

Volume 12
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23 May 2002

CDR WEEKLY



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Illness in military personnel in Bagram, Afghanistan

Between the 13 and 19 May, there were 29 cases of vomiting, diarrhoea, and fever affecting British military personnel in Bagram, Afghanistan (1,2). The illness mainly affected staff in the field hospital. The illness had a short incubation period and three cases were classified as seriously ill with circulatory collapse (Glasgow coma score 4) (3). Due to the difficult conditions in Bagram, ten of the cases were brought back to the United Kingdom (UK) for medical care in NHS hospitals. Another case was flown to Germany to receive care at an American military hospital. All cases have recovered and have been discharged from hospital. There have been no further cases reported from Bagram, the field hospital has re-opened, and infection control procedures have been enhanced.

There were three secondary cases: two medical personnel on the special military flight who looked after the first case to be brought back to the UK, and a close contact of this case who had physical contact with him after he was admitted to hospital in the UK. Two of these cases were hospitalised, but all have made a good recovery and have been discharged. There were two other unconfirmed cases of infection in personnel who had unloaded the aeroplane used for repatriation. There were no other cases reported in health care workers or community contacts.

All basic microbiological testing in the Bagram field laboratory was negative. Testing of the samples from the cases carried out by the PHLS at the Central Public Health Laboratory, Colindale, found Norwalk-like virus (NLV). Three techniques were employed to look for viral causes of gastroenteritis. Examination of the faecal samples by electron microscopy revealed virus particles with a morphology characteristic of small round structured viruses, tests using an antigen capture enzyme-linked immunosorbent assay (ELISA) utilising a panel of monoclonal antibodies directed against the capsid protein of Norwalk-like virus were positive, and NLV RNA was detected from five patients by RT-PCR. Characterisation of the virus by partial DNA sequencing of a region of the polymerase gene indicated that the virus was related to Genogroup II viruses detected previously in the environment in the UK. It was therefore concluded that the cause of the outbreak was NLV.

1. PHLS. Illness in United Kingdom military personnel in Afghanistan. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 23 May 2002]; 12 (20): news. Available at www.phls.org.uk/publications/CDR%20Weekly/pages/news.html#afghan.

2. Ministry of Defence. Illness at Bagram airfield. *UK Defence Today* [website] 20 May 2002 [cited 23 May 2002]. Available at news.mod.uk/news_headline_story.asp?newsItem_id=1702.

3. Teasdale G, Jennet B. Assessment of coma and impaired consciousness: a practical scale. *Lancet* 1974, ii: 81-4

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New primary care section in *CDR Weekly*

From this issue, *CDR Weekly* will include a regularly updated primary care section using data from the Royal College of General Practitioners (RCGP). This will comprise data from the Weekly Returns Service run by the Birmingham Research Unit of the RCGP on 16 different conditions, which will be

updated weekly, and longer items on topics of special interest that will be published less frequently. The first longer item explains the workings of the Weekly Returns Service. The new primary care button links to the weekly data, and the smaller button to its right links to the longer items. Comments from readers on this, and all other sections, are welcomed, please forward them to nhough@phls.org.uk.

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Virus infections, England and Wales: laboratory reports, weeks 17-20/02

Laboratory reports	Number of reports received				Total reports 17-20/02	Cumulative total 2002
	17/02	18/02	19/02	20/02		
Coxsackie A	–	–	3	–	3	7
Coxsackie B	1	1	3	1	6	28
Cytomegalovirus	11	33	5	23	72	397
Echovirus	11	4	4	4	23	143
Parvovirus B19	30	64	17	37	148	421
Varicella zoster virus	14	14	5	8	41	223

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Invasive meningococcal infections, England and Wales: laboratory reports, weeks 09-12/02

	Method of diagnosis			Total reports 09-12/02	Cumulative total* 2002
	CSF and blood		Other sites		
	culture	non-culture**	culture		
Group A	–	–	–	–	–
Group B	63	64	12	139	540
Group C	8	5	–	13	68
Group W135	5	2	3	10	40
Group X	–	–	–	–	2
Group Y	1	–	–	1	7
Group Z	–	–	–	–	–
Group 29E	–	–	–	–	–
Ungroupable	–	–	–	–	1
Ungrouped	–	15	–	15	50
Total	77	86	15	178	708

Enhanced surveillance of meningococcal disease

Regional enhanced surveillance of meningococcal disease (ESMD) began on 1 January 1998 in five regions of England, and from the 1 January 1999 was extended to include all other English regions, Wales, and Northern Ireland. 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. Additionally, CCDCs are asked to report details of any clusters of meningococcal disease in educational establishments.

