SARS-Like Virus Can Probably Pass From Person-to-Person

13 May 2013 (Reuters Health [Angus McDowall])—A second man in France was diagnosed with a severe acute respiratory syndrome (SARS)–like disease after sharing a hospital room with France’s only other sufferer.

World Health Organization (WHO) Assistant Director-General Keiji Fukuda told reporters in Saudi Arabia, the site of the largest cluster of infections, there was no evidence so far the virus was able to sustain “generalized transmission in communities”—a scenario that would raise the specter of a pandemic.

But he added: “Of most concern . . . is the fact that the different clusters seen in multiple countries . . . increasingly support the hypothesis that when there is close contact, this novel coronavirus can transmit from person to person.”

The first French patient was confirmed as suffering from the disease after traveling in the Gulf. The second patient was transferred to intensive care after the two men shared a room in a hospital in Lille.

Editorial comment. As of 18 May, the count is 131 cases with 35 deaths. The good news is that although the epidemic is continuing, it seems to be at a diminishing rate with no new cases since early May. If the decrease in rates continues, it is very likely related to the enormous efforts in China to reduce the potential of exposure to H7N9 by the massive closing of live bird markets. Other factors such as changes in weather could also be playing a role. Let’s hope that the decrease in cases continues.

China Reports 3 New Bird Flu Deaths, Toll Hits 35

13 May 2013 (Reuters Health [Koh Gui Qing])—Three more people have died in China from the new strain of H7N9 bird flu virus, raising the death toll to 35 while the total number of infections rose to 130 (plus 1 in Taiwan), state media said.

Without giving details of the deaths, Xinhua News Agency said a new case of H7N9, described by the World Health Organization (WHO) as one of the most lethal flu viruses around, was found in China’s eastern Jiangxi province. There has so far been no evidence of human-to-human transmission of the virus, a point reiterated by a spokesperson for the agency on Monday, citing health authorities. It noted that 57 of those infected have recovered.

Chinese scientists say the virus has been transmitted to humans from chickens, although according to the WHO, 40% of people infected with H7N9 had no contact with poultry.

The US Centers for Disease Control and Prevention has said the current strain of bird flu cannot start a pandemic but notes there is no guarantee it will not mutate and gain the potential to cause a serious pandemic.

Copyright © 2013 Reuters Limited. All rights reserved.
Exserohilum rostratum) resulting from injections of contaminated methylprednisolone acetate (MPA) had resulted in 741 reported cases and 55 deaths in 20 states. The total case count in Michigan was 261 and included 16 deaths. During the first 4 weeks of the outbreak, 7 September–5 October 2012, nearly all of the reported cases nationally met the Centers for Disease Control and Prevention (CDC) case definition solely for meningitis. However, at outbreak week 5, certain states, including Michigan, began reporting cases of localized spinal and paraspinal infections, including epidural abscesses, phlegmon, arachnoiditis, discitis, or vertebral osteomyelitis. Michigan has reported the highest number of spinal and paraspinal infection cases (167), accounting for 52% of the 320 cases reported nationally. Michigan also had reported an additional 43 spinal and paraspinal infection cases with meningitis.

Four pain management facilities in Michigan received 2225 of the approximately 17 000 vials of MPA that came from the contaminated lots distributed nationally. As of 29 January 2013, epidemiologic or clinical data were available for 180 patients in Michigan: 141 of the 165 patients (87%) received care for their infections from St Joseph Mercy Hospital in Ann Arbor. The 160 patients treated for their infections at St Joseph included 113 (80%) who had diagnoses only of spinal or paraspinal infection and not meningitis. Four (2%) of the 180 patients died.

Among patients with available information, median number of days from the last injection to the first positive magnetic resonance imaging (MRI) finding was 50 (range: 12–121 days) for all patients with a spinal or paraspinal infection, 52 (range: 12–121) for patients who received 1 injection, and 43 (range: 18–116) for patients who received 1 or more injections. Median number of days from the first positive lumbar puncture finding to the first positive MRI finding for patients with spinal and paraspinal infections and meningitis was 21.

Several reasons might explain the higher number and percentage of patients with spinal or paraspinal fungal infection in Michigan compared with other states including increased case finding, possible higher contamination of vials of MPA shipped to Michigan, or differences in injection technique (a transforaminal rather than translaminar approach preferred by clinicians at St Joseph Mercy Hospital). CDC guidelines urge clinicians to maintain a higher index of suspicion for patients who have unrecognized localized spinal or paraspinal infections and to embark on an assertive clinical management approach. However, because both voriconazole and liposomal amphotericin B, the most widely used therapies, can be toxic and MRI findings might be equivocal, a strategy of waiting 2–4 weeks for repeat MRIs while watching for signs of progression might be a reasonable alternative to immediate initiation of treatment.

Editorial comment. As of 24 May 2013, the US Food and Drug Administration has received reports of infections in patients who received MPA injections compounded by a pharmacy in Tennessee. At least 1 of these infections appears to be fungal in nature.

Impact of a Shortage of First-line Antituberculosis Medication on Tuberculosis Control—United States, 2012–2013

(MMWR 62:398, 2013)—In November 2012, the United States began to experience a severe interruption in the supply of isoniazid (INH). A survey showed that 79% of the responding health departments reported difficulties with procuring INH within the last month, with 15% reporting that they no longer had INH and 41% reporting that they would no longer have a supply within 1 month of the survey. Because of local interruptions in INH supply, responding tuberculosis programs were changing INH suppliers (69%), prioritizing only high-risk patients for treatment of latent tuberculosis infection (72%), delaying latent tuberculosis treatment (68%), and changing to alternative latent tuberculosis treatment regimens (88%).

Treatment of tuberculosis disease with second-line drugs can be less effective, more toxic, and more costly than treatment with first-line drugs.

Interruptions in the supply of second-line antituberculosis medications have been ongoing in the United States for several years, but since November 2012, tuberculosis control programs have experienced the first sustained generalized supply interruption of a first-line antituberculosis medication.

The INH shortage was unexpected, has affected US tuberculosis control efforts, and has lasted months longer than predicted. How the increased use of alternative regimens and the rising cost of INH driven by increased demand might affect the future supply of INH and other first-line antituberculosis medications is uncertain.