**PP-052** Risk of catching infectious diseases during autopsy – precautions to be taken  
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With the rise of HIV incidence in India, autopsy surgeons are now facing the risk of inadvertent catching of infection through conduction of autopsies. Most dangerous are those autopsies, which come as routine autopsies (e.g. deaths occurring in road side vehicular accidents). In many of such cases, even the relatives of the deceased are not aware of the HIV status of their bereaved ones. In such cases, if the doctor sustains a cut during autopsy, he must undergo a preventive regimen of anti HIV medication for one month. Maulana Azad Medical College, where the author teaches, caters to an area which is adjacent to a red light area, and a conclave of drug addicts, where the incidence of HIV is very high. Many beggars who roam around in this area are infected with HIV about which they are not aware themselves. When they are found dead on the roadside, they are brought by the police as “unknowns” for postmortem examination and the risk of catching HIV from them is very high. During one such autopsy examination of an “unknown” the author sustained a cut on his left index finger. Since it was a case of a beggar brought as “unknown”, it was considered best to undergo a preventive regimen of anti HIV medication for one month. Another alternative was to get the blood of the deceased tested for HIV, but since he could be in the “window” period, it was decided best to undergo the anti HIV medication. Similar problems are faced not only by autopsy surgeons but by surgeons, nurses and all paramedical personnel. The paper highlights the problems faced by doctors and paramedical personnel in this respect and attempts to chart a roadmap for dealing with such cases.

**PP-053** The colonic mucosa changes of HIV(+) patients with chronic diarrhea  
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**Aim:** To study the colonic mucosa changes of 60 HIV(+) patients with chronic diarrhea.

**Methods:** 60 HIV(+) patients underwent colonoscopy. 1-4 colonic mucosa biopsy specimens were taken from ileocecal junction, sigmoid colon and rectum each from every patient. 1-4 additional biopsy specimens were taken when necessary.

**Results:** Pathological examinations showed no pathological change or mild vascular changes in colonic mucosa in 14/60 patients; irregular or ring-shaped vessel hyperplasia in 33/60 patients and bleeding or ulcer in 13/60 patients.

**Conclusion:** The colonic mucosa changes may be one of the causes of chronic diarrhea in HIV(+) patients.

Left: ring-shaped vessel hyperplasia; right: irregular vessel hyperplasia.

**PP-054** HIV/AIDS and communication for behavior change in rural Bangladesh  
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Nowadays HIV/AIDS is receiving the most attention in the resurgence of infectious diseases as it has emerged as a global threat by causing extensive mortality in the world. The continuing threat of HIV/AIDS by risk and preparedness has made the developing countries more vulnerable where communication for behavior change can be an effective tool to overcome the crisis under resource constraints. As the subsequent risk for generating an epidemic human strain and effective ways of communication are still unknown, the proposed study will investigate the awareness and risk perception of HIV/AIDS and to examine the effective ways of communication for behavior change to resist such this deadly epidemic in Bangladesh – a densely populated country which has been exposed to be the intensified HIV/AIDS risks. Here it can be noted that this is an explorative study with a special reference to author’s Master’s dissertation (2001) on Communication and Change in Health Behavior at grass root level in Bangladesh.

**PP-055** Disseminated cryptococcal lymphadenitis as a manifestation of immune reconstitution inflammatory syndrome (IRIS)  
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**Introduction:** We present a patient who developed disseminated cryptococcal lymphadenitis following successful treatment for cryptococcal meningitis and despite fluconazole prophylaxis. This atypical presentation of cryptococcosis may represent a manifestation of IRIS.

**Case description:** A 45-year-old man was diagnosed with HIV-1 in October 2006 (CD4 count 61 cells/ul, viral load (VL) 610,036 copies/ml). He commenced anti-retroviral (ARV) therapy (Kivexa and Efavirenz) in November 2006. He was admitted with cryptococcal meningitis. Cryptococcus neoformans was isolated from cerebrospinal fluid and blood cultures. He required several therapeutic lumbar punctures and treatment with intravenous (IV) Ambisome and flucytosine. ARVs were stopped. He was discharged on fluconazole 400 mg od. ARVs were re-started and the fluconazole dose was reduced in January 2007. Efavirenz was changed to Nevirapine in April 2007. He achieved a VL of zero and his CD4 count peaked at 160.

In January 2008 the patient presented with multiple pathological lymph nodes. Excision biopsy showed granulomatous inflammation with fungal spores consistent with Cryptococcus species, but no acid-fast bacilli (image 1 – Grocott stain, image 2 – Mucicarmine stain). Fungal culture was negative.

In February 2008 the patient presented with a neck abscess. Serum Cryptococcus antigen was positive. Surgical incision and drainage (I&D) of the abscess was performed. He was treated with IV Ambisome and flucytosine and discharged on high dose fluconazole. ARVs were changed to Kivexa, and Ritonavir-boosted Fosamprenavir. The patient developed two further abscesses requiring I&D. In June he commenced prednisolone and has clinically improved. Histological review of the excision biopsy suggests that the combination of crenated and budding yeasts with a necrotising granulomatous response represented...