First quarter of 2002: weeks 01-13/2002

During the first quarter of 2002, ESMD identified 1040 cases of invasive meningococcal disease in the eight English regions, Wales, and Northern Ireland. This represents an increase of 19.7% on the total of 835 from the previous quarter. A similar number (1176) of cases were identified in the same period of 2001. The highest number of cases this quarter (168) was identified in Northern and Yorkshire region (table 1).

Table 1 Meningococcal Disease by region and country: weeks 1-13/2002

Region	B	C	Other	Infection not confirmed	Total
Eastern	32	1	2	20	55
London	34	5	4	69	112
North West	66	9	13	50	138
Northern & Yorkshire	84	6	16	62	168
Northern Ireland	25	3	–	11	39
South East	49	4	6	61	120
South West	51	11	8	32	102
Trent	61	4	8	53	126
Wales	44	5	8	26	83
West Midlands	37	4	9	47	97
Total	483	52	74	431	1040

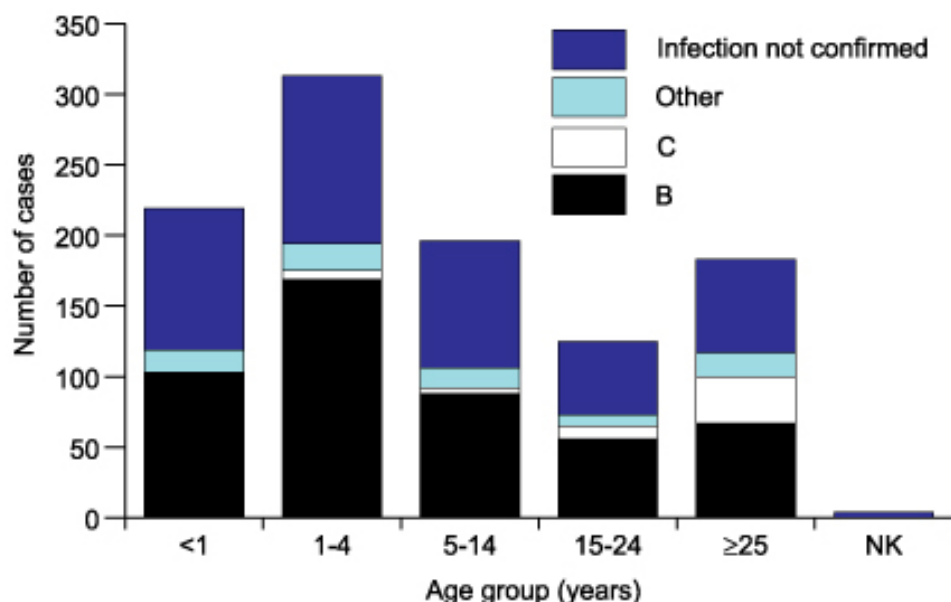
A clinical diagnosis of invasive meningococcal disease was reported for 949 cases identified in England and Wales. This is 56.6% more than the total number of cases (606) of meningitis and septicaemia in England and Wales officially notified to CDSC during the same period. An approximate overall fatality rate in those with a clinical diagnosis (in England, Wales, and Northern Ireland) was 3.9 per 100 cases of invasive disease. Case fatality rate for cases with septicaemia alone was slightly lower at 4.2 per 100 cases (table 2).

