



NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEamia

ZOONOSES

DIARY

BACK ISSUES

Published by: PHLS
Communicable
Disease Surveillance
Centre

Main stories this week:

Levels of acute respiratory virus infections remain low

Introduction of tuberculosis treatment outcome surveillance

Department of Health call for expressions of interest in a new chlamydia screening programme

Ebola outbreak in Gabon – update

1999/2000 Review of Communicable Diseases – England and Wales

The electronic CDR Weekly – one year on

Updated this week:

Enhanced surveillance of tuberculosis, England, Wales and Northern Ireland: 2000 - update 3 January 2002

Respiratory tract infections, England and Wales: laboratory reports, weeks 49-52/01

Common animal associated infections, England and Wales: laboratory reports, weeks 49-52/01

Common imported infections, England and Wales: laboratory reports, weeks 49-52/01

The epidemiology of HIV infection in Europe

Diary dates:

Residential course on sterilisation, disinfection, and hospital hygiene

Public health for international aid and development

For Acrobat Reader visit

<http://www.adobe.com/products/acrobat/readstep.html>

Best viewed at a screen resolution of 800 x 600 pixels

If you have any comments or encounter any problems with this website, please contact nhough@phls.org.uk

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEamia

ZOONOSES

DIARY

BACK ISSUES

News

Last updated: 20 December 2001

Next update due: 10 January 2002

Contents

[Levels of acute respiratory virus infections remain low](#)

[Introduction of tuberculosis treatment outcome surveillance](#)

[Department of Health call for expressions of interest in a new chlamydia screening programme](#)

[Ebola outbreak in Gabon – update](#)

[1999/2000 Review of Communicable Diseases – England and Wales](#)

[The electronic CDR Weekly – one year on](#)

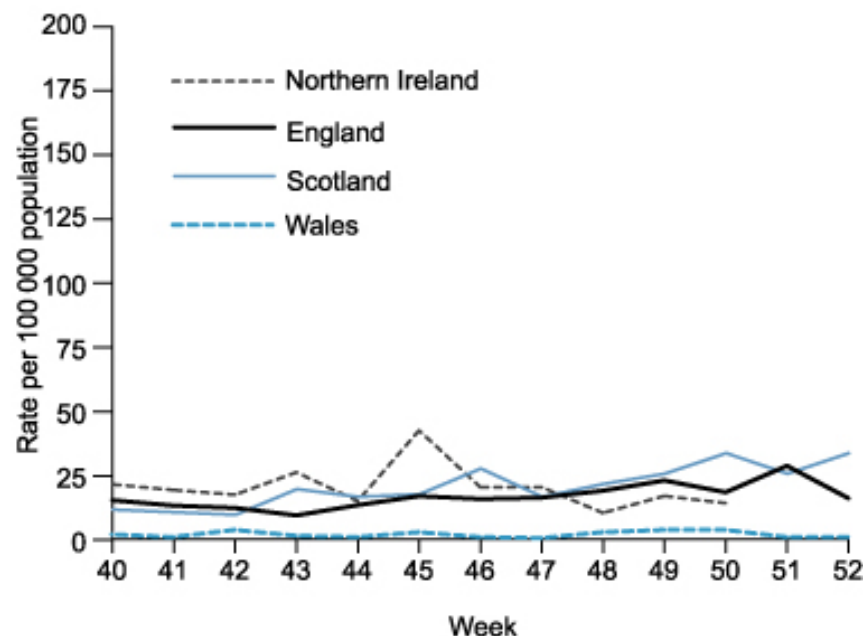
[Next](#) | [Top](#) |

Levels of acute respiratory virus infections remain low

Levels of acute respiratory virus infections, including influenza, continue to be reported at low levels in the United Kingdom. Although reporting levels are likely to have been affected by the holiday period, all other indices confirm generally low levels of acute respiratory virus illness at present.

General practitioner (GP) consultations for influenza and 'influenza-like illness' in England, Wales, and Scotland lie within the range of 'baseline' activity (figure 1). In England, GP consultation rates for acute bronchitis in the Royal College of General Practitioners weekly returns service remain within the range expected for the time of year. Children below 4 years of age are predominantly affected, but rates are also increasing in adults aged 65 years and over.

Figure 1 GP consultation rates for influenza and 'influenza-like illness' for England, Wales, Scotland, and Northern Ireland: 2001 and 2002



The numbers of laboratory reports of respiratory syncytial virus (RSV) made to CDSC are low for the time of year and are expected to peak over the next four weeks (figure 2). Reports of *Mycoplasma pneumoniae* are also low but are expected to increase over coming weeks in line with the anticipated cycle of increased mycoplasma activity during 2002 (figure 3).

