

Communicable Disease Report

Bat brings rabies to Britain

Four people in the vicinity of Newhaven, on the south coast of England, are thought to have been in contact since 30 May with an insectivorous bat with rabies. Three have already received vaccine and immunoglobulin as recommended¹ and the fourth, presently abroad, is being traced. Further enquiries have been made to establish whether other people or animals may have been in contact with the bat, and where the bat is likely to have come from. One of the contacts noticed that the bat was behaving oddly on 30 May. After euthanasia on 3 June the bat carcase was sent to the Ministry of Agriculture, Fisheries and Food's (MAFF) Central Veterinary Laboratory, where the diagnosis of rabies was confirmed. A notice under the *Rabies (Control) Order 1974* has been served on the room where the bat was housed, declaring it to be infected and in need of cleansing and disinfection, and restricting the movement of other bats therein.

MAFF routinely monitors reports of suspected rabies in mammals, including bats, and carries out diagnostic tests, but no cases have been found in Great Britain outside quarantine since 1970, and none among the 1800 bats tested since 1987. Bats, particularly if sick or injured, should not be handled. If bitten or scratched by a bat, a person should contact a doctor immediately. The consultant in communicable disease control should be informed and specialist advice sought (box). The wound should be thoroughly cleaned by scrubbing with soap and water under a running tap for five minutes as soon as possible¹. If the bat is caught it MAFF should be notified to arrange collection and testing for rabies (box).

Three human deaths in Europe in the past 30 years are known to have been associated with bat rabies, one in Finland and two in the former Soviet Union². Bat rabies in Europe is mainly confined to serotine bats, particularly in Holland, northern Germany, and Denmark. Serotine bats are relatively uncommon in Britain. There is no evidence that species of bat common in Britain carry rabies to a significant extent elsewhere and, although the rabies virus carried by bats can infect and kill humans and has killed laboratory rodents, there is no evidence that it can be passed from one terrestrial mammal to another in nature².

In the United States four cases of human rabies were reported in 1995, caused by different variants of rabies viruses associated with insectivorous bats, but without definite histories of bites³. Bat bites are small and may go unnoticed, but these cases suggest that limited physical contact with a rabid bat may be associated with transmission³.

1. UK Departments of Health. *Immunisation against infectious disease*. London: HMSO, 1992: 126-30.
2. British Medical Association. *BMA guide to rabies*. Oxford: Radcliffe, 1995.
3. CDC. Human rabies - California, 1995. *MMWR* 1996; 45: 353-6.

Multidrug resistant tuberculosis in a London hospital

Four cases of multidrug resistant tuberculosis have been reported among patients at St Thomas' Hospital, London. Links have been established between two of the cases and the possibility of links with the other two is being investigated. All four cases were transferred to special isolation facilities and one has subsequently died. An incident team is to investigate the cases, arrange follow up of contacts of the infectious cases, and review and strengthen local infection control procedures. Letters have been sent to all contacts advising them about the incident and arrangements for follow up. A telephone help line for concerned patients, contacts, and health care workers has been established on 0800 373 098.

Salmonella infections:
monthly report

Common gastrointestinal tract infections:
weeks 19 - 23/9

General outbreaks of foodborne illness:
weeks 19 - 23/96

Bacteraemia and bacterial meningitis:
weeks 19 - 23/96

Notice

Notifications of infectious diseases:
week 22/96

Box

Specialist contacts in the event of human contact with bats

About people

In England and Wales:
PHLS Virus Reference Division
(Tel 0181 200 4400)

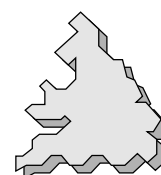
In Scotland:
Scottish Centre for Infection and Environmental Health
(Tel 0141 946 7120)

In Northern Ireland:
Department of Health and Social Services
(Tel 01232 650111)

About bats

During the week: contact a local MAFF animal health office.

At weekends: telephone a MAFF duty veterinarian on 0171 270 8080.



Salmonella infections, England and Wales: reports to the PHLS (salmonella data set)

Details of serotypes of the 1336 salmonella infections recorded in April 1996 are given in the adjacent table. In May 1996, 1766 salmonella infections were recorded and preliminary information was received about four outbreaks (see table overleaf).

* provisional.

† includes organisms reported to LEP without further identification and those yet to be identified.

