

TIMEBOMB:THE GLOBAL EPIDEMIC OF MULTI-DRUG RESISTANT TUBERCULOSIS pdf

1: Tuberculosis therapy in Mumbai: Critical importance of drug-susceptibility testing

*Timebomb:The Global Epidemic of Multi-Drug Resistant Tuberculosis [Lee B. Reichman, Janice Hopkins Tanne] on www.enganchecubano.com *FREE* shipping on qualifying offers. Two billion people - one-third of the world's population - are infected with latent tuberculosis.*

Reichman and Janice Hopkins Tanne. Reviewed by Rochelle Caviness - June 25, The battle against tuberculosis Tubercle Bacillus has been long and deadly, but just a few years ago it looked like we were about to win. Our jubilation was short lived. Tuberculosis TB has emerged from its near defeat, strong and more virulent than before. To make matters worse, multi-drug-resistant strains of tuberculosis are growing more numerous. The reasons for the growing prevalence of multi-drug resistant strains are discussed in detail in Lee B. In this eye-opening book, the authors explain the origin and spread of tuberculosis, and how drug-resistant varieties are cultivated. Particular attention is devoted to the catastrophic rise of drug resistant TB in the countries of the former Soviet Union, and how the Russian prison system helps to foster the spread of the disease by housing infected and non-infected inmates together in cramped, overcrowded cells that often lack adequate ventilation. Most alarming, they explain just how easy it is to become infected, and the arduous and time-consuming regiment that must be followed if there is any hope of a cure. Should patients fail to follow through with the prescribed treatment regiment, there is a risk that the strain of TB that they carry might become drug resistant. According to the authors, more than a third of the world population is infected with latent TB - they carry it but are not currently infectious. This equals to about 15 million Americans. A person carrying latent TB can become infectious at anytime - especially if their immune system becomes compromised by disease, malnutrition, or stress. As TB is a highly contagious, airborne bacterium, the infection can easily be passed from one person to another, hence it has been called "Ebola with wings. If the droplets are inhaled by a susceptible individual, they may develop TB. Small, costly epidemics have erupted from time to time, but a major outbreak has not yet occurred - but it may only be a matter of time before small outbreaks, such as the one in New York City in , begin to merge into a global pandemic. Written for a general audience, Timebomb: The Global Epidemic of Multi-Drug-Resistant Tuberculosis contains very little medical jargon and it lacks a detailed statistical analysis of the threat posed by TB. However, there are sufficient statistics cited to, justifiably, alarm any reader. This book will also serve as a wake-up call to political leaders and public health officials as to the importance of funding research on Tuberculosis and the necessity of being ever vigilant in identifying and effectively treating those who are infected with the disease.

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2: Timebomb:The Global Epidemic of Multi-Drug Resistant Tuberculosis

Wars and famines come and go but tuberculosis is a consistent and important fixture for humanity. A third of all people are infected at some stage during their lives. For tuberculosis, the paradox is that although it is quite easy to diagnose and treat, it is an increasing global scourge and the.

This article has been cited by other articles in PMC. In this issue of Lung India, Udwardia et al. The rationale to impose a standardized drug regimen for MDR-TB and harmonize medical practice is not unfounded. However, there is an undeniable risk of amplifying drug resistance by promoting one regimen for all, without taking the local epidemiology into account. In other words, nearly two-thirds of this sample would have received a suboptimal drug regimen and have been at risk for developing secondary resistance, had they been empirically treated under the recommended standardized regimen for MDR-TB. The imposition of a standardized empiric drug regimen for MDR-TB, while feasible in lower burden settings with a more homogenous epidemic, may compound the existing challenges to MDR-TB management in settings with diverse patterns of TB drug resistance. It is time we shed universal dogmas when confronting strains of TB that are unpredictable, inconsistent, and increasingly untreatable. Possible impact of the standardized category IV regimen on multidrug-resistant tuberculosis patients in Mumbai. Principles for designing future regimens for multidrug-resistant tuberculosis. Bull World Health Organ. A study of patient treatment seeking behavior. Quality of tuberculosis care in India: Int J Tuberc Lung Dis. Tuberculosis management by private practitioners in Mumbai, India: Has anything changed in two decades? Resistance patterns among multidrug-resistant tuberculosis patients in greater metropolitan Mumbai: Clinical profile and treatment outcomes of drug-resistant tuberculosis before directly observed treatment strategy plus: Lessons for the program. India should screen all tuberculosis patients for drug resistant disease at diagnosis. Alarming levels of drug-resistant tuberculosis in HIV-infected patients in metropolitan Mumbai, India. World Health Organization; The politics of TB: The politics, economics and impact of directly observed treatment DOT in India. Moving beyond directly observed therapy for tuberculosis. Pathways to multidrug-resistant tuberculosis diagnosis and treatment initiation: When treatment is more challenging than the disease: Toward a patient-centered model of care for drug-resistant tuberculosis and HIV. The End TB Strategy. Challenges and opportunities for India.

