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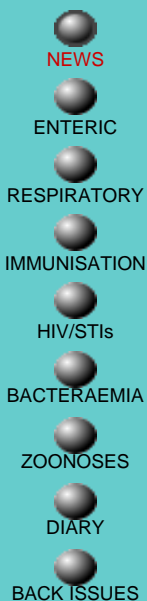
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Typhoid fever outbreak in Newport, Wales

Three children admitted to the Royal Gwent Hospital, Newport, during the past seven days have been diagnosed with typhoid fever following isolation of *Salmonella typhi* from blood cultures. The three strains have been identified as Vi-phage type A by the PHLS Laboratory of Enteric Pathogens (LEP). The cases, aged between 11 and 16 years, all live in the Pillgwenlly district of Newport and became ill between 21 and 25 July 2001. None had travelled abroad in the month before onset, or travelled far outside their area of residence. No family or social contacts have been ill or travelled abroad. General practitioners in Newport and physicians at the three local hospitals have been asked to report any person with prolonged, unexplained fever (several days) accompanied by one or more of the following: severe headache, malaise, anorexia, a rash on the trunk, constipation, or non-productive cough, with a date of onset after the first of July 2001, who lives in or has visited Pillgwenlly in the month before onset.

One hundred and sixty-five cases of typhoid fever were reported in England and Wales in 2000 (PHLS, provisional data), most of whom had travelled abroad or were in contact with somebody who travelled abroad. The last community outbreak of typhoid fever in England and Wales was in 1992 in east London, where five cases of typhoid occurred among 170 people who attend a private reception (1). Another outbreak in 1991 involving four cases was linked to a takeaway food shop in North London (2,3).

CDSC Wales would be grateful for information on any suspected or confirmed *S. typhi* infection occurring in people known to have visited the Pillgwenlly area in Newport, or who ate food purchased there. Contact Meirion Evans or Susan Hahné, tel: 029 20 521 997.

1. CDSC. Typhoid in North London. *Commun Dis Rep CDR Wkly* 1991; **1** (6): 25.
2. CDSC. Typhoid fever in East London. *Commun Dis Rep CDR Wkly* 1992; **2** (31): 141.
3. McEvoy M, Susman MD. Typhoid fever in North London. *Commun Dis Rep CDR Rev* 1993; **3** (8): R98-100.

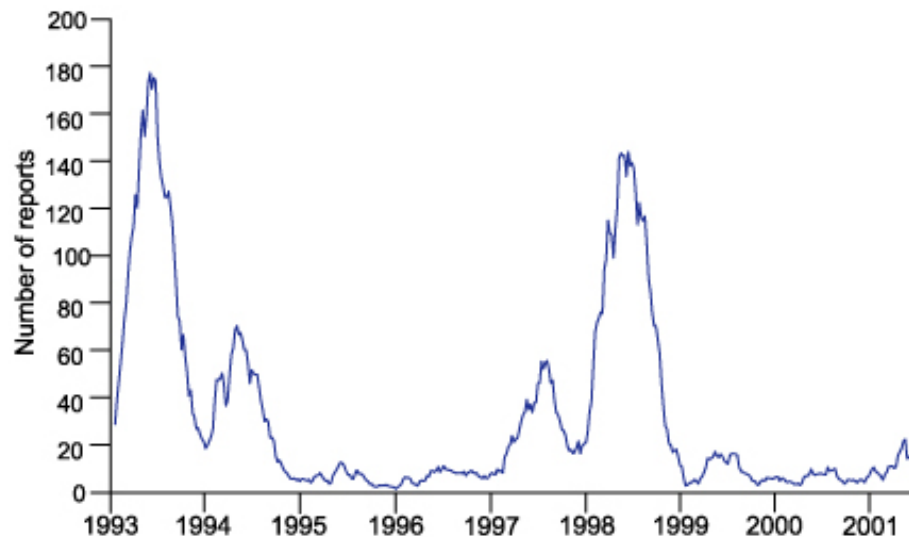
Investigation of rash illness and contact with rash illness in pregnancy

It is anticipated that the Royal College of Obstetricians and Gynaecologists' recently published book *Infection and pregnancy* (1) will lead to an increased demand from midwives, obstetricians, and other professionals for testing for infections in pregnant women. The book incorporates *Guidance on management of and exposure to rash illness in pregnancy* produced by a PHLS Working Group and posted on the PHLS website in November 2000 (2).

The PHLS guidance is aimed to improve investigation and management of pregnant women who present either with a rash that is compatible with a systemic viral illness, or with a history of contact with someone with such a rash. There are a number of possible causes. The infections with the greatest implications for clinical management are rubella, parvovirus B19, and varicella-zoster virus. Others include measles, enterovirus, Epstein-Barr virus, cytomegalovirus, syphilis, streptococcus, meningococcus, and a range of other infections not endemic within the United Kingdom (UK).