	April 1996*
Salmonella (total)	1336
S. enteritidis (PT4)	568
S. enteritidis (other PTs)	141
S. typhimurium	297
S. virchow	66
Others (typed)	264
Others (untyped)†	251

Figure 1 Salmonellosis in humans: monthly totals 1994 to 1996

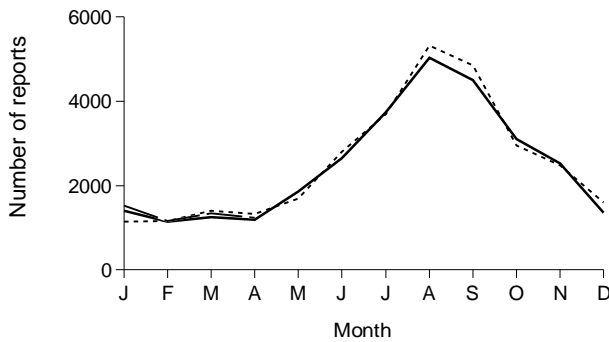
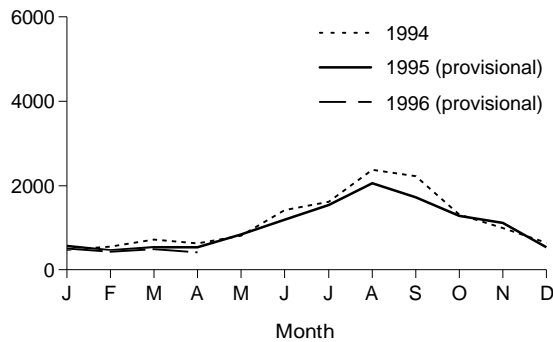


Figure 2 S. enteritidis PT4 in humans: monthly totals 1994 to 1996



The number of salmonellas reported in the first four months of 1996 was 1% higher than in the same period of 1995 (figure 1). Reports of *S. enteritidis* PT4 fell, however, with 12% fewer reports than in the same months of 1995. *S. enteritidis* PT4 accounted for 35% of all salmonellas reported in the first four months of 1996 (figure 2), compared with 42% in the same period of 1995.

Common gastrointestinal infections, England and Wales: laboratory reports, weeks 19 – 23/96

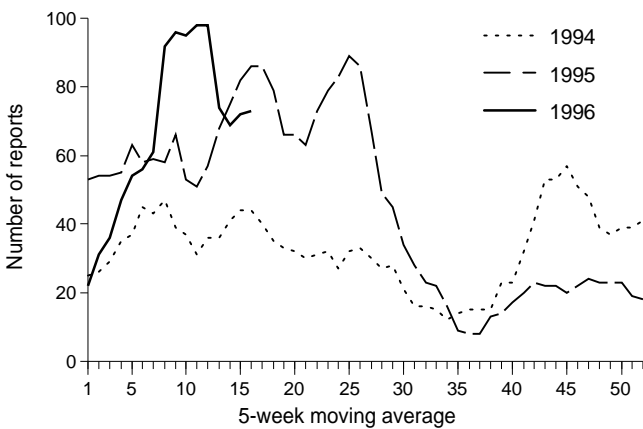
Organism	Number of reports					Total reports 19-23/96	Cumulative total to	
	19/96	20/96	21/96	22/96	23/96		23/96	23/95
Campylobacter	594	930	908	487	820	3739	15240	16437
Escherichia coli O157*	8	11	10	5	8	42	115	148
Shigella sonnei	11	30	21	8	24	94	492	2124
Rotavirus	449	717	627	415	526	2734	10862	14535
SRSV	190	87	58	73	85	493	1716	790
Cryptosporidium	73	110	136	44	48	411	1719	1589
Giardia	76	99	97	90	78	440	2083	2226

* Vero cytotoxin producing isolates (data from LEP)

Small round structured viruses

Small round structured viruses (SRSV) usually cause acute but relatively mild and short lived attacks of gastroenteritis in which vomiting is a prominent feature. The seasonality of SRSV infection has led to the clinical illness it causes to be known commonly as winter vomiting disease. In 1995, however, the greatest numbers of SRSV infections were reported during spring and summer months (figure 1), and the number of reports received during the second quarter was the highest quarterly total on record. In contrast, numbers of reports were unusually low during the fourth quarter of 1995. Reports started to rise in early 1996 and reached record levels early in the spring.

