



NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOONOSES

TRAVEL HEALTH

New

DIARY

BACK ISSUES

SEARCH

## Main stories this week:

Temporal cluster of suspected wound botulism in injecting drug users – update

An outbreak of pseudomonas folliculitis associated with a swimming pool

The new edition of *International travel and health* from WHO

Correction: *Escherichia coli*, *Proteus* spp, *Morganella morganii*, and *Providencia* spp bacteraemias: England and Wales, 2001

## Updated this week:

Invasive meningococcal infections, England and Wales: laboratory reports, weeks 47-52/01

Virus infections, England and Wales: laboratory reports, weeks 47-52/01

*Haemophilus influenzae* by age group and serotype, England and Wales: weeks 27-39/01

National enhanced surveillance of meningococcal disease: October to December 2001

AIDS and HIV infection in the United Kingdom: monthly report February 2001

Published by: PHLS  
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Disease Surveillance  
Centre

**Diary date:** INoPSU open session

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NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEamia

ZOOSES

TRAVEL HEALTH New

DIARY

BACK ISSUES

SEARCH

## News

Last updated: 28 February 2002

Next update due: 7 March 2002

### Contents

[Temporal cluster of suspected wound botulism in injecting drug users – update](#)

[An outbreak of pseudomonas folliculitis associated with a swimming pool](#)

[The new edition of \*International travel and health\* from WHO](#)

[Correction: \*Escherichia coli\*, \*Proteus\* spp, \*Morganella morganii\*, and \*Providencia\* spp bacteraemias: England and Wales, 2001](#)

---

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

### Temporal cluster of suspected wound botulism in injecting drug users – update

Five clinical cases of wound botulism have now been reported to the PHLS Communicable Disease Surveillance Centre (CDSC) and the Scottish Centre for Infection and Environmental Health (SCIEH) since the beginning of February 2002. The first date of onset was around 31 December 2001, the second was 28 January 2002, and the dates of onset for the subsequent cases are on or after 14 February. There is no geographical clustering.

All five patients are known to be injecting drug users. All have presented with a descending paralysis. The PHLS Food Safety Microbiology Laboratory (PHLS FSML) has confirmed that one case is due to infection with *Clostridium botulinum* type B, and two cases to *C. botulinum* type A.

Alerts have been sent to all consultants in communicable disease control (CCDCs) and public health laboratories, asking them to alert relevant clinical services. This is important, as cases are not necessarily reported automatically. Colleagues in European and other international centres have also been alerted.

During office hours, CCDCs, consultant microbiologists, and consultant neurologists are asked to inform Moira Brett at PHLS FSML (tel: 020 8200 4400 ext 4933) or Sarah O'Brien at PHLS CDSC (tel: 020 8200 6868 ext 4422) of any suspected cases of wound botulism. Out of hours, suspected cases should be reported to the CDSC duty doctor on 020 8200 6868.

Related articles:

[Temporal cluster of suspected wound botulism in the United Kingdom](#)

Published 21 February 2002

---

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

### An outbreak of pseudomonas folliculitis associated with a swimming pool

There has been an outbreak of pseudomonas folliculitis associated with a swimming pool in a town in the East Riding of Yorkshire. The outbreak began after the weekend of 9-10 February 2002, with a number of children presenting to their general practitioner (GP) with a rash. The rash was first thought to be 'friction burns' caused by contact with an inflatable structure that had been in use in the swimming pool. The practice nurse had noted that with many of the boys the rash was on the front of the body and with the girls it was in the groin area that had been in contact with the inflatable.

The pool operator was notified on 15 February 2002 and by 25 February 2002, 20 affected patients had been identified, seven of whom had skin swabs positive for *Pseudomonas aeruginosa*. Examination of the pool water showed no *P. aeruginosa*, coliforms, or *E. coli* per 100mL, a negative aerobic plate count, and adequate chlorine levels. The pool was closed and hyper-chlorinated.