Table 2 Clinically diagnosed cases (deaths) of meningococcal disease: England, Wales and Northern Ireland, weeks 01-13/02

Region	Meningitis	Septicaemia	Meningitis & Septicaemia	Not meningitis or septicaemia	Total
Eastern	22 (1)	26 (1)	7	–	55 (2)
London	45 (2)	41 (4)	19 (1)	4	109 (7)
North West	34 (1)	67 (1)	9	–	110 (2)
Northern & Yorkshire	44 (1)	77 (3)	36	5	162 (4)
Northern Ireland	7 (1)	21 (2)	5	5	38 (3)
South East	37	54	27 (2)	1	119 (2)
South West	44 (3)	36 (3)	22	–	102 (6)
Trent	40 (1)	58 (4)	25 (1)	3	126 (6)
Wales	11 (2)	61 (2)	–	–	72 (4)
West Midlands	28 (1)	59 (1)	7	–	94 (2)
Total	312 (13)	500 (21)	157 (4)	18	987 (38)

Five hundred and eighty-one (58.0% of all cases in England and Wales identified in ESMD) were confirmed as *Neisseria meningitidis*, compared with 753 confirmed infections reported to PHLS Meningococcal Reference Unit (MRU). Serogroup B infection was confirmed in 79.3% (483/609) of confirmed cases identified in ESMD, serogroup C in 8.5% (52/609), and the remaining 12.2% included other serogroups and ungrouped cases. Half (51.4%) of all confirmed cases were in children under 5 years of age, among whom serogroup B accounted for 86.9% of infections and serogroup C accounted for 1.9% (figure).

Figure Serogroups on *N. meningitidis* identified in cases in England, Wales and Northern Ireland by age: week: 01-13, 2002



Compared to the equivalent quarter in 2001 an overall reduction in cases of B and C was observed in 2002: serogroup B decreased by 20.3% (483 cases compared to 606 in 2001) and serogroup C decreased by 52.7% (52 cases compared to 110 in 2001). The reduction in serogroup C disease is attributable 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 11 January 2001]; **11**(2): news. Available from <www.phls.co.uk/publications/CDR%20Weekly/archive/news0201.html>.

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Primary care - weekly returns

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Primary care report

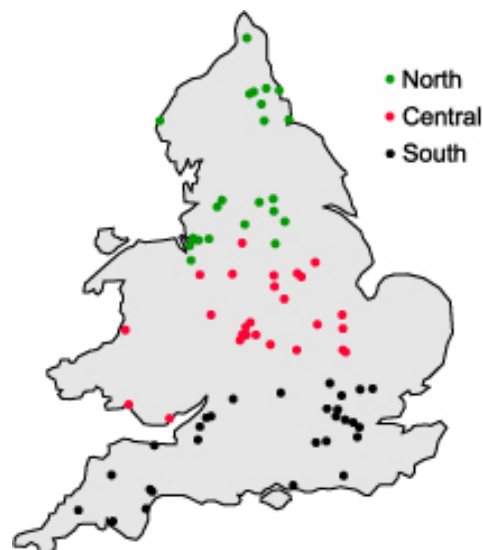
This page is the result of collaboration between Royal College of General Practitioners Birmingham Research Unit, which is responsible for the Weekly Returns Service (WRS) and the PHLS Communicable Disease Surveillance Centre.

The page includes graphs updated weekly and a quarterly report on a topic of special interest.



Conditions updated weekly

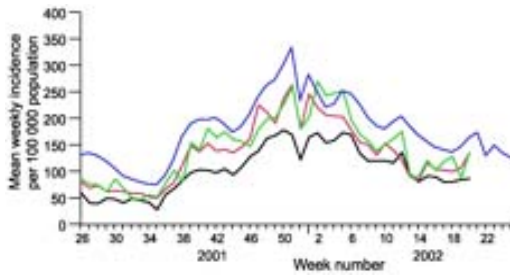
The graphs below show weekly incidence (per 100,000 population) for common illnesses in North, Central, and South RCGP-defined areas (figure) for week 26 of 2001 to the current week of 2002, compared with the seven-year average (1994-2000). For sexually transmitted and other genital infections, the current data are compared with the three-year average (1998-2000).



