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# CDR WEEKLY



NEWS

## Main stories this week:

## Immunisation:

ENTERIC

**New guidance on hepatitis C infected health care workers**

**Virus infections, England and Wales: laboratory reports, weeks 30-33/02**

RESPIRATORY

IMMUNISATION

**Outbreak of Verocytotoxin-producing *Escherichia coli* O157 (VTEC O157) and *Campylobacter* spp. associated with a campsite in North Wales**

**Invasive meningococcal infections, England and Wales: laboratory reports, weeks 21-24/02**

HIV/STIs

BACTERAEMIA

ZOONOSES

TRAVEL HEALTH

**Drinking water quality in England and Wales**

PRIMARY CARE

**Dengue Fever in the Galapagos Islands**

DIARY

BACK ISSUES

SEARCH

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Communicable  
Disease Surveillance  
Centre

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NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

## News

Last updated: 22 August 2002  
Next update due: 30 August 2002

### Contents

[New guidance on hepatitis C infected health care workers](#)

[Outbreak of Verocytotoxin-producing \*Escherichia coli\* O157 \(VTEC O157\) and \*Campylobacter\* spp associated with a campsite in North Wales](#)

[Drinking water quality in England and Wales](#)

[Dengue Fever in the Galapagos Islands](#)

---

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

### New guidance on hepatitis C infected health care workers

The Department of Health has issued new guidance on the management of hepatitis C infected health care workers (HCWs) (1,2). Previous guidance from the Advisory Group on Hepatitis (AGH) recommended that HCWs infected with hepatitis C should be restricted from undertaking exposure prone procedures (EPPs) only if they had been associated with transmission of infection to a patient (3). There have, however, now been five documented incidents in England and Wales in which infected health care workers have transmitted hepatitis C infection to a total of 15 patients during EPPs (4-8). As a consequence, the AGH has now made further recommendations to protect patients.

It is now recommended (1,2) that all HCWs who know they carry the hepatitis C virus (ie are hepatitis C virus RNA positive) should not perform EPPs. HCWs who are known to have antibodies to hepatitis C virus and who carry out EPPs should be tested for hepatitis C virus RNA. Hepatitis C infected HCWs who have received antiviral treatment and remain hepatitis C virus RNA negative six months after cessation of treatment may return to performing EPPs but will require a further check six months later to show they remain hepatitis C virus RNA negative.

It is also recommended that all HCWs intending to start professional training in a career that relies upon the performance of EPPs should be tested for antibodies for hepatitis C virus, and if antibody positive tested for hepatitis C virus RNA, before commencing training. The precise timing for testing will vary depending on the particular chosen career and further advice is given in the guidance. Those found to be hepatitis C virus RNA positive should only commence training if they have received antiviral treatment and are RNA negative six months after cessation of treatment. Routine testing for hepatitis C of all HCWs who currently perform EPPs is not recommended, but HCWs who perform EPPs and who believe they may have been exposed to hepatitis C are advised to seek professional advice on whether they should be tested. The major risk factors for hepatitis C in the general UK population are receipt of unscreened blood (prior to September 1991) or untreated plasma products (prior to 1985) and the sharing of injecting equipment whilst misusing drugs. Other potential risk factors include occupational exposure to blood of infected patients and working as a health care worker in parts of the world with poor infection control precautions or a high prevalence of hepatitis C.

Patient notification exercises are recommended whenever transmission of hepatitis C from an infected HCW to a patient has been identified. It has yet to be determined if patient notification is necessary when a HCW is found to be carrying the hepatitis C virus but transmission to patients has not been identified. In this situation, the UK Advisory Panel for Health Care Workers Infected with Blood Borne

Viruses should be approached for advice on an individual basis. Its secretariat may be contacted via The Medical Secretary, UKAP, Room 635B, Skipton House, 80 London Road, London SE1 6LH; tel: 020 7972 1533.

Guidance to assist in the implementation of the new arrangements is available online at <http://www.doh.gov.uk/hepatitisc/healthcareworkers.htm>.

