Leone, Liberia and Guinea. The NLFSFN was formed in 2007 to meet the need for a structured and sustained response to the control of the epidemic in Nigeria. We describe the spread of the epidemic from 2001-2007, the change in its seasonality, the rise in prevalence and the decline in case fatality rate (CFR) among hospital patients.

Methods: Review of surveillance data at the Federal Ministry of Health and the Institute of Lassa Fever Research and Control, ISTH, Irrua and review of the case load and outcome of suspected LF at the ISTH. The diagnosis of LF was based on defined criteria.

Results: From 2001 — 2006, 1-3 (average 1.7 or 5%) of the 36 States and the Federal Capital Territory reported LF compared to 7-12 (average 9.7) States in 2007-2009 (OR (95% CI) = 0.26 (0.13, 0.53), $p < 0.01$). Suspected LF constituted 0.53% of 41,440 admissions in 2001-06 compared to 2.16% of 35,484 admissions in 2007-09 (RR (95% CI) = 1.7 (1.64, 1.76), $p \ll 0.001$). Ninety (76%) of 118 cases of suspected LF managed at the ISTH in 2001-04 were seen in January to March compared to 49/103 (48%) in 2004-05 (RR (95% CI) = 1.9 (1.32,

2.62), $p \ll 0.001$) and 271/765 (35%) in 2007-09 (RR (95% CI) = 1.56 (1.09, 2.24), $p = 0.02$ for 2007-09 versus 2005-06). CFR from suspected LF was 97/221 (43.9%) in 2001-06 versus 102/768 (13.3%) in 2007-09 (RR (95% CI) = 0.61 (0.53, 0.7), $p \ll 0.001$). Overall, the diagnosis of LF was confirmed in 16-25% of cases of suspected LF in 2008-09. In each of the 3 Senatorial Districts in Edo State, the prevalence of suspected LF as seen at the ISTH increased by >149% from 2008 — 2009 while that of confirmed LF increased by >73%.

Conclusion: Both awareness of the epidemic and the index of suspicion in clinical diagnosis have increased as immediate gains from the LF control activities of the NLFSFN. The seasonality of LF has changed while the prevalence in Nigeria may have increased, perhaps in part due to the increased awareness and index of suspicion. Assistance of the international community is required to scale up the control initiatives, particularly with regard to capacity building in surveillance, laboratory diagnosis and case management.

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Immunocompromised patients with shingles - Therapeutic approach

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Background: The complexity of the therapeutic approach of the immunocompromised patients is determinate by the capacity of their immunoresponse corresponding with the arising infection. Among the patients with shingles with a comorbide immunodeficiency syndrome such as primary hypogamaglobulinaemia or secondary lymphopenia as a result of a long lasting immunosuppressive therapeutic treatment that is even more complex, due to threatening viral generalization, including visceral generalization of the illness as well as dermal and pulmonary bacterial superinfection.

Methods: During the 6 year long period, 20 immunocompromised patients with shingles were hospitalized and healed in our department. Dermal eruptions were spreaded on several dermatoms, in 8 patients with dermal generalization. Visceral generalization appeared in 4 cases with all consecutive disorders. Diagnostic criteria, including complete blood count (CBC), sedimentation, chemistry profile of renal and liver function tests, bacteriological (inducted expectorated) sputum sample testing, blood culture, pleural fluid analysis, chest xray and tomography, were determining moments in the diagnostic procedure and therapeutic treatment.

Results: Appearance of the Acyclovir (for oral or i.v. application), as a systemic virostatic with high efficiency, dramatically changed the evolution of the illness in this group of patients, their clinical symptomatology and expression, with the drastic reduction of the sequels and the epilogue of the illness. Due to the effect of viral replication blocking, its efficiency is evident, especially if it is applicated within the first 3 days of the illness (24-48-72 hours after the appearance of the first symptoms) at the period of the most intense viral replication. These patients were parenterally/peroral treated with Acyclovir (Virolex) and antibiotics - Penicillines, II and III generation Cephalosporines, Aminoglycosides, Macrolides, Quinolones, Clindamycin, Lincomycin, Co-trimoxazol.

Conclusion: All patients showed satisfying resolve of the dermal lesions, resolution of the pulmonary inflammation and correction of the chemistry profile of renal and liver function as well as abrogation of all clinical symptoms and subjective difficulties. Is it necessary to point out the importance of the substitutional and symptomatic therapy that have to be implemented simultaneously with antiviral and antibiotic therapy, as the only possible and satisfactory way of treatment of this group of patients along with necessary attention and care.

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Peculiar case of herpetic viral encephalitis

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Background: Herpetic viral encephalitis is a severe disease, especially in neonates and immunocompromised hosts. HSE with HSV 2 appears more frequently in persons younger than 20 and older than 50. Immunossupresion may be the cause of herpes simplex viral encephalitis.

Methods: The case presentation is supported by the information found in this patient's files from three medical services where he was admitted: Clinic of Internal Medicine, Neurosurgery, and finally Clinic of Infectious Diseases of the University of Oradea.

Results: A 16 years old rural male patient, presented starting with September 2009 headaches, night sweating, lack of appetite, vomiting, abdominal pain, diarrhea and