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Outbreak of legionnaires' disease in Barrow-in-Furness

On Tuesday 30 July 2002 a sporadic case of legionnaires' disease in a patient from Barrow-in-Furness was notified to the local consultant in communicable disease control. On the morning of Thursday 1 August a second case of legionnaires' disease came to light in East Lancashire. The case had recently visited Barrow and it was thought that there might be a link between the two cases. Consequently, the PHLS Communicable Disease Surveillance Centre (CDSC) was informed immediately. CDSC was also informed of a third case and on this basis, an outbreak control team meeting was convened for Friday 2 August. Two further two cases were discovered after the meeting had been convened. It was arranged for all available clinical staff from Cumbria and Lancashire Health Protection Unit to attend the hospital.

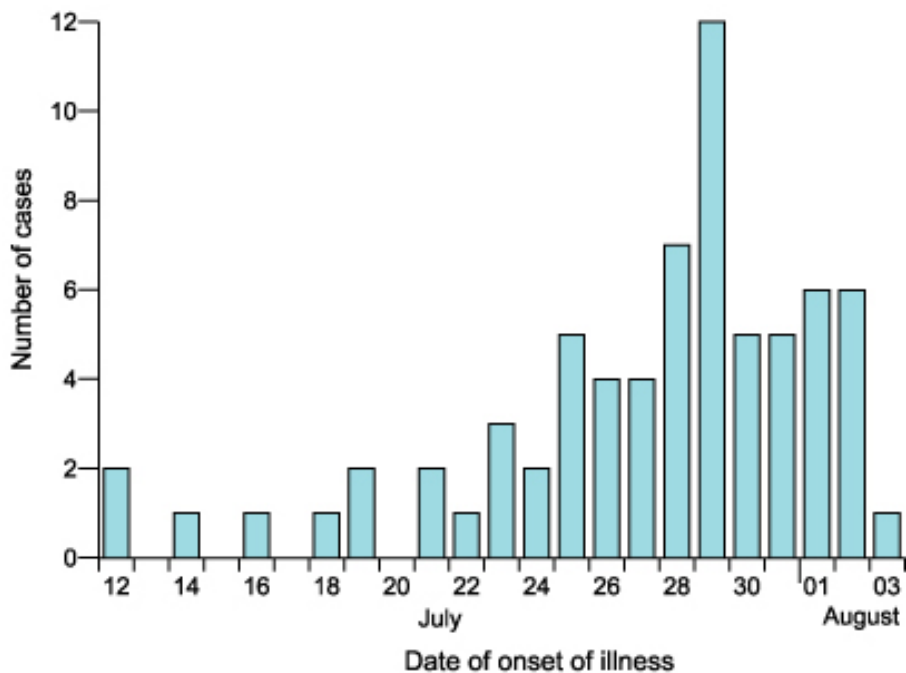
The outbreak control team met on the Friday morning, by which time local microbiologists had identified a further 20 potential cases of legionnaires' disease by urinary antigen detection. These cases had been admitted with community acquired pneumonia in the previous few days and their diagnosis was confirmed that day. Representatives from the local environmental health department were in attendance and reported that they had become aware of potential problems with the air conditioning unit at Forum 28, a council-owned building in the centre of Barrow, and had already closed down the plant the previous afternoon in case it was the source of the problem. Using the standard PHLS case definitions for legionella infection (1) a descriptive study commenced that collected data on exposure history and links with Barrow before onset of illness.

It rapidly became apparent that the only common factor linking the cases was having visited the centre of the town (in close proximity to the town hall) since 1 July and within the incubation period for legionnaires' disease before onset of illness. In particular, many cases reported walking down a lane between Forum 28 and a hardware shop (figure 1). There were also anecdotal reports from people who claimed to have seen a large amount of aerosol and water droplets emerging from an air conditioning vent in the lane. There were no other common risk factors. It was concluded that an environmental source – such as an air conditioning unit or evaporative cooling system in the vicinity of the town centre was the most likely source of the infection.