Figure 2 Laboratory reports to CDSC of infections due to respiratory syncytial virus, England and Wales: 1990 to 2002 (4 weekly)

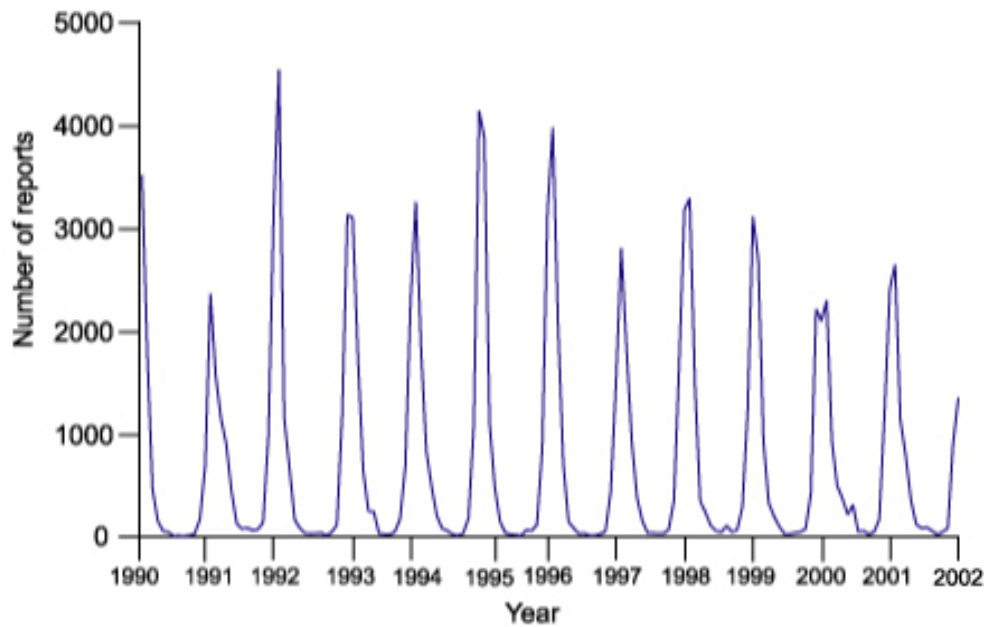
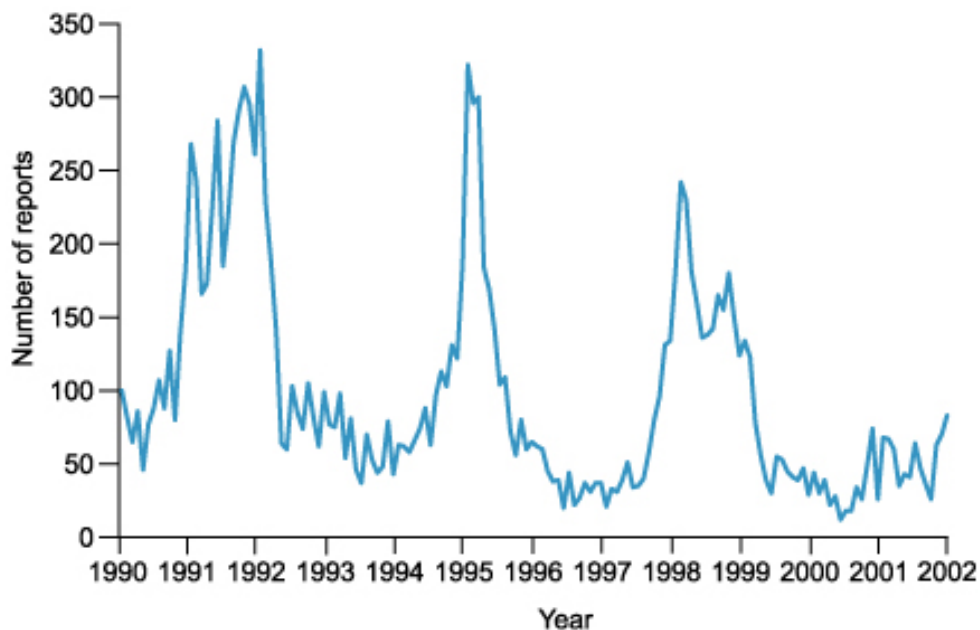


Figure 3 Laboratory reports to CDSC of infections due to *Mycoplasma pneumoniae* England and Wales: 1990 to 2002 (4 weekly)



Total calls made to NHS Direct for all symptoms increased over the Christmas holiday period but remained within the range expected for the time of year. The proportion of 'colds/flu' calls also increased but is lower than the same time last year. The age-group specific proportion of 'cold/flu' calls was highest for the 45 to 64 year age group.