Laboratory confirmations of acute parvovirus B 19 infection by the PHLS Enteric, Respiratory, and Neurological Virus Reference Laboratory (ERNVRL) have recently increased. Parvovirus B19 is one of the main causes of concern for pregnant women who develop a rash or come into contact with someone who has a rash illness. Infection in the first 20 weeks of pregnancy can lead to miscarriage or hydrops fetalis, treatable by intra-uterine blood transfusion (1). Parvovirus B19 infection causes erythema infectiosum (also known as fifth disease, and slapped cheek syndrome). About two-thirds of women in the UK are already immune to infection because they were infected as children. Those women who become infected in pregnancy often acquire the infection from their own children (3). Parvovirus B19 has a characteristic four to five year cycle, with the last epidemic year in 1997/98 (figure). The next epidemic year is anticipated shortly, in 2001/2. The recent cluster of infections confirmed by ERNVRL indicates that the next epidemic period may have already started. In response to the previous epidemic in 1997/8, the PHLS issued *Guidance for control of Parvovirus B19 infection in healthcare settings and the community*, also available on the PHLS website (4).

Figure Laboratory confirmed reports of parvovirus B19 infection, England and Wales: 1993 to 2001 (5 weekly moving average)



The important recommendation for a pregnant woman who develops a non-vesicular rash illness is that she should be investigated simultaneously for rubella and parvovirus B19 infection (1,2). Pregnant women who report having been in recent contact with someone who has a non-vesicular rash illness should be investigated for both asymptomatic parvovirus B19 infection and asymptomatic rubella infection unless there is satisfactory evidence of past rubella infection or immunity. Satisfactory evidence of past rubella immunity or infection is defined as follows:

- at least two previous rubella antibodies screening tests with detectable antibody or;
- at least two documented doses of rubella vaccine or;
- one documented dose of vaccine followed by one previous rubella antibody screening test with detectable antibody.

Pregnant women who are exposed to chicken pox (varicella zoster) can benefit from zoster immune globulin (1,2), available from the Immunisation Division at CDSC. Contact Joan Vurdien, tel: 020 8200 6868 ext 4405.

1. Morgan-Capner P, Crowcroft NS, Miller E. Investigation of rash illness, and exposure to rash illness, in pregnancy. In: MacLean A, Regan L, Carrington D, editors. *Infection and pregnancy*. London: Royal College of Obstetricians and Gynaecologists Press, 2001

2. Guidance on the management of, and exposure to, rash illness in pregnancy. London: PHLS, November 2000 [cited 8 August 2001]. PDF format. Available from: <www.phls.co.uk/advice/rash.pdf>

3. Valeur-Jensen AK, Pedersen CB, Westergaard T, Jensen IP, Lebech M, Andersen PK, Aaby P, Pedersen BN, Melbye M. Risk factors for parvovirus B19 infection in pregnancy. *JAMA* 2000; **281**: 1099-105

4. Crowcroft NS, Roth C, Cohen B, Miller E. Guidance for control of parvovirus B19 infections in healthcare settings and the community. *J Public Health Med* 1999; **21**(4): 439-46. Available online from <www.phls.co.uk/advice/parvovirusB19.pdf>

Drug resistant tuberculosis outbreak in north London: update

There have now been 60 cases of isoniazid resistant tuberculosis in the previously reported outbreak in north London (1,2,3). Seven additional linked cases have been identified in patients living outside London. Although the first case was diagnosed in 1995, most of the 67 London and linked cases were diagnosed in 1999 (15), 2000 (25), and 2001 (24 to date). All cases share the same strain type based on an initial rapid PCR- based method (RAPET). Thirty-two of the isolates have been subjected to standard IS6110 restriction fragment length polymorphism (RFPL) typing and all are indistinguishable.

The majority of the cases are in young adults of various ethnic groups. Several are part of a close social network, others have been in close personal contact with known cases. A number are recreational drug users. Sixteen of the 67 cases have a link with a London prison, of which nine are thought to have acquired their infection in prison.

Of the 67 London and linked cases, eight have been recently diagnosed. There are 416 named contacts for the remaining 59 cases. Twenty-nine contacts were found to have active disease – 19 of these are included in the totals of culture confirmed cases above. Twenty-four other contacts have been started on preventive chemoprophylaxis and 214 have been given the all clear. There are 20 contacts who have not attended for contact tracing or have not yet been traced. Efforts to trace all contacts are continuing.