Figure 1. A view of the lane in Barrow town centre, into which the air conditioning unit discharged



Figure 2 Confirmed cases of legionellosis by date of onset of symptoms: to 7 August 2002



Cases had urinary antigen testing, serology and – where clinically possible – sputum taken for culture. On 7 August there were 70 cases of legionnaires’ disease which fitted the case definition and have been confirmed by urinary antigen detection (figure 2).

Barrow Borough Council and the Health and Safety Executive have carried out checks on all known wet cooling systems in the town, and have looked extensively for any other potential sources that may not be on their registers. There were four wet air conditioning systems in the Barrow area, but the only system within the town centre is that in the Forum 28 building. Water samples were taken for culture and immunofluorescence (IF). *Legionella pneumophila* serogroup 1 has been demonstrated by IF in pond water samples from the Forum 28 air conditioning unit. Maintenance records have also been checked.

This incident highlights the importance of ensuring that wet air conditioning systems are properly maintained and tested as they have the potential to infect rapidly a large number of people if contaminated with *Legionella*.

1. JV Lee, C Joseph on behalf of the PHLS Atypical Pneumonia Working Group. Guidelines for investigating single cases of legionnaires’ disease. *Commun Dis Public Health* 2002; 5(2): 157-62. Available online at <http://www.phls.org.uk/publications/cdph/issues/CDPHvol5/No2/Guidelines1.pdf>

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Investigation of geographically associated cases of variant CJD in north east England

The North East Public Health Group has reported the outcome of an investigation involving three pairs of geographically associated cases of variant Creutzfeldt-Jakob disease (vCJD) in the region (1). The aim of the investigation was to establish whether or not there were any common factors linking the cases, other than geographic location, that might be related to their becoming infected with the bovine spongiform encephalopathy (BSE) agent. The investigation was conducted between October 2001 and May 2002 and involved consultants in communicable disease control, environmental health officers and other agencies across north east England, as well as representatives of a national steering group (see below).

Pairs of geographically associated cases were identified in three localities. Interviews were conducted with the relatives of five cases who consented, to clarify information on diet, food purchasing behaviour, medical and dental procedures, and possible occupational, educational, social and recreational exposures. Information was also collected on local butchery practices and beef supply chains, the distribution of BSE and feline spongiform encephalopathy in the north east, the proximity of vCJD cases to abattoirs, rendering plants and meat processing plants, associated waste management procedures, and the source, location and quality of water supplies. Although one pair of cases attended the same school the investigation did not reveal a link between these or between any of the cases that could represent a common source or possible route of infection. In particular, no unusual features were revealed in the local beef supply chains or butchery practices which might have increased the likelihood of cross contamination of beef carcass meat with bovine brain.

Guidance has been issued for the local reporting of CJD cases by clinicians (2). All suspect cases of CJD should be referred to the National CJD Surveillance Unit (NCJDSU) for confirmation of diagnosis. As soon as possible after referral the NCJDSU undertakes a medical assessment of the case and through interviews with a close family member seeks detailed information on diet, medical procedures, occupational, educational and residential histories. Geographically associated cases (GACs) are defined as two or more cases of probable or definite vCJD with a geographic association either through place of residence or through another link to the same area (occupational, educational and/or social). GACs may reflect a common experience that is related to the acquisition of vCJD – their investigation may serve to identify risk factors for transmission, determine whether the risk is continuing, and inform control measures.

A protocol has been developed for the systematic investigation of GACs (3). In the event of geographic associations between cases becoming apparent a national steering group provides guidance on the appropriate response and coordinates support to local investigations. Consent to obtain further information and to share this with the investigation team is sought from the relatives of each of the cases involved. Available information is reviewed, and further investigations and actions agreed and undertaken. Although a number of GAC investigations are currently underway, to date the only group of vCJD cases for which a plausible common source has been identified has been in Leicestershire. This cluster of five cases was thought to be due to the consumption of meat contaminated with bovine brain tissue using traditional butchery techniques during the 1980s, a practice that has been discontinued (4).