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3: Immigration's Silent Invasion, Deadly Consequences

NATURE MEDICINE €¢ VOLUME 7 €¢ NUMBER 11 €¢ NOVEMBER BOOK REVIEW *Timebomb: The Global Epidemic of Multi-Drug Resistant Tuberculosis* by Lee B. Reichman with.

They are not alone! Chagas is a nasty parasitic bug common in Latin America where 18 million people are infected and 50,000 deaths occur annually. Illegal aliens, by avoiding health screenings at U.S. ports. Ironically, because of First World personal hygiene and sanitation practiced in America, leprosy affected only people in the previous 40 years. However, illegal alien immigrants from India, Brazil, the Caribbean and up through Mexico have fueled the resurgence into the United States. Chagas, called the kissing bug disease because the parasite favors the face as a route of infection, comes in acute and chronic forms, which can damage your heart and intestines. This parasite now threatens our blood supply, yet no means to test the blood is currently available. Ironically the public health community has been aware of this danger for years. After a decade, 10 to 30 percent of them will die when their hearts or intestines, weakened by the disease, explode," according to a New York Times story, November 18, by Donald G. Three people received Chagas infected organs in , the first such cases reported in the United States ever! Two of those three died. Dengue Fever, reports of polio, and now, the first case of malaria in Texas trickle into the United States as the invasion of illegal aliens increases in numbers. Undiagnosed disease due to uncontrolled illegal immigration is not confined to the Border States. This health care crisis spreads daily across the nation. Health officials link immigrants to this outbreak and credit them with introducing the drug resistant strains. The CDC reports that last year one-half of all new TB cases were attributed to foreign born people, who have an eight times higher incidence of TB. It is thought that two-thirds of the cases of TB brought into the United States originated in three countries: Mexico, the Philippines and Vietnam. Though not usually fatal, there is a more serious strain called dengue hemorrhagic fever, which CAN kill you. Quoting a Fox News Report from April 4, , Miguel, an illegal alien who worked construction on a subway renovation project for months, was able to change his status to legal permanent alien. Unfortunately, Miguel was infected with tuberculosis. This did not stop the federal government from issuing Miguel a health waiver under the Immigration and Nationality Act, a waiver that permits him a green card, even though his disease made him inadmissible for the waiver. What does this mean to American citizens? Does it take the immediacy of a SARS or tuberculosis epidemic to force our Congress and president into action? After the deaths of dozens or thousands of innocent citizens? It means your children are at risk when attending school or going to the movies. It means that when a classmate from a foreign country sneezes or coughs, your child may be at risk for any number of diseases. If you eat at a fast food restaurant, a person infected with hepatitis could prepare your food. If you need a blood transfusion, the blood could be infected with Chagas Disease. What can you do? You may visit the principal of your school and insist that every child pass a complete health screening, especially for tuberculosis and hepatitis. You may ask local health inspectors to check restaurants in your community to see that all employees are legal residents or American citizens and have been health screened. For all these undetectable diseases, you may call your senator or representative, and demand they secure the U.S. Make the punishment worse than their profit.