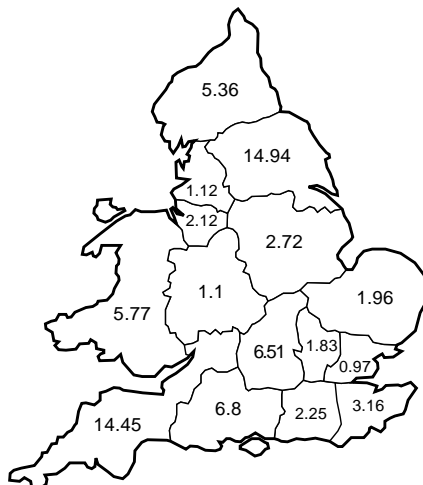
Figure 1 Laboratory reports of SRSV to CDSC: England and Wales, 1994 to 1996



There are wide regional variations in the reporting of SRSV (figure 3). Reporting rates are exceptionally high in Yorkshire and South Western regions and very low in North East Thames and West Midlands. These disparities probably reflect regional differences in the approach to investigation, sampling, and reporting of cases from outbreaks that are suspected to be viral in origin.

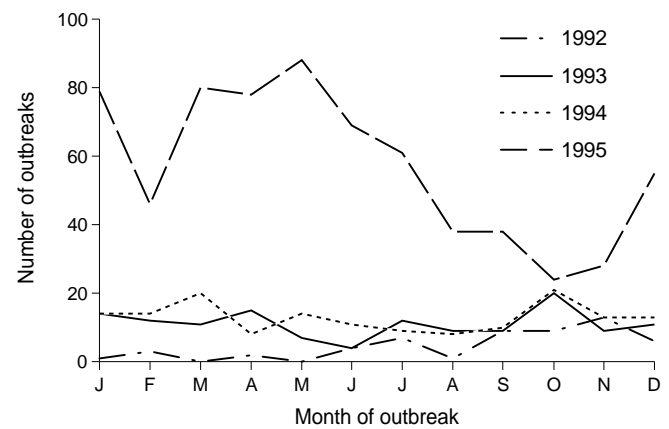
The age distribution of cases shows that reported illness is commonest at the extremes of age (figure 4). Young children with gastroenteritis are particularly vulnerable to

Figure 3 SRSV infection by region: 1995 (rate per 100000 population)



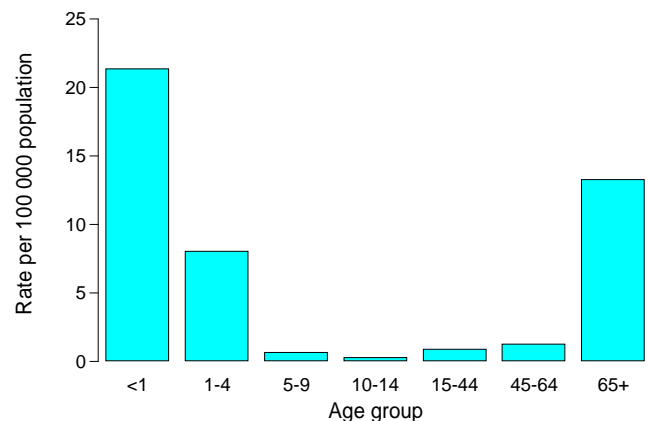
The number of outbreaks of SRSV infection reported to CDSC rose dramatically in 1995. This was partly due to increased ascertainment following the introduction of an enhanced surveillance system for outbreaks of viral gastroenteritis and partly to a true increase in the number of outbreaks seen in the community. In previous years most outbreaks had occurred between September and March (figure 2) whereas in 1995 most outbreaks occurred between March and July. This broadly reflects the seasonal pattern of laboratory reports, which is to be expected since routine investigations for SRSV are mainly limited to specimens obtained from cases in identified outbreaks.

Figure 2 General outbreaks of SRSV reported to CDSC: England and Wales, 1994 to 1995



dehydration and their parents are likely to seek medical attention for them when they might not do so for themselves, which may explain why rates of reporting for children, particularly infants (under 1 year), are so high. The high incidence of outbreaks of SRSV in residential homes for the elderly and elderly care units in hospitals (see *CDR 1996;6: 83*) accounts for the high rate in elderly people. Many adults may not seek medical attention unless their symptoms are severe or persistent.