The investigation is focused on an inflatable water play structure, which has repeatedly tested positive for *P. aeruginosa*, even after disinfection with a benzalconium chloride disinfectant. The inflatable is made of a flexible plastic material with a stitched construction, and is stored at the poolside. It is inflated from a pump through a flexible plastic hose and the stitched seams generate bubbles. Children come into close contact with the surface of the inflatable during its use. Examination of the deflated inflatable showed pools of water can collect on the plastic surface. Some of these had a visible biofilm and were slimy to the touch. The inside of the inflatable remains wet and there appears to be no mechanism for drying or disinfecting the inside. Further sampling of the equipment for the presence of pseudomonas is being undertaken and cultures have been sent to CPHL for typing. Local case finding is still being conducted.

There was an outbreak control team meeting, followed by a site visit, on Friday 22 February and it was agreed that the pool could be re-opened. It was also agreed that the inflatable should not be used again until the procedures for its disinfection were established.

If there are any other episodes of skin rash associated with swimming pool use, particularly where flexible plastic inflatables are involved, please contact Gordon Nichols from the Environmental Surveillance Unit (ESU) at CDSC Colindale, email: [gnichols@phls.org.uk](mailto:gnichols@phls.org.uk) and Stewart Mawer from Hull Public Health Laboratory, email: [hulsmawe@north.phls.nhs.uk](mailto:hulsmawe@north.phls.nhs.uk).

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

## **The new edition of *International travel and health* from WHO**

The World Health Organization (WHO) has published the 2002 edition of *International travel and health* (1), and have launched a new website to accompany it. The format has been changed in response to recent travelling trends and has expanded and strengthened its advice to travellers. The 2002 edition is twice as long as the previous version and covers a wider range of travel-related health risks that have acquired importance in recent years.

The nature of travel has changed, with more people travelling to less developed areas in addition to the tourist centres, and therefore exposing themselves to greater risks. The emergence of new diseases and the resurgence of others, often spreading to new places has also increased the likelihood of catching infectious diseases that can often be life-threatening.

The new edition also highlights other possible risks of travelling such as the effects of long-haul flights, accidents, exposure to sun, and risks of food and waterborne disease. Vaccination and chemoprophylaxis are important, but do not provide 100% protection. Avoiding mosquito bites is one of the most important preventative measures, especially with the increase in malaria and the recent upsurge of dengue fever (dengue haemorrhagic fever can be fatal). The mosquitoes that spread dengue fever bite during the day and are present in urban areas, so even package holiday or business travellers are at risk.

This book is compiled by WHO experts in conjunction with a panel of international travel medicine practitioners, so it provides guidance that may differ from national guidelines in some small respects.

Examples of differences with *Health information for overseas travel* (the UK 'Yellow Book') include:

- The WHO country-by-country list comprises yellow fever requirements and malaria advice, and does not include other recommended vaccinations such as hepatitis A, typhoid, and meningitis.
- Malaria chemoprophylaxis advice for travellers from the UK should be taken from the UK guidelines, as there are minor differences. For example, WHO recommend doxycycline from the age of 8 years, the UK guidelines recommend doxycycline from 12 years.
- WHO recommends hepatitis B vaccine for routine use, the UK guidelines recommend it for high-risk groups.

This book is a welcome addition to the body of travel health advice and should be used in conjunction with *Health information for overseas travel* (the 'Yellow Book'), *Immunisation against infectious diseases* (the 'Green Book') and the UK malaria guidelines.

*International travel and health* is available on the web at <[www.who.int/ith/](http://www.who.int/ith/)> or can be ordered directly from WHO or The Stationery Office.

1. WHO. *International travel and health: situation as on January 1 2002*. Geneva: WHO; 2002. ISBN 92 4 158027 5.

---

[Top](#) |

**Correction: *Escherichia coli*, *Proteus* spp, *Morganella morganii*, and *Providencia* spp bacteraemias: England and Wales, 2001**

(*CDR Wkly Commun Dis Rep* 2002; **12** (8): bacteraemias)

In [figure 8 of this article](#) the details of the percentages of *Escherichia coli* bacteraemias reported as resistant to gentamicin in North West region and Wales were transposed. The correct figures are North West 3%, and Wales 8%. The corrected graph has now been placed in the document.