Since week 40/2001, the Enteric, Respiratory and Neurological Virus Laboratory (ERNVL) at Colindale has detected influenza in nine specimens. Four are influenza A (H3N2), three of which are antigenically related to the influenza A (H3N2) Panama-like strain included in the current season's vaccine. Influenza A (H1N1) has been detected in five hospital-derived specimens, one of which has been shown to be antigenically related to the influenza A (H1N1) New Caledonia-like strain included in the vaccine composition. Further antigenic characterisation of the other specimens is underway. During the same period, eighteen samples have tested positive for RSV by PCR.

The European Influenza Surveillance Scheme (EISS) reports little or no activity from participating countries across Europe. Sporadic reports of influenza A (H3N2) and (H1N1) have been received over recent weeks, although very high levels of RSV activity have been reported in the south of France.

[Next](#) | [Top](#) |

Introduction of tuberculosis treatment outcome surveillance

Following the successful introduction of enhanced surveillance of tuberculosis in England and Wales in 1999, and in Northern Ireland in 2000, work has progressed to develop the next phase of the surveillance system which will enable the monitoring of the outcome of tuberculosis treatment. The purpose is to measure the operational effectiveness of tuberculosis aftercare at local, regional, and national levels, and generate useful information for future clinical management and national policy. Tuberculosis treatment outcome surveillance will provide insight into the proportion of patients who either successfully complete treatment, die, experience complications resulting in changed or prolonged drug therapy, or who are lost to follow-up prior to finishing treatment.

From January 2002, clinicians reporting a case of tuberculosis in the previous year will be asked to complete a short form detailing the patient's status 12 months after starting treatment. The system remains flexible, and districts may make their own arrangements with local tuberculosis services provided that they observe the standard classification of outcomes and that they have a satisfactory method of reporting to their regional co-ordinator for tuberculosis surveillance.

Systems to monitor treatment outcome are already in operation in several European countries and in the United States and have proven essential in evaluating and optimising the performance of tuberculosis services and the resources available to them.

More details about tuberculosis treatment outcome surveillance can be found on the PHLS website [<www.phls.co.uk/facts/TB/Outcome%20Surveillance.htm>](http://www.phls.co.uk/facts/TB/Outcome%20Surveillance.htm).

Department of Health call for expressions of interest in a new chlamydia screening programme

The Department of Health has put out a general call (1) to all health authorities, primary care trusts, genitourinary medicine consultants, and family planning clinics for expressions of interest in taking part in the initial roll-out of the national screening programme for genital chlamydial infection, announced by the Department of Health in the national sexual health and HIV strategy (2). Although the details of the programme have not yet been released, it is expected that screening will be based on an opportunistic model where selected populations of young women will be offered screening when attending designated health settings, irrespective of their initial reason for attendance, similar to that recently piloted in two health authorities (3). It is likely that termination of pregnancy and community family planning clinics will be among the first health settings to offer screening.

Interested parties have been asked to provide a summary of their population demographic and existing sexual health services, including the extent to which cross-specialty working occurs and future provision of services. The aim of this is to identify a range of areas that are representative of the country as a whole, such as inner city or rural areas, and those with extensive or less well developed sexual health services.

All bids should be sent to Sally Wellsted, Sexual Health Team, Room 651C Skipton House, 80 London Road, London SE1 6LH (email: sally.wellsted@doh.gsi.gov.uk) by 30 January 2001.

1. Department of Health Sexual Health and Substance Misuse. *Sexual health and HIV strategy: chlamydia screening*. Letter issued on 17 December 2001. Available from <www.doh.gov.uk/chlamydscreen.htm>.

2. Department of Health. *The national strategy for sexual health and HIV*. London: Department of Health, 2001. Pages 1-53.

3. Pimenta J, Catchpole M, Gray M, Hopwood J, Randall S. Evidence based health policy report: screening for genital chlamydial infection. *BMJ* 2000; **321**: 629-31.

Ebola outbreak in Gabon – update

The outbreak of Ebola haemorrhagic fever in northeast Gabon has now spread across the rainforest border into the neighbouring Republic of Congo. The World Health Organization (WHO) has confirmed 32 cases (15 laboratory confirmed, 17 epidemiologically linked) – 20 cases have been detected in Gabon and 12 in neighbouring villages in Republic of Congo. The cases include 17 deaths in Gabon and six in the Republic of Congo. Another seven suspected cases in Gabon and two in the Republic of Congo are being investigated by the international team.