Figure 4 Laboratory reports of SRSV to CDSC by age group: England and Wales, 1995



General outbreaks of foodborne illness, England and Wales: weeks 19 – 23/96

Preliminary information has been received about the following outbreaks

Health authority	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Comments	Evidence
Cambridge	<i>Salmonella enteritidis</i> PT4	Barbecue	May	8	8	None	–
South Essex	<i>S. enteritidis</i> PT4	Dinner party	May	3	2	None	–
West Pennine	<i>S. enteritidis</i> PT6A	College	May	4	4	None	–
Wakefield	<i>S. typhimurium</i> untyped	Restaurant	May				
East Surrey	<i>Bacillus subtilis</i>	Restaurant	April	2	–	Rice	M
East Norfolk	<i>Clostridium perfringens</i>	Restaurant	April	4	–	Pork stuffing	S
Manchester	<i>C. perfringens</i>	Nursing home	April	NS	6	None	M
Lambeth, Southwark and Lewisham	Viral	Day care centre	April	6	–	Tuna pasta bake	D

D (descriptive): other evidence, usually descriptive, reported by local investigators as indicating the suspect vehicle.

M (microbiological): identification of an organism of the same type

from cases and in the suspect vehicle or vehicle ingredient(s), or detection of toxin in faeces or food.

S (statistical): a significant statistical association between consumption of the suspected vehicle(s) and being a case.

Bacteraemia and bacterial meningitis, England and Wales: laboratory reports weeks 19 – 23/96

Organism	Number of reports		Age		Total reports 19-23/96	Cumulative total 1996
	Blood only	CSF only or CSF & blood	<1m	≥65y		
<i>Citrobacter sp</i>	16	–	–	11	16	122
<i>Enterobacter sp</i>	89	–	–	53	89	475
<i>Escherichia coli</i>	732	3	10	498	735	3835
<i>Klebsiella sp</i>	159	2	5	66	161	872
<i>Proteus sp</i>	128	–	–	104	128	630
<i>Salmonella sp</i>	32	–	–	10	32	104

Epidemiology and control of communicable diseases and environmental hazards

The PHLS Communicable Disease Surveillance Centre (CDSC), the Public Health Medicine Environmental Group, and the Department of Health, are holding their annual conference on the epidemiology and control of communicable diseases and environmental hazards from Monday 18 November to Friday 22 November 1996 at CDSC in Colindale. It is aimed primarily at consultants in communicable disease control, but will also interest medical microbiologists, and environmental health and nursing professionals involved in the control of communicable disease and environmental hazards. Trainees may be accommodated on some or all days if numbers permit.

The conference will address important public health issues that have developed over the past year and provide fresh perspectives on established areas of disease prevention and control. Short papers on recent outbreaks and surveillance initiatives will also be presented. Sessions will be held on Creutzfeldt-Jakob disease and the spongiform encephalopathies; chemical hazards, including lessons from the sarin poisoning incident in Tokyo; asthma and air quality; emerging communicable diseases and emerging vaccines; national surveillance for hospital acquired infections, food, and water; and sexually transmitted diseases and *Health of the Nation*. If you wish to attend, please contact Vivienne Fitch or Susan Edwards at CDSC, 61 Colindale Avenue, London NW9 5EQ (tel 0181 200 6868 ext 4569/3054).

Data are for England and Wales only, unless otherwise stated. Weekly numbers are provisional and should not be used to indicate trends.

Notifications of infectious diseases

Doctors in England and Wales have a statutory duty to notify a 'proper officer' of the local authority (usually the consultant in communicable disease control) of cases of certain infectious diseases (*CDR* 1993; 3: R19-25). Notifications of infectious diseases, not all of which are microbiologically confirmed, prompt local investigation and action to control the diseases. Proper officers are required each week to inform the registrar general at the

Office for National Statistics (ONS) of the numbers of cases of each disease that have been notified. ONS collates the resulting data for the analysis of local and national trends, but responsibility for their publication has been transferred to the PHLS Communicable Disease Surveillance Centre. Data published here – and an expanded form of table 2 with data to district level – are also available in an electronic format to Epinet subscribers on the PHLS network.

Table 1 Notifications of infectious diseases* in the past 6 weeks, with totals for the current year compared with corresponding periods of the two preceding years.

