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Two recent cases of severe tetanus

Two cases of severe tetanus in women aged 61 years with histories of incomplete vaccination were notified in April, the first cases reported so far this year.

The first case from West Yorkshire developed symptoms eight days after sustaining a head injury from a fall down stairs. Neither tetanus toxoid nor immunoglobulin was given at the time of her injury, which required stitches. She was admitted to intensive care four days later with respiratory and cardiac arrest, and severe trismus, and died two and a half weeks later. Only one dose of tetanus toxoid given eight years ago was shown in her medical records.

The second case from Suffolk presented to her general practitioner (GP) with classical symptoms of jaw stiffness and facial spasms. Three days prior to this she suffered a deep scratch on her forearm while gardening. The patient reported that she had suffered a mild episode of tetanus as a teenager, over 40 years ago, and her symptoms with this episode were so similar that she had correctly self-diagnosed tetanus before seeing her GP. Following admission to intensive care she had protracted muscular spasms and autonomic symptoms, and required repeated intravenous infusions of tetanus immunoglobulin. Tetanus antitoxin levels were tested in an admission blood sample at the PHLS Respiratory and Systemic Infection Laboratory, and were below protective levels. Cultures of swabs taken from the wound grew *Clostridium tetani* were confirmed by the Anaerobe Reference Unit in Cardiff.

Following the first infection the patient had received one vaccination in the mid-1970s, but had a mild adverse reaction to the vaccination and so had not received further doses. The patient is now improving and, as the only contraindication to vaccination against tetanus is anaphylaxis, has been started on a primary course of vaccination.

Immunity does not necessarily develop following tetanus disease and so the only protection against future infections is by vaccination. Patients who have had tetanus should be vaccinated when they have recovered sufficiently.

Herd immunity plays no part in tetanus control. High vaccination coverage in the childhood vaccination programme and opportunistic vaccination of those with histories of incomplete vaccination are required to ensure high levels of immunity in the whole population (1). Opportunistic vaccination should include groups such as those born before vaccination programmes were implemented and new arrivals with uncertain or incomplete vaccination histories. Tetanus vaccination coverage in most European Union member states including the UK, is good. Five doses of tetanus toxoid-containing vaccine are thought to give life-long protection – routine ten-yearly boosters are no longer recommended in the UK. Prompt and appropriate post-exposure prophylaxis is an important control measure. Doctors working in accident and emergency medicine need to maintain systems for providing post-exposure prophylaxis for tetanus and should preferably provide a vaccine that also includes an appropriate dose of diphtheria toxoid. Attendance at accident and emergency offers a good opportunity to check vaccination status: liaison with GPs will be required to ensure the completion of a vaccination course in unvaccinated individuals. This should be a good topic for audit of local practice.

Since 1930, most tetanus cases in the UK have occurred in older people, mainly women, who had never been vaccinated (2-4). Between two and seven tetanus cases per year occur in England and Wales. Family doctors should ensure that all their patients are fully vaccinated, targeting those born before 1961.

1. Department of Health. *Immunisation against infectious disease*. London: HMSO, 1996.

2. PHLS CDSC. Tetanus surveillance: England and Wales, 1981-3. *BMJ* 1985; **290**: 696-7.

3. Galbraith NS, Forbes P, Tillett H. National surveillance of tetanus in England and Wales 1930-79. *J Infect* 1981; **3**: 181-91.

4. CDSC. Tetanus surveillance in England and Wales. *Commun Dis Rep CDR Wkly* 1982; (07): 3-5.

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Erratum: Monitoring of antenatal screening for HIV in the United Kingdom

(*Commun Dis Rep CDR Wkly* 2002; **12**(17): news <[view article](#)>)

The last sentence of this item states that 'Systems for monitoring the offer and uptake of antenatal testing for HIV and other infections have been developed in the London, and Northern and Yorkshire region'. Such systems have also been developed in Eastern region.