The international team is operating on both sides of the border and is working closely out in the field with the teams from the Congolese and Gabonese Ministries of Health on outbreak control interventions. All 242 contacts (having direct or suspected contact with the blood or other body fluids of a case) are being closely monitored for signs of Ebola haemorrhagic fever for 21 days.

Ebola haemorrhagic fever was first recognised in Gabon in 1994. There were two outbreaks in 1996, and this outbreak is the fourth. Transmission of the Ebola virus has occurred by handling ill or dead infected chimpanzees, as was documented in Cote D'Ivoire and earlier outbreaks in Gabon. Healthcare workers have been infected while caring for patients. No specific treatment or vaccine exists and severe cases require intensive supportive care with strict barrier nursing techniques. The natural reservoir of the Ebola virus appears to reside in the rainforests but has not yet been identified.

1. World Health Organization. *Ebola haemorrhagic fever in Gabon – update 11*. Geneva: World Health Organization, 2 January 2002. Available from <www.who.int/disease-outbreak-news/n2002/january/04january2002.html>

[Next](#) | [Top](#) |

1999/2000 Review of Communicable Diseases – England and Wales

The third Review of communicable diseases <<http://www.phls.org.uk/publications/Annual%20Review/ReviewIndex.htm>> produced by the Public Health Laboratory Service has recently been published on the PHLS website. The previous review focused on sexually transmitted infections; the current volume focuses on tuberculosis. There is also a separate chapter about inequalities and communicable disease, following the announcement of policy initiatives to reduce health inequalities in the government white paper *Saving lives: our healthier nation*.

This is a special web version, produced to provide the information in as timely a fashion as possible. A full printed version will be available later this year.

[Top](#) |

The electronic CDR Weekly – one year on

CDR Weekly is now entering its' second year as a purely electronic serial, and we have marked the anniversary by upgrading the site. The aim was to improve both the appearance and the functionality. The navigation now allows readers to move directly into the archive material by clicking the oval button to the right of individual subject area buttons. The foot of each page includes links to a frequently asked questions (FAQ) page, to the main PHLS site, our sister publications Communicable Disease and Public Health and Eurosurveillance. Individual subject areas will be upgraded as they are republished during the four-weekly publishing cycle. For a full explanation of the page functions visit the FAQs page.

In the next few months we will be conducting a readership survey, both for visitors to the website and the email recipients. When the electronic CDR was first launched we received quite a few emails suggesting small changes, and highlighting problems – we tried to respond to these by making modifications during the year. What we rarely get is feedback on the actual content – whether it meets readers' needs and expectations – which is one area we hope to address in the survey. Until then, we still welcome any comments, which should be sent to the deputy editor at nhough@phls.org.uk.

[Back to top](#)

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEamia

ZOONOSES

DIARY

BACK ISSUES

Respiratory

Last updated: 3 January 2002
Next update due: 7 February 2002

Contents

[Enhanced surveillance of tuberculosis, England, Wales and Northern Ireland: 2000 - update 3 January 2002](#)

[Respiratory tract infections, England and Wales: laboratory reports, weeks 49-52/01](#)

Enhanced surveillance of tuberculosis, England, Wales and Northern Ireland: 2000 - update 3 January 2002

Enhanced surveillance of tuberculosis by age, sex, and site of disease, England, Wales and Northern Ireland: 2000*

Age group	Sex	Pulmonary**	Non-pulmonary only	Site unknown	Total
0-14 years	Male	98	79	–	177
	Female	109	79	2	190
	Unknown	1	–	–	1
	Total	208	158	2	368
15-34 years	Male	713	560	12	1285
	Female	622	451	2	1075
	Unknown	4	5	–	9
	Total	1339	1016	14	2369
35-54 years	Male	579	343	5	927
	Female	315	388	2	705
	Unknown	4	3	–	7
	Total	898	734	7	1639
55-74 years	Male	551	184	7	742
	Female	335	261	6	602
	Unknown	1	2	–	3
	Total	887	447	13	1347
75+ years	Male	234	76	2	312
	Female	164	76	1	241
	Unknown	–	1	–	1
	Total	398	153	3	544
Age unknown	Male	–	1	–	1
	Female	1	4	–	5
	Unknown	–	–	–	–
	Total	1	5	–	6
Total	–	3731	2513	39	6283

* provisional data. ** with or without extra-pulmonary disease. Source: Enhanced Tuberculosis Surveillance database (November 2001).