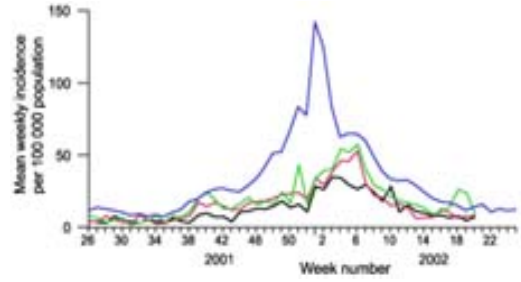
The total population covered by the RCGP WRS is approx 600,000, with 200,000 per area. A rate of 40/100,000 is therefore equivalent to 80 episodes per area. For further details or tabular data please contact the RCGP WRS at the address below.

Click on a graph to open a larger version in a new window. Use ctrl+p if you wish to print a specific graph.

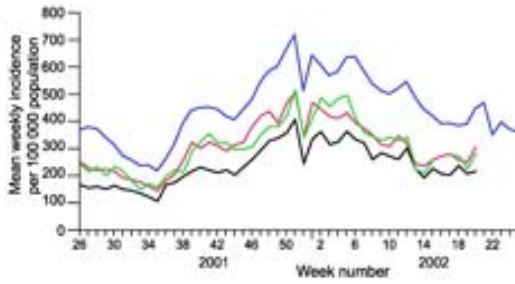
Common cold



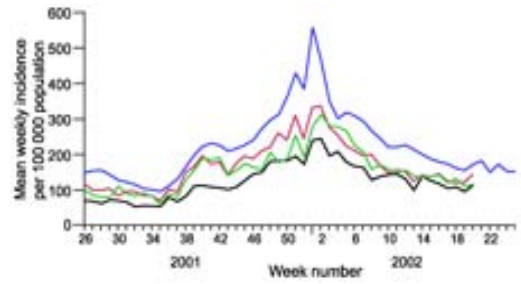
Influenza/influenza-like illness



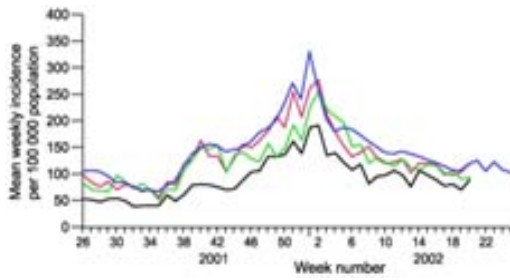
Upper respiratory tract infection



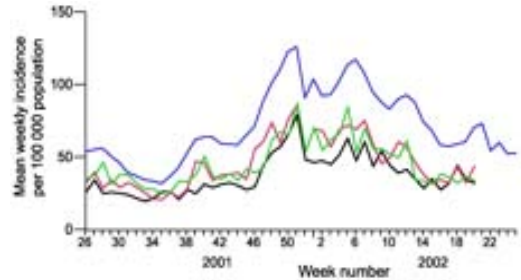
Lower respiratory tract infection