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Respiratory

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Respiratory tract infections, England and Wales: laboratory reports, weeks 14-17/02

	Number of reports received				Total reports
	14/02	15/02	16/02	17/02	14-17/02
Adenovirus (excluding EM faeces)	35	30	21	28	114
Coronavirus	–	–	–	–	–
Influenza A*	12	42	39	15	108
Influenza B*	2	2	1	7	12
Parainfluenza	13	2	2	7	24
RS virus	112	65	86	48	311
Rhinovirus	3	5	–	1	9
Chlamydia sp	5	14	7	7	33
Coxiella burnetti	–	–	–	–	–
Legionella sp	4	1	2	4	11
Mycoplasma pneumoniae	8	25	25	27	85

*Reports include cases diagnosed by culture, immunofluorescence and serology (including single high titre).

Adenovirus (excluding types 40, 41, group F, EM faeces): 114 cases were reported. Fifty-six patients had eye infections.

Coronavirus: no cases were reported

Influenza A: 108 cases were reported. M 86y had Guillain-Barre Syndrome. South East region reported 40 cases, Trent 21, Northern and Yorkshire and South West 12 each, Eastern nine, Wales six, West Midlands five, London two, and North West one case. Twenty-six per cent of cases were aged less than 15 years.

Influenza B: 12 cases were reported. Northern and Yorkshire region reported four cases, North West and South East three three each, and Trent and Eastern one case each. Seventeen per cent of cases were aged less than 15 years.

Parainfluenza (type 1,1; type 2,0; type 3,12; type 4,1; untyped 10). Twenty four cases were reported. London region reported 13 cases, Northern and Yorkshire six, North West three, and Trent two cases. Fifty per cent of cases were aged less than 1 year.

Respiratory syncytial virus: 311 cases were reported. Eight patients had bronchiolitis. M 1m had hospital-acquired infection. London region reported 66 cases, Northern and Yorkshire 63, Trent 57, South East 46, West Midlands 24, Wales 23, Eastern 14, South West 13 and North West five cases. Seventy-

seven per cent of cases were aged less than 1 year.

Rhinovirus: nine cases were reported. South East region reported five cases, Trent three, and North West one case.

Respiratory Chlamydia (*C. psittaci*, 4; *C. pneumoniae*, 6; *Chlamydia* sp, 23): 33 cases were reported. Two patients had pneumonia.

***Coxiella burnetii*:** No cases were reported.

Legionella: 11 cases were reported with pneumonia. Nine were males aged 35 to 59 years and two were female aged 60 to 65 years. There were no deaths. Six cases were associated with travel: Spain (1), Cyprus (2), France (1), England (2). The two cases who travelled to Cyprus were associated with a cluster. One of the cases who travelled in England is associated with a cluster in the northern region. Four cases, males aged 35, 47, 49 and 59 years had community acquired infection, two of which were associated with an outbreak in Ireland. One case, in a female, had possible nosocomial infection.

***Mycoplasma pneumoniae*:** 85 cases were reported. Eleven patients had pneumonia. F 45y had contact with birds. Northern and Yorkshire region reported 22 cases, South West 13, Wales 11, North West 10, Eastern nine, South East eight, West Midlands five, Trent four, and London three cases. Forty-two per cent of cases were aged less than 15 years.

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Common animal associated infections, England and Wales: laboratory reports, weeks 14-17/2002

Organism	Total reports for weeks 14-17/02		Cumulative totals for weeks 01-17	
	2002*	2001	2002*	2001
<i>Borrelia burgdorferi</i> **#	–	2	3	25
<i>Leptospira hardjo</i> **##+	–	–	–	–
<i>Leptospira icterohaemorrhagiae</i> **##+	1	–	2	4
<i>Leptospira other</i> **##+	1	1	4	3
<i>Pasteurella haemolytica</i>	–	–	1	1
<i>Pasteurella multocida</i>	3	26	44	93
<i>Pasteurella pneumotropica</i>	–	–	–	2
<i>Pasteurella spp</i>	2	7	11	18
<i>Toxocara canis</i>	–	–	–	–
<i>Toxocara cati</i>	–	–	–	–
<i>Toxocara spp</i>	–	–	–	–
<i>Toxoplasma gondii</i>	2	2	11	7
<i>Toxoplasma spp</i>	4	6	13	25

* provisional data; ** by specimen date; # Lyme Disease Reference Laboratory and CDSC; ## Leptospira Reference Laboratory and CDSC; +Corrected data. Provisional data was previously published.