[Back to top](#)

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOONOSES

TRAVEL HEALTH New

DIARY

BACK ISSUES

SEARCH

## Immunisation

Last updated: 28 February 2002

Next update due: 28 March 2002

### Contents

[Invasive meningococcal infections, England and Wales: laboratory reports, weeks 47-52/01](#)

[Virus infections, England and Wales: laboratory reports, weeks 47-52/01](#)

[Haemophilus influenzae by age group and serotype, England and Wales: weeks 27-39/01](#)

[National enhanced surveillance of meningococcal disease: October to December 2001](#)

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

### Invasive meningococcal infections, England and Wales: laboratory reports, weeks 47-52/01

	Method of diagnosis			Total reports 47-52/01	Cumulative total* 2001	Annual total 2000
	CSF and blood		Other sites			
	culture	non-culture**				
Group A	–	–	–	–	2	2
Group B	84	86	15	185	1695	1645
Group C	15	13	2	30	322	712
Group W135	11	4	–	15	135	109
Group X	–	–	–	–	7	4
Group Y	4	–	–	4	31	29
Group Z	–	–	–	–	–	–
Group 29E	–	–	–	–	–	–
Ungroupable	–	–	–	–	9	22
Ungrouped	–	11	–	11	139	137
<b>Total</b>	<b>114</b>	<b>114</b>	<b>17</b>	<b>245</b>	<b>2340</b>	<b>2660</b>

\* combined CDSC and Meningococcal Reference Unit data. \*\* latex antigen, microscopy, polymerase chain reaction.

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

### Virus infections, England and Wales: laboratory reports, weeks 04-08/02

Laboratory reports	Number of reports received					Total reports 04-08/02	Cumulative total 2002
	04/02	05/02	06/02	07/02	08/02		
Coxsackie A	–	–	–	–	–	–	3
Coxsackie B	–	1	–	3	–	4	10
Cytomegalovirus	12	14	14	11	6	57	136
Echovirus	3	20	1	4	1	29	80
Parvovirus B19	3	13	14	19	7	56	100
Varicella zoster virus	3	17	10	9	–	39	78

---

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

## ***Haemophilus influenzae* by age group and serotype, England and Wales: weeks 40-52/01**

*Haemophilus influenzae* reports for weeks 40 to 52 (October to December) in 2001 remained at a similar level to the same period in 2000.

The number of *H. influenzae* serotype b infections rose to 54, compared to 37 in 2000.

**Table Laboratory reports of *Haemophilus influenzae*, by serotype and age group: fourth quarter 2001 (2000)**

Serotype	Age					Total
	<1 year	1-5 years	5-14 years	15 years+	not known	
b	8 (5)	28 (17)	2 (4)	15 (10)	1 (1)	54 (37)
nc	1 (9)	2 (4)	– (1)	19 (37)	1 (–)	23 (51)
a, e, f	– (1)	2 (2)	– (–)	8 (8)	– (–)	10 (11)
not typed	5 (1)	6 (2)	– (1)	26 (27)	6 (–)	43 (31)
<b>Total</b>	<b>14 (16)</b>	<b>38 (25)</b>	<b>2 (6)</b>	<b>68 (82)</b>	<b>8 (1)</b>	<b>130 (130)</b>

---

[Top](#) | [PDF](#) |

## **National enhanced surveillance of meningococcal disease: October to December 2001**

Regional enhanced surveillance of meningococcal disease (ESMD) began on 1 January 1998 in five regions of England, and was extended to include all English regions, Wales, and Northern Ireland from 1 January 1999. The national enhanced surveillance system requires consultants in communicable disease control (CCDCs) to report confirmed and probable cases of meningococcal disease occurring in their district each week. Data are collated at the relevant regional PHLs Communicable Disease Surveillance Centre (CDSC) and sent on to CDSC Colindale each quarter. In addition, CCDCs are asked to report details of any clusters of meningococcal disease in educational establishments.

### **Fourth quarter of 2001: weeks 40-52/2001**

During the fourth quarter of 2001, 835 cases of invasive meningococcal disease in the eight English regions, Wales, and Northern Ireland were identified through ESMD, an increase of 16% on the total of 719 from the previous quarter. A similar number (836) of cases were identified in the same period of 2000. The highest number of cases this quarter (115) was identified in the Northern and Yorkshire region (table 1).