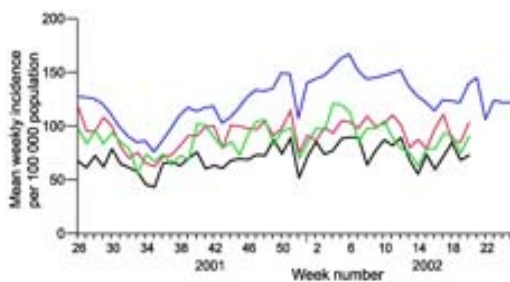
Acute bronchitis



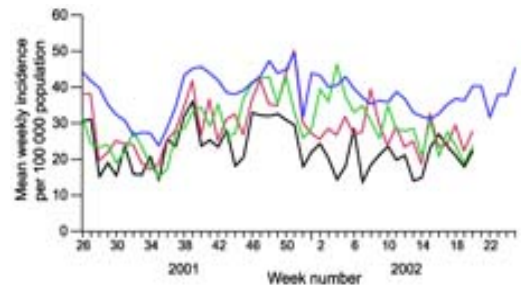
Acute otitis media



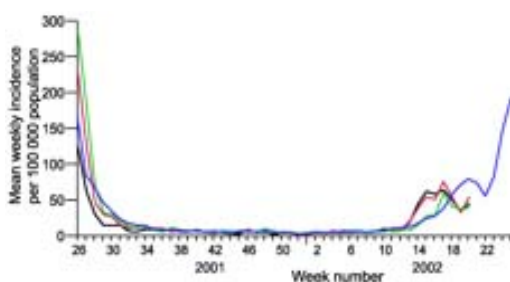
Tonsillitis/sore throat (acute)



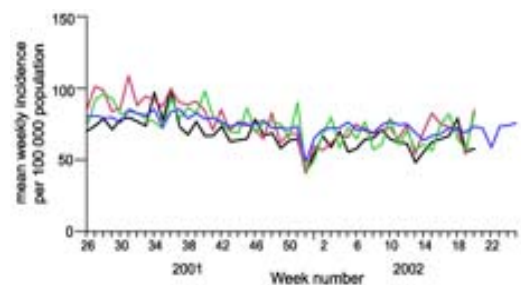
Asthma



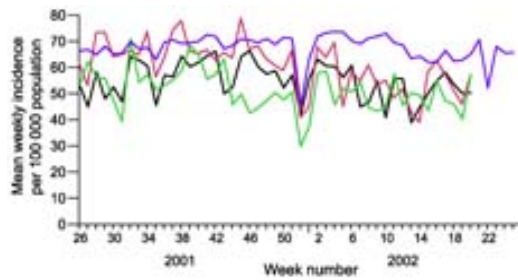
Hayfever/allergic rhinitis



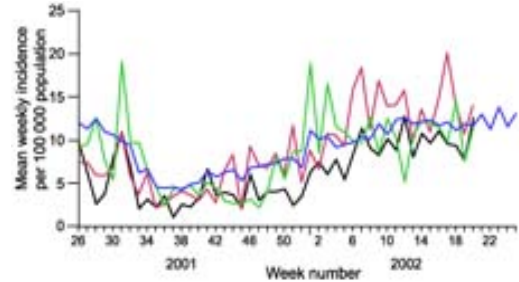
Skin/subcutaneous tissue infections



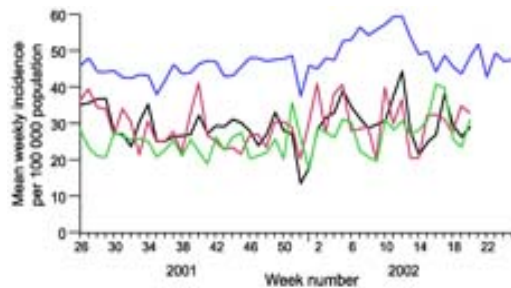
Urinary tract infection/cystitis



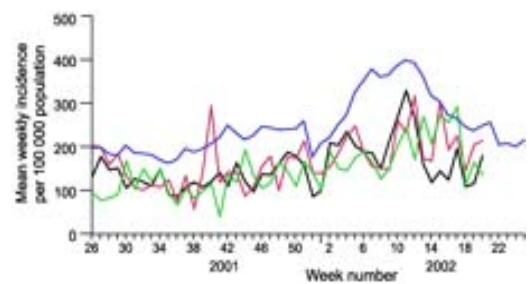
Chickenpox



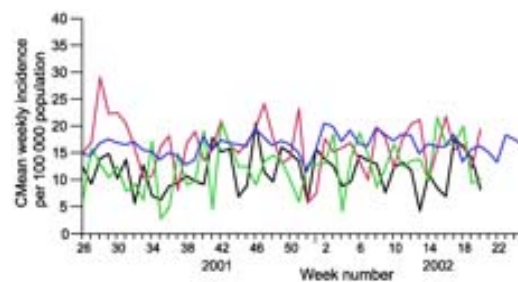
Infectious intestinal disease



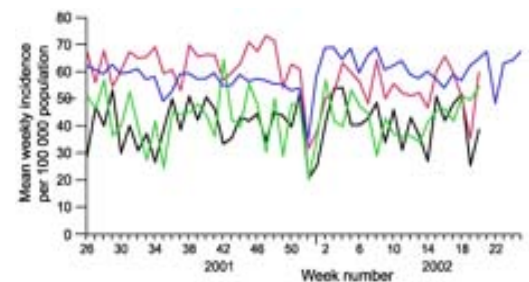
Infectious intestinal disease: 0-4 years