Common imported infections, England and Wales: laboratory reports, weeks 14-17/02

Organism	Total reports for weeks 14-17/02		Cumulative totals for weeks 01-17	
	2002*	2001	2002*	2001
Arbovirus	–	–	–	–
Dengue virus	–	–	1	–
<i>Ascaris</i> spp	16	4	40	35
Hookworm (unspecified)	51	–	102	8
<i>Ancylostoma duodenale</i>	–	–	–	–
<i>Necator americanus</i>	–	–	–	–
<i>Leptospira</i> spp	–	1	–	2
<i>Hymenolepis diminuta</i>	–	–	–	–
<i>Hymenolepis nana</i>	4	1	11	6
<i>Hymenolepis</i> spp	–	–	–	–
<i>Schistosoma haematobium</i>	5	3	19	16
<i>Schistosoma intercalatum</i>	–	–	–	–
<i>Schistosoma mansoni</i>	5	–	13	8
<i>Schistosoma</i> spp	–	2	6	7
<i>Strongyloides stercoralis</i>	2	4	8	16
<i>Strongyloides</i> spp	–	1	–	1

* provisional data



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Travel health

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Deaths from malaria in travellers

In the last decade 100 people of all ages have died in the United Kingdom (UK) from malaria contracted in malarious areas. Only one of these people was taking full doses of what would currently be considered an adequate antimalarial, nine were taking antimalarials that would no longer be recommended as providing adequate protection, eight were taking prophylactic regimens which would never have been recommended as adequate, and the vast majority were taking no chemoprophylaxis at all. Of the nine most recent deaths from malaria in the UK during 2001, eight were taking no prophylaxis and one had discontinued prophylaxis early.

Among the last 100 fatal cases of malaria in the UK for whom the country of infection is known, 94 were contracted in Africa and six in the countries of South Asia. Four African countries accounted for 67% of all the fatal cases (Kenya 25%, Nigeria 17%, the Gambia 14% and Ghana 11%). Of the six cases contracted in south Asia, four were contracted in India and one each in Pakistan and Sri Lanka. The majority of deaths occur in people on holiday or business visits, but deaths also occur in those of African descent now resident in Britain and who may be returning to Africa to see friends and relations.

There are now suitable prophylactic regimens for travellers in good health going to any malarious places (see the UK current malaria guidelines at <www.phls.org.uk/advice/index> or in <www.malaria-reference.co.uk>). In particular there are three possible chemoprophylactic agents for areas with highly chloroquine-resistant falciparum malaria: mefloquine, doxycycline, or atovaquone/proguanil (Malarone). Usually one of these regimens will be suitable also for those with pre-existing illnesses or who are on medication for such conditions.

Statistics on imported malaria for the year 2001

The annual malaria statistics for 2001 show a close similarity to those for the preceding year, with 1576 cases of the potentially lethal falciparum malaria – identical to that for 2000 – and a continuing fall in non-falciparum cases and mixed infections from 493 in 2000 to 474 in 2001. The case fatality rate for falciparum malaria (using provisional figures as there remain some queries about two cases) was back to 0.63%, following two years when it was around 1%.

