







# CDR WEEKLY

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## News

Last updated: **2 December 2004**  
Next update due: **9 December 2004**

-  [Falciparum malaria in travellers who fail to take prophylaxis in endemic areas](#)
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### Falciparum malaria in travellers who fail to take prophylaxis in endemic areas

There has been a recent increase in the number of cases of potentially fatal *Plasmodium falciparum* malaria reported in North American and European travellers to the Dominican Republic (DR). Seven cases have been reported in Europe and five from North America.

One of the European cases was a resident of the United Kingdom (UK), who returned on 5 November 2004 from a two week package holiday to Bavaro, just north of Punta Cana on the east coast of the DR [Marie Blaze, UK Malaria Reference Laboratory, personal communication, 1 December 2004]. Another case was from Spain and five cases were from Germany; all of these cases had also travelled to Punta Cana (1).

Two cases (one to Punta Cana and one to San Francisco de Macoris) were reported from the United States (US) (2) and three from Canada [Ron St.John, Health Canada, personal communication, 30 November 2004]. None of the travellers with malaria took chemoprophylaxis. The UK currently recommends chloroquine prophylaxis for travellers to all areas of the Dominican Republic and this is reinforced in the latest update to the UK malaria guidelines (3). As a precautionary measure, the Berlin Institute of Tropical Medicine, the Public Health Agency for Canada and the Centers for Disease Control and Prevention in the US have now amended their malaria advice to include chloroquine prophylaxis for travellers to all areas of the Dominican Republic including tourist resorts on the east coast.

On 4 November 2004, a British man aged 69 years died from falciparum malaria after a seven-day package holiday to The Gambia. He took no prophylaxis despite The Gambia being a highly endemic country for malaria. Between January and August 2004, there have been 14 cases of falciparum malaria reported in travellers to The Gambia, nine of whom took no prophylaxis. A cluster of five falciparum malaria cases, all of whom had failed to take malaria prophylaxis while travelling in The Gambia, was reported in the northwest of England at the end of 2003 (4).

Malaria caused by *P. falciparum* is a potentially fatal disease that is preventable by insect-bite avoidance measures (5) and the use of chemoprophylaxis. All travellers to malaria endemic countries such as the Dominican Republic and The Gambia, should be advised to take prophylaxis as recommended by the *Guidelines for malaria prevention in travellers from the United Kingdom for 2003* (6).

With the Christmas holiday season approaching it is important to ensure that travellers seeking winter sun in malarious locations are given adequate preventive advice. This includes last minute holidays booked over the telephone or on the Internet. Travel companies should remind travellers that they should seek appropriate travel health advice before their departure. Travellers should ideally allow adequate time before their trip to start taking anti-malaria prophylaxis, although if required it is better to start before the flight than not at all.

Specific travel health advice for health professionals about malaria can be obtained from the Malaria Reference Laboratory, tel: 020 7636 3924 or from the National Travel Health Network and Centre, tel: 020 7380 9234.