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First, you would create a social and economic environment that promotes poverty and inequity. Second, you would temporarily subject those who have infectious tuberculosis to squalid and overcrowded conditions, let them mix with an uninfected population, and then release them back into the general population. Third, you would provide just enough treatment to prevent those who have the disease from dying but not enough to cure them, so that they would remain infectious longer. Fourth, you would provide inadequate treatment, guaranteed to create drug resistance. Fifth, you would add the possibility of infection with human immunodeficiency virus HIV to increase dramatically the risk of progression from infection to active tuberculosis disease. Timebomb, written by Lee Reichman with Janice Hopkins Tanne, shows that this desperate situation has already occurred. Though clearly unintentionally, a combination of politics, economics, the emergence of a new infectious disease, and scientific belief has contributed to a major epidemic of tuberculosis in Russia. Multidrug resistance is a major component of this epidemic in prisons and parts of the civilian population. What makes the situation so worrisome is that the epidemic was well under way even without the added boost of HIV infection. This appalling combination of HIV infection and multidrug-resistant tuberculosis is -- as the authors quite rightly assert -- a deadly time bomb, with consequences that reach far beyond the borders of any one country. This is not a scientific analysis of the global dimensions of multidrug-resistant tuberculosis. In fact, the title is something of a misnomer, since in geographic scope the book mainly covers events in Russia and New York. Having set the scene with a description of a tuberculosis outbreak caused by a Ukrainian man traveling to the United States in , the authors provide an excellent introduction to the science and history of tuberculosis, written primarily for the lay reader with little or no knowledge of tuberculosis. They then return to the main theme: Reichman, who is executive director of the New Jersey Medical School National Tuberculosis Center, has been involved in issues related to tuberculosis in Russia for the past few years, and his insights into what he calls a world of "smoke and mirrors" make compelling reading. Indeed, the authors are at their best in telling a story, with vivid and often detailed descriptions of people and events. The personalities are diverse and memorable: There are several minor mistakes in the book. For example, the countries listed at the end of the book are not the "hot spots" of multidrug-resistant tuberculosis that have been identified by the World Health Organization but rather are the 22 countries that together account for 80 percent of the global tuberculosis burden; the London conference on tuberculosis was held in , not ; and most historians of tuberculosis control would assert that the principle of directly observed treatment for people with tuberculosis was promoted before . An exploration of the reluctance of the Russian government to adopt a policy of international competitive bidding for tuberculosis drugs, as required in the proposed World Bank loan, would also have been interesting. Timebomb is an important book with many lessons for those involved in public health. First, history repeats itself; as the poet Steve Turner says, "has to -- no one listens. In , on announcing his discovery of the tubercle bacillus, Robert Koch described the disease as killing at least one third of people in the economically active age groups. The fact that the same bacterium continues to kill nearly 2 million people worldwide each year, despite the availability of a cheap and effective treatment, reminds us that complacency is one of the greatest threats to public health. Second, the book demonstrates the multifaceted and complex nature of modern epidemics. Mix an intransigent medical profession with a judicial system based on imprisonment, and add a couple of virulent microorganisms to an environment of socioeconomic upheaval and inequity, and the results will be predictably appalling. Third, self-interest on the part of medical professionals can thwart attempts to improve the health status of the poor. Historians of health and development have documented many examples from the past. That they continue to do so in the present is a reminder that none of us are immune to this temptation.

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The story is unfinished. The time bomb has yet to go off. There is still time to act, and proven strategies for tuberculosis control are available that can work -- as long as they are adopted quickly and widely. Whether this time bomb will be defused remains to be seen. The fact that it can be defused is indisputable. I look forward to reading the sequel.

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Incomplete treatment, wrong therapy, and co-infection with other diseases, for instance, HIV, may give rise to new resistant strains of TB (multiple drug resistant, or MDR strains).