Enhanced surveillance of tuberculosis by region and site of disease, England, Wales and Northern Ireland: 2000*

Region	Pulmonary**	Non-pulmonary only	Site unknown	Total
Northern & Yorkshire	358	199	16	573
Trent	284	172	–	456
Eastern	168	105	–	273
London	1467	1153	23	2643
South East	338	189	–	527
South West	164	64	–	228
West Midlands	436	298	–	734
North West	361	262	–	623
Wales	121	53	–	174
Northern Ireland	34	18	–	52
Total	3731	2513	39	6283

* provisional data. ** with or without extra-pulmonary disease. Source: Enhanced Tuberculosis Surveillance database (November 2001).

[Top](#) |

Respiratory tract infections, England and Wales: laboratory reports, weeks 49-52/01

	Number of reports received				Total reports
	49/01	50/01	51/01	52/01	49-52/01
Adenovirus (excluding EM faeces)	9	40	24	8	81
Coronavirus	–	–	–	–	–
Influenza A	1	7	7	–	15
Influenza B	–	4	–	–	4
Parainfluenza	20	37	14	2	73
RS virus	276	445	528	99	1348
Rhinovirus	1	–	1	–	2
<i>Chlamydia sp</i>	1	7	7	3	18
<i>Coxiella burnetti</i>	–	1	–	–	1
<i>Legionella sp</i>	1	8	6	1	16
<i>Mycoplasma pneumoniae</i>	29	31	20	3	83

Adenovirus (excluding types 40, 41, group F, EM faeces): 81 cases were reported. Forty-nine patients had eye infections.

Coronavirus: no cases were reported

Influenza A: 15 cases were reported, three patients had pneumonia. F 21y with cystic fibrosis; F 69y had chronic obstructive pulmonary disease. Trent region reported eight cases, Northern and Yorkshire, North West, and South East two each, and Eastern one. Forty per cent of cases were aged between 15 and 44 years.

Influenza B: four cases were reported. Trent, and South East regions reported two cases each. One case was aged less than 1 year, and one case aged 85 years or more.

Parainfluenza (type 1,20; type 2,22; type 3,26; type 4,1; untyped 4). Seventy-three cases were reported. M 4y had pertussis. North West region reported 25 cases, Trent 16, and Wales 12, West Midlands seven, London, and South West four each, South East three, Northern and Yorkshire, and Eastern one each. Sixty-seven per cent of cases were under 1 year of age.

Respiratory syncytial virus: 1348 cases were reported. 281 patients had bronchiolitis. M 1y had sepsis; M 5y was infected in an outbreak; F 6m had respiratory failure; F 1y and M 2m had hospital acquired bronchiolitis. North West region reported 264 cases, West Midlands 239, Northern and Yorkshire 168, Eastern 164, Trent 163, South East 134, Wales 87, South West 74, and London 55. Eighty-two per cent of cases were under 1 year of age.

Rhinovirus: two cases were reported, both from the West Midlands.

Respiratory chlamydia (*C. psittaci*, 6; *C. pneumoniae*, 1; *Chlamydia* sp, 11): 18 cases were reported. Two patients had pneumonia.

Coxiella burnetii: one case was reported by the South East region.

Legionella: 16 cases were reported (14 males aged between 35 and 84 years, and two females aged 67 and 73 years. All had pneumonia. M 44y died. Ten cases were associated with travel abroad: Spain 3; England, Portugal, Greece, Cyprus, Italy and Mexico 1 each; one case travelled to both Germany and Scotland. Six male cases, aged between 42 and 84 years had community acquired infection, including one, aged 43 years, who was associated with a cluster in London.

Mycoplasma pneumoniae: 83 cases were reported. Fourteen patients had pneumonia. M 56y had leucocytosis and vasculitis; F 2y had lymphadenopathy; F 28y had liver failure. Trent region reported 19 cases, Northern and Yorkshire 10, North West, and Wales 11, Eastern 12, South West nine, South East six, West Midlands four and London one. Thirty-six per cent of cases were under 15 years of age.

[Back to top](#)

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEamia

ZOOSES

DIARY

BACK ISSUES

HIV/STIs

Last updated: 3 January 2002
Next update due: 7 February 2002

The epidemiology of HIV infection in Europe

Europe-wide surveillance of the effects of HIV infection has been organised by the European Centre for the Epidemiological Monitoring of AIDS at the Institut de Veille Sanitaire, Paris, France since the mid-1980s. Until the advent of highly active antiretroviral therapy (HAART), surveillance relied on the reporting of AIDS cases by the national surveillance centres. With the introduction of therapy that effectively postponed the development of AIDS in treated individuals, AIDS cases on their own could no longer provide an adequate basis for surveillance. Since 1997, therefore, national surveillance centres in a position to do so have been asked to report all diagnosed HIV infections in addition to those who have developed AIDS. The resulting data sets were analysed and presented at the EuroHIV meeting on HIV/AIDS in Europe in November 2001. This report is a summary of that presentation.