## References

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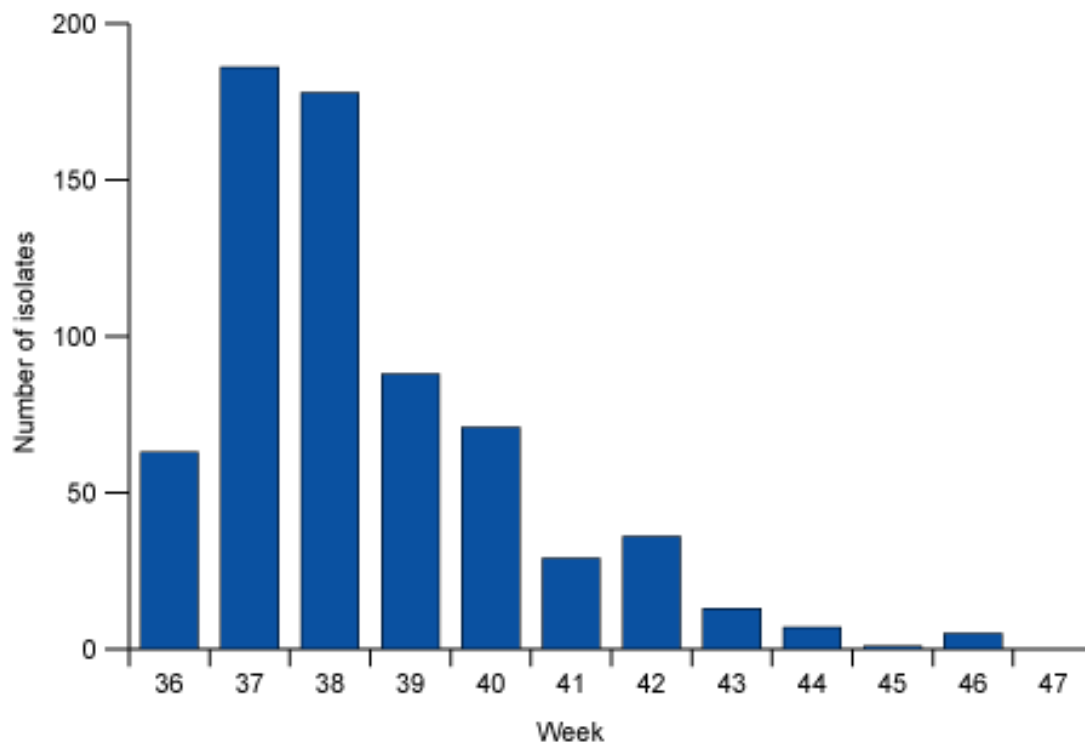
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## Update on the national outbreak of *Salmonella* Newport infection



The outbreak of *Salmonella enterica* serovar Newport affecting England, Scotland, Northern Ireland, and the Isle of Man previously reported in *CDR Weekly* (1,2) is thought to be over. Cases continue to be confirmed by the Health Protection Agency's Laboratory of Enteric Pathogens, but disease incidence has returned to background levels (figure).

**Figure National outbreak of *S. Newport* infection, England and Northern Ireland: 2004**



Since 9 September 2004, 677 cases of *S. Newport* infection in England and in Northern Ireland have been reported. Molecular typing performed on 350 of the isolates show that 297 of the strains are indistinguishable from each other.

Case-control studies undertaken locally in north east Lincolnshire and Northern Ireland found that consumption of lettuce was associated with being a case of *S. Newport* infection. A similar case-control study undertaken in the West Midlands failed to identify a vehicle of infection, possibly due to the small number of controls recruited into the study (26 cases and 12 controls). A pooled analysis of data is underway.

Extensive local environmental investigations identified a number of potential links between suppliers of lettuce to premises implicated in the outbreaks. It has not been possible, however, to trace supply chains back to a single source or to a country of origin. Various food and environmental samples tested negative, possibly reflecting the short shelf life of the implicated vehicle of infection.

## References

1. HPA . Update – Outbreak of *Salmonella* Newport infection in England, Scotland, and Northern Ireland : association with the consumption of lettuce. *Commun Dis Rep CDR Wkly* [serial online] 2004 [cited 2 December 2004]; 14 (41): News. Available at <<http://www.hpa.org.uk/cdr/PDFfiles/2004/cdr4104.pdf>>.
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## Update from the National Chlamydia Screening Programme in England

As a part of the wider sexual health strategy, the Health Protection Agency (HPA) has worked in close collaboration with the Department of Health (DH) to facilitate the phased implementation of the National Chlamydia Screening Programme (NCSP) in England . The programme focuses on provision of chlamydia screening outside genitourinary medicine (GUM) clinics with active patient treatment and partner follow-up by local chlamydia screening teams.

The programme is now established in 82 primary care trusts through two phases from September 2002. Recently, the DH and HPA jointly sponsored the first annual chlamydia screening programme conference to highlight the results of the first year.

