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Case of coccidioidomycosis in England

A case of coccidioidomycosis has been reported in south west England. The diagnosis was made by isolation of *Coccidioides immitis* from a of culture broncheo-alveolar lavage fluid and rising serological titres. The case is a 72 year old man with a history of angina who was admitted to his local hospital with a one week history of profuse night sweats, cough, pyrexia, myalgia, and arthralgia and lethargy. He initially responded to treatment but relapsed after two weeks and needed to be readmitted on 30 November.

The onset of symptoms was one week after the patient attended the World Championship of Model Aeroplane Flying in Lost Hills Valley, Kern County, California, from 5 to 14 October 2001. The championship was an international event with teams from 30 countries – a maximum of nine competitors and one manager and an assistant per country. Thirty-eight people from United Kingdom (UK) attended the championship – nine competitors, two support staff and 27 spectators. The index case was a spectator. After the championship, he travelled in central California for a few days and flew back to UK on 18 October.

Kern County in California is well known for coccidioidomycosis (also known as valley fever). Surveys suggest that about 30% of the local population have been infected (often without symptoms) and are now immune. All those who attended the championship were given a short information leaflet on Valley Fever. Through the event organisers, CDSC is checking all those who went to the championship. It is also inviting those exposed to join an investigation of how many of the UK travellers have serological markers of infection and hence to identify relevant risk factors. An early warning has been sent to national public health centres in Europe suggesting that they act similarly. By agreement, CDSC is co-ordinating efforts within the European Union countries while the World Health Organization and the United States Centres for Disease Control and Prevention are co-ordinating efforts elsewhere. To date no further cases have been found in UK, but one very similar case has been reported from Finland (see <www.eurosurv.org/update>).

Coccidioidomycosis (valley fever) is a fungal infection caused by *Coccidioides immitis*, which occurs in arid and semi-arid regions of western hemisphere. There has been a rise in infected cases especially in California in the 1990s. It is transmitted by inhalation of the infective arthroconidia from soil. It is not directly transmissible from human to human or animal to humans. The incubation period is one to

four weeks, although it may occasionally disseminate insidiously years after the primary infection if the immune system weakens. The primary infection may be entirely asymptomatic or resemble an acute influenzal illness with fever, chills, cough and rarely pleuritic pain. About 5% of all primary infections develop erythema nodosum (most often in Caucasian females). Reactivation and dissemination may occur if the patient is immunocompromised.

Diagnosis is by demonstrating fungus microscopically, or by culture of sputum, pus, urine, cerebrospinal fluid, or biopsies of skin lesions. IgM antibodies appear from one week to four months after the onset of symptoms, while IgG appears one to two months after symptoms start and lasts for six to eight months. Serial serological tests may be necessary to confirm a recent infection. Treatment of choice for meningeal infection is oral or intravenous fluconazole (400-800mg/day). Ketoconazole and itraconazole have been useful in chronic non-meningeal infections. In case of disseminated disease, amphotericin - B is recommended (0.5-0.7mg/kg/day intravenously).

People travelling to highly endemic areas, such as parts of western United States should be advised of the possibility of acquiring infection, especially during very dry, windy conditions. The elderly and immunocompromised (such as those on steroids or diabetics) may especially be at risk. Doctors seeing patients who have travelled to endemic areas and present with atypical pneumonias should consider this diagnosis, and can contact Elizabeth Johnson of the PHLS Mycology Reference Laboratory in Bristol, tel: 0117 928 5030 for expert advice, and to access laboratory diagnosis. Any suspected cases should also be reported to the CDSC duty doctor on 020 8200 6868.

1. Mandell GL, Bennett JE and Dolin R, editors. *Mandell, Douglas and Bennett's principles and practice of infectious diseases, 5th Ed.* New York: Churchill Livingstone, 2000.

2. Rosenstein NE, Emery KW, Werner SB, Kao A, Johnson R, Rogers D *et al.* Risk factors for severe pulmonary and disseminated coccidioidomycosis: Kern County, California, 1995-1996. *Clin Infect Dis* 2001; **32**: 708-14.

3. Galgiani JN, Ampel, NM, Catanzaro, A, Johnson RH, Stevens DA, Williams PL. Practice guidelines for the treatment of coccidioidomycosis. *Clin Infect Dis* 2000; **30**: 658-61.