The epidemiology of HIV infection in Europe is diverse, but can be used to divide the region into three broad zones (figure 1). The West zone includes Israel and on its eastern border Finland, Germany, Austria, Italy, and Greece; the Centre zone runs from Poland in the North to Turkey in the South East; and the East zone covers the countries of the former Soviet Union.

Figure 1 The three zones of the HIV epidemic in Europe



The West

In the countries of the West zone the epidemic is well established. HIV incidence peaked among men who have sex with men (MSM) and injecting drug users in the mid-1980s, but reports of newly diagnosed infections have not decreased in the 1990s (figure 2). People infected heterosexually form an increasing proportion of those newly diagnosed, but the majority of infections have been acquired in countries where there is a generalised epidemic (defined as a prevalence of more than 1% in pregnant women) (figure 3). Most of the countries with such an epidemic are in sub-Saharan Africa. Among the indigenous population of western Europe MSM and injecting drug users remain the groups at greatest risk of acquiring HIV infection. Since the advent of effective antiretroviral therapy, AIDS incidence (figure 4) and HIV-related deaths have declined sharply in the West zone, while broadly similar numbers of infections are being diagnosed each year, which means that the prevalence of diagnosed infections is rising. AIDS incidence did not decline in all countries at the same time. In Portugal, for instance, the decline is very recent and is still small. This may be due to an IDU-associated epidemic of later onset than elsewhere in the West zone.

Figure 2 HIV infections diagnosed per million population by European region: 1993 to 2000

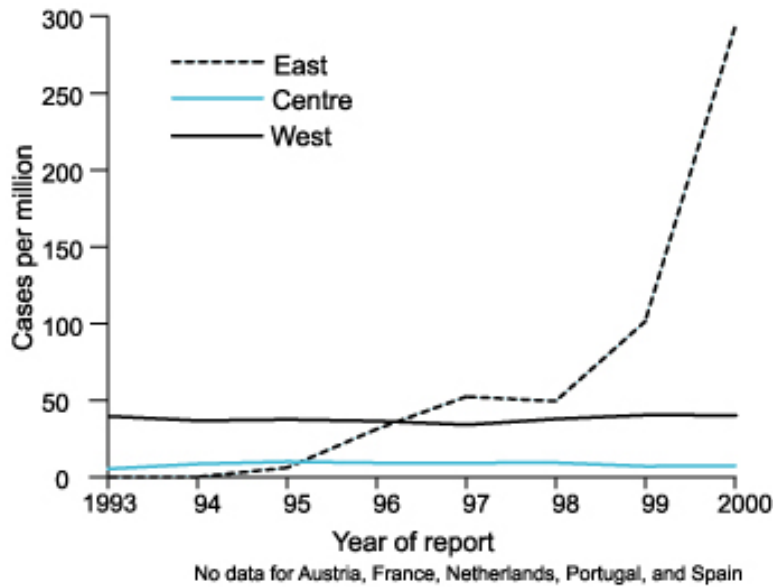


Figure 3 Percentage of diagnoses of heterosexual HIV infections acquired in a country with a generalised epidemic*: 1997 to 2000