Highlight and copy the desired format. *Emerging Infectious Diseases*, 24 11 , Among a prison population of inmates, 29 TB case-patients were already undergoing treatment. We found an additional presumptive TB case-patients and confirmed TB in of them. In March , the prevalence rate of confirmed TB was We detected an additional 14 cases of rifampin-resistant TB and initiated treatment in all 14 of these case-patients. Overcrowded living conditions and poor nutrition appeared to be the driving factors behind the high TB incidence in this prison. Globally, the prevalence of TB in prisons is much higher than in the general population, both in high- and low-income countries 2. Several factors, such as poor ventilation, HIV infection, overcrowding, malnutrition, lack of sunshine, stress, prolonged incarceration, and inadequate access to care, contribute to the rapid spread and high prevalence of MDR TB in prisons 2. One of the critical barriers to TB control in prisons is limited access to high-quality TB diagnosis, which is attributable to limited screening, inaccuracy of diagnostic algorithms, and lack of laboratory facilities 7 , 8. Preliminary data from an antimicrobial drug resistance survey in show a prevalence of rifampicin-resistant TB of 2. The World Health Organization recommends this assay as a first-line diagnostic test for persons with suspected pulmonary TB who are considered to be at risk for harboring MDR TB bacilli By the end of , the laboratory had confirmed TB in 31 of 57 sputum specimens from prisoners with presumptive TB; this number included, for the first time in the prison records, 3 patients with rifampicin-resistant TB. A total of 72 documented TB cases occurred in the prison that year, almost twice the figure. After being alerted about the situation, the NTP head office in Kinshasa launched an outbreak investigation on January 5, Two NTP experts M. We report here the outcomes of this outbreak assessment, including the incidence of TB and MDR TB, the drug-susceptibility patterns of the circulating *Mycobacterium tuberculosis* isolates, and associated risk factors for TB infection. For this report, we only used specimens and data collected in the course of routine patient care and drug-susceptibility surveillance. Data were delinked from any personal identifiers before data analysis and reporting. All persons who had TB or rifampicin-resistant TB diagnosed received the recommended treatment regimen 6 months for TB and 9 months for rifampicin-resistant TB. Mbuji-Mayi Central Prison is a medium-security correctional facility built in with a capacity of inmates. It is surrounded by schools, houses, and government offices. It houses on average inmates i. Figure 1 Figure 1. A Cell 4 is 37 m², with 1 door solid red line and They eat with the inmates of the same cell but meet those of other cells during morning sessions, gym, and vocational training. They also have close contact with prison staff, judges, and their own families. The prison has a clinic, run by 1 medical doctor and 2 healthcare workers. Located close to the prison is an NTP clinic that conducts direct smear microscopy no radiology and can provide TB treatment to prisoners. Prisoners were not routinely screened for TB on entry. The NTP national policy on screening in prisons instructs chest radiograph screening upon entry, followed by smear microscopy if the radiograph results are suggestive. Further screening has to be systematically conducted every 6 months and upon release. However, prison-based TB control measures in DRC are limited in practice because of lack of resources. Study Procedures The outbreak investigation team reached Mbuji-Mayi mid-January and reviewed all available NTP records as well as the prison admission register and patient files. The team also extracted from the NTP registers data on the TB notification rate in this prison for the 7 years preceding the investigation. Assisted by provincial-level program staff and prison medical personnel, the team screened all inmates for presumptive TB. A standard form was used to collect data on previous history of TB, symptoms, duration of stay, and location in the cell. Awareness was raised among inmates about the signs and symptoms of TB, and the chief inmate of each cell as well as 10 peer educators, all inmates, were trained to recognize the major symptoms of TB. Inmates with a history of TB or clinical symptoms e. These patients were asked to submit 1 early morning sputum sample. Samples were