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The Annual Report of the Chief Medical Officer of the Department of Health 2001 – *E. coli* O157, learning from Lanarkshire

The publication of On the State of Public Health, the annual report of the Chief Medical Officer (CMO) of the Department of Health 2001 (1), highlights four current public health issues. These are: health inequalities, high blood pressure, liver cirrhosis (which includes the mention of the role of hepatitis B and C), and *E. coli* O157. The latter describes the public health importance of Vero cytotoxin-producing *Escherichia coli* O157 (VTEC O157) as a cause of serious human disease. After reviewing evidence obtained from a range of expert groups, including the joint Food Standards Agency/Scottish Executive Task Force Report on *E. coli* O157 (2), the CMO's recommendations include the following:

- Develop better information for the public on the risks of VTEC O157 from contact with contaminated food, farm animals and environments and how to avoid infection.
- Rigorously implement known control methods throughout the food industry as outlined in the report by the Advisory Committee on the Microbiological Safety of Foods and the Pennington Group (3,4).
- Raise the awareness of health professionals on approaches to treatment as outlined by the FSA/SE Task Force.
- Raise the awareness of farmers and farm workers on the actions needed to prevent the spread of VTEC O157.

Recommendations were also aimed at nursery schools. The CMO also suggested that the Food Standards Agency should aim to reduce the number of cases of foodborne VTEC O157 through its foodborne disease strategy.

1. Chief Medical Officer. *Annual Report of the Chief Medical Officer of the Department of Health 2001.* London:

Department of Health, 2001. Available online at <www.doh.gov.uk/cmof/annualreport2001/index.htm>.

2. Joint Food Standards Agency Scotland/Scottish Executive Task Force on E. coli O157. *Task Force on E. coli O157 – Final Report*, Edinburgh: Scottish Executive; 2001. <www.foodstandards.gov.uk/pdf_files/taskforce_ecoli.pdf>.

3. Advisory Committee on the Microbiological Safety of Food. *Report on verocytotoxin-producing Escherichia coli*. London: HMSO 1995.

4. The Pennington Group. *Report on the circumstances leading to the 1996 outbreak of infection with E. coli O157 in central Scotland, the implications for food safety and the lessons to be learned*. Edinburgh: The Stationery Office, 1997.

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Food poisoning: management risk factors in catering – a new study

A new research study, commissioned and funded by the Food Standards Agency, has been set up by the University of Wales College of Medicine to identify key management risk factors, which lead to food poisoning.

A collaborative team of researchers from the University of Wales College of Medicine, CMi Consulting, and the Public Health Laboratory Service will use a matched case control study to compare management practices in businesses where an outbreak has occurred with such practices in another comparable catering business.

The results of this study will provide evidence to support environmental health officers in undertaking outbreak investigations and routine inspections, and enable the catering industry to target resources effectively.

Further details regarding the project can be obtained by telephoning Sarah Jones at CMi Consulting on 01993 885654 (email: sarah.jones@cmi-plc.com).

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Launch of Welsh STI prevention campaign

The National Assembly for Wales recently launched a sexual health campaign to tackle the continuing increase in cases of sexually transmitted infections (STIs) in Wales. The campaign is one of the measures outlined in the National Assembly's consultation document, A strategic framework for promoting sexual health in Wales, aimed at reducing the incidence and prevalence of STIs in Wales. The campaign, which targets 16 to 30 year olds, aims to raise awareness of the health risks associated with STIs, promote safer sex, and highlight the services available to people if they are worried about infection. The campaign will be raising awareness primarily through 'convenience' advertising with a series of information posters placed in the toilet areas of more than 270 nightclubs, pubs, and universities and colleges across Wales.

The posters have been carefully designed to convey key messages in an appealing manner for the target age group. Memorable English and Welsh language slogans are accompanied by strong visuals and the Sexual Health Wales helpline number (0845 604 8484). In keeping with the informative, yet humorous, nature of the posters, the campaign was launched at the 'Glee Club' in Cardiff Bay by a local comedian. The campaign is being supported by PHLS in Wales, FPA Cymru, NUS Wales, and local genitourinary medicine consultants, including former Welsh Woman of the Year, Olwen Williams from Wrexham Maelor Hospital. Further information about the campaign can be obtained from Suzanne Mckeown, at the National Assembly for Wales, tel: 029 2082 5028.

Ten catchy numbers

The top ten sexually transmitted infections in Wales

stimix
Top ten sexually transmitted infections in Wales

1. Genital warts
2. Chlamydia
3. Non-specific urethritis (NSU)
4. Genital herpes
5. Gonorrhoea
6. Pubic lice / scabies
7. Trichomoniasis
8. Hepatitis B
9. HIV
10. Syphilis

Sexually transmitted infections are more common than you think.
They don't always show symptoms and can seriously affect your health.

Use a condom for your protection.

