

Volume 11
Number 28
12 July 2001

CDR WEEKLY



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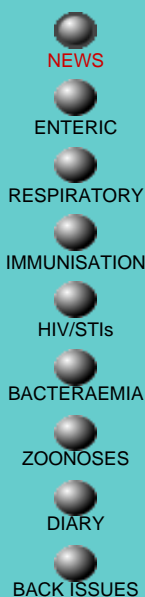
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PHLS Communicable Disease Surveillance Centre





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Report of the task force on *E. coli* O157

The task force set up in Scotland in September 2000 in the light of evidence that infection with *E. coli* O157 was originating from environmental sources and human contact with animals as well as through contaminated food, has issued its final report.

The report includes the following recommendations:

- testing all diarrhoeal samples for *E. coli* O157 and referral of all *E. coli* O157 isolates to the national reference laboratory should be formalised in diagnostic laboratories protocols. This was also recommended in 1995 by the Advisory Committee on the Microbiological Safety of Food (1);
- creation of a surveillance system for haemolytic uraemic syndrome (HUS) to include both children and adults;
- giving high priority to ensuring that outbreaks are adequately investigated, sources and outcomes traced, reports produced and copies forwarded to the appropriate national surveillance centre;
- integrated surveillance of human, food, animal and environmental sources of *E. coli* O157;
- a wide programme of information and support to patients, carers and families;
- action by farmers to protect their families, especially children, from cross-contamination (for example, keeping working clothes separate from the home and vehicles and keeping farm animals and working dogs separate from home and vehicles);
- an awareness-raising campaign among farmers and contractors on waste storage, treatment and application of slurries, manures etc;
- keeping farm animals off fields for three weeks prior to use for recreational purposes (for example, camping) and keeping farm animals off fields during recreational use;
- making core advice available on open farm visits;
- an education programme on the correct handling of raw salad and vegetables;
- improving labelling and traceability of cheeses, salads and vegetables;
- actions to better protect private water supplies.

The task force on *E. coli* O157, chaired by Professor Bill Reilly of the Scottish Centre for Infection and Environmental Health, was appointed by the Minister of Health and Community Care to the Scottish Parliament under the joint sponsorship of the Food Standards Agency Scotland and Scottish Executive Health Department. In welcoming the report, the minister praised the speed with which the task force had produced a practical document. The Scottish Executive and the Food Standards Agency are now developing inter-related action plans to take these recommendations forward.

The report can be found on the following websites:

E. coli O157 Task Force <www.foodstandards.gov.uk/scotland/ecoli.htm>

The Scottish Executive <www.scotland.gov.uk>

1. Advisory Committee on the Microbiological Safety of Food. *Report on Verocytotoxin-producing Escherichia coli*. London: HMSO, 1995.

Further information:

Locking ME, O'Brien SJ, Reilly WJ, Wright EM, Campbell DM, Coia JE, *et al*. Risk factors for sporadic cases of *Escherichia coli* O157 infection: the importance of contact with animal excreta. *Epidemiol Infect* (in press).

First report of the monitoring programme on the impact of control of the foot and mouth epidemic on physical human health

The *CDR Weekly* of 1 June (1) described a qualitative risk assessment led by the Department of Health (DH) *A rapid qualitative assessment of possible risks to public health from current foot and mouth disposal options* (2), and a multiagency programme for monitoring the affects of the foot and mouth disease (FMD) epidemic in animals on physical human health. The first monthly report *Foot and Mouth disease: disposal of carcasses, first report on results of monitoring public health has now been published on the PHLS websites at:* <www.phls.co.uk/advice/FMDIndex.htm>

The results reported to date show:

- three cases of Q fever in a team assisting with the culling of animals;
- no human cases of foot and mouth disease;
- no reported indication of adverse physical health effects from communities affected by the outbreak;
- no likely adverse health effects expected from air pollution results;
- concentrations of dioxins and dioxin-like polychlorinated biphenyls in milk, eggs and chicken samples are within expected ranges except for hen eggs from a farm in Anglesey and hens sampled at one site in Scotland;
- no reports of contamination of source waters used for public supplies;
- no reported indication of pollution of private water supplies.

