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# CDR WEEKLY



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## News

**Last updated: 30 May 2002**  
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### Outbreak of Norwalk-like virus infection in a London hospital

An outbreak of Norwalk-like virus (NLV) infection has been reported from a district general hospital in north east London. Four cases were identified on 21 May and numbers of cases have since increased by approximately 10-15 new cases per day. Over 80 patients and 70 staff have been affected across 13 different wards, including a care of the elderly ward and an intensive treatment unit. Symptoms include mild-to-moderate diarrhoea and vomiting, lasting between 24 and 48 hours. NLV was identified by electron microscopy in three of the early cases.

An incident management team was established. The team reviewed infection control measures, closed affected wards to admissions and GP referrals, and subsequently the Accident and Emergency Department has been closed temporarily.

Neighbouring hospitals have also reported some in-patients with a similar syndrome, and further spread of infection has been contained. These were not confirmed as NLV cases and were unrelated to the outbreak described here.

NLV, previously described as small round structured virus (SRSV), usually causes mild and short-lived illness. A prominent symptom is projectile vomiting which can lead to widespread environmental contamination, resulting in indirect but rapid person-to-person spread. It is the most common cause of infectious intestinal disease (IID) in the United Kingdom (UK), Netherlands and USA, with an estimated annual incidence of 600 000 to 1 million cases in England (1-3). From the beginning of 2002 to the end of May, the PHLS Communicable Disease Surveillance Centre (CDSC) received 124 preliminary reports of outbreaks of NLV in England and Wales, 59 of which occurred in hospitals. While this is an increase on the figures for 2001, it is below the levels reported in previous years (table).

**Table Preliminary reports to CDSC of outbreaks of NLV infection, England and Wales: 1999-2002**

Year	Total number of outbreaks reported	Hospital outbreaks only
1999	145	69
2000	195	96
2001	114	45
2002*	124	59

\*provisional

Between 1992 and 2000, CDSC received reports of 1877 outbreaks of laboratory confirmed NLV infection. Hospitals accounted for 754 of these outbreaks, but in most of these fewer than 20 people were affected (4,5). In the winter of 2001/2002, however, 20 hospitals were affected in Scotland, giving rise to major disruptions including cancellation of admissions (6).







The number of promptly reported AIDS cases has decreased greatly from 1190 in 1994 to 458 in 2001. The decline was steepest between 1996 and 1998, from 943 to 522. Reported AIDS cases may be levelling-off, as the limits of currently available treatment options in delaying AIDS onset are reached. The reduction in reported AIDS cases has been largely confined to those with a 'long' diagnosis interval, while the number with a 'short' diagnosis interval has remained more or less constant over time (figure 1). Similar numbers of individuals have been presenting each year with HIV-related disease, at or around the time when their level of immune suppression allows an AIDS-defining condition to develop. It is unlikely that there will be a further fall in AIDS cases, unless these numbers presenting late in disease progression can be reduced. Thus far, the benefits of early diagnosis have been greatest for those infected through sex between men; the number of promptly reported 'long' diagnosis interval cases decreased from 384 in 1996 to 43 in 2001. For those infected heterosexually, 'long' diagnosis AIDS cases also fell, from 117 in 1996 to 33 in 2001. The numbers diagnosed at or around AIDS diagnosis rose, however, with the result that there has been little change in the overall numbers of AIDS cases for this exposure category. For those infected through injecting drug use the numbers of promptly reported cases fell from 76 to 14, and over a six year period more than 70% of these were 'long' diagnosis interval cases; the small numbers of HIV cases being recognised at diagnosis of AIDS confirms that for this risk-group the great majority of established infections have been diagnosed.

### Indicator diseases recorded at AIDS diagnosis

The pattern of AIDS indicator diseases at AIDS diagnosis might be expected to have been influenced by the widespread use of HAART, but only for those individuals diagnosed long enough for therapy to have been effective, before developing an AIDS-defining condition (table 1a). The indicator diseases present at AIDS diagnosis in those with a short interval between the diagnosis of HIV and AIDS will be largely uninfluenced by HAART (table 1b).