For confidential information phone **0845 604 8484**

NSU • Gonorrhoea • Genital Herpes • HIV • Chlamydia • Genital Warts • NSU • Gonorrhoea

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The World Health Organization Global Outbreak and Response Network – what can Europe learn from this example?

The second meeting of the Global Outbreak and Response Network (GOARN) was held on 29-30 November 2001 in Geneva, Switzerland and was attended by more than 120 people representing 82 institutions and governments. The Network was formed in April 2000 by the Department of Communicable Disease Surveillance and Response of the World Health Organization (WHOCSR) <www.who.int/emc/pdfs/csr%20strategyE.pdf> and partners as an international collaboration of technical associates in the area of epidemic alert and response, including relevant public sector, intergovernmental, and non-governmental organisations, and the private sector <www.who.int/emc/pdfs/network.pdf>.

The achievements of GOARN are impressive in relation to communicable disease outbreaks. Since April 2000, the network has established detailed standard operating procedures and documents on its structure, an outbreak verification procedure, guiding principles on alert and response, logistical support, and a communications protocol, providing a basis for international collaboration during major outbreaks <www.who.int/emc/index.html>.

GOARN was able to draw successfully on international network partners for the response to several major outbreaks. Four of these were presented at the Geneva meeting: control of Ebola haemorrhagic fever in Gulu, Uganda (2000) and Crimean-Congo haemorrhagic fever in Kosovo (2000); investigation of febrile deaths of unknown cause in young adults in Bangladesh (2001); and prevention of epidemics of yellow fever in Côte d'Ivoire (2001).

To complement those activities, WHO-CSR is coordinating the current major revision of the International Health Regulations (IHR) to make them more responsive to public health needs. The revision was prompted by the inadequacies of the IHRs that became apparent during the Ebola outbreak in Kikwit (Zaire, 1995) and the plague outbreak in Maharashtra state (India, 1994).

GOARN has been able to respond rapidly to events such as the recent spate of anthrax releases in the United States (2). It has very quickly produced a second edition of its guidelines, available at <www.who.int/emc/pdfs/BIOWEAPONS_exec_sum2.pdf>. At the Geneva meeting, a session on deliberate release was led by Hungary's ambassador, Tibor Toth, who is the president of the Fifth Review Conference of the States Parties To The Biological Weapons Convention <www.un.org/Depts/dda/WMD/bwc/fifth/>, which is currently in session in Geneva, and David Heymann, the executive director of WHO's communicable disease services <www.who.int/emc/index.html>. Both emphasised that whether the initial appearance of a communicable disease is 'natural' or due to deliberate release, the initial surveillance mechanism and public health response is the same. Dr Heymann also pointed out that since the health services are now in the front line of the health services they could legitimately request support from government defence and security budgets.

GOARN is currently performing better than its European equivalent in its central coordinating capacity, engagement of partners, communications, and ability to respond to national and international crises. Ingredients of the WHO success probably include the ability to recruit and retain full time, highly motivated, and skilled experts, a clear direction from the new director of WHO, an administrative structure that is focused on supporting the technical aspects rather than the administrative structures above them, and WHO and its experts treating the institutions in their network as true partners.

To respond to deliberate releases of infectious and chemical agents, the European Commission is now convening a task force to coordinate actions and resources in this field. This will prevent duplication of effort and allow for sharing of resources – for example, of vaccines and therapeutic agents (2,3). A different emphasis has, however, emerged among EU field epidemiologists. Bioterrorism issues constitute only a limited part of the tasks that must be urgently taken care of if the coordination of surveillance and response to infectious diseases and chemical threats from in and beyond Europe are to be dealt with efficiently. On the basis of this consensus a technical coordination unit, along the lines of that developed by WHO, urgently needs to be created at the EU/Commission level, employing full time, highly motivated, and skilled experts drawn from the wealth of talent in Europe(4).

1. Jernigan JA, Stephens DS, Ashford DA, Omenaca C, Topiel MS, Galbraith M, et al. Bioterrorism related inhalation anthrax: the first ten cases reported in the United States. *Emerg Infect Dis* 2001; **7**: 1-21. Available at <www.cdc.gov/ncidod/eid/vol7no6/jernigan.htm>

2. Lightfoot N, Wale M, Spencer R, Nicoll A. Appropriate responses to bioterrorist threats. *BMJ* 2001; **323**: 877-8. Available at <www.bmj.com/cgi/content/full/323/7318/877>

3. Institut de Veille Sanitaire. Guide pour l'investigation épidémiologique Variole. Saint-Maurice: InVS, 7 November 2001. Available at <www.invs.sante.fr/publications/guides_biotox/guide_variole.pdf>