Table 1 Imported malaria cases by geographic area, United Kingdom: 2001

Geographic Area	Pf	Pv	Pm	Po	Pf/Pv	Pf/Pm	Pf/Po	Pm/Po	P?	Total	2000 Total
North Africa	-	-	-	-	-	-	-	-	-	-	3
Central Africa	52	1	2	8	-	-	-	-	-	63	47
East Africa	168	28	7	25	-	1	1	1	-	231	246
Southern Africa	93	6	5	16	-	3	1	-	-	124	139
West Africa	922	5	18	67	1	1	3	-	-	1017	971
Africa - unspec	34	5	1	8	-	-	-	-	-	48	45
Middle East	3	1	-	-	-	-	-	-	1	5	2
Asia	14	147	-	2	1	-	-	-	-	164	181
Asia -unspec	-	-	-	-	-	-	-	-	-	-	3
Far East/SE Asia	6	17	-	1	2	-	-	-	-	26	30
Far East - unspec	-	1	-	-	-	-	-	-	-	1	4
Central/ S America	1	8	-	-	-	-	-	-	-	9	11
Oceania	1	10	-	-	-	-	-	-	-	11	22
Not given	282	34	4	30	-	-	1	-	-	351	365
Total	1576	263	37	157	4	5	6	1	1	2050	2069

*Data from Malaria Reference Laboratory and London School of Hygiene & Tropical Medicine

Pf: *Plasmodium falciparum*; Pv: *Plasmodium vivax*; Pm: *Plasmodium malariae*; Po: *Plasmodium ovali*; P?: Type not known.

Table 2 Imported malaria cases in the United Kingdom by age and stated nationality, United Kingdom: 2001

Age	British	Indian descent	African descent	African	Indian subcon	Middle East	Rest of World	Not stated	Total	2000 Total
<5	1	4	40	9	1	-	-	24	79	76
5-9	7	7	44	25	1	-	-	20	104	88
10-14	6	1	34	30	4	-	-	20	95	109
15-19	22	4	25	32	12	-	3	31	129	139
20-24	44	11	20	44	14	-	6	52	191	214
25-34	92	16	103	133	33	1	18	136	532	528
35-44	63	5	119	126	10	1	6	115	445	417
45-54	33	15	55	73	5	-	-	53	234	269
55-64	30	6	29	32	2	-	4	36	139	157
65-74	12	6	13	11	9	-	-	8	59	38
75-84	4	2	1	1	3	-	-	4	15	11
≥85	1	-	-	-	-	-	-	-	1	2
Not known	-	-	5	2	-	-	1	19	27	21
Total	315	77	488	518	94	2	38	518	2050	1981

*Data from Malaria Reference Laboratory and London School of Hygiene & Tropical Medicine

Table 3 Imported malaria cases by population group and species, United Kingdom: 2001

Population group	Pf	Pv	Pm	Po	Pf/Pv	Pf/Pm	Pf/Po	Pm/Po	P?	Total	2000 Total
New entrant	72	45	1	11	–	–	–	–	–	129	109
Visiting family in country of origin	527	69	12	31	–	1	2	–	–	642	524
UK citizen living abroad	24	7	1	5	–	–	–	–	–	37	49
Civilian sea/air crew	–	–	–	–	–	–	–	–	–	–	4
British armed services	16	7	1	10	–	–	–	–	–	34	76
Business/professional travel	66	13	3	12	–	–	1	–	1	96	116
Foreign student studying in the UK	27	4	–	2	–	–	–	–	–	33	35
Holiday travel	145	36	4	18	2	3	1	–	–	209	275
Foreign visitor ill while in UK	87	12	2	8	–	–	–	–	–	109	101
Children visiting parents living abroad	3	1	–	1	–	–	–	–	–	5	3
Not stated	609	69	13	59	2	1	2	1	–	756	777
Total	1576	263	37	157	4	5	6	1	1	2050	2069

*Data from Malaria Reference Laboratory and London School of Hygiene & Tropical Medicine

Pf: *Plasmodium falciparum*; Pv: *Plasmodium vivax*; Pm: *Plasmodium malariae*; Po: *Plasmodium ovalis*; P?: Type not known.

