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Gonococcal resistance programme annual report published

The first annual report of the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) has been published (1). GRASP is a collaborative surveillance initiative established between the PHLS Communicable Disease Surveillance Centre with the PHLS Genitourinary Infection Reference Laboratory (Bristol PHL) and Imperial College (University of London). It aims to determine and monitor the prevalence of antimicrobial resistance in *Neisseria gonorrhoeae* in England and Wales. The methodology for GRASP has been described previously (2,3). Briefly, during June, July, and August 2000, 30 microbiology laboratories in England and Wales submitted all isolates of gonococci to two reference laboratories for antibiotic susceptibility testing. Their associated genitourinary medicine (GUM) clinics collected detailed demographic and behavioral data on all patients diagnosed with gonorrhoea. Three thousand one hundred and sixty-six patients were included in the collection, making GRASP one of the largest national surveys of gonococcal infection to date.

GRASP provides the first robust prevalence estimates of antimicrobial resistance in *N. gonorrhoeae* across a wide geographical base in England and Wales. Along with penicillin, the current United Kingdom guidelines for the treatment of uncomplicated gonorrhoea now recommend the use of fluoroquinolones (either ciprofloxacin or ofloxacin) (4). Minimum inhibitory concentrations (MIC) for penicillin, ciprofloxacin, tetracycline, ceftriaxone and spectinomycin were determined for each GRASP isolate. Overall, 1.8% of isolates showed resistance (≥ 1 mg/l) to ciprofloxacin, and a further 2.4% showed intermediate resistance (≥ 0.05 and < 1 mg/l). Higher than predicted levels of ciprofloxacin resistance were observed outside London, particularly in Northern and Yorkshire region (6.5%). These higher prevalences occurred mainly among heterosexuals and may be a direct result of earlier outbreaks of ciprofloxacin resistant gonococcal disease reported in the north of England during 1999/2000. Some form of resistance to penicillin was seen in 9.3% of isolates. High-level plasmid-mediated penicillin resistance was greatest in the London (5.8%) and Eastern regions (8.2%). Chromosomally mediated resistant *N. gonorrhoeae* showed even higher prevalences in Northern and Yorkshire region (18%) and the South East (11%). For tetracycline, 38% of all isolates showed some resistance.

Results from the first year also confirm the non-random distribution of gonorrhoea irrespective of antibiotic susceptibility within the general population, with young people, homosexual men, and some ethnic minorities bearing a disproportionate burden of disease. In 2000, 29% of all diagnoses of gonorrhoea reported to GRASP were among women and 71% among men. Twenty-five per cent of infections in London and 19% outside of London were diagnosed among homosexual men. As described in previous *ad hoc* research studies, black and ethnic minority groups are also disproportionately affected, accounting for 47% of diagnoses in women and 39% of diagnoses in men. Reinfection with gonorrhoea was common, with almost a third (32%) of patients reporting having a previous diagnosis. This suggests continued contact with transmission networks and possible failure of clinic and population-based prevention strategies. Just over 44% of women and 12% of men had no symptoms, which highlights the importance of sexual health screening among those at greatest risk to prevent onward transmission and the development of complications (5).

These findings illustrate the public health potential of this enhanced antibiotic resistance surveillance programme. GRASP also provides a mechanism for more detailed monitoring of disease epidemiology. This may be particularly useful for identifying outcome indicators or setting of disease prevention targets. The clinical data and outcomes also provide a mechanism for monitoring the quality of clinical care, adherence to antibiotic prescribing policies and treatment guidelines. Surveillance is currently underway to enable changes over time to be monitored.

1. GRASP Steering Group. *The Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) year 2000, report*. London: Public Health laboratory Service, 2001. Available online at <www.phls.co.uk/facts/STI/grasp.htm>
2. CDSC. National sentinel surveillance of antimicrobial resistance in *Neisseria gonorrhoeae*. *Commun Dis Rep CDR Wkly* 2000; **10**: 22.
3. TC Paine, KA Fenton, A Turner, C Ison, I Martin, A Herring, *et al*. GRASP: a new national sentinel surveillance initiative for monitoring gonococcal antimicrobial resistance in England and Wales. *Sex Transm Inf*. In press.
4. Bignell C. National guidelines for the management of gonorrhoea in adults. *Sex Transm Infect* 1999; **75** (suppl 1): S13-5.
5. Department of Health. *The national strategy for sexual health and HIV*. London: Department of Health, 2001. Available at <www.doh.gov.uk/nshs/bettersexualhealth.pdf>.

National strategy for sexual health and HIV

'Good sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life, and living free from discrimination. Essential elements are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unwanted pregnancy, illness, or disease.'

