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CDR WEEKLY



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Immunisation against meningococcal meningitis for Hajj and Umrah

An outbreak of meningococcal serogroup A infection occurred among pilgrims on the Hajj pilgrimage to Mecca in 1987, resulting in outbreaks in other countries including the United Kingdom (UK). There were 18 primary cases among pilgrims returning to the UK and 15 subsequent cases among Muslims over the following 19 months. The strains were shown to be of the same clone as the strains from the Mecca outbreak and had only rarely been encountered in England before this outbreak (1). The Saudi Arabian authorities required that for the 1988 Hajj, pilgrims should produce proof of vaccination with meningococcal meningitis serogroup A vaccine.

This was the first time that meningococcal immunisation was required as a condition of travel, and while going beyond the International Health Regulations (IHR), was a response to the outbreak and an attempt to prevent further events. The meningococcal vaccine (containing groups A and C) was not at that time widely available for travellers or licensed in the UK. The requirement at first resulted in some inconvenience for those seeking immunisation and a challenge for those administering it. During the 1990s, however, the requirement became established, the vaccine licensed and more easily available, and pilgrims received the vaccine routinely. The Saudi authorities stipulated that the vaccine should be received at least two weeks prior to travel and originally was only acceptable within two years of travel, a requirement that was later extended to three years.

An outbreak of serogroup W135 meningococcal infection occurred among pilgrims on Hajj in 2000, and cases associated with those returning were reported from many countries including Finland, France, Germany, Iran, Kuwait, Morocco, Netherlands, Oman, Singapore, Spain, UK and the United States, in addition to those reported in Saudi Arabia. In the UK there were 45 cases in 2000 and 52 in 2001, including pilgrims, contacts of pilgrims, and also to some with no known contacts.

Following this outbreak, the Department of Health (DH) recommended immunisation with vaccine that included serogroup W135. The quadrivalent vaccine (ACWY) had not been widely available in the UK up to that time, being used only for contacts of this hitherto unusual strain. Coverage among pilgrims was low (2). Further cases of serogroup W135 were reported as associated with the 2001 pilgrimage and the Department of Health (DH) launched a campaign to increase vaccine uptake for Hajj in 2002. The quadrivalent vaccine is now widely available.

The dates for Hajj vary annually; in 2002 it is expected to take place in the last week of February or early March. Umrah is performed outside of the period of Hajj, and some pilgrims will have left the UK for that purpose in November. Information about immunisation was published in the *CDR Weekly* at that time (3).

Pilgrims going on Hajj should be further reminded about immunisation requirements. The Saudi Arabian authorities now require proof of vaccination with the quadrivalent vaccine when a visa for Hajj or Umrah is issued. The proof of vaccination is valid for three years. Details of immunising children below the age of two years can be found in *CDR Weekly* (3). In addition to the meningitis vaccine, pilgrims may wish to take optional immunisation for their individual health protection, such as typhoid

and hepatitis A. Routine immunisation including diphtheria, tetanus, and polio should be up to date prior to travel. Advice on food and water hygiene and that pilgrims will be among large crowds of people is given on the DH website (4).

An International Certificate of Vaccination against yellow fever is required for entry to Saudi Arabia from countries with infected areas. This does not affect those travelling directly from the UK.

1. Jones DM, Sutcliffe EM. Group A meningococcal disease in England associated with the Hajj. *J Infect* 1990; **21**(1): 21-5.
2. Hahne SJM, Aguilera J-F, Crowcroft NS, Gray SJ, Kaczmarek EB, Nichols T, *et al.* W135 meningococcal disease in England and Wales associated with the Hajj 2000 and 2001. *Lancet* In press 2002.
3. PHLS. Quadrivalent meningococcal immunisation required for pilgrims to Saudi Arabia. *Commun Dis Rep CDR Weekly* [serial online] 2001; [cited 17 January] **11** (45): news. Available at <www.phls.org.uk/publications/CDR%20Weekly/archive/news/news4501.html#Pilgrims>
4. Department of Health. Health advice for travellers. Guard against meningitis and save lives at Hajj or Umrah this year. [online] London: Department of Health, 2 January 2002 [cited 17 January 2002]. Available from <<http://www.doh.gov.uk/traveladvice/hajj.htm>>

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An international outbreak of *Salmonella* Oranienburg infection

From 15 October 2001 to 14 January 2002, the Robert Koch-Institut (RKI) in Germany received 373 reports of *S. Oranienburg* infection from throughout the country (1). On 19 November the RKI was informed of an isolate of *S. Oranienburg* in chocolate originating from an in-house sample by a chocolate producer. The contaminated batch was due for export to the United States and was reported as having been destroyed. A case-control study and further microbiological investigations revealed an association between infection and consumption of a brand of chocolate produced by the previously noted company and distributed exclusively through one chain of supermarkets. Human isolates and strains from partly consumed chocolate products had identical pulsed field gel electrophoresis (PFGE) patterns. The product was recalled on 18 December 2001.