These results are included in two recent publications:

- (i) *The First Steps... annual report of the National Chlamydia Screening Programme in England, 2003/04* produced collaboratively by the DH and HPA and provides an excellent overview of the programme components and structure, and implementation process for the first phase. It also includes results from screening, patient management, and partner contact tracing activities (1).
- (ii) Establishing the National Chlamydia Screening Programme in England : results from the first full year of screening, published in the journal of *Sexually Transmitted Infections* in October 2004. This paper includes detailed epidemiologic analysis of the opportunistic screening data among young men and women (2).

These early results indicate that opportunistic screening for chlamydial infection outside of GUM clinics is feasible, and successful treatment provision to patients testing positive and their partners can occur. The disease burden within the young adult population is also quite high: 10.1% of women and 13.1% of men aged under 25 years opportunistically screened tested positive for the infection. This is similar to the levels of disease found in the original pilot of opportunistic screening in England (from September 1999 to August 2000) (3). The programme also demonstrated that 98% of people screened received treatment with a 76% effective partner treatment rate (1).

The need to improve the sexual health of the population was recently highlighted in the White Paper on public health (4). The Health secretary announced a further £300 million to modernise sexual health services across England . This announcement comes at a time when recent statistics from the HPA indicate continuing deterioration of the sexual health of young people through increased rates of STIs (5). The increase is particularly notable for genital chlamydial infection where there has been steady progression of increased rates of diagnosed cases from genitourinary medicine clinics since 1995 (5). Chlamydia infection is particularly devastating to women, as untreated infection can cause pelvic inflammatory disease (PID), which is a major contributor to ectopic pregnancy and infertility.

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The recent government announcement for increased funding and commitment , in *Choosing Health* (4) , and subsequent announcements to full national coverage of the chlamydia screening programme by March 2007 is a positive development for enhanced disease control and stemming the tide of increasing infections among young people throughout England.

## References

1. Department of Health. The *first steps...annual report of the National Chlamydia Screening Programme in England* , 2003/04 . London: Department of Health; November 2004. Available at <<http://www.dh.gov.uk/assetRoot/04/09/24/61/04092461.pdf>>.
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## Zoonoses report 2003 published by DEFRA



The Department for Environment, Food and Rural Affairs (DEFRA) has published the latest Annual report on zoonoses for the UK, *Zoonoses Report UK 2003*. The Report draws together information on zoonoses from many sources and gives information in the situation in man, food, and animals, and focuses on major foodborne and waterborne zoonoses, notifiable zoonotic diseases of animals, and other zoonoses. It has been produced by DEFRA in conjunction with the devolved administrations, the Veterinary Laboratory Agencies, Scottish Agricultural College, Scottish Centre for Infection and Environmental Health, Health Protection Agency, Welsh Assembly Government, Food Standards Agency, the Department of Agriculture and Rural Development Northern Ireland, and the Departments of Health of the United Kingdom (UK).

Some highlights include a continued fall in the number of reports of *Campylobacter* species, with around 49,050 reports in the United Kingdom (UK) in 2003 compared with a peak of just over 65,000 in 1998. The ratio of infection in the community to reports to national surveillance for *Campylobacter* spp is estimated to be approximately 8:1 (1). This means that in 2003, there were nearly 400,000 campylobacter cases in the community. The overall number of salmonella infections in humans continues to decline, despite an increase in non-phage type 4 *Salmonella* Enteritidis in all parts of the UK, accounting for a slight increase in total *S. Enteritidis* reports overall. The incidence of *Salmonella* Typhimurium increased slightly in England and Wales, resulting in an overall increase in reports of *S. Typhimurium* in the UK.

Between 2002 and 2003, there was a small increase in the number of human cases of Vero cytotoxin-producing *E. coli* (VTEC) O157 in Northern Ireland, and England, Wales and a decrease in the number in Scotland. In 2003, 874 laboratory-confirmed cases of VTEC O157 infection were reported in the UK, a slight increase from the number of confirmed reports in 2002 (852). Until 1995 there was a rising trend in the number of cases of VTEC O157 reported throughout the UK. Since then, however, the number of reported cases has stabilised at approximately 1000 cases per year.