Sexual health strategy 2001 (1)

The first national sexual health strategy was announced by the Department of Health on 27 July 2001. This is a comprehensive framework for promoting good sexual health and preventing the sexual causes of premature death and ill health. The key aims of the strategy are to ensure that everyone has access to the knowledge and skills necessary to achieve positive sexual health, and that services should be readily available to all who require them. The specific objectives are to reduce the undiagnosed prevalence and transmission of sexually transmitted infections (STIs) and HIV, to reduce unintended pregnancies, and to improve social and health care for people living with HIV. The proposals will increase the role of primary care in service delivery, and strengthen links between specialist services and other local agencies. The government announcement coincided with the publication of evidence of the potential effectiveness of public health campaigns on sexual health (2), and the continuing deterioration in STI trends in England and Wales (3).

The economic case for such a strategy is strong, if it is effective. The strategy document points out that the average lifetime treatment cost for each HIV infected adult is estimated as between £135,000 and £181,000. The monetary value of preventing a single onward HIV transmission is estimated at between £0.5 and £1 million in terms of individual health benefits, treatment costs, and years of productive life lost (1). The costs of genital chlamydial infection (the commonest treatable STI) and associated pelvic inflammatory disease and preventable female infertility are not included in the strategy but have been stated elsewhere (4). Key elements of the strategy, are listed in table 1 and the targets in table 2.

Table 1 Strategy recommendations

Prevention
New public education campaign from 2002
Targeted local prevention campaigns
More responsive national telephone helplines
Development of evidence-base for sexual health promotion
Standards and targets
National standards for sexual health services
Development of care pathways
HIV testing to be encouraged
Targets to reduce incidence of HIV and gonorrhoea by 2007
Services
Widened role for primary care
Improved access to GUM services
Increased community role for sexual health advisers
Closer working between primary and secondary care with single commissioning
Managed clinical networks for HIV services (regional commissioning)
Improved access to NHS terminations of pregnancy
Immunisation
Enhanced hepatitis B immunisation of those at risk
Screening
All people attending GUM clinics to be offered HIV testing
Targeted chlamydia screening to begin in 2002*
All females attending GUM clinics
Women receiving terminations of pregnancy
Women having their first cervical smear

Microbiological Aspects
Increased chlamydial and HIV testing
Research and Training
Supporting education, training and research agenda
Evaluation of 'one-stop' youth clinics and specialist primary care provision
Resources
£47.5M new money over two years

* more widespread screening to depend on the outcome of pilots undertaken in Wirral and Portsmouth in 2000/1

Table 2 Proposed targets

To reduce by 25% the number of newly acquired HIV infections and gonorrhoea infections by the end of 2007
Reducing undiagnosed HIV:
By the end of 2004, all GUM clinic attendees should be offered an HIV test on their first screening for sexually transmitted infections (and subsequently according to risk) with a view to:
increasing the uptake of the test by those offered it to 40% by the end of 2004 and to 60% by the end of 2007
reducing by 50% the number of previously undiagnosed HIV infected people attending GUM clinics who remain unaware of their infection after their visit by the end of 2007
To increase the uptake of hepatitis B vaccine:
by the end of 2003, all homosexual and bisexual men attending GUM clinics should be offered hepatitis B immunisation at their first visit
expected uptake of the first dose of the vaccine, in those not previously immunised, to reach 80% by the end of 2004 and 90% by the end of 2006
expected uptake of the three doses of vaccine, in those not previously immunised, within one of the recommended regimens to reach 50% by the end of 2004 and 70% by the end of 2006

The strategy document also asks the readers a series of specific questions and is out for consultation until December 2001. The PHLS STI/HIV advisory committee will be responding to this and will publish its response.

1. Department of Health. *The national strategy for sexual health and HIV*. London: Department of Health, 2001. Available at <www.doh.gov.uk/nshs/bettersexualhealth.pdf>.
2. Nicoll A, Hughes G, Donnelly M, Livingstone S, De Angelis D, Fenton K, *et al*: Assessing the impact of national anti-HIV sexual health campaigns: trends in the transmission of HIV and other sexually transmitted infections in England. *Sex Transm Inf* 2001; **77**: 242-7.
3. CDSC. Diagnoses of gonorrhoea reach a ten-year high. *Commun Dis Rep CDR Wkly* [serial online] 2001 [cited 1 August 2001]; **11** (30): news. Available at <www.phls.co.uk/publications/CDR%20Weekly/archive/news3001.html#gonorrhoea>
4. Washington AE, Katz P. Cost of and payment source for pelvic inflammatory disease: trends and projections 1983 through 2000. *JAMA* 1991; **266**: 2565-9.

