the drivers listed above will exert a downward pressure on posts. There are considerably more trainees than consultant vacancies anticipated as a result of retirements / resignations and this is aside from the potential freezing of posts or even redundancies. Therefore, personally, I consider that it is in the interest of all parties to work towards a single CCT in infection. As it may not be possible to achieve this in a single step, I am very comfortable with the current recommendation to recruit all trainees from CMT (or equivalent), followed by common or core infection training (CIT), with subsequent further specialist training leading to separate CCTs in ID, MM or MV.

I should be very interested to receive feedback to inform our further contribution to the Infection Training Working Party.

STOP PRESS: I understand that the Royal College of Pathologists will be surveying its Fellows and trainees to formally determine views on this debate. I urge you all to respond to it.

All members, regardless of their current training pathway or specialty may contact me, and I shall represent all views as fairly as I am able to.

Albert J Mifsud

Journal of Infection top ten articles of 2011

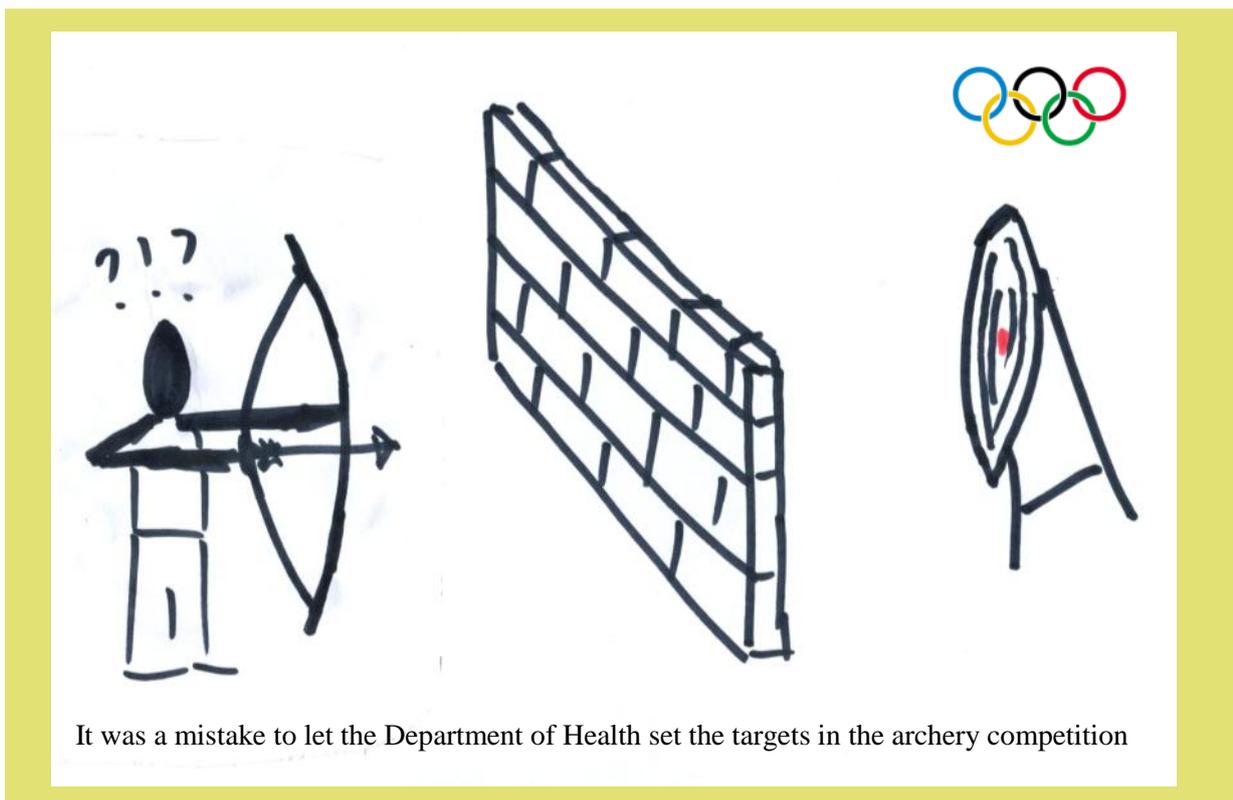
Below is a table of the top ten articles downloaded through the Journal of Infection site on ScienceDirect during 2011. All BIA member subscribers to the journal will soon receive regular email updates telling them the contents of each issue as it is released with links through to each article. All member subscribers can access the journal and these articles at the journal website: www.journalofinfection.com. If you have not yet registered please visit the website and register in the top right hand corner. If you are having problems registering please call the Elsevier customer services team on +44 1865 843087 or email JournalsCustomerServiceEMEA@elsevier.com and let them know that you are a BIA member subscriber.