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transported to the provincial reference laboratory located 3 km from the prison. We also recorded demographic data of patients and their TB history. A 2-mL aliquot of each sputum sample was processed in Xpert according to standard methods 12 , One aliquot without additive was transported to Kinshasa for culture. Sputum samples were decontaminated with NaOH according to a modified Petroff technique The methodology for PCR amplification and sequencing of genes encoding gyrase A and B has been described elsewhere Skilled counselors performed pretest group counseling. Posttest counseling was carried out in a private one-on-one setting by the same counselors. Both datasets were compared by using Epi Info 7. The primary outcomes of interest for this study were the prevalence rates of TB and rifampicin-resistant TB, computed as the proportion of confirmed TB or rifampicin-resistant TB patients over the total number of prisoners at the time of our visit. For this analysis, we divided the prison into 3 areas. Area 1 comprised cells 1â€”3 the VIP or first-class cells, where inmates get better conditions in exchange for payment. Area 2 comprised cells 4â€”7 the second-class cells. Area 3 comprised cells 8 and 9, the areas for women and juveniles. We mapped the spatial distribution of TB in the cells on a sketch showing the location of each prisoner. We calculated means including SDs and medians and ranges for continuous variables. For 2 patients, no information on location was recorded, and they were not present any longer during our outbreak investigation. Area 1 housed inmates Median age of inmates was 30 years interquartile range 25â€”42 years , and 29 inmates were already undergoing TB treatment all 29 had TB diagnosed after their entry into the prison. Out of the remaining inmates, 45 were absent for various reasons or declined to be screened. The mean age of inmates with presumptive TB was 32 years median 31 years , and their mean duration of incarceration was 72 months median 42 months, range 1â€” months. The remaining tests were negative. The overall prevalence rate of TB among the prisoners housed in March was The overall proportion of inmates with HIV infection was 1. Trend of TB Figure 2 Figure 2. TB cases include bacteriologically positive and clinically diagnosed TB patients. Clinical diagnosis was based Among them, 17 8. Among the 14 cases documented in March Table 2 , all but 1 were new cases. For the 3 first detected cases, documented in , the delay between diagnosis to start of treatment was 21 days. This delay decreased to 48 hours for the remaining patients. No second-line drug resistance was identified among any rifampicin-resistant TB patient. This finding supports the possibility of clonal spread of 1 strain containing a mutation in the rpoB codon or, less likely, the codon. In cells 4 and 7, the available surface per person was no more than 0. The frequency of TB and rifampicin-resistant TB increased significantly with the number of inmates per area. Of the confirmed TB patients, 19 resided in area 1, in area 2, and 3 in area 3. The prevalence of confirmed TB was 2. Out of the 14 rifampicin-resistant TB case-patients identified during Januaryâ€”March , only 1 resided in area 1 7. In the subgroup of confirmed TB patients, Malnutrition was significantly higher among TB patients than among the other inmates odds ratio 4. Discussion Our findings provide an account of the high prevalence of TB and drug-resistant TB in a large prison in DRC, where overcrowded living conditions were appalling. The TB problem at Mbuji-Mayi Central Prison probably remained undetected for years because of lack of screening and the weak sensitivity of smear microscopy. During our investigation, we observed the presence of several risk factors for TB spread in the prison, such as lack of TB screening upon arrival, overcrowding, lack of sunshine, very poor ventilation, and malnutrition 3 , 22 â€” These factors were also documented in other prison TB outbreaks 3 , 23 , 27 â€” 32 , but the degree of overcrowding at Mbuji-Mayi Central Prison was a staggering 6 times higher than its capacity. Some prisoners stated that they did not eat for 3 days before our investigation. One limitation of our study is that no further investigations were conducted to check if the M. Probably both factors were at work. The preliminary results of a nationwide antimicrobial resistance survey conducted in M. The high TB rates in Mbuji-Mayi Central Prison reflect this problem in the community, but in all probability the prison environment acted as an effective amplifier. As an immediate response measure, the NTP team initiated TB therapy for all confirmed TB case-patients and transferred the rifampicin-resistant TB case-patients to a special isolation ward at the local hospital. We also initiated screening of prisoners upon prison entry. Our findings also led to an acceleration of pending judicial proceedings, which resulted in

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decongestion of the prison, and the World Food Program intervened to provide supplementary feeding. However, sustained control of TB among incarcerated populations requires sustained efforts Table 4. Overcrowding should be avoided, and inmates should have access to better nutrition and more sunlight exposure. Dedicated TB control with adequate diagnostic technology is needed. In prisons, use of this technology is warranted at entry point and thereafter. Passive and active case-finding should be conducted simultaneously and systematically. The high risk for TB in prison settings underscores the urgent need for dedicated TB programs to protect not only the health of prison inmates but also the health of the wider community. However, to avoid outbreaks of MDR TB in similar contexts, living conditions in prisons should be adequate.