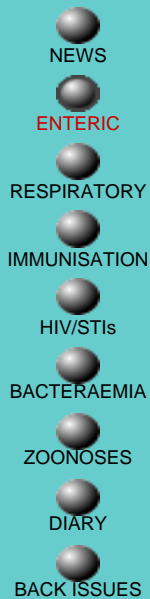
Of the 60 London cases, 19 are known to have already completed treatment, and two died before the end of treatment, one as a result of tuberculosis. Seven cases are poorly compliant and still on treatment and four others who were poorly compliant have been lost to follow up (only one is thought likely to be infectious). One in-patient who was difficult to treat has now developed multi-drug resistant tuberculosis. The remainder are continuing on treatment.

The Incident Control Committee (ICC) has emphasized the importance of adequate local resourcing to ensure that such outbreaks are properly investigated and managed. This is especially important to ensure compliance with treatment. In addition, the ICC has recommended British Thoracic Society guidelines for the management of cases and contacts as the gold standard to be adhered to (4,5,6). The ICC has also recommended free anti-tuberculous drugs in the interests of public health and will be raising the issue with the Department of Health. This outbreak is a reminder that prisons are an integral part of a district and must be included in the provision of TB services. In this outbreak TB liaison nursing was helpful and this is a model of the provision of services that the ICC would recommend.

For further information and to provide information about potentially linked cases, contact Helen Maguire, Regional Epidemiologist, CDSC London (tel: 020 7725 2734; email: h.maguire@cdsc.nthames.nhs.uk)

1. CDSC. Drug resistant tuberculosis in north London. *Commun Dis Rep CDR Wkly* 2000; **10** (32): 285,8
2. CDSC. Drug resistant tuberculosis in north London. *Commun Dis Rep CDR Wkly* [serial online] 2001 [cited 8 August 2001]; **11** (03): news. Available at <www.phls.co.uk/publications/CDR%20Weekly/archive/news0301.html#drug>
3. CDSC. Drug resistant tuberculosis in north London: Update on prison links. *Commun Dis Rep CDR Wkly* [serial online] 2001 [cited 8 August 2001]; **11** (18): news. Available at <www.phls.co.uk/publications/CDR%20Weekly/archive/news1801.html#prison>
4. Joint Tuberculosis Committee of the British Thoracic Society. Chemotherapy and management of tuberculosis in the United Kingdom: recommendations 1998. *Thorax* 1998; **53**: 536-48
5. Subcommittee of the Joint Tuberculosis Committee of the British Thoracic Society. Management of opportunistic mycobacterial infections: Joint Tuberculosis Committee guidelines 1999. *Thorax* 2000; **55**: 210-8
6. Joint Tuberculosis Committee of the British Thoracic Society. Control and prevention of tuberculosis in the United Kingdom: code of practice 2000. *Thorax* 2000; **55**: 887-901

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General outbreaks of foodborne illness, England and Wales: laboratory reports, weeks 28-31/01*

Health authority	Organism	Place of outbreak	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
Enfield and Haringey	<i>Salmonella enteritidis</i> PT4	Restaurant	July	>1	>1	–	–
Warwick-shire	<i>S. enteritidis</i> PT4	Museum	July	7	7	–	–
Avon	<i>S. enteritidis</i> PT4	Residential	July	>1	>1	–	–
Lincolnshire	<i>S. enteritidis</i> PT4	Residential	July	4	4	–	–
Portsmouth and SE Hampshire	<i>S. enteritidis</i> PT4	Restaurant	July	2	2	–	–
Buckinghamshire	<i>S. enteritidis</i> PT4	Public house	July	2	2	–	–
North and East Devon	<i>S. enteritidis</i> PT4	Wedding meal	July	9	9	–	–
Ipswich	<i>S. enteritidis</i> PT4	Residential	July	7	7	–	–
North Hampshire	<i>S. enteritidis</i> PT5A and 6	Restaurant	July	8	8	–	–
Merton, Sutton and Wandsworth	<i>S. enteritidis</i> PT6	Residential home	July	7	7	–	–
Salford and Trafford	<i>S. enteritidis</i> PT8	Religious festival	July	>14	>14	Chocolate mousse	D
Manchester	<i>S. typhimurium</i> DT104	Retailer	July	>12	>12	Turkey	M
South Humber	<i>S. typhimurium</i> DT104	Retailer	June	4	4	–	–
East Surrey	<i>S. typhimurium</i> U288	Nursery	July	4	4	–	–
West Midlands	Unknown	Hotel	June	13	–	–	–
Northamptonshire	<i>E. coli</i> O157 phage type 21/28	Private house	June	5	4	Beef-burger	M

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

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

Details of serotypes of the 1617 salmonella infections recorded in June 2001 are given in the table below. In July 2001, 1764 salmonella infections were recorded and preliminary information was received about 14 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)