		Week						Cumulative totals to week 22†			Cumulative totals from mid-year to week 22‡		
		17/96	18/96	19/96	20/96	21/96	22/96	1994 (ii)	1995 (ii)	1996 (iii)	93/94(a)	94/95(b)	95/96(c)
Typhoid fever presumed contracted	Cases	5	5	3	7	2	4	95	104	74	189	232	201
	Abroad§	4	5	3	6	2	4	83	91	67	165	214	181
	GB	1	–	–	1	–	–	12	13	7	24	18	20
Paratyphoid fever presumed contracted	Cases	7	2	3	1	2	4	61	62	44	108	125	100
	Abroad§	7	2	3	1	2	4	58	53	42	100	111	94
	GB	–	–	–	–	–	–	3	9	2	8	14	6
Dysentery	Cases	66	45	42	57	40	29	2 460	2 417	911	5 098	5 886	2 838
Food poisoning formally notified otherwise ascertained	Cases	1 298	1 315	1 196	1 559	1 632	1 320	26 030	27 476	27 445	66 169	76 029	75 767
	Cases	808	786	687	906	927	757	15 516	16 543	16 045	40 018	45 216	44 330
	Cases	490	529	509	653	705	563	10 514	10 933	11 400	26 151	30 813	31 437
Tuberculosis†	Cases	101	135	94	122	99	114	2 408	2 418	2 384	5 246	5 273	5 221
Whooping cough	Cases	32	30	27	30	40	29	1 608	898	514	4 212	3 006	1 354
Scarlet fever	Cases	107	114	108	116	116	95	3 679	3 082	2 902	5 781	5 190	4 756
Meningitis meningococcal influenzal (<i>Haemophilus influenzae</i>) other specified unspecified	Cases	39	45	30	38	40	36	877	1 010	1 176	1 734	1 816	2 316
	Cases	17	18	13	17	21	18	479	535	629	956	918	1 163
	Cases	–	1	–	–	1	–	31	27	12	74	46	42
	Cases	17	16	15	11	10	13	264	320	377	527	620	762
	Cases	5	10	2	10	8	5	85	128	158	177	232	349
Meningococcal septicaemia (without meningitis)	Cases	16	14	25	18	16	10	207	343	544	400	543	875
Tetanus	Cases	–	–	–	–	–	–	1	1	1	5	3	6
Measles	Cases	153	169	101	144	137	109	7 260	4 143	3 222	11 132	11 672	6 195
Mumps	Cases	46	55	39	35	45	21	1 085	976	798	2 079	2 202	1 665
Rubella	Cases	364	317	225	276	256	214	3 127	2 747	6 371	5 902	5 503	9 360
Viral hepatitis	Cases	65	42	38	64	52	37	1 765	1 409	1 168	4 183	3 141	2 839
Malaria	Cases	25	49	28	40	34	39	371	336	478	1 022	1 015	1 322
Leptospirosis	Cases	–	–	–	–	–	–	12	6	2	19	16	10
Acute encephalitis infective post-infectious	Cases	–	–	–	–	–	2	10	18	13	18	32	30
	Cases	–	–	–	–	–	2	6	13	10	12	24	26
	Cases	–	–	–	–	–	–	4	5	3	6	8	4
Ophthalmia neonatorum	Cases	2	9	3	4	2	6	125	110	103	283	238	224
Special Cases													
Cholera	Cases	1	–	–	2	–	–	14	12	10	42	46	33
Diphtheria	Cases	–	1	–	1	–	–	4	9	4	8	13	8
Typhus	Cases	–	–	1	–	–	–	1	2	2	1	4	4

All figures include late returns

* includes notifications from Port Health Authorities

† Cumulative totals commencing week ended (i) 7 Jan (ii) 6 Jan (iii) 5 Jan

‡ Cumulative totals from mid-year commencing week ended (a) 3 July (b) 9 July (c) 8 July

§ Includes cases of unstated origin

¶ Excluding chemoprophylaxis

Table 2 Notifications of infectious diseases in week 22/96 (standard regions, counties, and unitary authorities)