1. CDSC. Foot and mouth disease epidemic disposal measures – assessment and monitoring of possible risks to public health. *Commun Dis Rep CDR Wkly* [online publication] 2001 [cited 6 July 2001]; **11** (22): news. Available at <www.phls.co.uk/publications/CDR%20Weekly/archive/news2201.html#fmd>.

2. Department of Health. *A rapid qualitative assessment of possible risks to public health from current foot and mouth disposal options*. London: Department of Health, 2001. Available online at <www.doh.gov.uk/fmdguidance/disposalriskassessment.htm>

Ninth annual report from the National CJD Surveillance Unit

The latest surveillance report on Creutzfeldt-Jakob disease (CJD), including variant-CJD (vCJD), in the United Kingdom (UK) was published last week (1), and is available from the National CJD Surveillance Unit <www.cjd.ed.ac.uk>. The report provides a detailed overview of the situation for all forms of CJD.

By the end of 2000, there had been 84 deaths from definite or probable variant vCJD in the UK. Incidence of vCJD is estimated to be increasing by a factor of 1.35 annually, 95% CI (1.13 to 1.61). The predicted total number of deaths for 2001, assuming this trend continues, is 36 (95% CI 21 to 58). By the end of June 2001 the total number of definite and probable cases of vCJD reported in the UK had reached 102 (2).

Of the 84 deaths to the end of 2000, 75 were confirmed neuropathologically with a further two awaiting neuropathological confirmation. The clinical, neuropathological and epidemiological features of all these cases of vCJD are remarkably uniform and consistent with previous descriptions. A case of neuropathologically confirmed vCJD in an individual who died aged 74 years in October 1999 significantly extends the known age range for vCJD.

Analysis by standard region suggests that the incidence of vCJD in the 'North' of Great Britain (defined as North West, Yorkshire and Humberside, Northern standard regions and Scotland) may be higher than in the 'South' (South West, South East, Wales, West Midlands, East Midlands, and East Anglia); rate ratio (north vs south) based on place of residence in 1991 was 1.81 (95% CI 1.20, 2.74). The mean Carstairs' deprivation score for areas of residence of people with vCJD was -0.41 (95% CI -1.02, 0.19), which overlaps the national average of zero, indicating no evidence for an association with deprivation. Regional rates of vCJD were correlated with consumption of other meat or meat products as classified and recorded by the Household Food Consumption and Expenditure Survey (Spearman's rank correlation=0.73; p=0.02), but not with similar data from the Dietary and Nutritional Survey of British Adults. Investigators of the five cases of vCJD in Leicestershire that formed a cluster, concluded that the purchase and consumption of beef in the early 1980's from butcher's shops where the meat could have been contaminated with brain tissue from cattle affected with bovine spongiform encephalopathy (BSE) provided a plausible explanation for the cluster (3,4).

Risk factors for the development of vCJD include age, residence in the UK and methionine homozygosity at codon 129 of the prion protein gene – 87 cases of vCJD with available genetic analysis have all been methionine homozygotes. The analyses in the ninth annual report do not provide conclusive evidence of an increased risk of vCJD associated with past surgery, previous blood transfusion, occupation or a range of dietary factors. The power of the case-control study from which these results are derived is, however, limited by the relatively small number of cases and controls. For some putative risk factors, such as blood transfusion or surgery, it may be many years before an accurate assessment of risk can be made because of the likely prolonged incubation periods.

From 1990 to 2000, the average annual mortality rates from sporadic CJD in England, Scotland, Wales,

and Northern Ireland were 0.75 per million population, 0.86/million, 1.00/million, and 0.46/million respectively; these rate differences were not statistically significant ($p=0.3$). The rates are similar to those observed in other countries in Europe and elsewhere in the world, including countries that are free of BSE. The variation seen in the observed mortality rates between different regions in the UK was not significant ($p=0.5$). There was no convincing evidence of space-time clustering. Whether this increase in incidence is due to improved case ascertainment or is a reflection of an underlying incidence rise is impossible to say with certainty.