On 10 December 2001 an enquiry was sent to all Enter-net participants (2) to ascertain if any associated cases had occurred. An increase in the number of cases had already been noted in Denmark on 16 November – 16 cases were reported between 18 October and the end of 2001 (3). A link with consumption of chocolate purchased in Denmark from the same supermarket chain implicated in Germany had been suggested, although no further investigation took place until the Enter-net alert was received. Danish outbreak strains were found to match those from Germany, although some have slightly different antibiotic resistance patterns. Warnings were issued on 18 and 21 December, concurrent with the withdrawal of the implicated brands of chocolate.

Eighteen recent cases of infection with *S. Oranienburg* have been reported in Sweden, and two isolates obtained from the same German chocolate (4). Five of the human and both of the chocolate strains have the same PFGE pattern as the strains from Germany. Six cases have been reported from the Netherlands. Four of these are known to have eaten chocolate bought in Germany from the implicated supermarket chain – strains from two cases have so far been typed and are identical to the German strains. An increase in cases was also noticed in Austria and Belgium, where investigations are continuing. *Salmonella* is reported to have been isolated from the implicated German chocolate in Finland (where three cases are also being investigated) and Croatia. The Canadian Food Inspection Agency also discovered that batches of the implicated product had been imported into Canada. The product was recalled, and *S. Oranienburg* has been isolated from the chocolate. No chocolate is known to have been imported into the United Kingdom, and no increase in the number of cases of infection has been seen.

Salmonella infections after consumption of contaminated chocolate, although rare, have been known since the 1960s. The low moisture and high sugar content in chocolate increase the temperature resistance of bacteria. The high fat content is protective against the stomach acid and is believed to be responsible for the low infective dose of salmonella in chocolate (4). The increasingly wide distribution

of food products raises further the importance of the international Enter-net network for the surveillance and rapid reporting of salmonella outbreaks. Harmonised molecular subtyping of microorganisms and the electronic capture and transfer of the gel images of these strains has improved the capacity for identifying, and investigating, international outbreaks of infection. As a result of the information disseminated by Enter-net, the early recognition of an international outbreak of *S. Oranienburg* was facilitated and control measures implemented more rapidly.

1. Werber D, Dreesman J, Feil F, van Treeck U, Fell G, Hauri A, *et al.* International outbreak of *Salmonella* Oranienburg, October-December 2001, Part 1: Germany. *Eurosurveillance Weekly* [serial online] 2002; [cited 17 January 2002] **6**: 020117. Available at <<http://www.eurosurv.org/2002/020117.htm>>

2. Fisher IST, on behalf of the Enter-net participants. The Enter-net international surveillance network – how it works. *Eurosurveillance* 1999; [cited 17 January 2002] **4**: 52-5. Available at <<http://www.eurosurveillance.org/eurosurveillance.htm>>.

3. Ethelberg S. International outbreak of *Salmonella* Oranienburg, October-December 2001, Part 2: Denmark. *Eurosurveillance Weekly* [serial online] 2002; [cited 17 January 2002] **6**: 020117. Available at <<http://www.eurosurv.org/2002/020117.htm>>

4. Fisher I, de Jong B, van Pelt W, Aramini J, Berghold C, Matthys F, *et al.* International outbreak of *Salmonella* Oranienburg, October-December 2001, Part 3: other countries. *Eurosurveillance Weekly* [serial online] 2002; [cited 17 January 2002] **6**: 020117. Available at <<http://www.eurosurv.org/2002/020117.htm>>

5. D'Aoust JY. Salmonella and the chocolate industry. *J Food Protection* 1977; **40**: 718-27.

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Bacteraemia

Last updated: 17 January 2002
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Bacteraemia, England and Wales: laboratory reports 2000 and 2001*