STI and other genital infections - males



STI and other genital infections - females



Key

- North region
- Central region
- South region
- seven year average

Definitions

Upper respiratory tract infections: common cold, otitis media, sinusitis, tonsillitis

Lower respiratory tract infections: acute laryngitis/tracheitis, acute bronchitis, influenza, pleurisy, pneumonia

Sexually transmitted and other genital infections: syphilis, gonococcal infections, other venereal disease, pelvic inflammatory disease, trichomoniasis, genital herpes, anogenital warts, urogenital candidiasis, pediculosis pubis, yaws, urethritis, orchitis and epididymitis, prostatic inflammatory disease, vaginal discharge not specified. (NB chlamydia is included under site of infection).

Any enquires regarding this page, data from primary care, or tabular data should be addressed to:

Douglas Fleming – RCGP WRS Director
tel: 0121 426 1125; email: dfleming@rcgpbhamresunit.nhs.uk

Rachel Chapman – Primary Care Scientist (joint RCGP/CDSC position)
tel: 0121 426 1125; email: rchapman@rcgpbhamresunit.nhs.uk

Gillian Smith – Regional Epidemiologist CDSC West Midlands
tel: 0121 773 7077; email: GESmith@phls.org.uk

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The Royal College of General Practitioners' Weekly Returns Service



Many illnesses, including several infections of importance to public health, (eg most enteric and respiratory infections) are treated almost exclusively in primary care. Microbiological investigation is undertaken rarely for most disorders so cannot give any real indication of the burden of illness from infection. Information about disease incidence in the community is therefore vital.

The aim of this first report on the Primary Care page is to briefly describe the Weekly Returns Service (WRS) of the Royal College of General Practitioners (RCGP) and give an indication of the type of data that are available.

How the Weekly Returns Service works

GPs in 'spotter' practices in England and Wales (currently 78 practices) send data on diagnoses and episode types for a defined population (currently about 650,000) to the Birmingham Research Unit (BRU). Data are extracted and analysed to provide age- and sex-specific weekly incidence of episodes of diseases. Data extracts are taken from the practices each Tuesday night and procedures exist to follow up missing data. Practice computer systems provide tabular data on numbers of patients consulting with diagnostic Read codes and information about the practice population, by age group and sex. Read codes are mapped to the International Classification of Disease (ICD) 9th revision for analysis (1). A preliminary analysis of data covering the seven days ending on the previous Sunday is usually available early on Wednesday afternoon. Data are thus reported in the week after the patient first consulted, the intention is to provide information at the earliest possible opportunity. A second weekly transmission also takes place for the week Thursday to Wednesday with data available on a Friday afternoon, this is currently only used for respiratory infection surveillance.

Recording procedures

General practitioners are required to summarise the content of each consultation in terms of the working diagnosis and its episode type. Working diagnoses are not always correct and whilst we have made recommendations to recorders on the amendment of incorrect information, our systems for data capture do not allow for corrections because these are usually not made within the recording week. In practical terms, errors are usually infrequent but regardless of the risk of error, it is worth remembering that the use of health care resources is primarily dependent on the general practitioners' assessment or working diagnosis even if it is incorrect.

In addition to the diagnosis, the consultation or episode type is also recorded. Three episode types are used:

- F = the first consultation for a **first time ever** occurrence of a diagnosis.
- N = the first consultation for a **new occurrence** of a previous diagnosis (regardless of when the first occurrence happened).
- O = **other consultations**, which includes all follow-up consultations.