Between 1970 and 2000, 42 cases of iatrogenic CJD have been ascertained, 6 in recipients of dura mater implants, 35 in human-derived growth hormone (hGH) recipients, and one in a recipient of human gonadotrophin (hGN). The mean age at death of the hGH/hGN group was 29 years (range 20-45 years) and for the dura mater recipients was 43 years (range 27-59 years). The first recognised case in a dura mater recipient died in 1979, and the first hGH-related death was in 1985.

1. The National CJD Surveillance Unit. Creutzfeldt-Jakob disease surveillance in the UK – Ninth annual report 2000. Edinburgh: National CJD Surveillance Unit, 2001 <www.cjd.ed.ac.uk>

2. Monthly Creutzfeldt-Jakob disease figures. Press release 2. London: Department of Health, July 2001.

3. CDSC. Report on Leicestershire vCJD cluster published. *Commun Dis Rep CDR Wkly* [serial online] 2001[cited 11 July 2001]; **11** (12): news. Available at <www.phls.co.uk/publications/CDR%20Weekly/archive/news1201.html#report>

4. Bryant G, Monk P. *Summary of the final report of the investigation into the North Leicestershire cluster of variant Creutzfeldt-Jakob disease*. Leicester: Leicestershire NHS Health Authority, 2001. Available online at <www.leics-ha.org.uk>.

United Kingdom guidelines on the management of sexually transmitted infections and closely-related conditions

A number of guidelines on the management of sexually transmitted infections and closely-related conditions have been published by the Clinical Effectiveness Group, a body with nominations from the Medical Society for the Study of Venereal Diseases (MSSVD), the Association for Genitourinary Medicine (AGUM), and the Royal College of Physicians of London's Genitourinary Medicine Committee. The guidelines cover the most common and important sexually transmitted infections and genital conditions seen in the United Kingdom and include:

Urethritis

- [Management *Chlamydia trachomatis* genital tract infection](#)
- [Management of non-gonococcal urethritis](#)
- [Management of gonorrhoea in adults](#)

Vaginal discharge

- [Management of bacterial vaginosis](#)
- [Management of vulvovaginal candidiasis](#)
- [Management of *Trichomonas vaginalis*](#)

Genital ulceration

- [Management of genital herpes](#)
- [Management of early syphilis \(DRAFT\)](#)
- [Management of late syphilis \(DRAFT\)](#)
- [Management donovanosis \(granuloma inguinale\)](#)
- [Management of lymphogranuloma venereum](#)
- [Management of chancroid](#)

Systemic presentation and complications

- [Management of prostatitis](#)
- [Management of epididymo-orchitis](#)
- [Management of pelvic infection and perihepatitis](#)
- [Management of viral hepatitis A, B and C](#)
- [Management of sexually acquired reactive arthritis](#)

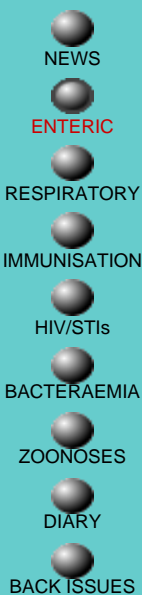
Miscellaneous

- [Management of anogenital warts](#)
- [Management of scabies](#)

- [Management of *Phthirus pubis* \(pediculosis\)](#)
- [Management of molluscum contagiosum](#)
- [Management of adult victims of sexual assault](#)
- [Management of vulval conditions](#)
- [Management of suspected STIs in children and young people \(DRAFT\)](#)

These guidelines are also accessible at the websites of the two sponsoring organisations <www.mssvd.org.uk> and <www.agum.org.uk>. They are all in the process of being revised but the revisions should be completed in the next few months and will be available on the two websites. The original versions of most of the guidelines were published as a supplement to *Sexually Transmitted Infections* (1999; **75**: supplement 1). Comments on these guidelines are welcome and should be sent to Dr Keith Radcliffe, Chairman, Clinical Effectiveness Group (MSSVD/AGUM), Whittall Street Clinic, Department of GU Medicine, Whittall Street, Birmingham, B4 6DH (email: ruth.Lawrence@bscht.wmids.nhs.uk).