Rank	D'Ids	Article Title	Vol	Is- sue	Page	Paper Type	Cover Date	Author(s)
1	1,972	British Infection Society guidelines for the diagnosis and treatment of tuberculosis of the central nervous system in adults and children	59	3	167-187	Full length article	01-Sep-2009	Thwaites, G.; Fisher, M.; Hemingway, C.; Scott, G.; Solomon, T.; Innes, J.
2	1,732	UK malaria treatment guidelines	54	2	111-121	Full length article	01-Feb-2007	for the HPA Advisory Committee on Malaria Prevention in UK Travellers; Laloo, D.G.; Shingadia, D.; Pasvol, G.; Chiodini, P.L.; Whitty, C.J.; Beeching, N.J.; Hill, D.R.; Warrell, D.A.; Bannister, B.A.
3	1,644	Recurrent Clostridium difficile infection: A review of risk factors, treatments, and outcomes	58	6	403-410	Review article	01-Jun-2009	Johnson, S.
4	1,373	Post-infectious encephalitis in adults: Diagnosis and management	58	5	321-328	Review article	01-May-2009	Sonneville, R.; Klein, I.; de Broucker, T.; Wolff, M.
5	1,371	Prosthetic joint infection: Recent developments in diagnosis and management	61	6	443-448	Review article	01-Dec-2010	Cataldo, M.A.; Petrosillo, N.; Cipriani, M.; Cauda, R.; Tacconelli, E.
6	1,345	The diagnostic role of Procalcitonin and other biomarkers in discriminating infectious from non-infectious fever	60	6	409-416	Review article	01-Jun-2010	Limper, M.; de Kruif, M.D.; Duits, A.J.; Brandjes, D.P.M.; van Gorp, E.C.M.
7	1,259	Infectious spondylodiscitis	56	6	401-412	Review article	01-Jun-2008	Cottle, L.; Riordan, T.
8	1,163	Diagnostic accuracy of cerebrospinal fluid lactate for differentiating bacterial meningitis from aseptic meningitis: A meta-analysis	62	4	255-262	Review article	01-Apr-2011	Sakushima, K.; Hayashino, Y.; Kawaguchi, T.; Jackson, J.L.; Fukuhara, S.
9	1,155	Aeromonas spp. clinical microbiology and disease	62	2	109-118	Review article	01-Feb-2011	Parker, J.L.; Shaw, J.G.
10	1,131	New concepts in the pathogenesis, diagnosis and treatment of bacteremia and sepsis	63	6	407-419	Review article	01-Dec-2011	Huttunen, R.; Aittoniemi, J.

Trainees' Committee

The trainees have formed a new committee hoping to better represent the whole of the UK. The area reps will act as a point of contact for trainees in their regions to either gather or disseminate information. WE are also trying to improve our current database of trainees so we can liaise with them better. All trainee members should receive an e-mail soon asking for an update to contact details. Please do fill it in so we can let you know about any training issues.

Name	Region
Sulman Hasnie	Scotland and Northern Ireland
Ewan Hunter	Northern
Thomas Fletcher	North West/Mersey and Military
Jane Cunningham	Yorkshire (East and South)
Tim Kemp	Yorkshire (West and North)
Susan Larkin	Midlands
Rajeka Lazarus and Amy Chue	Oxford and South East
Si Huei Tan	London
Rosie Fok	South West
Richard Morton	CMT rep/London
Gayti Islam	HIS rep
David Partridge	BIA Council trainee rep (communications)
Thushan Se Silva	BIA Council trainee rep (professional affairs)
Fiona McGill	BIA Council trainee rep (meetings)



BIA Spring meetings

2012

The BIA Spring meetings will once again be held at SOAS, Russell Square, London this year and will be on the 24th and 25th of May.

Trainees' meeting—24th May

The Trainees' meeting will have the theme of "infections old and new" and an excellent line-up of speakers has been arranged for what should be a very interesting and educational day. Abstracts are invited for the case presentation session and should be e-mailed to fiona.mcgill@liv.ac.uk on the abstract submission form available via [this link](#) and abstracts should be received before 27th April 2012.

BIA Spring meeting—25th May

The full Spring meeting on the Friday also promises to be an excellent day with three high calibre invited speakers in addition to the usual interesting mixture of research and case presentations which make the meeting a success year after year. Steve Green, the meetings secretary should once again be thanked for putting the programme together but I'm sure that he'd particularly appreciate submission of high quality abstracts for presentation at the meeting. Details can be found via [this link](#) and abstracts should be submitted no later than 20th April 2012.