Table 4 Stated time interval between return to the UK and diagnosis of malaria: 2001

Interval	Pf	Pv	Pm	Po	Pf/Pv	Pf/Pm	Pf/Po	Pm/Po	P?	Total	2000 Totals
<1 month	825	57	10	19	1	2	4	–	–	918	873
1-5 months	85	64	10	48	–	1	–	–	1	209	211
6-11 months	5	37	–	23	–	1	–	–	–	66	60
≥1 year	–	13	–	6	–	–	–	–	–	19	25
Not stated	661	92	17	61	3	1	2	1	–	838	900
Total	1576	263	37	157	4	5	6	1	1	2050	2069

*Data from Malaria Reference Laboratory and London School of Hygiene & Tropical Medicine

Pf: *Plasmodium falciparum*; Pv: *Plasmodium vivax*; Pm: *Plasmodium malariae*; Po: *Plasmodium ovalis*; P?: Type not known.

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

Annual conference on epidemiology and control of communicable diseases and environmental hazards (health protection)

The annual conference on the epidemiology and control of communicable diseases and environmental hazards (health protection) will be held at CDSC Colindale, London from Monday 4 November to Wednesday 6 November 2002. It is aimed primarily at consultants in communicable disease control, but will also interest medical microbiologists, public health scientists and environmental health and nursing professionals involved in health protection. This year the conference will celebrate the 25th anniversary of CDSC.

The conference will address important public health issues that have arisen in the past year and provide fresh perspectives on established areas of disease prevention and control. Short papers on recent outbreaks and surveillance initiatives will also be presented. Registration forms will be available at the end of June from Vivienne Fitch at PHLS/CDSC, 61 Colindale Avenue, London NW9 5EQ, tel 020 8200 6868 ext 4569, fax 020 8200 7868, email: vfitch@phls.org.uk. Detailed information on the conference programme will be available later this year.

Call for papers

Abstracts are invited for papers and posters on the following conference themes and should be submitted by 14 June 2002. Abstracts should include: a title, the family names, authors initials and institutional affiliations in brackets, as follows: eg, Jones, MJ (Wapping Health Authority), Rice, A (Royal Biggleswade Infirmary), and an abstract narrative not exceeding 300 words. Abstracts should be sent by email to vfitch@phls.org.uk no later than 31st May 2002.

- Immunisation: new vaccines/current controversies
- Health protection: new approaches after Getting Ahead of the Curve
- Assessing and communicating risks
- Surf and turf: food, water and animals
- Surveillance, control and prevention: expanding the evidence base
- Emerging hazards/emerging infections

Hospital Infection Society/PHLS Laboratory of Hospital Infection course on hospital infection control

There are a few places available on the next course on hospital infection control. This course is aimed at infection control doctors and nurses, and will be held at PHLS Colindale, from Monday 24 February 2003 to Friday 28 February. The course covers epidemiology, bacterial typing and antibiotic resistance, control and management of outbreaks and bloodborne viruses, hospital hygiene, ventilation, and other aspects of infection control, including policies and guidelines. The course is recognised for CPD points (Continuing Professional Development) and IS as a module for the diploma in hospital infection control offered by the Hospital Infection Society, PHLS and London School of Hygiene & Tropical Medicine. The fee is £450 (non-resident). For further information and an application form, please write to Greta Howell, Laboratory of Hospital Infection, PHLS Central Public Health Laboratory, 61 Colindale Avenue, London NW9 5HT, or email: ghowell@phls.org.uk.

Course on sterilisation, disinfection, and hospital hygiene

A few places are left on this course on sterilisation, disinfection and hospital hygiene aimed at infection control doctors and nurses being held at the Eastwood Park Training Centre in Falfield, (near Bristol), Gloucestershire, from Monday 21 October 2003 to Friday 25 October. The course 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 fee for this residential course is £950. For details regarding registration and further information about the course please write to Prof. Barry Cookson, Laboratory of Hospital Infection, PHLS Central Public Health Laboratory, 61 Colindale Avenue, London NW9 5HT, tel: 020 8200 4400 ext 4221, email: ghowell@phls.org.uk.

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