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6: Timebomb: The Global Epidemic of Multi-Drug-Resistant Tuberculosis - History in Review

Timebomb The Global Epidemic Of Multi Drug Resistant Tuberculosis The Global Epidemic Of Multi Drug Resistant Tuberculosis Pdf Books Download placed by Gabriel Jameson on October 24 This is a downloadable file of Timebomb The Global Epidemic Of Multi Drug Resistant Tuberculosis The Global Epidemic Of.

Having published a scientific textbook on tuberculosis TB in , he has now written a fascinating though terrifying novel-like book about it with Janice Hopkins. You do not need to be a public health expert to understand this book but if you are one it is compulsory reading. The subtitle is a bit misleading. Though multidrug-resistant TB is the main theme we are guided through the whole known history of TB, starting in about BC and ending with a look into the future with new drugs and vaccines. It provides us with medical and public health as well as social and political background data about the disease and about the efforts to control and eliminate it. However, they give their opponents sufficient space to explain the motives behind this thinking. Knowing and understanding these motives might be a good starting point for discussing the so desperately needed change. Of course a lot of space is given to the surge and threat of multidrug-resistant TB. The authors also make it clear that the main reason for the creation of this multidrug resistance is the improper implementation of DOTS, and, they say, this is more often the fault of the doctor than of the patient. They picture convincingly the threat of this multidrug-resistant TB for the whole global community, characterizing it as a timebomb steadily ticking away. The subject is written up in 13 chapters, each of which is a story in itself. This approach sometimes causes repetition of the facts but is convenient for those who may want to read the chapters independently of each other. The experiences described are mostly those of the first author. It would make even stronger the argument that the disease was neglected when tools were there to control it. It would also stress the point that, though society is changing its response towards this devastating illness, the battle has not yet been won. The Epilogue about the Kursk Syndrome, which describes the rejection of the World Bank loan for TB control activities by the Russian Government, serves as a perfect illustration of this. There is also a large gap between the countries producing most of the web-based TB information and the countries most affected by TB. A large proportion of web-based information relating to TB is produced by western academic institutions and is not necessarily aimed at audiences in the south, in terms of relevant content or language. Nonetheless, there are still many web sources that provide excellent information for the general public, TB patients, researchers and health care professionals. Because these are both large, well-resourced, technically-oriented umbrella organizations, their websites contain comprehensive, accurate and up-to-date information regarding TB. CDC has a large online catalogue of educational materials and guidelines for clinicians, the general public and patients, which can be ordered free of charge: In an ideal world such a wealth of information would also be accessible to those who do not understand English. Curry National Tuberculosis Center [http:](http://) One of these is the PubMed website [http:](http://) Unfortunately these articles may be prohibitively expensive for most people in developing countries. There are a number of websites, though not nearly enough, that offer the viewer a feel for the TB situation in a given country. One can hope that over time more and more locally-driven websites relating to TB will arise, with locally-generated content and news. The digital divide between north and south still needs to be bridged in terms both of access to TB information and the production of it. The most important aim is surely to reach those in greatest need of relevant information in the most heavily affected countries. All the discussions are stored at: This is a popular perception at national and global levels: Whatever the case, few would argue against the need to find ways to give more people a voice at the TB policy table. Within a short time, the eForum emerged as a common meeting ground for health care providers, those working in advocacy, programme managers, researchers, policy planners, and media personnel throughout the world. The number of subscribers shot up to more than in the first six months, with considerable input from people in low-income and high TB-burden countries. Not all the contributions related to problems: A valuable evaluation of the early months of the eForum has been