**Table 1 Meningococcal disease by region and country: weeks 40-52, 2001**

Region	Group				Total
	B	C	Other*	Infection not confirmed	
Northern and Yorkshire	45	7	9	54	115
Trent	44	8	5	49	106
Eastern	28	7	5	30	70
London	15	–	2	88	105
South East	26	–	1	64	91
South West	16	1	2	42	61
West Midlands	25	–	4	56	85
North West	42	6	14	42	104
Wales	30	5	4	38	77
Northern Ireland	13	–	1	7	21
<b>Total</b>	<b>284</b>	<b>34</b>	<b>47</b>	<b>470</b>	<b>835</b>

\* includes W135, X, Y, 29E, ungroupable and ungrouped

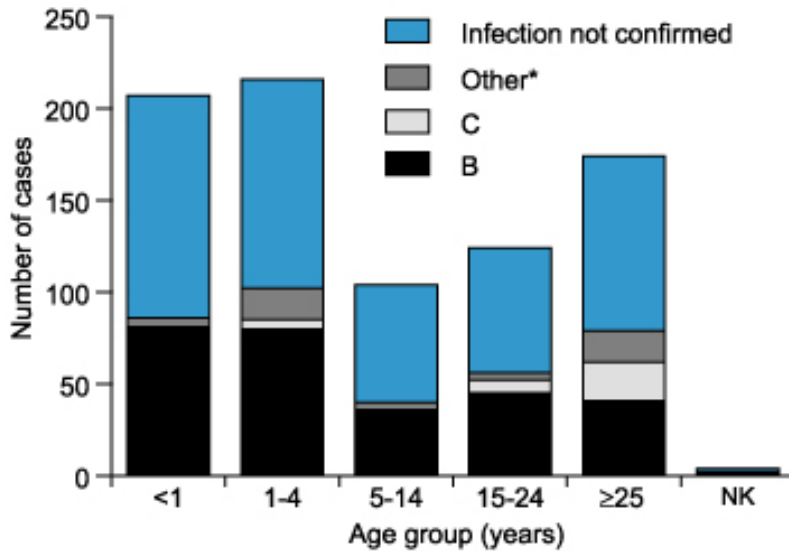
A clinical diagnosis of invasive meningococcal disease was reported for 785 cases identified in England and Wales. This is 55% more than the total number of cases (507) of meningitis and septicaemia in England and Wales officially notified to CDSC during the same period. The overall fatality rate in cases with a clinical diagnosis (in England, Wales, and Northern Ireland) was approximately 5.7 per 100 cases of invasive disease. Case fatality rate for cases with septicaemia alone was slightly higher, at 7.5 per 100 cases. (table 2).

**Table 2 Clinically diagnosed cases (deaths) of meningococcal disease: England, Wales, and Northern Ireland: weeks 40-52, 2001**

Region	Meningococcal infection				Total
	Meningitis	Septicaemia	Meningitis and septicaemia	Not meningitis or septicaemia	
Northern and Yorkshire	26	53	31 (1)	2	112 (1)
Trent	43 (2)	45 (5)	13 (1)	5	106 (8)
Eastern	35 (1)	26 (4)	6 (1)	–	67 (6)
London	74 (2)	13 (2)	14 (1)	1	102 (5)
South East	41 (1)	33	14	1	89 (1)
South West	25 (3)	20 (1)	14 (2)	1	60 (6)
West Midlands	26 (1)	50 (5)	9	–	85 (6)
North West	40 (1)	46 (2)	5 (1)	–	91 (4)
Wales	16	53 (5)	4	–	73 (5)
Northern Ireland	6	7 (2)	7 (2)	1	21 (4)
<b>Total</b>	<b>332 (11)</b>	<b>346 (26)</b>	<b>117 (9)</b>	<b>11</b>	<b>806</b>

Three hundred and fifty-one cases (43%) in England and Wales identified in ESMD were confirmed as *Neisseria meningitidis*, compared to 519 confirmed infections reported to PHLS Meningococcal Reference Unit (MRU). Serogroup B infection was confirmed in 78% (284/365) of confirmed cases identified in ESMD, serogroup C in 9% (34/365,) and the remaining 13% included other serogroups and ungrouped cases. Fifty-one per cent of all confirmed cases were in children aged less than 5 years, among whom serogroup B accounted for 86% of infections and serogroup C for 3% (figure).