Q fever

Following the identification of Q fever in early June in three people who worked on farms to help with the culling of cattle as a result of the national foot and mouth disease (FMD) outbreak (1), case finding in the Northern and Yorkshire region and elsewhere in England and Wales has identified a fourth case of acute Q fever in a contract worker. The worker was part of a team who cleaned up a farm in Cumbria following culling for FMD. He was admitted to hospital in early July, but has now been discharged and is recovering. People he worked with on the farm are being traced. Workers were supplied with and wore coveralls and gloves. Masks were available but it is not clear if they were worn.

An additional 12 cases of acute infection have been identified in England and Wales, none of whom are known to have had any FMD contact. Two cases were identified in slaughterhouse workers – one, a meat inspector works in a number of slaughterhouses, and the other, a slaughterman, slaughtered sheep as part of the contiguous or welfare cull. Neither had direct contact with animals known to be infected with FMD. Two cases had visited the Canary Islands, one worked in a garage, one was a water company worker, and one a keen recreational golfer. Three cases lived in rural areas. Two cases were in members of HM Forces; one had recently returned from a tour of duty in Kosovo and the other regularly drove through a rural area of Britain. Neither had any FMD contact.

Q fever is not a statutorily notifiable disease but is reportable to the Health and Safety Executive (HSE) under the *Reporting of injuries diseases and dangerous occurrences regulations 1995* (RIDDOR '95) 'for work involving contact with animals, their remains or untreated products'. Incidents should be reported to the HSE if a doctor advises an employer that the employee is suffering from a work-related disease; the self-employed are responsible for reporting the disease to HSE themselves. Diseases arising from work can be reported to HSE's incident contact centre by telephone, fax, mail, or the Internet. Further information on the reporting of work-acquired infectious disease can be found at <www.riddor.gov.uk/info.html>.

For the duration of the FMD epidemic it would be helpful if colleagues could voluntarily report any background information about confirmed cases to Dr Robert Smith at CDSC (Wales) (tel: 029 2052 1997: email robert.smith@cdsc.wales.nhs.uk)

1. CDSC. Occupational exposure risk for zoonoses among those working on control of the foot and mouth disease epidemic. *Commun Dis Rep CDR Wkly* [serial online] 2001 [cited 1 August]; **11** (25): news. Available at <www.phls.co.uk/publications/CDR%20Weekly/archive/news2501.html#occupational>

Influenza immunisation campaign 2001/2002

The Chief Medical Officer's guidelines for the 2001/02 influenza immunisation programme were recently published by the Department of Health (DH) and can be found at <www.doh.gov.uk/cmo/cmo0104.htm> (1).

The policy for 2001/02 remains unchanged from the previous year, with vaccination being recommended for all people aged 65 years and over, those in long stay residential and nursing homes or other long stay facilities, and those of any age in the following risk groups: chronic respiratory disease including asthma, chronic heart disease, chronic renal disease, diabetes or immunosuppression. As in 2000, NHS employers should offer immunisation to employees directly involved in patient care.

This year the DH aims to achieve a minimum 65% uptake in those aged 65 years and over in all primary care groups and trusts, and health authorities. Timely monitoring of vaccination uptake will be undertaken by the PHLS on behalf of the DH. Data will be collected monthly between October and December using methods similar to those used in 2000. Information will be circulated to health authority flu co-ordinators in the near future.

Eleven million, three hundred thousand doses of vaccine have been made available for distribution within the United Kingdom for 2001/02. The influenza vaccine for 2001/02 will consist of the following three components:

- an A/New Caledonian/20/99 (H1N1)-like virus
- an A/Moscow/10/99 (H3N2)-like virus*
- a B/Sichuan/379/99-like virus

*the widely used vaccine strain A/Panama/2007/99, is an A/Moscow/10/99-like virus; B/Johannesburg/5/99 and B/Victoria/504/2000 are B/Sichuan/379/99-like viruses, which have been used for vaccine production.

1. Chief Medical Officer, Chief Nursing Officer, Chief Pharmaceutical Officer. *Influenza immunisation programme 2001/2002*. (PL/CMO/2001/04) London: Department of Health, 2001.