British Infection Association Trainees Day

Thursday 24th May 2012

Brunei Gallery, School of Oriental and African Studies, Thornhaugh Street, Russell Square, London WC1H 0XG



PROGRAMME

<p>Kindly sponsored by an unrestricted educational grant from:</p>     	<p>09.15 <i>Registration & Coffee</i></p> <p>09.45 Introduction: Old & new!</p> <p>09.50 HIV from a public health perspective</p> <p>10.30 Syphilis: a clinical update</p> <p>11.10 <i>Coffee</i></p> <p>11.30 New and old antibiotics for <i>Staphylococcus aureus</i> bacteraemia</p> <p>12.10 Case presentations by trainees</p> <p>13.15 <i>Lunch</i></p> <p>14.15 HTLV-1: a neglected tropical disease with complex clinical patterns</p> <p>15.15 <i>Coffee</i></p> <p>15.40 What's new in brain infections?</p> <p>16.20 What's new about <i>C. difficile</i>?</p> <p>17.00 <i>Meeting Close & Refreshments</i></p>	<p>Dr Fiona McGill <i>BIA Trainee Representative</i></p> <p>Dr Valerie Delpech <i>Consultant Epidemiologist HPA Centre for Infections</i></p> <p>Dr John White <i>Consultant Physician in HIV & Sexual Health Guy's & St Thomas' NHS Foundation Trust</i></p> <p>Dr Guy Thwaites <i>Consultant in Infectious Diseases Imperial College London</i></p> <p>Professor Eduardo Gotuzzo <i>Instituto de Medicina Tropical Alexander von Humboldt of the Universidad Peruana Cayetano Heredia</i></p> <p>Professor Tim Solomon <i>Director - Institute of Infection & Global Health Head - Brain Infections Group University of Liverpool</i></p> <p>Professor Mark Wilcox <i>Professor of Medical Microbiology University of Leeds Lead on <i>C. difficile</i> infection in England Health Protection Agency Leeds General Infirmary</i></p>
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Call for abstracts: "Old & new"

Please email your abstract to Fiona McGill (f.mcgill@gmail.com) no later than Friday 27th April 2012

Online registration is now available at www.hartleytaylor.co.uk

For further information please contact Katie on katie@hartleytaylor.co.uk or telephone the Hartley Taylor office on 01844 275650

British Infection Association 15th Annual Meeting

Friday 25th May 2012

Brunei Gallery Lecture Theatre
School of Oriental and African Studies (SOAS),
Thornhaugh Street, Russell Square
London, WC1H 0XG



Provisional Meeting Programme

<p>08-45 to 09-15 Registration, coffee/tea & poster viewing</p> <p>09-15 to 09-20 Welcome Dr Jane Stockley (Worcester), President of the BA</p> <p>09-20 to 10-45 Free Scientific Papers (12 minutes each) Chairs & discussants -</p> <p>10-45 to 11-05 Coffee/tea & poster viewing</p> <p>11-05 to 12-00 International Keynote Lecture Professor Eduardo Gotuzzo, Director del Instituto de Medicina Tropical "Alexander von Humboldt", Universidad Peruana Cayetano Heredia, Lima Peru, & Course Director for the Gorgas Tropical Medicine Courses "Tropical Medicine in South America in the 21st Century" Chair & discussant -</p> <p>12-00 to 12-45 British Infection Association AGM Dr Jane Stockley (Worcester), Dr Beryl Oppenheim (Birmingham) Professor Alistair Leanord (Glasgow)</p> <p>12-45 to 13-30 Lunch & poster viewing</p> <p>13-30 to 14-30 Clinical Papers (10 minutes each) Chairs & discussants -</p> <p>14-30 to 15-00 International Invited Lecture Dr Brian Angus, University of Oxford, UK "Meliodosis in the 21st Century" Chair & discussant -</p> <p>15-00 to 15-15 Coffee/tea & poster viewing</p> <p>15-15 to 16-05 Free Scientific Papers (12 minutes each) Chairs & discussants -</p> <p>16-05 to 16-35 UK State of the Art Lecture Dr Ann Chapman, Sheffield Teaching Hospitals "OPAT in the 21st Century" Chair & discussant -</p> <p>16-35 to 16-45 Comfort break & poster viewing</p> <p>16-45 to 17-35 Free Scientific Papers (12 minutes each) Chairs & discussants -</p> <p>17-35 to 17-40 Close of proceedings Professor Steve Green, BIA Meetings Secretary Dr Jane Stockley, BIA President</p>

Selected Poster Presentations:

Online registration is now available at <http://www.hartleytaylor.co.uk>

Meet the new members of BIA council!



Steve Barrett
Treasurer Elect

As treasurer elect, I'm looking forward to taking on the Treasurer's role once I've picked up the threads. I've had various society roles in the past with HIS and AMM, and was the AMM's Honorary Secretary until the merger with BIA. Job-wise, I've gone round in a circle, and am now back in the consultant post I left at Southend 20 years ago when the attractions of commuting, and jobs at St Mary's and then Charing Cross, got the better of me. I hope to continue keeping the BIA in its present solid financial state.