1 *Investigation of geographically associated cases of variant Creutzfeldt-Jakob disease in the North East: summary report*. Regional Investigation Team, July 2002. (Requests for information should be directed to Dr Vivien Hollyoak, VHollyoak@phls.org.uk)

2 Department of Health. *Guidance on local reporting of Creutzfeldt Jakob disease (CJD) and local action by consultants in communicable disease control (CsCDC)*. London: Department of Health, April 2001. Available online at <<http://www.doh.gov.uk/cjd/cjdguidance.htm>>.

3 National Steering Group. *Protocol for the investigation of geographically associated cases of variant Creutzfeldt-Jakob disease*. London: Department of Health, April 2001. Available online at <<http://www.doh.gov.uk/cjd/cjdguidance.htm>>.

4 Bryant G, Monk P. *Final report of the investigation into the North Leicestershire cluster of variant Creutzfeldt-Jakob disease*. Leicester: Leicestershire NHS Health Authority, April 2001. Available online at <<http://www.leics-ha.org.uk>>.

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Update on the transmission of prion diseases by blood transfusion

Researchers at the United Kingdom (UK) Institute for Animal Health have released further data from their ongoing study of the transmission of prion diseases by blood transfusion (1). This group has previously reported a single case of experimental transmission of the bovine spongiform encephalopathy (BSE) agent between sheep by whole blood transfusion (2).

The recent article, published electronically 'ahead of print' on 16 July, reports interim results from a study in which blood from sheep experimentally infected with the BSE agent has been transfused into 24 recipient sheep. In addition to the case reported in 2000, clinical infection with the BSE agent has now been identified in a second recipient and two further sheep are showing early clinical signs (1). The authors conclude that their results justify the precautionary measures, such as the importation of plasma from the United States, taken to safeguard the UK blood supply.

Blood or blood products have never been identified as transmitting the human prion disease Creutzfeldt Jakob disease in any of its forms (3). The National Blood Service has emphasised that blood is a life saving product and that prion diseases cannot be contracted by donating blood. An assessment of the safety of blood and blood products is currently being updated on behalf of the UK Spongiform Encephalopathy Advisory Committee, and the views of the Committee on the Microbiological Safety of Blood and Tissue for Transplantation and the Committee on the Safety of Medicines are being actively sought (4).

1. Hunter N, Foster J, Chong A, McCutcheon S, Parnham D, Eaton S, *et al.* Transmission of prion diseases by blood transfusion. *J Gen Vir* [online publication] 2002 [cited 8 August 2002]; **83**. Available at <<http://www.socgenmicrobiol.org.uk/JGVDirect/18580/18580a.htm>>.

2. Houston F, Foster JD, Chong A, Hunter N, Bostock CJ. Transmission of BSE by blood transfusion in sheep. *Lancet* 2000;**356** (9234): 999-1000.

3. Brown P, Cervenakova L, Diringer H. Blood infectivity and the prospects for a diagnostic screening test in Creutzfeldt-Jakob disease. *J Lab Clin Med* 2001;**137**(1):5-13.

4. Spongiform Encephalopathy Advisory Committee. *Draft minutes of the 74th meeting held on 13 June 2002*. Available online at <<http://www.defra.gov.uk/animalh/bse/bse-publications/seac/mins13-06-02.pdf>>

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fpa launches Sexual Health Week

This week, the fpa (formerly the Family Planning Association) launched its annual sexual health week in order to focus attention on the serious public health issue of sexually transmitted infections (STIs) (1). Over 600,000 STI diagnoses were made in genitourinary medicine (GUM) clinics in the United Kingdom (UK) in 2000, an increase of 33% since 1995 (2). The fpa has consequently called on the Government to provide long-term investment in local GUM services to ensure speedy treatment and prevent further transmission of infections.