	Number of bacteraemia reports (number of CSF reports +/- bacteraemia)				2001 ranking	
	Jan - Dec 2000		Jan - Dec 2001#		In section	Overall
Gram negative bacteria						
<i>Acinetobacter</i> sp	774	(8)	801	(18)	6	12
<i>Aeromonas</i> sp	71	(0)	86	(0)	14	31
<i>Alcaligenes</i> sp	56	(2)	68	(0)	19	37
<i>Campylobacter</i> sp	120	(14)	73	(7)	17	34
<i>Citrobacter</i> sp	416	(2)	427	(2)	11	18
<i>Comamonas</i> sp	18	(0)	79	(0)	16	33
<i>Enterobacter</i> sp	1721	(11)	1534	(17)	4	9
<i>Escherichia coli</i>	11032	(33)	11140	(52)	1	2
<i>Fusobacterium</i> sp	55	(2)	72	(2)	18	36
<i>Haemophilus influenzae</i>	317	(13)	350	(23)	12	20
<i>H. influenzae</i> type b	21	(4)	36	(5)	-	-
<i>Klebsiella</i> sp	3147	(14)	2969	(9)	2	6
<i>Moraxella</i> sp	82	(1)	83	(3)	15	32
<i>Morganella morganii</i>	275	(0)	255	(0)	13	22
<i>Neisseria meningitidis</i>	823	(211)	651	(207)	7	13
<i>Proteus</i> sp	1646	(4)	1497	(1)	5	10
<i>Providencia</i> sp	69	(0)	65	(0)	20	38
<i>Pseudomonas</i> sp	2105	(13)	2165	(19)	3	8
<i>P. aeruginosa</i>	1544	(12)	1676	(16)	-	-
<i>Salmonella</i> sp	394	(2)	460	(1)	10	17
<i>S. typhi</i> and <i>S. paratyphi</i>	191	(0)	241	(0)	-	-
<i>Serratia</i> sp	592	(3)	622	(8)	8	15
<i>Stenotrophomonas maltophilia</i>	402	(2)	485	(1)	9	16
Totals	24115	(335)	23882	(370)	-	-
Gram positive bacteria						
<i>Bacillus</i> sp	143	(18)	149	(27)	11	26
<i>Corynebacterium</i> sp	188	(4)	252	(4)	8	23
<i>Enterococcus</i> sp**	3606	(28)	3709	(34)	3	4
<i>Gemella</i> sp	39	(1)	50	(1)	16	39
<i>Listeria monocytogenes</i>	53	(6)	73	(13)	15	34
<i>Micrococcus</i> sp	89	(5)	116	(9)	14	30
<i>Propionibacterium</i> sp	157	(9)	121	(7)	13	28

Staphylococci						
<i>S. aureus</i>	12187	(101)	12032	(83)	1	1
coagulase negative	4334	(224)	5461	(291)	2	3
Streptococci						
pyogenic streptococci	2527	(52)	2297	(37)	5	7
group A	897	(6)	770	(1)	-	-
group B	912	(43)	854	(34)	-	-
group C/G	718	(3)	673	(2)	-	-
' <i>S. anginosus</i> group'	431	(7)	410	(4)	7	19
' <i>S. bovis</i> group'	161	(1)	173	(0)	10	25
' <i>S. mitis</i> group'	612	(14)	646	(16)	6	14
' <i>S. mutans</i> group'	58	(0)	28	(0)	17	40
<i>S. pneumoniae</i>	3657	(160)	3428	(132)	4	5
' <i>S. salivarius</i> group'	151	(3)	122	(2)	12	27
' <i>S. sanguinis</i> group'	238	(0)	216	(1)	9	24
Totals	28631	(633)	29283	(661)	-	-
Anaerobic bacteria						
Anaerobic cocci##	155	(0)	119	(0)	3	29
<i>Bacteroides</i> sp	881	(2)	837	(1)	1	11
<i>Clostridium</i> sp	402	(3)	328	(2)	2	21
Totals	1438	(5)	1284	(3)	-	-
<i>Mycobacterium avium</i> - <i>intracellulare</i> group	22	(0)	9	(0)	-	41
other bacterial pathogens***	2442	(92)	2631	76	-	-
Overall totals	56648	1065	57089	1110	-	-

*genera/groupings where 50 plus bacteraemia reports received in 2001; #provisional data as reports are often delayed;

**includes group D streptococci; ##Includes *Peptococcus* sp, *Peptostreptococcus* sp, *Veillonella* sp;

***genera/groupings with less than 50 bacteraemia reports in 2001-

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Annual scientific meeting of the society of Occupational Medicine

The Society of Occupational Medicine will be holding its annual scientific meeting at Collingwood College in Durham from 2 - 4 July 2002. The theme of this year's meeting will be Infection: new developments, new technologies. This is the first call for submissions of abstracts based on research in the field of occupational and environmental medicine. The scientific committee will consider the abstracts for oral presentations or posters. Participants are invited to submit work under the following headings:

- Infection and specific working environments
- Vulnerability to infection
- Accidents at work
- Treatment
- Prevention
- Multi-disciplinary working
- Public Health aspects

Abstracts should be sent as an attached document, by e-mail to john.Harrison@ncl.ac.uk. They should be prepared in a Word 2000 format. It should fit onto a single A5 sheet within the standard landscape margins. Submissions not conforming to this layout will be returned. The e-mail should also contain the details of the presenter, including full name, affiliation, address, contact phone, fax and e-mails. For further information and updates on the meeting visit http://www.som.org.uk/meetings/macs_loc.html#som_asm.