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undertaken the report, published in February , is available from: However, the evaluation also highlighted weaknesses with the current approach to the eForum. It is only available in English, and it is of note that there seem to be fewer contributors from South America and eastern Europe than might be expected from the high TB-burden of these regions. There also appeared to be few contributions from people with TB. Furthermore, the technology required to join the eForum may exclude the poor and many in rural areas. In our opinion the answer is certainly yes. Clearly, ways need to be found to include more people, perhaps by providing translations into another major language Spanish, Russian, or Chinese would be strong contenders. A call also needs to go out to involve more subscribers in the discussions. The eForum needs to become a place where we can share our mistakes as well as our successes: In addition, as most of our inboxes are full each morning, and the moderators of the eForum have a critical role in limiting the frequency and length of contributions. There is plenty of scope for increased collaboration, an example of which is the recent agreement to merge the tb. The electronic highway has an increasingly important place in our battle against TB. If policy makers do not listen and programmes do not deliver, then you will probably read about it first by email. Correspondence should be addressed to this author. Alternatively, Supercourse can be downloaded from the following URL: In essence it is an ever-growing, Internet-based, freeware, distance learning tool. It is intended for students beginning to explore epidemiology, global health, and the opportunities of learning through the Internet. But more than that, it is a resource for lecturers and academics seeking to find new ways to present material or compare their way of teaching with that of others across the world. I personally first came across Supercourse while struggling with the finer points of epidemiology during my Masters course in public health and was delighted by the treasures waiting to be discovered. Not being someone who enjoys reinventing the wheel, I find the concept of the Supercourse very appealing and oh so sensible. The front page is clear and uncluttered. It offers an introduction to the principles behind the Supercourse and presents hyperlinks under the headings: What is the Supercourse; 2. Other Supercourse lectures; and 4. Want to join us? The topic portal leads you to around 20 subject headings arranged under the labels "Epidemiology", "Special Diseases", "Public Health", "Telecommunications", and "Biostatistics". You then choose your subject area, such as "Cancer", and are led to a hyperlinked list of around 25 separate cancer-related lectures. The other method of quickly searching is to use the alphabetic listing. Thus you could hunt for "screening" under "s" in the alphabetic portal or in "Epidemiology - Basic Methods" using the topic portal. Supercourse is not a comprehensive source of lectures on all aspects of each subject heading. Rather it is an organized collection of personal best lectures on important or pet subjects. Once you find the lecture that you want, you are presented with a standard format in terms of front page, navigation buttons, general layout, and closing summary and review slides. The lectures are of a relatively standard length around 25 - 30 slides but of variable quality - some gems, some very ordinary, some far too specialized for a global audience. The driving principles behind this "library of free lectures" are attractive and forward thinking. The course developers, at the School of Public Health, University of Pittsburgh, Pittsburg, PA, USA, have a desire to use the potential of the Internet to maximum effect in teaching and have built in a robust quality assurance programme for the preparation of new lectures and the evaluation and revision of old ones. With an eye on the practicalities of information technology in less developed countries, the graphics have been deliberately compressed into small files to speed up access from the Web. Institutions around the world are encouraged to set up "Supercourse Mirror Sites" of which there are currently 33 and of course the CD-ROM containing over epidemiology lectures is available free for users without Internet facilities. Lectures are mainly in English but there are now 34 multilingual lectures. And then there are the add-on extras consisting of hyperlinks to the BMJ, the National Library of Medicine, and other useful sites and journals. The most valuable of these is the link to two online free textbooks from the BMJ collection Epidemiology for the uninitiated and Statistics at square one. There are three small irritations that I must mention: Supercourse has a safe place in the "Favourites" folder on my Internet browser, and I will certainly be keeping the contents of the CD-ROM on my hard drive. For those of you starting out on a career in public health, this is a resource to use and tell others about. For those in senior positions, this is a venture to

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support in word and deed. If Supercourse remains focused on its original aims, it will provide a valuable ongoing resource for the international public health community.

7: Timebomb: The Global Epidemic of Multi-Drug-Resistant Tuberculosis by Lee B. Reichman

Get this from a library! Timebomb: the global epidemic of multi-drug-resistant tuberculosis. [Lee B Reichman; Janice Hopkins Tanne] -- Timebomb is the story of multi-drug resistant diseases - the latest scourge to hit medicine.

8: Expert Warns of Tuberculosis "Time Bomb" in Russia - www.enganchecubano.com

Web-based information on tuberculosis. Given the magnitude of the tuberculosis (TB) epidemic worldwide, there is a relative dearth of TB-related information to be found on the Internet, in comparison with HIV/AIDS.

9: a book review of "Timebomb"

About the e-Book Timebomb: The Global Epidemic of Multi-Drug Resistant Tuberculosis pdf Two billion people - one-third of the world's population - are infected with latent tuberculosis.

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Troubleshooting: when the feedback session doesn't go as you planned Windsor Red (A Charmian Daniels Mystery)
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