This attention on sexual health comes at a time of growing concern about the deterioration of sexual health in Britain. Some of the key issues were recently raised by the PHLs in its submission of evidence to the Health Select Committee's review of sexual health services, and summarised in a report entitled *Sexual Health in Britain* (3). The report highlights the population-wide changes in high-risk sexual behaviours over the past decade as illustrated in the *2nd National Survey of Sexual Attitudes and Lifestyles* (4), and examines their potential impact on the transmission of STIs including HIV infection. Diagnoses of acute bacterial STIs more than doubled between 1995 and 2000, and new diagnoses of HIV continue to rise, with an increase of 23% in 2001 on the 2000 figure. The report also includes a number of recommendations aimed at tackling the current burden of STIs, some of which have already been identified and are supported in the implementation action plan (5) for the Government's sexual health and HIV strategy (6). Special emphasis has, however, been placed on the need to target population sub-groups who are at increased risk of contracting HIV and STIs such as gay men, young people, and some ethnic minorities.

The *Sexual Health and HIV Strategy* (6) was released for consultation in 2001 and its implementation action plan was released in June 2002 (5). Key activities planned during this the first year of its

establishment include the roll out the national chlamydia screening programme, the launch of a national information campaign, and extending the availability of hepatitis B vaccine.

1. fFpa. Local GUM services need long-term investment, says fpa (press release). London: fpa, 2002. Available at <<http://www.fpa.org.uk/news/press/020725.htm>>

2. PHLS, DHSS&PS and the Scottish ISD(D)5 Collaborative Group. *Sexually transmitted infections in the UK: new episodes seen at genitourinary medicine clinics, 1995 to 2000*. London: Public Health Laboratory Service, 2001.

3. HIV/STI Division, PHLS Communicable Disease Surveillance Centre. *Sexual health in Britain*. [online]. London: PHLS, 2002 [cited 7 August 2002]. Available at <http://www.phls.co.uk/topics_az/hiv_and_sti/publications/sexual_health.pdf>

4. Johnson AM, Mercer CH, Erens B, Copas A, McManus S, Wellings K, *et al*. Sexual behaviour in Britain: partnerships, practices, and HIV risk behaviours. *Lancet* 2001; **358**: 1835-42.

5. Department of Health. The national strategy for sexual health and HIV – implementation action plan. London: Department of Health, 2002. Available at <<http://www.doh.gov.uk/sexualhealthandhiv>>.

6. Department of Health. *The national strategy for sexual health and HIV*. London: Department of Health, 2001. Available at <<http://www.doh.gov.uk/nshs/bettersexualhealth.pdf>>.

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PHLS Board responds to Department of Health consultation documents on the new Health Protection Agency

The PHLS board has published its response to the Department of Health consultation documents on the creation of the Health Protection Agency (1) and the configuration of microbiology services (2).

The publication of the consultation documents followed the publication in January 2002 of *Getting Ahead of the Curve* a strategy document on combating infectious diseases and other aspects of health protection, which contained a proposal for the creation of a new Health Protection Agency (HPA) (3). The PHLS Board has broadly welcomed these proposals, including the principle of a single agency to bring together biological, chemical and radiation protection issues. The Board has, however, expressed concern about the need for the new arrangements to preserve the benefits of the existing PHLS managed network of laboratories that, under the proposals, would transfer to NHS management, about the timescale proposed for implementing change, and about the legislative process for establishing the HPA.

The Board's response to the consultation documents can be found at <http://www.phls.co.uk/hpa_info/index.htm>.

1. Department of Health. Health Protection. *A consultation document on creating a health protection agency*. London: Department of Health, 2002. Available online at <<http://www.doh.gov.uk/consultations/live.htm>>.