**Table 1 AIDS indicator diseases as a percentage of all indicator diseases by year of diagnosis. Adult AIDS cases reported from England, Wales, and Northern Ireland ‡ : data to end March 2002**

‡ numbers of cases, particularly for recent years, are likely to increase as delayed reports are received

#### a) interval between diagnosis of HIV infection and AIDS - three months or greater

Indicator Disease	Year of AIDS Diagnosis									
	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Pneumocystis carinii pneumonia (PCP)	24	22	21	22	22	22	23	22	20	17
Candidiasis	20	16	17	17	15	13	13	12	12	14
Kaposi's sarcoma (KS)	14	13	14	11	12	14	12	13	13	15
Mycobacterium tuberculosis*	2	6	6	6	7	11	13	9	11	22
Wasting	9	8	8	7	9	6	6	7	4	3
Encephalopathy	5	5	6	6	6	3	4	2	2	0
Lymphoma	4	3	3	4	4	9	11	11	9	10
Mycobacterium - other	3	6	6	6	6	6	4	6	6	6
Cytomegalovirus	6	6	4	6	5	3	2	2	6	5
Toxoplasma	4	3	3	3	3	2	3	2	2	2
Other opportunistic infections†	9	12	12	13	11	10	9	13	15	6
Total % indicator diseases	100	100	100	100	100	100	100	100	100	100
Total number indicator diseases (long interval)	1064	1251	1345	1263	912	491	305	241	208	110
<b>Total number of AIDS cases (long interval)</b>	<b>1011</b>	<b>1221</b>	<b>1251</b>	<b>1220</b>	<b>874</b>	<b>490</b>	<b>304</b>	<b>252</b>	<b>209</b>	<b>108</b>

\* includes pulmonary TB from 1993 onwards; † Includes 5 diagnoses of cervical carcinoma

## b) interval between diagnosis of HIV infection and AIDS - less than three months

Indicator Disease	Year of AIDS Diagnosis									
	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Pneumocystis carinii pneumonia (PCP)	41	39	39	38	37	43	35	33	31	33
Candidiasis	13	12	11	11	10	10	13	11	9	8
Kaposi's sarcoma (KS)	10	11	10	10	10	7	8	6	8	7
Mycobacterium tuberculosis*	5	9	9	11	13	12	16	14	20	22
Wasting	8	5	7	4	6	6	5	7	7	8
Encephalopathy	2	2	2	4	3	3	2	3	1	2
Lymphoma	4	4	2	3	4	3	4	4	3	2
Mycobacterium - other	2	2	3	4	2	2	3	3	3	2
Cytomegalovirus	4	3	3	2	4	2	3	3	3	2
Toxoplasma	3	4	4	4	5	4	3	3	4	4
Other opportunistic infections†	8	9	9	9	8	8	9	12	11	10
Total % indicator diseases	100	100	100	100	100	100	100	100	100	100
Total number indicator diseases (short interval)	653	613	656	583	624	604	517	533	616	501
<b>Total number of AIDS cases (short interval)</b>	<b>566</b>	<b>565</b>	<b>602</b>	<b>546</b>	<b>555</b>	<b>576</b>	<b>471</b>	<b>480</b>	<b>556</b>	<b>450</b>

\* includes pulmonary TB from 1993 onwards; † Includes 6 diagnoses of cervical carcinoma

Throughout the decade from 1992 to the end of 2001, pneumocystis pneumonia (PCP) was the most common AIDS indicator disease in both diagnosis interval groups, accounting for 37% (2195/5900) of all AIDS-defining conditions recorded at diagnosis in the shorter interval group, and 22% (1587/7190) in the longer. The proportion was lower in those with identified HIV infection, as a result of the availability to this group of effective PCP prophylaxis. In the short diagnosis interval group the proportion of indicator diseases formed by Kaposi's sarcoma (KS) has declined from 11% to 7%, while tuberculosis (TB) has risen. The rise in the relative importance of TB reflects partly the addition of pulmonary TB to the list of AIDS-defining conditions in 1993, but also the rising contribution of HIV infections acquired heterosexually to AIDS cases. These are often acquired in Africa where TB is widespread. If TB prophylaxis were effectively preventing progression in those known to be infected with HIV, TB would be expected to form a smaller contribution to AIDS cases in the long interval group. There is some evidence that this is the case - TB accounts for 7% of AIDS defining conditions in the long interval group, and 13% in the short. TB is now the commonest AIDS-defining illness in African patients. The impact of HAART on AIDS presentation would be expected to be identifiable from mid-1990s onward in table 1a. Although the absolute number of lymphoma cases has fallen, there has been a clear rise in the percentage contribution of lymphoma to the total AIDS-defining illnesses over this period.

Between 1992 and 2001, the ratio of the number of AIDS cases to the number of indicator diseases at AIDS diagnosis has been consistently higher for those with a short diagnosis interval (ranging from 1:1.05 to 1:1.15) than for those with a longer diagnosis interval. This is presumably because a single diagnosing condition is more likely to be recognised in those already diagnosed as HIV-infected than in those not known to be infected.

### HIV-2 infections identified in the UK

The diagnoses of HIV-2 infections in the UK were last summarised in May 2001 (1). This report updates the account to the end of March 2002. A total of 75 adults in the UK have been reported to have HIV-2 infection.

Sixty-two of these in the UK have been diagnosed as having HIV-2 infection only (32 male and 30