**Serogroups of *N. Meningitidis* identified in cases in England, Wales and Northern Ireland by age: weeks 40-52, 2001**



\* includes W135, X, Y, 29E, ungroupable and ungrouped

An overall reduction in cases of infection with serogroups B and C was seen in 2001 when compared to the equivalent quarter in 2000: serogroup B decreased by 8% (284 cases compared to 310 in 2000) and serogroup C decreased by 54% (34 cases compared to 74). The reduction in serogroup C disease can be attributed to the use of meningococcal serogroup C conjugate vaccine, which was introduced in November 1999 (1,2).

1. CDSC. Vaccination programme for group C meningococcal infection is launched. *Commun Dis Rep CDR Wkly* 1999; **9** (30): 261,264.

2. CDSC. The impact of conjugate group C meningococcal vaccination. *Commun Dis Rep CDR Wkly* [serial online] 2001 [cited 28 February 2002]; **11**(2): news. Available from <[www.phls.co.uk/publications/CDR%20Weekly/archive/news0201.html](http://www.phls.co.uk/publications/CDR%20Weekly/archive/news0201.html)>.

[Back to top](#)

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEamia

ZOONOSES

TRAVEL HEALTH New

DIARY

BACK ISSUES

SEARCH

## HIV/STIs

Last updated: 28 February 2002

Next update due: 28 March 2002

### AIDS and HIV infection in the United Kingdom: monthly report February 2001

*United Kingdom data from the PHLS HIV and STI Division, Scottish Centre for Infection and Environmental Health, Institute of Child Health, London, and Oxford Haemophilia Centre (on behalf of the UK Haemophilia Centre Doctors' Organisation).*

#### AIDS and HIV current totals

By the end of December 2001, 48,226 HIV infected individuals had been reported in the United Kingdom (UK) (1). AIDS but not death had been reported in 6047 (13%), and death with or without AIDS in 14,550 (30%). Surveillance of prevalent diagnosed HIV infections recorded 21,717 individuals with diagnosed HIV infection seen for care in the UK during 2000 (2).

#### Ethnicity and HIV infection diagnosed in the United Kingdom

Information on ethnicity has been requested on the AIDS reporting forms, which are completed by clinicians, since the start of surveillance in the early 1980s. The reporting of diagnoses of HIV infection from microbiology laboratories began in the mid-1980s when tests for HIV antibody were developed. Information on ethnicity was first requested on this report form in 1993 when the ethnic categorisation was aligned with that used in the 1991 UK national census (3). The proportion of new HIV diagnoses where ethnicity was reported has increased from 44% (1150/2636) in 1995 to 85% (3094/3654) in 2000 (table 1). For 2001 the proportion of new diagnoses for which ethnicity is recorded is 76%, but this is likely to rise as a result of follow-up for likely route of infection. The data reflect increasing diagnoses of infections acquired through sex between men and women, the majority of which have probably been acquired in Africa (4). Among those for whom ethnicity is recorded, the proportion of black-Africans has risen from 25% in 1995 to 51% in 2001. Over the same period the proportion recorded as of white ethnicity has declined from 67% to 40%.

**Table 1 HIV infected individuals\* by ethnicity and year of first diagnosis in the UK: data to the end of 2001**

Ethnic group	Year of diagnosis**						
	1995	1996	1997	1998	1999	2000	2001
White	775	1024	1127	1155	1133	1431	1009
Black-African	282	369	542	685	880	1318	1302
Black-Caribbean	31	41	68	77	100	112	109
Black-other	8	20	21	20	34	34	18
I/P/B	18	25	39	41	41	66	29
Other#/mixed	36	49	69	100	97	133	84
Subtotal	1150	1528	1866	2078	2285	3094	2551
Not known	1486	1155	855	712	729	560	791
<b>Total</b>	<b>2636</b>	<b>2683</b>	<b>2721</b>	<b>2790</b>	<b>3014</b>	<b>3654</b>	<b>3342</b>

\* individuals with laboratory reports or clinician reports of infection plus those with AIDS or death for whom no matching laboratory report has been received