The number of reported cases of cryptosporidiosis in the UK rose from 3663 in 2002 to 6626 in 2003, although this is still less than the 7083 cases in 2000. The number of cases of bovine spongiform encephalopathy (BSE) confirmed in cattle in Great Britain continued to fall, with 547 cases confirmed in 2003, compared with 1039 in 2002.

Zoonoses are defined by the World Health Organization (WHO), as 'diseases and infections which are transmitted naturally between vertebrate animals and man'. They cover a broad range of diseases with different clinical and epidemiological features, with varying control measures because the causative organism may be bacterial, fungal, protozoal, parasitic, viral, or any other communicable agent (for example, prions).

Further information can be found in the report, which can be found on the DEFRA website at <http://www.defra.gov.uk/animalh/diseases/zoonoses/reports.htm>.


### References

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## Respiratory

Last updated: 2 December 2004

Next update due: 7 January 2005

 [Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales: weeks 45-48/04](#)



### Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales: weeks 45-48/2004

Data are recorded by week of report, but only include specimens taken in the last eight weeks (*ie*, recent specimens).

**Table 1 Reports of influenza infection made to CDSC, by week of report: weeks 45-48/2004**

Week	45/04	46/04	47/04	48/04	Total
Week ending	07/11/04	14/11/04	21/11/04	28/11/04	
<b>Influenza A</b>	1	–	6	5	<b>12</b>
Isolation	–	–	–	1	<b>1</b>
DIF	–	–	–	–	–
Four-fold rise in paired sera	1	–	4	–	<b>5</b>
PCR	–	–	–	–	–
Other	–	–	2	4	<b>6</b>
<b>Influenza B</b>	1	–	2	1	<b>4</b>
Isolation	–	–	–	–	–
DIF	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–
PCR	–	–	–	–	–
Other	1	–	2	1	<b>4</b>
<b>Influenza (untyped)</b>	–	–	–	–	–
Isolation	–	–	–	–	–
DIF	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–
PCR	–	–	–	–	–
Other	–	–	–	–	–

DIF = Direct Immunofluorescence.

'Other' = 'Antibody detection - single high titre' or 'method not specified'.

**Table 2 Respiratory viral detections by any method (culture, direct immunofluorescence, PCR, four-fold rise in paired sera, single high serology titre, genomic, electron microscopy, other method, other method unknown), by week of report: weeks 45-48/2004**

Week	45/04	46/04	47/04	48/04	Total
Week ending	07/11/04	14/11/04	21/11/04	28/11/04	
Adenovirus*	14	18	7	20	59
Coronavirus	–	–	–	–	–
Parainfluenza†	3	4	5	16	28
Rhinovirus‡	4	3	15	8	30
Respiratory syncytial virus (RSV)	109	222	259	476	1066

\*Respiratory samples only. Excludes diagnoses made by electron microscopy (EM).

†Includes parainfluenza types 1, 2, 3, 4, and untyped.

**Table 3 Respiratory viral detections by age group: weeks 45-48/2004**

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥65 years	Unknown	Total
Adenovirus*	13	8	10	22	2	1	3	59
Coronavirus	–	–	–	–	–	–	–	–
Influenza A	–	–	1	5	3	3	–	12
Influenza B	–	–	–	2	1	1	–	14
Parainfluenza†	10	7	–	2	4	2	3	28
Rhinovirus‡	15	7	4	2	1	1	–	30
Respiratory syncytial virus (RSV)	901	144	5	4	4	4	4	1066

\*Respiratory samples only, and excludes diagnoses made by electron microscopy (EM).

†includes parainfluenza types 1, 2, 3, 4, and untyped.