WHO websites on infectious diseases

The following websites are taken from the current Weekly Epidemiological Record and may be useful for all those working in infectious disease surveillance and control (1):

Antimicrobial resistance information bank <oms2.b3e.jussieu.fr/arinfobank/>

Buruli ulcer <www.who.int/gtb-buruli>

Eradication/elimination programmes <www.who.int/infectious-disease-news>

Filariais <www.filariais.org>

Geographical information systems <www.who.int/emc/healthmap/healthmap.html>

Health topics <www.who.int>

Infectious diseases <www.who.int/health-topics/idindex.htm>

Influenza network (FluNet) <oms.b3e.jussieu.fr/flunet/>

Integrated management of childhood illnesses <www.who.int/chd/>

International travel and health <www.who.int/ith/>

Intestinal parasites <www.who.int/ctd/intpara>

Leprosy <www.who.int/lep/>

Malaria <www.rbm.who.int>

Newsletter (Action against infection) <www.who.int/infectious-disease-news/>

Outbreaks <www.who.int/disease-outbreak_news>

Poliomyelitis <www.who.int/gpv/>

Rabies network (RABNET) <oms.b3e.jussieu.fr/rabnet>

Report on infectious diseases <www.who.int/infectious-disease-report/>

Salmonella surveillance network <www.who.int/salmsurv/>

Surveillance and response <www.who.int/emc>

Tropical disease research <www.who.int/tdr>

Tuberculosis <www.who.int/gtb/> and <www.stoptb.org/>

Vaccines <www.who.int/gpv/>

Weekly Epidemiological Record <www.who.int/wer/>

WHO pesticide evaluation scheme (WHOPES) <www.who.int/ctd/whopes/>

1. World Health Organisation. WHO web sites on infectious diseases. *Wkly Epidemiol Rec* 2001; **76** (30): 231. Available at <www.who.int/wer/>

Attribution of items in *CDR Weekly*

Very little in public health can be achieved in isolation - to paraphrase John Donne, no part of the PHLS is an island, complete onto itself. The various disparate parts of the Service usually contribute in some way to the work of all the other parts. To reflect this, the attribution of items in the *CDR Weekly* is being changed. In the past, items have been referenced as being authored by CDSC – from 1 August the attribution will be to the PHLS as a whole. This item would therefore be referenced:

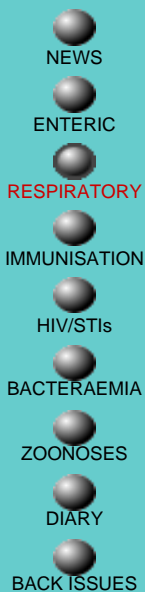
PHLS. Attribution of items in *CDR Weekly*. *Commun Dis Rep CDR Wkly* [serial online] 2001 [cited 2 August]; **11** (31): news. Available at <www.phls.co.uk/publication/CDR%20Weekly/index.html>.

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Where an outside body, or a particular part of the service outwith CDSC, has made a significant contribution to the preparation of a report, due acknowledgment will be clearly given. Acknowledgments will not usually appear for contributions to news items. Individual contributors will continue to be listed by name in the annual index. None of these changes are retrospective, and past editions should be referenced as before.

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Respiratory tract infections, England and Wales: laboratory reports, weeks 27-30/01

	Number of reports received				Total reports
	27/01	28/01	29/01	30/01	27-30/01
Adenovirus (excluding EM faeces)	26	22	10	37	95
Coronavirus	–	–	–	–	–
Influenza A	5	3	1	26	35
Influenza B	–	2	1	29	32
Parainfluenza	16	19	3	34	72
RS virus	12	5	6	17	40
Rhinovirus	1	6	–	1	8
<i>Chlamydia</i> sp	2	5	8	5	20
<i>Coxiella burnetii</i>	1	3	1	3	8
<i>Legionella</i> sp	3	10	7	6	26
<i>Mycoplasma pneumoniae</i>	18	18	11	16	63

Adenovirus (excluding types 40, 41, group F, EM faeces): 95 cases were reported. 35 patients had eye infections. One patient had pneumonia. M 3y had impaired immunity.

Coronavirus: no cases reported.

Influenza A: 35 cases were reported. North West region reported 26 cases, Northern and Yorkshire six, South East two, and South West one. Thirty-four per cent of cases were aged between 45 and 64 years.

Influenza B: 32 cases were reported. M 36y and F 9y had a recent history of foreign travel. North West region reported 29 cases, South West two, South East one. Forty-four per cent of cases were aged between 15 and 44 years.

Parainfluenza (type 1, one; type 3, 69; untyped, two). 72 cases were reported. F 3m died. North West region reported 18 cases, Northern and Yorkshire 17, Trent 10, South West eight, West Midlands six, Eastern and Wales five each, South East two, and London one. Sixty-one per cent of cases were aged less than 1 year.