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General outbreaks of foodborne illness, England and Wales: laboratory reports, weeks 23-27/01*

Health authority	Organism	Place of outbreak	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
Middlesborough	<i>Salmonella enteritidis</i> PT4	Residential	June	5	5	–	–
Middlesborough	<i>S. enteritidis</i> PT4	Prison	June	3	3	–	–
Nottingham	<i>S. enteritidis</i> PT4	Retailer	June	2	2	Sandwiches	–
Enfield and Haringey	<i>S. enteritidis</i> PT4	Club	May	4	4	–	–
Shrewsbury	<i>S. enteritidis</i> PT4	Restaurant	June	10	10	–	–
National	<i>S. newport</i>	National	June	19	19	Salad	M
Manchester	<i>S. virchow</i> PT31	Hospital	June	3	3	–	–
Preston	<i>Escherichia coli</i> O88	Caterer	February	20	16	–	–
Southampton	<i>Clostridium perfringens</i>	Public house	March	3	2	Rolled leg of lamb	S
Wirral	Unknown	Hotel	March	9	–	–	–

* Preliminary data. Final information will be published in the quarterly report. 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 suspect vehicle(s) and being a case.

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

Details of serotypes of the 997 salmonella infections recorded in May 2001 are given in the table below. In June 2001, 1503 salmonella infections were recorded and preliminary information was received about seven outbreaks (see table above).

* figures quoted from the PHLS salmonella data set are for isolates confirmed and typed by PHLS Laboratory of Enteric Pathogens (LEP)

	May 2001
<i>Salmonella</i> (provisional total)	997
<i>S. enteritidis</i> (PT4)	281
<i>S. enteritidis</i> (other PTs)	308
<i>S. typhimurium</i>	132
<i>S. virchow</i>	31
Other (typed)	245

Common gastrointestinal infections, England and Wales: laboratory reports, weeks 23-27/01

Laboratory reports	Number of reports received					Total reports	Cumulative reports	
	23/01	24/01	25/01	26/01	27/01	23-27/01	2001	2000
<i>Campylobacter</i>	990	1180	2379	1425	2311	8285	27687	26575
<i>Escherichia coli</i> O157*	10	17	14	32	23	96	246	311
<i>Shigella sonnei</i>	14	22	46	22	40	144	494	390
Rotavirus	420	465	420	471	982	2758	13822	15256
SRSV	17	24	11	10	22	84	1079	1444
<i>Cryptosporidium</i>	19	33	38	42	106	238	1306	2179
<i>Giardia</i>	41	36	62	98	109	346	1629	1973

* Vero cytotoxin producing isolates (data from LEP)

Other gastrointestinal infections, England and Wales: laboratory reports, weeks 14-26/01