\*\* numbers, particularly for recent years, will increase as further reports are received

# includes Chinese and south east Asian

## Ethnicity of prevalent diagnosed HIV infections

The annual survey of prevalent HIV infections diagnosed (SOPHID) records the ethnicity of patients seen for HIV-related care in England, Wales, and Northern Ireland during the preceding year. In 2000, the latest year for which data are available, the survey recorded 21,717 individuals seen for HIV-related care (table 2). Information on ethnicity was available for 20,111 (93%) individuals, 65% of whom were white, 24% black African, 4% other or mixed, 3% black Caribbean, 1% Indian/Pakistani/Bangladeshi, 2% black other, and 1% other Asian.

**Table 2 Individuals seen for HIV-related care in 2000 by ethnicity and region of residence when last seen\***

NHS executive region of residence	Ethnic Group							Total
	White	Black-Carib.	Black-African	Black-Other/unspec.	Indian/Pakistani/Banglad.	Other/mixed#	Not known	
Northern & Yorkshire	606	4	68	8	9	18	14	<b>727</b>
Trent	527	6	81	6	39	23	10	<b>692</b>
West Midlands	605	37	119	8	16	16	10	<b>811</b>
North West	1350	11	99	7	31	36	30	<b>1564</b>
Eastern	559	19	174	9	7	22	24	<b>814</b>
London	6888	414	3931	261	166	757	884	<b>13301</b>
South East	1200	21	328	12	22	55	502	<b>2140</b>
South West	675	9	63	1	2	38	15	<b>803</b>
England total**	12410	521	4865	312	292	965	1490	<b>20855</b>
Wales	296	3	13	–	2	16	2	<b>332</b>
Northern Ireland	97	–	5	–	–	2	–	<b>104</b>
<b>Total</b>	<b>12803</b>	<b>524</b>	<b>4883</b>	<b>312</b>	<b>294</b>	<b>983</b>	<b>1492</b>	<b>21291</b>
Other/abroad	38	1	12	2	3	6	5	<b>67</b>
Not known	144	7	74	6	3	16	109	<b>359</b>
<b>Overall total</b>	<b>12985</b>	<b>532</b>	<b>4969</b>	<b>320</b>	<b>300</b>	<b>1005</b>	<b>1606</b>	<b>21717</b>

Banglad: Bangladeshi; Carib.: Caribbean; Unspec: Unspecified.

\*patients seen for statutory medical HIV-related care at services in England, Wales and Northern Ireland in 2000 (includes 288 children born to HIV infected mothers in 2000 whose HIV infection status had not been confirmed: 223 resident in London, 24 in South East, nine in West Midlands, eight Northern & Yorkshire, seven in Trent, six in South West, five in Eastern, four in North West, and two where region was not reported).

\*\*includes three patients whose region of residence not known.

#Includes 167 of other Asian/Oriental ethnicity.

## Ethnicity and region of residence of prevalent diagnosed infection

Sixty-two per cent (13,301/21,291) of UK residents seen for treatment and care in 2000 (SOPHID survey) were reported to live in the London region,. Eighty-eight per cent (3991/4883) of those recorded as being of black African ethnicity are resident in the London region. Of the patients seen for treatment and care in the London region, for those whom ethnicity was recorded, 55% (6888/12417) were white, 32% (3931) black African, 5% (648) other or mixed, 3% (414) black Caribbean, 2% black other (228), and 1% (166) Indian/Pakistani/Bangladeshi. For regions other than London, South East, and Eastern, 80% (5915/7382) of patients of known ethnicity were reported to be white and 13% (952) black African.

## Ethnicity and route of HIV infection

Of the 10,411 individuals seen for HIV-related care in 2000 who probably acquired HIV infection through sex between men and for whom ethnicity was recorded, 9325 (90%) were white, 541 (5%) other or mixed, 202 (2%) black Caribbean, and 137 (1%) black African (table 3). Among the 6552 categorised as infected through sex between men and women for whom ethnicity was recorded, 3881 (59%) were of black African ethnicity, 1867 (28%) white, 241 (4%) black Caribbean, 241 (4%) other or mixed, and 175 (3%) Indian/Pakistani/Bangladeshi. Ethnicity in this group was not recorded for 210 individuals. Of those exposed to HIV by routes other than sexual contact for whom ethnicity was recorded, 90% of those categorised as infected through injecting drug user were white, as were 84% of those infected through blood or blood products. Of the children of recorded ethnicity born to HIV infected mothers, 71% were black African.