Respiratory syncytial virus: 40 cases were reported. One patient had pneumonia, and one bronchiolitis. North West region reported 12 cases, Northern and Yorkshire nine, South East seven, London six, South West and West Midlands two each, and Trent and Wales one each. Fifty-two per cent of cases were aged less than one year.

Rhinovirus: eight cases were reported. Northern and Yorkshire region reported four cases, and Trent, West Midlands, London, and Wales one each. Seventy-five per cent of cases were aged less than one year.

Respiratory chlamydia (*Chlamydia psittaci*, 15; *C.pneumoniae*, 1; *Chlamydia* sp, 4): four patients had pneumonia.

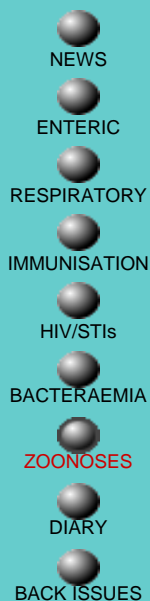
Coxiella burnetii: eight cases were reported. One patient had pneumonia. M 29y had acute hepatitis. Northern and Yorkshire region reported three cases, South West and Wales two each, and London one.

Legionella: 25 cases were reported with pneumonia, twenty-one were males aged between 33 and 86 years and four were females aged between 44 and 66 years. One case, a 75 year old male, had non-pneumonic infection. Three males aged 61, 70, and 86 years died. Fourteen cases were associated with travel: Spain (four), Turkey (three), Greece (two), and Channel Islands, Italy, and France one each. Two cases who had travelled to both Morocco and Tunisia are associated with an overseas outbreak. Ten males aged between 33 and 86 years had community acquired infection, five of whom were associated

with outbreaks. A 49 year old male was part of an outbreak in Central London; two males, including one aged 86 years who died, were part of an outbreak in Oxford, and two males were part of an outbreak in Rotherham. One case, a 79 year old male acquired his infection in hospital.

Mycoplasma pneumoniae: 63 cases were reported. Ten patients had pneumonia. F 42y with Guillain-Barré syndrome; M 46y and F 11y had a recent history foreign travel. South East and South West regions each reported 14 cases, North West 10, London nine, Eastern eight, and Northern and Yorkshire, Trent, West Midlands, and Wales two each. Forty-four per cent of cases were aged less than 15 years.

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Common animal associated infections, England and Wales: laboratory reports, weeks 27-30/01

Organism	Total reports for weeks 27-30/01		Cumulative totals for weeks 01-30	
	2001*	2000	2001*	2000
<i>Borrelia burgdorferi</i> **#	1	82	17	115
<i>Leptospira hardjo</i> **##	–	4	2	5
<i>Leptospira icterohaemorrhagiae</i> **##	–	5	4	16
<i>Leptospira other</i> **##	1	1	13	3
<i>Pasteurella haemolytica</i>	–	1	2	3
<i>Pasteurella multocida</i>	37	9	174	126
<i>Pasteurella pneumotropica</i>	–	1	2	1
<i>Pasteurella spp</i>	18	2	48	28
<i>Toxocara canis</i>	–	–	–	2
<i>Toxocara cati</i>	–	–	–	–
<i>Toxocara spp</i>	–	1	–	1
<i>Toxoplasma gondii</i>	2	3	15	21
<i>Toxoplasma spp</i>	6	7	37	35

* provisional data; ** by specimen date; # Lyme Disease Reference Laboratory and CDSC; ## Leptospira Reference Laboratory and CDSC

Common imported infections, England and Wales: laboratory reports, weeks 27-30/01

Organism	Total reports for weeks 27-30/01		Cumulative totals for weeks 01-30	
	2001*	2000	2001*	2000
Arbovirus	–	–	–	–
Dengue virus	–	–	–	3
<i>Ascaris spp</i>	11	6	65	59
Hookworm (unspecified)	9	1	36	38
<i>Ancylostoma duodenale</i>	–	–	–	–
<i>Necator americanus</i>	–	–	–	–
<i>Leptospira sp</i>	3	–	8	3
<i>Hymenolepis diminuta</i>	–	–	–	1
<i>Hymenolepis nana</i>	10	1	26	11
<i>Hymenolepis sp</i>	–	–	–	–
<i>Schistosoma haematobium</i>	2	–	31	31
<i>Schistosoma intercalatum</i>	–	–	–	–
<i>Schistosoma mansoni</i>	–	–	10	7
<i>Schistosoma sp</i>	3	–	14	21
<i>Strongyloides stercoralis</i>	2	–	17	7
<i>Strongyloides sp</i>	1	–	2	2

* provisional data