Area	Measles	Mumps	Rubella	Dysentery	Scarlet fever	Whooping cough	Viral hepatitis	TB all forms*	Meningitis†	Food poisoning notified§	Food poisoning ascertained‡	Malaria
North	8	2	10	–	10	1	1	8	3	45	61	–
Tyne and Wear [¶]	3	1	2	–	6	–	–	4	1	5	22	–
Cumbria	1	–	4	–	–	–	–	–	1	7	23	–
Durham	1	1	2	–	2	1	–	–	–	20	11	–
Northumberland	2	–	1	–	1	–	–	1	1	3	5	–
<i>Hartlepool</i>	–	–	–	–	–	–	1	–	–	2	–	–
<i>Middlesbrough</i>	–	–	1	–	1	–	–	–	–	5	–	–
<i>Redcar & Cleveland</i>	–	–	–	–	–	–	–	–	–	1	–	–
<i>Stockton-on Tees</i>	1	–	–	–	–	–	–	3	–	2	–	–
Yorkshire and Humberside	26	8	28	4	22	–	2	10	2	89	72	6
South Yorkshire [¶]	11	1	3	1	3	–	–	2	2	24	19	1
West Yorkshire [¶]	7	2	17	3	9	–	1	6	–	36	45	4
North Yorkshire	2	2	4	–	2	–	–	1	–	20	7	–
<i>City of Kingston upon Hull</i>	1	–	3	–	3	–	–	–	–	–	–	1
<i>East Riding of Yorkshire</i>	–	–	–	–	–	–	1	–	–	–	–	–
<i>North East Lincolnshire</i>	1	–	–	–	1	–	–	–	–	3	1	–
<i>North Lincolnshire</i>	4	1	1	–	–	–	–	–	–	1	–	–
<i>York</i>	–	2	–	–	4	–	–	1	–	5	–	–
East Midlands	8	–	22	–	10	4	1	2	4	66	28	–
Derbyshire	3	–	5	–	2	2	–	1	–	28	–	–
Leicestershire	4	–	4	–	2	1	–	1	–	6	5	–
Lincolnshire	–	–	2	–	1	–	–	–	–	3	2	–
Northamptonshire	1	–	4	–	1	1	–	–	1	12	12	–
Nottinghamshire	–	–	7	–	4	–	1	–	3	17	9	–
East Anglia	2	1	11	–	3	–	–	2	1	30	27	–
Cambridgeshire	1	–	4	–	1	–	–	–	–	8	5	–
Norfolk	–	1	3	–	–	–	–	2	1	13	19	–
Suffolk	1	–	4	–	2	–	–	–	–	9	3	–
South East	39	7	71	18	32	8	19	66	9	291	156	19
Greater London	16	3	25	8	15	4	14	49	3	117	16	14
Bedfordshire	2	–	5	1	–	–	–	1	–	14	7	–
Berkshire	3	–	8	2	1	–	–	3	–	13	29	1
Buckinghamshire	–	–	2	–	1	–	–	–	1	2	8	1
East Sussex	3	–	1	1	2	–	–	1	–	6	5	–
Essex	5	–	2	1	2	–	–	1	–	36	6	–
Hampshire	3	–	4	1	6	1	–	1	1	18	21	–
Hertfordshire	3	–	6	–	–	–	2	4	1	10	28	2
Kent	1	1	7	1	2	1	2	3	2	31	5	1
Oxfordshire	–	–	6	–	–	–	–	–	–	3	1	–
Surrey	–	–	3	2	1	2	1	2	–	32	17	–
West Sussex	2	3	1	1	2	–	–	1	1	8	13	–
<i>Isle of Wight</i>	1	–	1	–	–	–	–	–	–	1	–	–
South West	6	–	16	1	3	2	4	4	5	50	70	–
Cornwall and Isles of Scilly	1	–	1	1	–	–	–	–	–	3	19	–
Devon	2	–	3	–	–	–	1	1	1	25	1	–
Dorset	1	–	–	–	–	–	2	1	–	3	26	–
Gloucestershire	–	–	1	–	–	1	–	–	–	3	1	–
Somerset	1	–	4	–	1	–	–	1	2	3	–	–
Wiltshire	–	–	1	–	1	–	1	–	–	6	–	–
<i>Bath & North East Somerset</i>	–	–	2	–	–	1	–	–	–	2	–	–
<i>Bristol</i>	–	–	2	–	–	–	–	1	1	2	11	–
<i>North Somerset</i>	1	–	2	–	1	–	–	–	–	3	5	–
<i>South Gloucestershire</i>	–	–	–	–	–	–	–	–	1	–	7	–
West Midlands	11	2	24	1	6	11	3	7	1	45	41	8
West Midlands [¶]	5	2	6	–	1	5	2	5	1	14	13	7
Hereford and Worcester	1	–	6	1	2	3	–	1	–	5	1	–
Shropshire	–	–	9	–	–	1	–	1	–	4	14	–
Staffordshire	3	–	3	–	1	–	–	–	–	21	13	–
Warwickshire	2	–	–	–	2	2	1	–	–	1	–	1