**Table 3 Individuals seen for HIV-related care in 2000 by ethnicity and exposure category in England, Wales, and Northern Ireland\***

Exposure	Ethnic Group							Total
	White	Black Carib.	Black African	Black other	IPB**	Other#/Mixed	Not Known	
Sex between men	9325	202	137	137	69	541	969	<b>11380</b>
Sex between men and women	1867	241	3881	147	175	241	210	<b>6762</b>
Injecting drug use	749	4	16	0	6	61	36	<b>872</b>
Blood/blood products	365	7	34	2	14	14	27	<b>463</b>
Mother to infant	87	13	493	3	8	86	133	<b>823</b>
Not known	592	65	408	31	28	62	231	<b>1417</b>
<b>Total</b>	<b>12985</b>	<b>532</b>	<b>4969</b>	<b>320</b>	<b>300</b>	<b>1005</b>	<b>1606</b>	<b>21717</b>

Carib: Caribbean

\* patients seen for statutory medical HIV-related care at services in England, Wales and Northern Ireland in 2000 (includes 288 children born to HIV infected mothers in 2000 whose HIV infection status had not been confirmed: 223 resident in London, 24 in South East, nine in West Midlands, eight Northern & Yorkshire, seven in Trent, six in South West, five in Eastern, four in North West, and two where region was not reported).

\*\* Indian/Pakistani/Bangladeshi

# includes Chinese and south east Asian

## References:

1. PHLS Communicable Disease Surveillance Centre. *Unpublished quarterly surveillance tables No 53, 01/4 Table 1.*
2. PHLS. AIDS and HIV infection in the United Kingdom: monthly report. *Commun Dis Rep CDR Wkly* [serial online] 2002; **12** (5): HIV archive. Available from <[www.phls.co.uk/publications/CDR%20Weekly/hivarchive.html](http://www.phls.co.uk/publications/CDR%20Weekly/hivarchive.html)>.
3. Office of Population Censuses and Surveys and General Register Office for Scotland. *1991 census, ethnic group and country of birth.* London: HMSO, 1993.
4. CDSC. AIDS and HIV infection in the United Kingdom: monthly report. *Commun Dis Rep CDR Wkly* [serial online] 2001; **11** (4): HIV archive. Available from <[www.phls.co.uk/publications/CDR%20Weekly/hivarchive.html](http://www.phls.co.uk/publications/CDR%20Weekly/hivarchive.html)>.

[Back to top](#)



NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOOSES

TRAVEL HEALTH New

DIARY

BACK ISSUES

SEARCH

## Diary

Last updated: 28 February 2002

Next update due: 7 March 2002

### INoPSU open session

The International Network of Paediatric Surveillance Units (INoPSU) will be holding an open session as part of their second international conference. The session will take place on the morning of Monday 15 April from 10:00 to 13:00 at York University, and will precede the first plenary session of the RCPCH scientific meeting. Discussion subjects will include: *Haemophilus influenzae* b vaccination strategies; MMR vaccination; mother-to-child transmission of HIV worldwide; inflammatory bowel disease; cerebral oedema and diabetic ketoacidosis; vCJD in UK children – implications for the world; European Organisation for Rare Diseases – a parental support perspective. The INoPSU session is CPD accredited and attendance costs £62 (college members), £77 (others), and £44 (non-medics) but will be free for those registering for the plenary session. Further information on this session is available from <[www.rcpch.ac.uk/visitors/Spring\\_Meeting/spring\\_meeting.htm](http://www.rcpch.ac.uk/visitors/Spring_Meeting/spring_meeting.htm)>. For other information and details on registration contact the RCPCH academic department at [amanda.Leighton@rcpch.ac.uk](mailto:amanda.Leighton@rcpch.ac.uk) or visit the College website on <<http://www.rcpch.ac.uk>>.