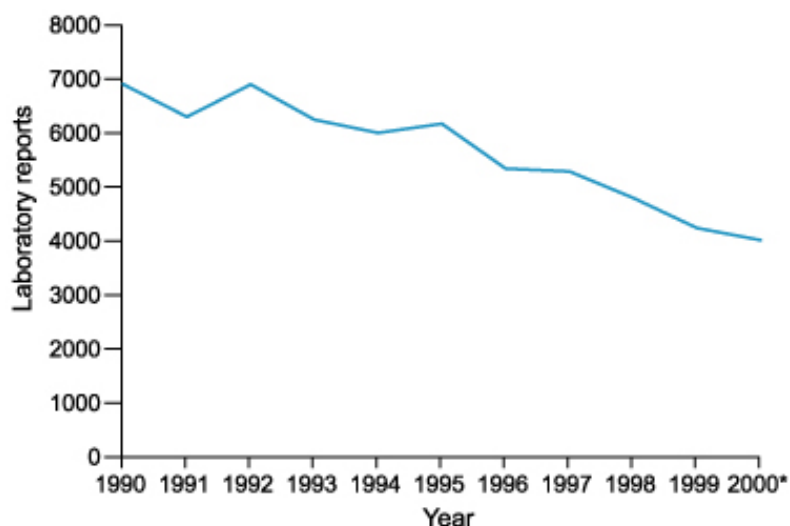
	Number of reports 14-26/01	Cumulative reports	
		2001	2000
Adenovirus*	25	61	132
Astrovirus	41	92	193
Calicivirus	4	14	30
<i>Shigella boydii</i>	22	30	26
<i>Shigella dysenteriae</i>	13	18	18
<i>Shigella flexneri</i>	40	85	92
Aeromonas	40	73	108
Plesiomonas	7	15	14
Vibrio	14	25	33
Yersinia	8	16	18
<i>Entamoeba histolytica</i>	61	136	134
<i>Blastocystis hominis</i>	107	160	117
<i>Dientamoeba fragilis</i>	64	110	83
<i>Taenia spp</i>	12	39	26
<i>Tichostrongylus</i>	–	1	–
<i>Trichuris trichiura</i>	23	45	33

* include adenovirus EM faeces and adenovirus group F

Giardiasis in England and Wales

A total of 1629 cases of *Giardia lamblia* were reported to the PHLS Communicable Disease Surveillance Centre up to the end of week 27 in 2001, 17% less than the number reported in the same period of 2000 (1973 cases). According to week of laboratory report, a total of 4015 cases were reported in 2000, 5% less than the 4240 cases reported in 1999. This continues the downward trend observed since 1990 (figure 1).

Figure 1 Laboratory reports of *Giardia lamblia*, England and Wales: 1990 to 2000



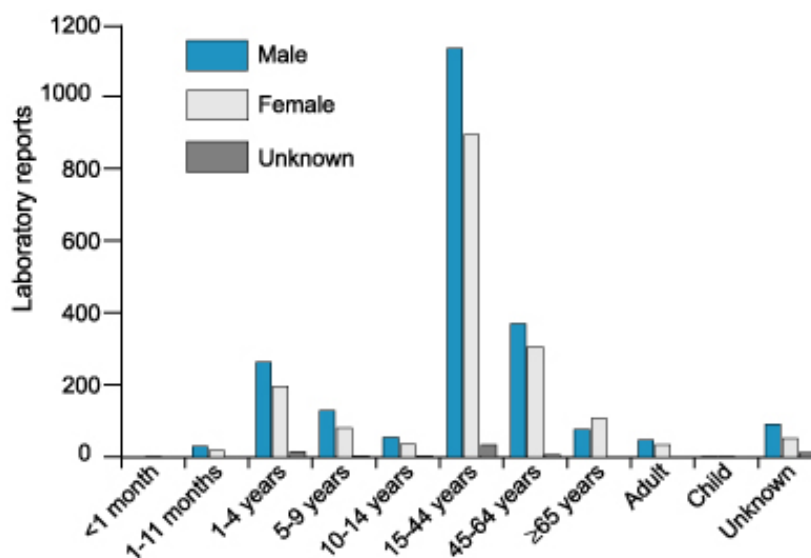
All regions reported cases in 2000. South East region continues to report the highest number of cases (table); an increase of 8% (884) in 2000 compared with 1999 (807).

Table Regional distribution of giardiasis cases, England and Wales: 1999 and 2000

Region	1999	2000
Northern and Yorkshire	362	287
Trent	340	302
Eastern	582	522
London	457	407
South East	807	884
South West	679	625
West Midlands	285	263
North West	524	425
Wales	204	300
Total	4240	4015

Over 50% of cases reported in 2000 were aged between 15 and 44 years, which is consistent with previous years. It is notable that in all age groups except for those aged 65 years or over, more males were affected than females. This was particularly evident in the 15 to 44 year age group (figure 2).

Figure 2 Laboratory reports of *Giardia lamblia* by agegroup and sex, England and Wales: 2000



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