Table 2 (continued)

Area	Measles	Mumps	Rubella	Dysentery	Scarlet fever	Whooping cough	Viral hepatitis	TB all forms*	Meningitis†	Food poisoning notified§	ascertained#	Malaria
North West	7	1	21	5	8	2	5	12	7	73	57	6
Greater Manchester†	1	1	9	2	4	–	4	5	3	18	15	1
Merseyside†	3	–	7	3	3	1	1	3	3	18	10	1
Cheshire	1	–	2	–	1	1	–	–	–	11	18	–
Lancashire	2	–	3	–	–	–	–	4	1	26	14	4
Wales	2	–	11	–	1	1	2	3	4	68	51	–
Anglesey	–	–	2	–	–	–	1	–	1	3	2	–
Gwynedd	1	–	3	–	–	–	–	–	1	2	3	–
Conwy	–	–	–	–	–	–	–	–	–	8	1	–
Denbighshire	–	–	1	–	–	–	–	–	–	2	2	–
Flintshire	–	–	–	–	–	–	–	–	–	2	5	–
Wrexham	–	–	–	–	–	–	–	1	2	3	4	–
Powys	–	–	–	–	–	–	–	–	–	1	–	–
Ceredigion	–	–	–	–	–	–	–	–	–	1	1	–
Pembrokeshire	–	–	–	–	–	–	–	–	–	–	–	–
Carmarthenshire	–	–	–	–	–	–	–	1	–	–	–	–
Swansea	–	–	–	–	–	–	–	–	–	4	–	–
Neath & Port Talbot	–	–	–	–	–	–	–	–	–	–	–	–
Bridgend	–	–	–	–	–	–	–	–	–	–	–	–
Vale of Glamorgan	–	–	–	–	–	–	–	–	–	12	–	–
Rhondda, Cynon, Taff	–	–	–	–	–	–	–	–	–	6	–	–
Merthyr Tydfil	–	–	–	–	–	–	–	–	–	1	–	–
Caerphilly	–	–	1	–	1	1	–	–	–	4	–	–
Blaenau Gwent	–	–	–	–	–	–	–	–	–	2	–	–
Torfaen	–	–	–	–	–	–	–	–	–	1	–	–
Monmouthshire	–	–	1	–	–	–	–	–	–	–	2	–
Newport	1	–	1	–	–	–	–	–	–	4	–	–
Cardiff	–	–	2	–	–	–	1	1	–	12	31	–

* Excluding prophylaxis. † All forms. § Formally notified. # Ascertained by other means. ¶ Metropolitan county.

Notifications in week 22/96 of infectious diseases not shown in table 2

Acute encephalitis – two cases; in Bedfordshire and in Greater London.

Meningitis – meningococcal: 18 cases; three in Greater Manchester, two in each of Nottinghamshire, Somerset, and Wrexham, and one in each of Hampshire, Kent, Merseyside, Norfolk, Northumberland, South Gloucestershire, Tyne and Wear, West Midlands, and West Sussex.

Meningococcal septicaemia (without meningitis): 10 cases; two in West Yorkshire, and one in each of Bedfordshire, Cumbria, Greater London, Merseyside, North Somerset, South Yorkshire, Surrey, and West Midlands.

Ophthalmia neonatorum: six cases; two in West Yorkshire, and one in each of Berkshire, City of Kingston upon Hull, North Yorkshire, and South Yorkshire.

Paratyphoid fever: four cases; three cases presumed to have been contracted abroad – two from West Midlands and one from Greater London, and one case of unknown origin – from Greater Manchester.

Typhoid fever: four cases; three cases presumed to have been contracted abroad – one from each of Greater London, Greater Manchester, and Lancashire, and one case of unknown origin – from Greater London.

No cases of acute poliomyelitis, anthrax, cholera, diphtheria, leptospirosis, meningitis influenzal (*Haemophilus influenzae*), plague, rabies, relapsing fever, smallpox, tetanus, typhus, viral haemorrhagic fever, or yellow fever were notified.

