

Aarhus University Network for Interdisciplinary Drug Resistance Research – IDRRES

9 January 2015, 14-16, Skejby (Infektionsmedicinsk Afdeling Q)

Summary of the 1st 2015 meeting in the network

Thematic focus on drug-resistant tuberculosis

Presentations by Christian Wejse, Niels Brimnes and Jens Seeberg.

Minutes

Participants	Tina Sørensen Dalgaard, Christian Wejse, Mette Søgaard, Lars Bach, Bjarke Nielsen, Niels Brimnes, Birgitte Brock, Mikala Wang, Eskild Petersen, Jens Seeberg, Martin D. Larsen (ref.)
Regrets	Svend Ellermann-Eriksen, Lars Jørgen Østergaard, Niels Nørskov-Lauritsen, Andreas Roepstorff, Uffe Juul Jensen, Viola Burau, Thomas Vorup-Jensen, Ulrika Enemark.

Three presentations on TB

<i>TB presentations</i>	<p>MDR Tuberculosis, by Christian Wejse, Dep. of Infectious Diseases, Skejby. Focus on drug resistant, multidrug resistant, and extensively drug resistant TB; high burden countries, e.g. India; case reg. MDR-TB patient from Somalia at Skejby. <u>See annex 1.</u></p> <p>Approaches to Drug Resistant Tuberculosis - India and beyond 1955-1992, by Niels Brimnes, Dep. of Culture and Society (<i>history</i>). Focus on India's national TB programme in the 20th century, and the awareness and/or rejection of TB resistance and its consequences. <u>Se annex 2.</u></p> <p>MDRTB in India, by Jens Seeberg, Dep. of Culture and Society (<i>anthropology</i>). Focus on MDR-TB cases in India; private healthcare (in Odisha) and the unregulated pharmaceutical industry; research on DOTS from patient perspective; new research orientations; some collaborative perspectives. <u>See annex 3.</u></p>
-------------------------	--

Comments, questions & discussion*Q & A*

Wejse: There have been 4 cases of TB in Denmark during the last 12 months. 2 of the persons were from India.

Q: Is it possible to make MDR-TB in the laboratory?

A: in principle yes, but would be much easier to obtain abroad. Also, it would be 'class 3 lab work'.

Q: How to conclude when a patient is no longer infectious?

A: When no TB bacteria can be detected by microscopy.

Wejse: To few TB patients in Denmark for substantial studies. It could be a good idea to announce proposals at TBNET – w. 49 countries (cf. annex 1; slide 19) – regarding access to bigger TB cohorts.

*Suggestion - TBNET**Discussions on India; medicine and mortality rate*

Wejse reg. India: there are no national numbers, only from regions.

Brimnes concludes: India closed its eyes for TB resistance until 2005/07.

Seeberg: States that India's MDRTB curve rises steadily (cf. annex 3; slide 5), and asks what went wrong? A part of the answer is substandard medicine (small-scale industries, locally produced medicine), and big profits in the private sector.

Mortality rate without any treatment = 50 percent. Wejse: today, using multidrug medicine can cure the patient. DOTS approach: here you only treat the top of the iceberg.

Brimnes: It's possible to conclude that fewer people die of TB today (even though the amount of TB infected hasn't decreased).

Seeberg: Gates' Global Fund promotes access to medicine and technology but the way it is done is not effective in the absence of investment in healthcare systems. The new WHO strategy is to outrun MDRTB by inventing new medicine.

Global Fund – access to treatment

Petersen: more square meters per person in the household decrease TB (hand in hand with general health improvements). Q: Has anyone done research on the most severe disease carriers? You would then follow up with treatment of family members (in

<p><i>Reg. possible treatment of latent patient groups</i></p>	<p>the same household) = latent TB disease carriers.</p> <p>Wejse: This demands active case finding. The medical industry would be interested; would include 1/3 of the world's population!</p> <p>Treating latent TB patients has been done in Greenland with positive effects on the amount of deceased. But such a smallcase may not be relevant in relation to the global picture.</p> <p>Wejse: In Guinea-Bissau there are good results from 9 months of treatment of latent TB (daily treatment w. one type of medicine); you do not see high drug resistance among people treated for latent TB.</p> <p>Brimnes: If this was done in India people wouldn't be cured but you would not develop resistance either.</p> <p>Wejse: yes, to really do something you would need to treat big groups of latent infected. But a main obstacle for this to happen is the fear of resistance; yes, it would mean more ordinary resistance, but 'so what'?</p>
<p><i>Reflections on research projects</i></p>	<p>MDRTB project in India: Existing network contacts can be utilized; India is a main hub for the world's TB and MDRTB, easy to identify large number of cases; Indian MDRTB patients appear increasingly in the rest of the world due to mobility; difficult to obtain research permit.</p> <p>MDRTB project in Greenland: Easy access, incl. to existing data; little has been done in the field of MDRTB in Greenland. (<i>The following added after the meeting</i>) This is probably because it has so far been virtually non-existent with only one case reported by 2010 (see http://www.selskaberne.dk/LF/UFL/2011/12/pdf/VP12100471.pdf)</p> <p>EPI-NYT 3-2015 has an overview of TB in Denmark 2013: http://www.ssi.dk/Aktuelt/Nyhedsbreve/EPI-NYT/2015/Uge%203%20-%202015.aspx. According to this, people from Greenland constitute the biggest group of TB patients in Denmark among those not born in Denmark. While mono-</p>

	resistance was found among 7% of new patients, only one has MDRTB and one had XDRTB, and both were from Russia.
Meeting plan	<p>The doodle was only clear reg. the February meeting. We just need one more colleague to 'vote' for the March, April and May meeting to clear these dates – see: http://doodle.com/9hbqtmawg8kc7y#table</p> <p>Next meeting is (Monday) 16 February, 14-16</p> <p>The hosts are Mette Søgaard and Mikala Wang, who will present the theme: 'resistance in relation to ordinary bacteria'.</p> <p>Mødested: 'Det store mødelokale', Klinisk Epidemiologisk Afdeling, Oluf Palmes Alle 43-45, 8200 Aarhus N.</p>