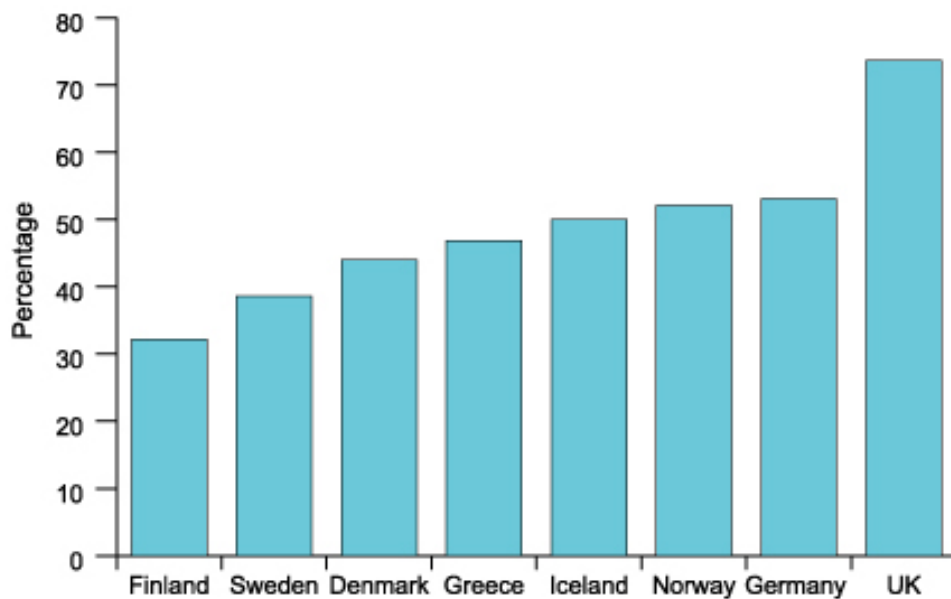
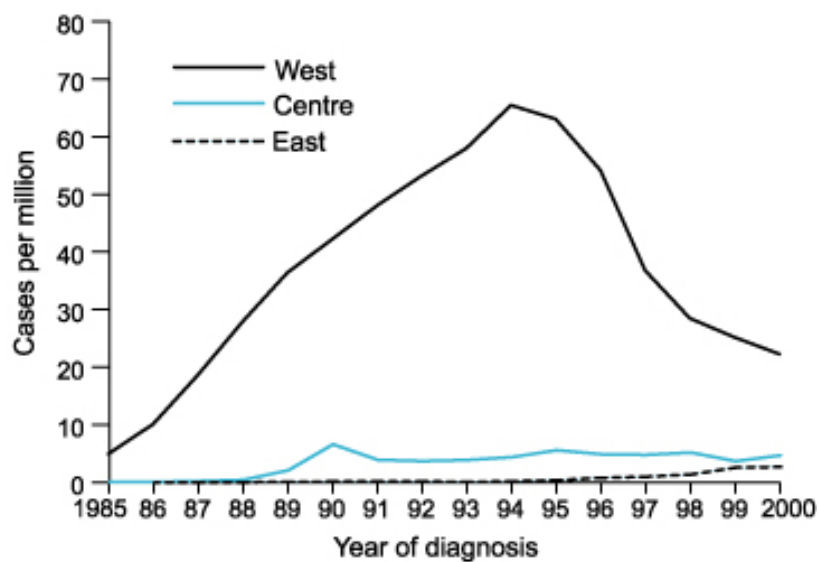


Figure 4 AIDS incidence per million population, by European region: 1985 to 2000



The challenge for the West zone is to prevent complacency among policy makers, public health officials, and at risk populations, to maintain and develop surveillance efforts to include such aspects as the transmission of antiretroviral resistant HIV, and to provide timely diagnosis and treatment for those already infected.

The Centre

In these countries the HIV epidemic has generally remained at a low level, although there are exceptions. In Romania there was a large nosocomial outbreak among children in orphanages in the late 1980s, and in Poland there was an epidemic IDUs in the early 1990s, for instance. Over the last 10 years around 4 to 5 per million new AIDS cases have been reported, and AIDS incidence has been little affected by the introduction of HAART. Reports of HIV infection have remained relatively stable, at 7 to 10 per million since 1994.

The challenge for the Centre zone is to avoid the spread of HIV seen elsewhere in Europe. This will involve efforts to limit IDU associated transmission, and the sexual behaviours associated with increased risk of transmission of HIV and other infections.

The East

In the East zone, reports of AIDS cases have risen slowly from close to zero in the 1980s to nearly 3 per million population in 2000. Diagnoses of HIV infection have risen very much faster, to nearly 300 per million in 2000. The Russian Federation, Estonia, and Latvia have all seen considerable increases in the number of diagnoses reported in the last year or two. Three hundred per million is more than seven times the rate in the West zone and 40 times the rate in the Centre zone and these newly diagnosed infections will be a major drain on health resources which the countries will find difficult to meet. The rapid spread of HIV began among IDUs in a few localised areas in 1996, and currently affects most of the countries in the zone. In many areas sexual spread has been facilitated by epidemics of other sexually transmitted diseases, and although the extent of both homosexual and heterosexual HIV transmission is largely unknown it is probably already considerable.

Apart from providing care for those already infected with HIV, the challenge for the East zone of Europe is to control injecting drug use, and develop harm minimisation measures which avoid needle sharing among those who continue to inject. The further escalation of injecting drug use related HIV epidemics, and large scale sexual transmission of HIV are all too possible in this region.

We are grateful for access to analysis by Dr Françoise Hamers and the European Centre for the Epidemiological Monitoring of AIDS from which this material is drawn.