2 Department of Health. *Getting ahead of the curve: action to strengthen the microbiology function in the prevention and control of infectious diseases - a discussion paper on the future contribution of microbiology services in the public health regions*. London: Department of Health, 2002. Available online at <<http://www.doh.gov.uk/consultations/live.htm>>.

3. Chief Medical Officer. *Getting ahead of the curve*. London: Department of Health, 2002. Available online at <<http://www.doh.gov.uk/cmo/idstrategy/index.htm>>

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General outbreaks of foodborne illness, England and Wales: laboratory reports, weeks 27-30/02*

Health authority	Organism	Place of outbreak	Month of outbreak	No. ill	Cases positive	Suspect vehicle	Evidence
Merton, Sutton, and Wandsworth	<i>Salmonella</i> Enteritidis PT6A	Reception	June	>3	3	None	–
Warwickshire	S. Enteritidis PT8	Hotel	July	>17	>17	None	–
Brent and Harrow	S. Enteritidis PT21	Restaurant	July	3	3	Fish balls	M
Suffolk	S. Enteritidis PT34	Restaurant	July	21	11	Egg fried rice	–
South Worcestershire	Campylobacter	Residential	June	4	4	chicken casserole	D
Northumberland, Newcastle and Tyneside	Campylobacter	Farm	June	3	3	Raw milk	–

* Preliminary data. Final information will be published in the quarterly report.

M (microbiological): identification of an organism of the same type from cases and in the suspect vehicle, or vehicle ingredient(s), or detection of toxin in faeces or food; S (statistical): a significant statistical association between consumption of the suspect vehicle(s) and being a case; D (descriptive): other evidence, usually descriptive, reported by local investigators as indicating the suspect vehicle.

Salmonella infections (faecal specimens), England and Wales: reports to the PHLS (salmonella data set*)

Details of serotypes of the 972 salmonella infections recorded in June 2002 are given in the table below. In July 2002, 1666 salmonella infections were recorded and preliminary information was received about four outbreaks.

*figures quoted from the PHLS salmonella data set are for isolates confirmed and typed by PHLS Laboratory of Enteric Pathogens (LEP)

	June 2002
Salmonella (provisional total)	972
S. Enteritidis (PT4)	218
S. Enteritidis (other PTs)	426
S. Typhimurium	130
S. Virchow	13
Other (typed)	185

Common gastrointestinal infections, England and Wales: laboratory reports, weeks 27-30/02

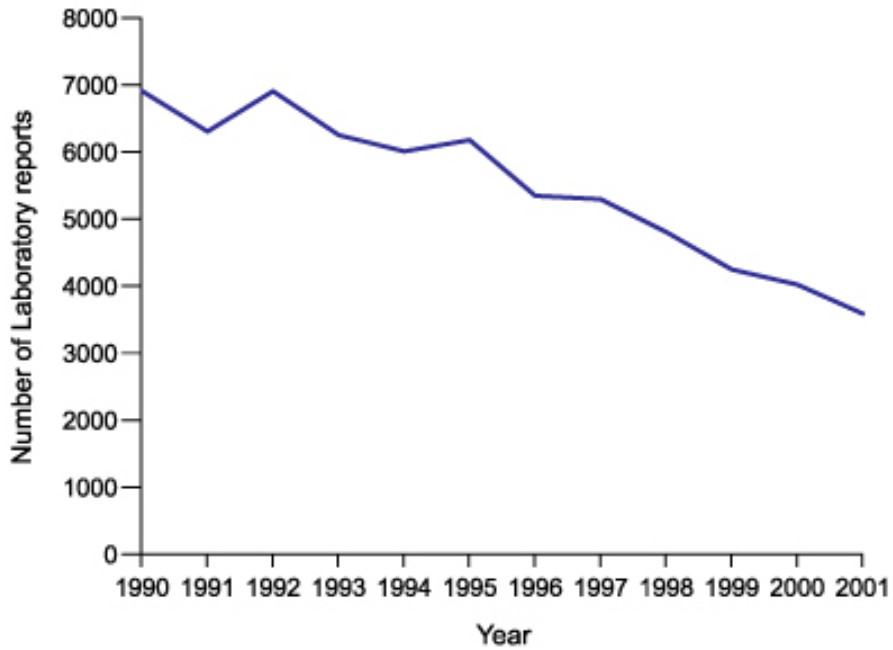
Laboratory reports	Number of reports received				Total reports	Cumulative total to	
	27/02	28/02	29/02	30/02	27-30/02	30/02	30/01
Campylobacter	671	1316	1052	1364	4403	25017	31624
Escherichia coli O157*	11	8	21	17	57	216	311
Salmonella	350	362	389	433	1534	5813	7090
Shigella sonnei	4	8	20	19	51	391	534
Rotavirus	72	169	106	195	542	13133	14568
Norwalk-like virus	25	52	103	149	329	1668	1142
Cryptosporidium	26	26	51	36	139	1377	1447
Giardia	23	57	50	83	213	1714	1817