4. Petersen LR, Catchpole M. Surveillance for infectious diseases in the European Union *BMJ* 2001; **323**: 818-9.

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General outbreaks of foodborne illness, England and Wales: laboratory reports, weeks 45-49/01*

Health authority	Organism	Place of outbreak	Month of outbreak	No. ill	Cases positive	Suspect vehicle	Evidence
Cardiff	<i>S. enteritidis</i> PT6D	Restaurant	October	>1	>1	None	–
West Kent	<i>S. enteritidis</i> PT12	Restaurant	September	19	17	Scallops, king prawns	M
Dorset	<i>S. typhimurium</i> DT193	Retailer	October	24	17	Cooked meat	D

* 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.

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Common gastrointestinal infections, England and Wales: laboratory reports, weeks 45-49/01

	Number of reports received					Total reports	Cumulative reports	
	45/01	46/01	47/01	48/01	49/01		45-49/01	2001
Laboratory reports								
<i>Campylobacter</i>	1666	748	2020	972	750	6156	54169	52193
<i>Escherichia coli</i> O157*	16	15	13	10	32	86	767	868
<i>Shigella sonnei</i>	32	9	37	11	5	94	861	684
Rotavirus	43	61	124	74	98	400	16142	16380

SRSV	10	3	58	14	37	122	1536	1892
<i>Cryptosporidium</i>	130	87	253	110	71	651	3479	5147
<i>Giardia</i>	127	60	208	73	47	515	3386	3791

* Vero cytotoxin producing isolates (data from LEP)

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

Details of serotypes of the 2042 salmonella infections recorded in October 2001 are given in the table below. In November 2001, 1333 salmonella infections were recorded and preliminary information was received about three outbreaks.

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

	October 2001
Salmonella (provisional total)	2042
S. enteritidis (PT4)	599
S. enteritidis (other PTs)	882
S. typhimurium	198
S. virchow	41
Other (typed)	322

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General outbreaks of foodborne illness in humans, England and Wales: quarterly report

Table 1 Final information on general outbreaks of foodborne illness: April to June 2001

Health Authority	Organism	Place of outbreak	No. ill	Cases positive	Suspect vehicle	Evidence
Bassetlaw	<i>S. enteritidis</i> PT4	Residential Institution	2	2	Raw egg	D
Kensington & Chelsea	<i>S. enteritidis</i> PT4	Restaurant	>38	>38	Egg fried rice	M
Portsmouth	<i>S. enteritidis</i> PT4	Restaurant	>1	>1	NA	NA
Tees	<i>S. enteritidis</i> PT4	Residential Institution	>13	>13	NA	NA
Enfield	<i>S. enteritidis</i> PT4	Golf club	4	4	None	–
Gedling	<i>S. enteritidis</i> PT4	Retailer	29	8	Cooked chicken	S
National	<i>S. newport</i>	National	19	19	Pre-packed salad	M,S
North Devon	<i>S. typhimurium</i> DT104	Community	9	9	None	–
Wyre	<i>Escherichia coli</i> O88	Caterers	20	16	None	–
New Forest	<i>Clostridium perfringens</i>	Public House	3	2	Rolled leg of lamb	S
Wigan	Rotavirus	Residential Institution	30	4	None	–

Hartlepool	SRSV	Restaurant	18	3	Buffet	D
North Devon	SRSV	Hotel	57	2	Turkey	S
Herefordshire	SRSV	Public House	38	1	None	–
Wirral	Unknown	Hotel	9	0	None	–

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.

Table 2 Outbreaks of salmonella infection in: July to September 2001

Outbreak type	<i>S. enteritidis</i>		Other serotypes	<i>S. typhimurium</i>	Total
	Phage type 4	Other phage types			
General	13	14	3	3	33
Household	59	76	21	8	164
Acquired abroad	14	24	3	4	45
Total	86	114	27	15	242

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Salmonella serotypes recorded in the PHLS salmonella dataset July to September 2001

All serotypes recorded in the PHLS salmonella data set in the third quarter of 2001 are listed below. There were more than ten reports of 34 serotypes, two to ten reports of 48 serotypes and one report of 54 serotypes.