Generally speaking the 'O' consultation/episode type is easy to apply. There are some difficulties with episode type 'F'. For very common conditions in adults it can be difficult to say whether a diagnosis is truly a first ever. For practical purposes it is essential to record the 'F' episode type correctly for major and serious illness. For simple and common conditions like upper respiratory tract infections, it is

reasonable to assume the episode type as 'N'; except in very young babies where clearly there is a first one. We routinely report the combined numbers of first and new episodes of disease indicating the incidence of new episodes.

Available data

The WRS has been operating since 1967, so in addition to current disease incidence reporting it has a huge historical database. The data collected by the WRS have increased dramatically since 1967 and are available as summarised in the following table:

Table Summary of the type and availability of data collected by the WRS since 1967

Year	Diseases	Age (years)/sex	Current status
1967-1971	Common infections including respiratory and intestinal	0-4, 5-14, 15-44, 45-64, ≥65, males and females combined	Paper records
1972-1975	As above	As above	Currently being computerised
1976-1993	As above plus additional diseases eg asthma, duodenal ulcer	As above	Currently being computerised
1994-1998	A. Some practices became fully automated and reported all diagnoses B. Remaining practices continued as 1976-1993 but gradually migrated to full automation	A. <1, 1-4, 5-14, 15-24, 25-44, 45-64, 65-74, ≥75, males and females separately B. As 1976-1993	A. Fully computerised B. Fully computerised
	These data can be combined or reported separately depending on age/sex breakdown required.		
1999-date	All diagnoses	<1, 1-4, 5-14, 15-24, 25-44, 45-64, 65-74, ≥75, males and females separately	Fully computerised

The data can be split into areas – we routinely examine respiratory infections in North, Central, and South regions of England and Wales.

How the data are used

The data have been used in a variety of ways. A few examples are:

1. Timely alert function eg twice weekly influenza rates published by CDSC
2. Historical data to identify trends and define epidemics
3. Monitoring interventions eg vaccination policies
4. Seasonality of diseases eg patterns of acute bronchitis in different age groups
5. Integration with other data sources eg microbiology, hospital admissions or deaths.

In addition to providing routine data the WRS is involved in various research projects and produces an annual report of weekly incidence data.

1. World Health Organization. *Manual of the International Classification of Diseases, Injuries and Causes of Death. Volume 1. 9th revision.* London: HMSO, 1977.

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Diary

Last updated: 23 May 2002



Safe dinking water in developing countries

A seminar will be held on 10 July 2002 at the Royal Institute of Public Health on world water and how the UK's contribution to provision of water supplies in developing countries might be maximised. Taking into account the difficulties of working in areas of economic instability and civil unrest, the programme will look at multi-agency partnership working and will consider how current models and strategies could be integrated. For further information fees and booking on please contact Geri Maylin, tel. 020 7291 8362, email: gmaylin@riph.org.uk, and for all other enquiries including exhibition space, contact Penny Moore, tel. 020 7291 8361, email: pmoore@riph.or.uk.



Are We Too Clean? A Question of Immunity Balance

The Royal Institute of Public Health will be holding a symposium entitled Are We Too Clean? A Question of Immunity Balance on the 9 September 2002. The idea that we could be too clean for our own good has received a great deal of attention in the media. But what do the scientists make of the issue, and how are health and hygiene professionals to respond? This programme will review the evidence in the debate: could being cleaner be one of the factors behind the steep rise in asthma, eczema and similar atopic conditions? Might it be counter-productive to improve the hygiene performance of cleaning products, and to educate the public in domestic hygiene? Or is the 'hygiene hypothesis' an idea which might encourage a dangerous laxity in hygiene, which could result in increased infection rates for food poisoning and the like?

This programme will provide an up-to-the minute assessment of the debate and suggest a balanced and pragmatic response.

For further information fees and booking on please contact Geri Maylin, tel. 020 7291 8362, email: gmaylin@riph.org.uk, and for all other enquiries including exhibition space, contact Penny Moore, tel. 020 7291 8361, email: pmoore@riph.org.uk.