* Vero cytotoxin producing isolates (data from LEP)

Giardiasis in England and Wales

One thousand seven hundred and fourteen cases of *Giardia lamblia* were reported to the PHLS Communicable Disease Surveillance Centre up to the end of week 30 in 2002, 5.7% less than the number reported in the same period of 2001 (1818 cases). According to week of laboratory report, a total of 3580 cases were reported in 2001, 11% less than the 4015 cases reported in 2000. This continues the downward trend seen since 1990 (figure 1).

Figure 1: Laboratory reports of *Giardia lamblia*, England and Wales: 1990 to 2001



Over 50% of cases reported in 2001 were aged between 15 and 44 years, which is consistent with previous years. All regions reported cases in 2001. South East region continues to report the highest number of cases (table).

Table: Regional distribution of giardiasis cases, England and Wales: 2001

Region	Laboratory reports
Northern and Yorkshire	393
Trent	239
Eastern	411
London	353
South East	803
South West	612
West Midlands	245
North West	323
Wales	201
Total	3580

Typhoid and paratyphoid, England and Wales: laboratory reports, April to June 2002

Organism and phage type	Number of cases	Yes	No	Not reported	Excretors and carriers
S. Typhi					
A	1	1	-	-	-
B1	1	1	-	-	-
B2	2	-	-	2	-
C1	1	1	-	-	-
D1	1	1	-	-	-
E1	19	14	-	5	-
E3	2	2	-	-	-
O	3	2	-	1	-
40	2	1	-	1	-
Degraded Vi-15	1	1	-	-	-
Degraded Vi-18	1	-	-	1	-
Untypable	1	1	-	-	-
Unypable Vi-2	1	1	-	-	-
S. Paratyphi A					
RDNC	5	4	-	1	-
1	8	4	-	4	-
1A	9	6	-	3	-
2	3	2	-	1	-
3	1	-	-	1	-
4	6	4	-	2	-
11	1	1	-	-	-
13	9	4	-	5	-
S. Paratyphi B					
Taunton	3	2	-	1	-

Thirty-six cases of *Salmonella* Typhi infection were reported in the second quarter of 2002. Twenty-six cases were infected abroad (Indian subcontinent 17, Ghana, Ethiopia, Nigeria, Indonesia, Tenerife one each, more than one country one, abroad three). In ten cases the country of infection was not stated

Forty-two cases of *Salmonella* Paratyphi A were reported in the second quarter of 2002. Twenty-five cases were infected abroad (Indian subcontinent 23, Germany one, abroad one). In 17 cases the country of infection was not stated.

Three cases of *Salmonella* Paratyphi B infection were reported in the second quarter of 2002. Two patients were infected abroad (Indian subcontinent 2). In one case the country of infection was not stated.