	July to September (provisional)
<i>S. agama</i>	13
<i>S. agona</i>	54
<i>S. anatum</i>	23
<i>S. arizonae</i>	11
<i>S. blockley</i>	40
<i>S. braenderup</i>	71
<i>S. brandenburg</i>	17
<i>S. bredeney</i>	27
<i>S. chester</i>	12
<i>S. corvallis</i>	13
<i>S. derby</i>	11
<i>S. enteritidis</i>	4853
<i>S. hadar</i>	103
<i>S. heidelberg</i>	34
<i>S. indiana</i>	12
<i>S. infantis</i>	72
<i>S. java</i>	32
<i>S. kentucky</i>	23
<i>S. kottbus</i>	21
<i>S. livingstone</i>	17
<i>S. mbandaka</i>	26
<i>S. montevideo</i>	35
<i>S. muenchen</i>	31
<i>S. newport</i>	57

<i>S. ohio</i>	12
<i>S. oranienburg</i>	24
<i>S. panama</i>	11
<i>S. saint-paul</i>	20
<i>S. stanley</i>	40
<i>S. thompson</i>	20
<i>S. typhimurium</i>	854
<i>S. virchow</i>	134
<i>S. weltevreden</i>	12
Salmonella unnamed	56
Others (typed)	282
Salmonella (total)	7073

Two to ten of each of the following serotypes were received:

Two to ten reports			
<i>S. abony</i>	6	<i>S. litchfield</i>	9
<i>S. ahuja</i>	3	<i>S. london</i>	5
<i>S. ajiobo</i>	7	<i>S. manhattan</i>	10
<i>S. alachua</i>	2	<i>S. mikawasima</i>	8
<i>S. albany</i>	10	<i>S. mississippi</i>	4
<i>S. altona</i>	4	<i>S. muenster</i>	8
<i>S. arechavaleta</i>	4	<i>S. napolis</i>	2
<i>S. bardo</i>	3	<i>S. orion</i>	2
<i>S. bareilly</i>	10	<i>S. oslo</i>	2
<i>S. bonariensis</i>	2	<i>S. ouakam</i>	2
<i>S. bovis-morbificans</i>	3	<i>S. plymouth</i>	2
<i>S. cerro</i>	3	<i>S. pomona</i>	2
<i>S. colindale</i>	2	<i>S. poona</i>	7
<i>S. eastbourne</i>	4	<i>S. potsdam</i>	3
<i>S. emek</i>	6	<i>S. reading</i>	5
<i>S. give</i>	5	<i>S. rissen</i>	5
<i>S. gold-coast</i>	9	<i>S. rubislaw</i>	3
<i>S. grumpensis</i>	10	<i>S. schwarzengrund</i>	6
<i>S. haifa</i>	7	<i>S. senftenberg</i>	9
<i>S. havana</i>	4	<i>S. sofia</i>	2
<i>S. hindmarsh</i>	2	<i>S. tennessee</i>	4
<i>S. hvittingfoss</i>	4	<i>S. uganda</i>	4
<i>S. javiana</i>	3	<i>S. virginia</i>	2
<i>S. kedougou</i>	6	<i>S. zanzibar</i>	3

One report of each of the following serotypes was received:

<i>S. aba</i>	<i>S. concord</i>	<i>S. galiema</i>	<i>S. kirkee</i>	<i>S. shubra</i>
<i>S. aberdeen</i>	<i>S. curacao</i>	<i>S. haardt</i>	<i>S. loma-linda</i>	<i>S. soerenga</i>
<i>S. adelaide</i>	<i>S. douala</i>	<i>S. hartford</i>	<i>S. marburg</i>	<i>S. stanleyville</i>
<i>S. agbeni</i>	<i>S. dubrovnik</i>	<i>S. hull</i>	<i>S. marina</i>	<i>S. stourbridge</i>
<i>S. augustenburg</i>	<i>S. durban</i>	<i>S. ibadan</i>	<i>S. negev</i>	<i>S. tel-aviv</i>
<i>S. berta</i>	<i>S. durham</i>	<i>S. idikan</i>	<i>S. nima</i>	<i>S. utah</i>
<i>S. bispebjerg</i>	<i>S. ealing</i>	<i>S. irumu</i>	<i>S. okatie</i>	<i>S. wangata</i>
<i>S. bonn</i>	<i>S. eimsbuettel</i>	<i>S. israel</i>	<i>S. oritamerin</i>	<i>S. welikade</i>
<i>S. canada</i>	<i>S. falkensee</i>	<i>S. kamoru</i>	<i>S. pharr</i>	<i>S. wimbourne</i>
<i>S. chicago</i>	<i>S. florida</i>	<i>S. kiambu</i>	<i>S. richmond</i>	<i>S. yovokome</i>
<i>S. coeln</i>	<i>S. fresno</i>	<i>S. kintambo</i>	<i>S. ruiru</i>	