**Table 4 Laboratory reports of infections associated with atypical pneumonia, by week of report: weeks 45-48/2004**

Week	45/04	46/04	47/04	48/04	Total
Week ending	07/11/04	14/11/04	21/11/04	28/11/04	
<i>Coxiella burnettii</i>	–	–	1	–	1
Respiratory <i>Chlamydia</i> sp*	4	1	1	4	10
<i>Mycoplasma pneumoniae</i>	5	11	4	8	28
<i>Legionella</i> sp	15	15	3	6	39

\* Includes *Chlamydia psittaci*, *Chlamydia pneumoniae*, and *Chlamydia* sp detected from blood, serum, and respiratory specimens.

**Table 5 Reports of legionnaires' disease (pneumonic and non-pneumonic\*) cases in England and Wales, by week of report: weeks 45-48/2004**

Week	45/04	46/04	47/04	48/04	
Week ending	07/11/04	14/11/04	21/11/04	28/11/04	Total
Nosocomial	–	–	–	–	–
Community	4	3	2	2	<b>11</b>
Travel abroad	10	11	1	4	<b>26</b>
Travel UK	1	1	–	–	<b>2</b>
<b>Total</b>	15	15	3	6	<b>39</b>
Male	11	10	3	5	<b>29</b>
Female	4	5	–	1	<b>10</b>

Thirty-nine cases were reported with pneumonia: 29 males aged between 41 and 87 years and ten females aged between 46 and 80 years. Eleven cases were community-acquired infections. Two deaths were reported, F 74y and F 80y.

Twenty-eight cases were travel-associated: Spain (11), United States (3), two of each France, Malta, Spain and United Kingdom, and United Kingdom and one each of Australia and Singapore, Australia and United Arab Emirates, Caribbean, Italy, Turkey, and United Arab Emirates.

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## Zoonoses

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### Common animal associated infections, England and Wales laboratory reports: weeks 45-48/04

#### Common animal associated infections, England and Wales laboratory reports: weeks 45-48/04

	Total reports for weeks 45-48		Cumulative totals for weeks 01-48	
	2004*	2003	2004*	2003
<i>Borrelia burgdorferi</i> *‡	23	9	245	281
<i>Leptospira hardjo</i> †§	1	–	3	–
<i>Leptospira icterohaemorrhagiae</i> †§	5	1	9	8
<i>Leptospira other</i> †§	7	–	20	8
<i>Pasteurella haemolytica</i>	1	–	9	3
<i>Pasteurella multocida</i>	24	26	263	257
<i>Pasteurella pneumotropica</i>	–	1	6	8
<i>Pasteurella</i> spp	5	9	73	78
<i>Toxocara</i> spp	–	–	3	4
<i>Toxoplasma gondii</i>	2	3	23	30
<i>Toxoplasma</i> spp	6	2	51	52
<i>Capnocytophaga</i> spp	1	1	5	11
<i>Echinococcus granulosus</i>	–	–	4	10
<i>Coxiella burnetii</i>	1	2	31	35
<i>Chlamydia psittaci</i>	3	20	65	87
<i>Brucella</i> spp	1	–	16	3
Orf-paravaccinia virus	–	–	1	3

\* provisional data; † by specimen date; ‡ Lyme Disease Reference Laboratory and CDSC.

§ *Leptospira* Reference Laboratory and CDSC. NA = Not available.

#### Comment

## Comment

### Lyme borreliosis

M 5y, recent tick exposure; M 7y, New Forest resident; M 22y, recent tick bite in France; M 41y, recent tick bite in Sweden with erythema migrans; M 50y, tick bite in July, rash and myalgia; M 51 y, no clinical details; M 51y, erythema migrans; M 70y, flu-like illness, erythema migrans, headaches following recent tick exposure in USA.

F 5y, pale rash following holiday in Sweden; F 35y, tick bite and erythema migrans following holiday in Sweden; 3 females aged 35y with recent infection; F 45y, erythema migrans, works in a forest; five females 43y-73y with erythema migrans; F 46y, erythema migrans following recent exposure in New England; two females with no clinical details but recent exposure to ticks; F, age not stated.

