

the use of these new agents in monotherapy, owing to its relative low genetic barrier, was associated with a rapid development of resistance to the drugs and that the use of ribavirin was always necessary. These new agents will be available for general clinical use in the next years but they must be used as a complement of current therapy.

doi:10.1016/j.ijid.2010.02.1516

13.004

### Management of HIV and Hepatitis C Co-infection

M. Brito

*University of Illinois, Chicago, IL, USA*

The rate of coinfection of HIV with Hepatitis C is high in countries where the mode of transmission is predominantly intravenous drug abuse. The success of highly active antiretroviral therapy (HAART) in decreasing HIV related morbidity and mortality has shifted the focus of care for people living with HIV. More attention is being paid to the management and prevention of chronic ailments such as cardiovascular, liver and renal disease. Thus, it is important for the clinician treating HIV infected patients to recognize the clinical presentations, spectrum of disease, efficacy of treatment and principles of management for coinfecting patients. Patients coinfecting with the HIV and Hepatitis C viruses have an increased risk of liver related morbidity and a more rapid progression to end-stage liver disease. The treatment of these patients is complex owing to the significant side effects and limited efficacy of Peg Interferon and Ribavirin. This lecture will review the epidemiology, natural history, diagnosis, management and newer treatment modalities in HIV/HCV coinfection.

doi:10.1016/j.ijid.2010.02.1517

### Infectious diseases following catastrophes (Invited Presentation)

14.001

#### Infectious diseases and infection control after natural disasters

J. Ambrosioni\*, D. Lew, I. Uçkay

*University Hospitals of Geneva, Geneva, Switzerland*

Infections are frequent complications after natural catastrophes. Previous reports suggest a high prevalence of colonisation and infection with multi-resistant Gram-negative pathogens in victims of natural disasters.

Literature regarding infections and infection control measures after natural disasters was reviewed from 1986 through the end of 2009, with special emphasis on the 2004 tsunami. Local microbiology of patients followed in our institution was also reviewed.

Patients admitted after natural disasters often have polymicrobial infections with atypical bacteria and fungi. Moreover, they are usually colonised or infected with multi-drug resistant organisms. These pathogens are

are more prevalent than Gram-positive bacteria. A high incidence of colonisation and infection with extended spectrum  $\beta$ -lactamase-producing bacteria, multi-resistant non-fermenting Gram-negative rods and difficult to treat fungal infections are found in these patients and may pose challenges in routine hospital care.

According to published data and our own experience, we recommend pre-emptive contact isolation for victims of natural disasters during hospitalisation until results of microbiological cultures become available. If respiratory symptoms are present, droplet isolation must be included. These measures should also be applied during the air transportation of these patients. Considering the different multi-resistant colonisers, cohorting patients must be avoided whenever possible. In cases of life-threatening infections, empiric antibiotic therapy must cover multi-resistant non-fermenting Gram-negative rods. Clinicians must be aware of unusual microbiological findings in these patients.

doi:10.1016/j.ijid.2010.02.1518

14.002

### Infectious diseases and war conflicts in the Middle East

A. Shibl

*King Saud University, Riyadh, Saudi Arabia*

Infectious diseases and war have been witnessed for as long as human life. Historically, infectious diseases have been responsible for the majority of deaths during war; however, numerous medical and military advances have reversed this trend, resulting in more deaths from battle than infectious diseases in the 20th century. Wounds incurred in war are grossly contaminated with bacteria and most will become infected unless appropriate treatment is initiated quickly. Common infections include respiratory as well as gastrointestinal infections. Endemic diseases are also reported during the war and they include Brucella, Q-fever, Malaria, Sandfly fever and Leishmaniasis. Non-battle injuries such as mental and combat stress are common; while battle associated infections such as trauma-related complications are extensively reported.

Multidrug resistances (MDR) Gram negative bacilli have been reported in war wound infections, particularly *Acinetobacter* spp, *Enterobacter* spp. and *Pseudomonas* spp. and therefore empirical treatment for infected war wounds should be given to cover MDR. Other war related infections such as malaria, MDR tuberculosis, chronic Q fever and brucellosis may become apparent after returning home and therefore they should be considered due to their lengthy reactivation periods. In addition to this, vaccines have proven to be an important breakthrough to help prevent the spread of several infectious diseases.

War wounds are predisposed to infection due to environmental conditions on the battlefield, devitalized tissue, and foreign bodies in the wound as well as delays in evacuating casualties. Knowledge of likely pathogens for particular infections and sites, as well as optimal antibiotics to eradicate those pathogens will aid battlefield