Tony Elston
Clinical Services Secretary (Microbiology) .

Please see Tony's first report as CSC chair on page 4.



Fiona McGill
Trainee representative

I have taken over from Susan Larkin as trainee meetings representative as of 1st December 2011. I am an SpR in Infectious Diseases and Microbiology in the Yorkshire and Humber Deanery, although currently I am undertaking a PhD on viral meningitis at the University of Liverpool with Prof Tom Solomon's brain infections group.



Thushan DeSilva
Trainee representative

I have recently taken over as the BIA trainee professional affairs secretary, although Fiona and I may share responsibilities between the two posts over the next 2 years. Having qualified from Bristol and completed SHO jobs in Oxford and London, I am currently an SpR in Infectious Diseases/Microbiology at Sheffield Teaching Hospitals NHS Foundation Trust. I have also recently completed an MRC Clinical Research Training Fellowship based at the MRC Laboratories, the Gambia, working with HIV-1 and HIV-2 infected cohorts in the Gambia and Guinea Bissau. Please email me on thushandesilva@hotmail.com if you have any comments or con-

A Trivial Infection—infection control Sudoku

A new inattentive bed manager at your hospital got the wrong end of the stick in her infection control induction. Exactly nine cases of each of the following transmissible pathogens were admitted to your MAU, which has 9 rooms with 9 beds in each. Unfortunately, rather than cohorting the patients, the manager worked very hard not to place 2 patients with the same infection in any of the rooms. What's more, no patients with the same infection ended up in the same row or column either (you get the picture!). How did they do it?

N= Norovirus

M= MRSA

C= C. difficile

I = Influenza

T = Tuberculosis

G = Group A strep

R = Rotavirus

V = Varicella

S = Salmonella

		N		R	G	V		
T						I	G	
R		G				C	N	M
V					T	R		
				G				
		S	I					V
N	M	V				T		
		R						G
		I	V	C		N		

For answers, please click on the following link:

www.britishinfection.org/drupal/content/bia-newsletter

Events calendar

Dates	Title	Venue	Organising body	Website
<u>April</u>				
18th-20th	BHIVA Annual Conference	Birmingham	BHIVA	http://www.bhiva.org/AnnualConference2012.aspx
29th-1st May	BSMM annual scientific meeting	Cardiff	BSMM	http://www.bsmm.org/conferences.asp

May

2nd-3rd	Norovirus Infection in Health and Social Care - How do we deal with the problem?	London	Royal Society for Public Health University of Liverpool	http://www.rsph.org.uk/en/courses-conferences-and-events/events/index.cfm/Norovirus
17th-18th	Liverpool Neurological Infections Course	Liverpool		http://www.liv.ac.uk/neuroidcourse/
24th	BIA Trainees' meeting	London	BIA	http://www.britishtinfection.org/drupal/content/bia-trainees-meetings
25th	BIA Spring Meeting	London	BIA	http://www.britishtinfection.org/drupal/content/bia-annual-spring-meeting

June

18th	DON'T PANIC - Practical Aspects of Infection Control	Sheffield	HIS	http://www.shu.ac.uk/faculties/hwb/cpd/dontpanic/
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September

3rd-5th	SGM Autumn Conference	Warwick	SGM	http://www.sgm.org.uk/meetings/MTGPAGES/Warwick2012.cfm
4th-7th	ESCV Annual Meeting	Madrid	ESCV	http://www.escv2012madrid.com/
9th-12th	ICAAC	San Francisco	ASM	http://www.icaac.org/
11th-12th	Health Protection 2012	Warwick	HPA	https://www.hpa-events.org.uk/hpa/frontend/reg/thome.csp?pageID=64783&eventID=144&eventID=144

October

2nd	Antimicrobial resistance BHIVA Conference for the Management of HIV / Hepatitis Co-infection	London	RCP/RCPATH/HPA/RCVS	http://www.rcvs.org.uk/news-and-events/news/one-world-theme-to-bring-scientists-together-on-amr/
3rd	BHIVA Autumn Conference	London	BHIVA	http://www.bhiva.org/BHIVAHIVHep2012.aspx
4th-5th	BHIVA Autumn Conference	London	BHIVA	http://www.bhiva.org/AutumnConference2012.aspx
17th-21st	ID week 2012	San Diego	IDSA	http://www.idweek.org/

November

19th-21st	FIS-HIS	Liverpool	HIS	http://hisconference.org.uk/
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Contact the editor: David Partridge, Department of Microbiology, Royal Hallamshire Hospital, Sheffield, S10 2JF. David.partridge@sth.nhs.uk