[Back to top](#)

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEamia

ZOONOSES

DIARY

BACK ISSUES

Zoonoses

Last updated: 3 January 2002
Next update due: 7 February 2002

Contents

Common animal associated infections, England and Wales: laboratory reports, weeks 49-52/01

Common imported infections, England and Wales: laboratory reports, weeks 49-52/01

Common animal associated infections, England and Wales: laboratory reports, weeks 49-52/01

Organism	Total reports for weeks 49-52/01		Cumulative totals for weeks 01-52	
	2001*	2000	2001*	2000
<i>Borrelia burgdorferi</i> **#	7	26	241	323
<i>Leptospira hardjo</i> **##	1	4	5	12
<i>Leptospira icterohaemorrhagiae</i> **##	1	3	6	25
<i>Leptospira other</i> **##	–	4	23	17
<i>Pasteurella haemolytica</i>	–	1	6	4
<i>Pasteurella multocida</i>	11	39	272	256
<i>Pasteurella pneumotropica</i>	–	1	9	4
<i>Pasteurella spp</i>	1	4	68	60
<i>Toxocara canis</i>	–	–	–	3
<i>Toxocara cati</i>	–	–	–	–
<i>Toxocara spp</i>	–	2	3	6
<i>Toxoplasma gondii</i>	3	3	33	37
<i>Toxoplasma spp</i>	7	3	60	53

* 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 49-52/01

Organism	Total reports for weeks 49-52/01		Cumulative totals for weeks 01-52	
	2001*	2000	2001*	2000
Arbovirus	–	–	–	1
Dengue virus	1	–	2	4
<i>Ascaris</i> spp	11	9	131	119
Hookworm (unspecified)	10	2	66	66
<i>Ancylostoma duodenale</i>	–	–	–	–
<i>Necator americanus</i>	–	–	–	–
<i>Leptospira</i> spp	8	–	19	16
<i>Hymenolepis diminuta</i>	–	–	1	1
<i>Hymenolepis nana</i>	2	–	44	23
<i>Hymenolepis</i> spp	–	1	–	1
<i>Schistosoma haematobium</i>	4	–	54	56
<i>Schistosoma intercalatum</i>	–	–	–	–
<i>Schistosoma mansoni</i>	–	–	20	12
<i>Schistosoma</i> spp	3	–	36	35
<i>Strongyloides stercoralis</i>	2	–	29	15
<i>Strongyloides</i> spp	–	–	2	4

* provisional data



NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOOSES

DIARY

BACK ISSUES

Diary

Last updated: 20 December 2001

Next update due: 10 January 2002

For information about other conferences, courses, and events visit
<http://www.phls.org.uk/news/index.htm>

Public health for international aid and development

A one-day conference about developing training and recruitment in public health for international aid and development will be held on 24 January 2002. The conference will take place at the Department of Radiography, City University, Charterhouse Square in London. The programme in the morning will include: aid agencies - what public health skills do they need? and how public health skills can be used internationally. After lunch: public health registers – experience from International Health Exchange, and the lead role of the NHS and Department of Health; accreditation, training and continuing medical education - the role of the Faculty of Public Health Medicine and VSO training partnerships. The aims of this one day conference are threefold: to raise awareness of opportunities for public health practitioners to work in overseas aid and development, to debate the role of registers of public health practitioners in international aid and development, and to debate the role of international public health work in training, accreditation and CME. Workshops will also be held in the afternoon. Registration is £20. For further details/registration contact Caroline Wren at Faculty of Public Health Medicine, 4 St Andrew's Place, London, NW1 4LB, tel: 0207 935 0243; e-mail: caroline.wren@talk21.com. For directions to the Department of Radiography, Charterhouse Square, London view the map at <http://www.city.ac.uk/aboutcity/smithfield.htm>

Residential course on sterilisation, disinfection, and hospital hygiene

A few places are left on the residential course on sterilisation, disinfection and hospital hygiene being held at the Eastwood Park Training Centre in Falfield, (near Bristol), Gloucestershire, from Monday, 29 April to Friday, 3 May 2002. The course, which is aimed at infection control doctors and nurses, covers sterilisation, disinfection, ventilation and other aspects of hospital hygiene, and is recognised as a module for the diploma in hospital infection control offered by the Hospital Infection Society, PHLS, and London School of Hygiene and Tropical Medicine. The cost of the course is £950. For details regarding registration and further information about the course please write to Barry Cookson, Laboratory of Hospital Infection, PHLS Central Public Health Laboratory, 61 Colindale Avenue, London NW9 5HT, or email ghowell@phls.nhs.uk.

The course will be repeated at the same venue from Monday, 21 October to Friday, 25 October 2002. When applying please indicate which week you wish to attend.