June 2001	
<i>Salmonella</i> (provisional total)	1617
<i>S. enteritidis</i> (PT4)	560
<i>S. enteritidis</i> (other PTs)	586
<i>S. typhimurium</i>	136
<i>S. virchow</i>	35
Other (typed)	300

Common gastrointestinal infections, England and Wales: laboratory reports, weeks 28-31/01

	Number of reports received				Total reports 28-31/01	Cumulative reports	
	28/01	29/01	30/01	31/01		2001	2000
Laboratory reports							
<i>Campylobacter</i>	1082	1491	1364	1351	5228	32967	31420
<i>Escherichia coli</i> O157*	9	17	29	38	93	339	434
<i>Shigella sonnei</i>	8	24	8	14	54	547	441
Rotavirus	213	216	353	146	928	14749	15567
SRSV	15	8	40	43	106	1185	1565
<i>Cryptosporidium</i>	32	44	67	40	183	1489	2446
<i>Giardia</i>	53	72	64	71	260	1889	2246

* Vero cytotoxin producing isolates (data from LEP)

Typhoid and paratyphoid, England and Wales: laboratory reports, April to June 2001

Organism and phage type	Number of cases	Infection acquired abroad			Excretors and carriers
		Yes	No	Not reported	
<i>S. typhi</i>					
A	7	5	–	2	–
D1	1	–	–	1	–
D2	1	1	–	–	–
E1	16	10	–	6	–
E3	1	–	–	1	–
M3	1	1	–	–	–
O	4	1	–	3	–
Untypable	7	5	–	2	–
Untypable Vi-2	1	1	–	–	–
Degraded	1	1	–	–	–
46	2	2	–	–	–
<i>S. paratyphi A</i>					
A1	15	10	–	5	–
A1A	9	7	–	2	1
A2	2	2	–	–	–
A3	10	6	–	4	–
A4	9	8	–	1	–
A11	6	2	–	4	–
A13	20	15	–	5	–
RDNC	2	2	–	–	–
<i>S. paratyphi B</i>					
1	1	–	–	1	–
3a1 var1	1	1	–	–	–
Battersea	1	–	–	1	–
Taunton var 1	1	1	–	–	–
RDNC	1	1	–	–	–

Forty two cases of *Salmonella typhi* infection were reported in the second quarter of 2001. Twenty-seven cases were infected abroad (Indian subcontinent 22, Africa 1, Greece 1, Middle East 1, Morocco 1, 'abroad' 1). In 15 cases the country of infection was not stated. Sixty-nine cases of *Salmonella paratyphi* A infection were reported in the second quarter of 2001. Forty-nine cases had recently been abroad (Indian subcontinent 48, >more than one country, 1). In 20 cases the country of infection was not stated. Two patients had two phage types each (A1A/A13 isolated from blood, A4/A13 isolated from faeces). One patient had three phage types (A1/A4/A13) isolated from blood. One excreter was reported.

Four cases of *Salmonella paratyphi* B infection were reported in the second quarter of 2001. Two patients were infected abroad (Indian subcontinent 1, south America 1). One patient had two phage types (RDNC/3A1 var 1) isolated from blood. In two cases the country of infection was not stated.

Surveillance of *Shigella boydii* and *S. dysenteriae* infection in England and Wales: 2000

The PHLS Laboratory of Enteric Pathogens (LEP) provides a reference service for the confirmation and typing of *Shigella boydii* and *S. dysenteriae*. In 2000 LEP confirmed 56 cases of *S. boydii* infection and 26 cases of *S. dysenteriae* infection from cultures referred by laboratories in England and Wales.

Forty of the 56 cases of *S. boydii* infection were reported to have acquired their infections while travelling abroad (table). Most cases visited Asia (16) or Africa (12). Three cases reported recent travel to South America and two cases reported travel in Europe (Spain, Kosovo).

Twenty of the 26 cases of *S. dysenteriae* infection acquired their infection abroad with nine each from Africa and Asia and only one from South America.

Region/country	Number of cases	
	<i>S. boydii</i>	<i>S. dysenteriae</i>
Africa		
Egypt	2	3
Ghana	1	2
Kenya	1	–
Morocco	3	–
Nigeria	2	–
Tunisia	1	–
Somalia	–	2
South Africa	1	–
Uganda	1	–
West Africa	–	1
Zanzibar	–	1
Asia		
Bangladesh	2	–
China	1	–
India	6	7
Pakistan	3	2
Yemen	1	–
Asia (more than one country)	3	–
Americas		
Cuba	1	–
Mexico	1	–
Peru	1	1
Europe		
Spain	1	–
Kosovo	1	–
Others		
Abroad (country not stated)	7	2
Country not stated	16	5
Total	56	26

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