### Leptospirosis

*Leptospira hardjo*: M 39y

*Leptospira icterohaemorrhagiae*: M 34y; M 72y walks dog which swims in gravel pits; M 46y, fell in ditch whilst playing golf; M 46y, overseas acquired; M 32y, canoeing in France.

*Leptospira spp (serovar not identified)*: M 64y, farmer with related exposures; M 30y, immersion in river water; M 60y, renovating rodent infested house; M 26y, fishing in Thailand; M 71y; M age not stated.

*Leptospira australis*: M 38y.

### Pasteurellosis

*Pasteurella haemolytica*: M 61 y, no clinical details.

*Pasteurella multocida*: 16 females aged between 1y-81y, two with recorded dog bites, two with reported cat bites; eight males aged between 9y and 71y

*Pasteurella spp*: three males, two females aged 18-79y, one with reported dog bite.

### Toxoplasmosis

Three males aged 13y-21y; 5 females aged 19y-35y, one of whom was 12 weeks pregnant.

### *Capnocytophaga* spp

M 72 y, no clinical details.

### Q fever

M 33y, no clinical details.

### Psittacosis

M 73y; F 16y; Sex not stated 58y with atypical pneumonia.

### Brucellosis

*Brucella melitensis (untyped)*: F 36y.

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## Diary

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For information about other conferences, courses, and events visit  
[http://www.hpa.org.uk/hpa/about\\_us/events.htm](http://www.hpa.org.uk/hpa/about_us/events.htm)

 [West Midlands Communicable Disease Control Course – April 2005](#)

 [The prevention and control of zoonoses - from science to policy](#)

 [One-day Symposium: \*Current topics on bacterial STIs\*](#)

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### West Midlands Communicable Disease Control Course – April 2005

#### ***Emergency Communicable Disease Control and Other On-Call Duties Monday 25 th to Wednesday 27 th April 2005 - Hornton Grange, University of Birmingham***

This course is primarily aimed at those who have to cover on-call CCDC duties or may have to cover the CCDC in his/her absence. It will therefore be of interest to:

- Consultant Public Health Physicians who cover out of hours rotas (key target group)
- Consultants who undertake CCDC duties and wish to update or revise basic skills and knowledge in an interactive way
- Trainees in Public Health Medicine who cover out of hours rotas or who may wish to specialise in communicable disease control
- Medical Microbiologists or Infectious Disease Physicians who may wish to apply for jobs with CCDC responsibilities

The course is fairly intensive in order to limit the amount of study leave needed, but is largely interactive in style and held in high quality facilities in order to maximise learning and interest. The six previous courses have been highly evaluated by previous attendees. Hornton Grange is an impressive Edwardian style gentleman's residence and forms part of the University of Birmingham 's Conference Centre.

To obtain details of course content and a booking form go to <http://pcpoh.bham.ac.uk/publichealth/programmes/cdsc/index.htm> or contact Ms Laura Manzie, Department of Public Health & Epidemiology, University of Birmingham, Edgbaston, Birmingham B15 2TT, email: [WARMStudy@medgp3.bham.ac.uk](mailto:WARMStudy@medgp3.bham.ac.uk) Tel: 0121 415 8183 Fax: 0121 415 8184

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### The prevention and control of zoonoses - from science to policy

The Health Protection Agency , in partnership with the Department for Environment, Food and Rural Affairs , the Department of Health and the Food Standards Agency , will be hosting a conference on zoonoses on 15-17 June 2005 Crowne Plaza Hotel, Princes Dock, Liverpool, UK

The aims of the conference will be to bring together leading national practitioners and policymakers in both human and veterinary medicine with their counterparts from Europe and other areas of the world 1.

Further details will be available on the conference website in January 2005 at <http://www.hpazoonosesconference.org.uk/>. Further details and information are available via email: [zoonosesconference@hpa.org.uk](mailto:zoonosesconference@hpa.org.uk)