Table 3 Weekly analysis report of notifications above expected rates in week 22/96

District	County	Observed number	Expected number	Ratio observed/expected	District	County	Observed number	Expected number	Ratio observed/expected
Dysentery					Measles				
Kirklees	West Yorkshire	3	0.22	13.80	North Lincolnshire	North Lincolnshire	4	0.33	12.13
Merton	Greater London	2	0.10	20.08	Rotherham	South Yorkshire	7	0.56	12.40
Newbury	Berkshire	2	0.08	25.14	Thurrock	Essex	4	0.30	13.43
Wirral	Merseyside	3	0.19	16.03	Meningitis				
Food poisoning					<i>All</i>				
<i>All</i>					Wrexham				
Barnet	Greater London	20	7.88	2.54	Wrexham	Wrexham	2	0.09	23.22
Breckland	Norfolk	10	2.87	3.49	<i>Meningococcal</i>				
Cardiff	Cardiff	43	7.84	5.49	Wrexham				
Carlisle	Cumbria	9	2.64	3.41	Wrexham	Wrexham	2	0.04	46.45
Conwy	Conwy	9	2.83	3.18	Mumps				
Ellesmere Port & Neston	Cheshire	10	2.08	4.80	York				
Gateshead	Tyne & Wear	13	5.18	2.51	York	York	2	0.07	30.66
Harrogate	North Yorkshire	10	3.68	2.72	Rubella				
Kirklees	West Yorkshire	31	9.89	3.13	Bridgnorth				
Leeds	West Yorkshire	35	18.53	1.89	Shropshire				
Mole Valley	Surrey	10	2.02	4.95	Ipswich				
Northampton	Northamptonshire	13	4.80	2.71	Suffolk				
Plymouth	Devon	16	6.54	2.45	Wellingborough				
Shrewsbury & Atcham	Shropshire	8	2.42	3.31	Wokingham				
South Lakeland	Cumbria	9	2.56	3.51	Berkshire				
South Shropshire	Shropshire	6	1.01	5.97	Scarlet Fever				
St Albans	Hertfordshire	11	3.29	3.34	Wakefield				
Stoke-on-Trent	Staffordshire	18	6.50	2.77	West Yorkshire				
Surrey Heath	Surrey	9	2.09	4.30	York				
Vale of Glamorgan	Vale of Glamorgan	12	3.04	3.95	York	York	4	0.31	13.01
Wokingham	Berkshire	10	3.62	2.76	Tuberculosis				
<i>Formally notified</i>					Blackburn				
Barnet	Greater London	14	4.52	3.10	Lancashire				
Breckland	Norfolk	9	1.64	5.47	Greater London				
Canterbury	Kent	7	1.96	3.57	Brent				
Cardiff	Cardiff	12	4.50	2.67	Greater London				
Conwy	Conwy	8	1.62	4.93	Newham				
Derby	Derbyshire	13	3.38	3.85	Redbridge				
Maldon	Essex	5	0.78	6.37	Waltham Forest				
Merton	Greater London	9	2.60	3.46	Greater London				
North East Derbyshire	Derbyshire	6	1.45	4.13	Greater London				
Plymouth	Devon	16	3.75	4.27	Greater London				
Redbridge	Greater London	13	3.30	3.94	Lancashire				
Rossendale	Lancashire	5	0.96	5.20	North Yorkshire				
Scarborough	North Yorkshire	8	1.59	5.02	South Yorkshire				
Sheffield	South Yorkshire	17	7.77	2.19	Surrey				
Surrey Heath	Surrey	9	1.20	7.50	Essex				
Tendring	Essex	7	1.92	3.65	Essex				
Thurrock	Essex	7	1.93	3.63	Cheshire				
Vale Royal	Cheshire	8	1.68	4.76	Vale of Glamorgan				
Vale of Glamorgan	Vale of Glamorgan	12	1.74	6.88	Durham				
Wear Valley	Durham	5	0.93	5.38	Malaria				
Malaria					Burnley				
Burnley	Lancashire	2	0.07	29.24	Greater London				
Hackney	Greater London	3	0.15	20.63	Greater London				
Newham	Greater London	3	0.17	17.50	Greater London				

Note: This table shows those districts from which the rates of notifications reported this week were significantly higher than expected ($P < 0.005$). The number of notifications in each district is shown in the third column (observed). The number expected if the national rate is applied to the district population is shown in the fourth column (expected). The fifth column shows by how many times the number of notifications exceeds the expected number (ratio observed/expected). Caution must be exercised when interpreting this table, as listing is wholly dependent on comparable reporting of notifiable infectious diseases from all districts of England and Wales and on local patterns of disease.

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