1. Department of Health. *Hepatitis infected health care workers. Health Service Circular HSC 2002/010*. London: Department of Health, 2002. Available online at <http://www.doh.gov.uk/hepatitisc/hsc0102002.pdf>.
2. Department of Health. *Hepatitis C iInfected health care workers*. London: Department of Health, 2002. Available online at <http://www.doh.gov.uk/hepatitisc/healthcareworkers.htm>.
3. CDSC. Hepatitis C virus transmission from health care worker to patient. *Commun Dis Rep CDR Wkly* 1995; **5** (26) : 121.
4. Duckworth GJ, Heptonstall J, Aitken C. Transmission of hepatitis C virus from a surgeon to a patient. *Commun Dis Public Health* 1999; **2**(3): 188-92.
5. CDSC. Transmission of hepatitis C virus from surgeon to patient prompts lookback. *Commun Dis Rep CDR Wkly* 1999; **9** (44): 387.
6. CDSC. Two hepatitis C lookback exercises – national and in London. *Commun Dis Rep CDR Wkly* 2000;**10** (14): 125,8.
7. CDSC. Hepatitis C lookback exercise. *Commun Dis Rep CDR Wkly* 2000; **10** (23): 203,6.
8. CDSC. Hepatitis C lookback in two trusts in the south of England. *Commun Dis Rep CDR Wkly* [serial online] 2001 [cited 20 August 2002]; **11** (21): news. Available at [http://www.phls.org.uk/publications/cdr/archive/back\\_issues01.html#2101](http://www.phls.org.uk/publications/cdr/archive/back_issues01.html#2101).

---

[Top](#) |

## **Outbreak of Verocytotoxin-producing *Escherichia coli* O157 (VTEC O157) and *Campylobacter* spp associated with a campsite in North Wales**

An outbreak of gastroenteritis due to mixed infection with Verocytotoxin-producing *Escherichia coli* (VTEC) O157 and *Campylobacter* spp. has been identified among visitors to a small campsite in North Wales. Both pathogens have been identified in the private water supply. Following investigation of reports of illness in one party, case finding among all site users and screening of contacts revealed 16 confirmed cases: ten VTEC O157, four of whom had a mixed infection with *Campylobacter* spp, another five with only *Campylobacter* spp, and one case with mixed *Campylobacter* and *Salmonella* spp infection. No cases required hospital admission. Onset of illness ranged from 6 to 11 August 2002, and cases were aged between 4 and 76 years.

The water tap on the campsite is served by an untreated private water supply fed from a spring arising on grazed land nearby. Unusually heavy rainfall occurred a week prior to the first case. A boil water notice was served under the *Water Industry Act 1991* within 24 hours of identification of the outbreak. VTEC O157 and *Campylobacter* spp were later cultured from a sample of water from the site tap. The PHLS Laboratory of Enteric Pathogens confirmed that isolates from patients and water belonged to phage type (PT)4 . They possessed genes for VT2 but not VT1 and had the same subtype of VT2 sequence. Isolates will be compared by pulsed field gel electrophoresis. To the end of July 2002, 12 human isolates of VTEC O157 PT4 were identified but none were from Wales. In 2001, this phage type represented only 3% of the total human VTEC O157 in England and Wales. Water supplies to rural campsites are frequently supplied with water from untreated private supplies. Evidence suggests that such supplies are commonly contaminated (1) and the microbiological quality can depend on the weather.

In the United Kingdom this year, two outbreaks have been reported to be associated with private water sources supplying campsites. The latest of these occurred in Scotland where an outbreak of *E. coli* O157 was associated with a contaminated treated private water supply to a caravan park and campsite during July/August 2002 (2). Prior to this, in North Wales, an outbreak of *Campylobacter* spp was found to be possibly associated with an untreated private water supply to a campsite attached to a farm during June 2002 (due to be published in next CDR review of waterborne outbreaks).

These recent outbreaks highlight the fact that water supplies to rural campsites may be private supplies which may receive little, incomplete, or no treatment. It is desirable that the owners of campsites providing water from a private supply advise campers to sterilize water before use for drinking, cooking or oral hygiene, or use proprietary bottled water. The circumstances of private water supplies are recognised to be highly variable (3).

1. Rutter M, Nichols GL, Swan A, De Louvois J. A survey of the microbiological quality of private water supplies in England. *Epidemiol Infect* 2000; **124**(3): 417-25.
2. SCIEH. *E. coli* O157 outbreak. *SCIEH Weekly Report* 2002; **36** (31): 206,8.
3. Drury D. Private water supplies: classification and monitoring. *Commun Dis Rep CDR Rev* 1995; **5** (7): R98-9.

---

[Top](#) |

## Drinking water quality in England and Wales

The annual report on drinking water quality by the Chief Inspector of the Drinking Water Inspectorate (DWI) entitled *Drinking Water 2001* (1) was published in July 2002. The report documents the water quality of the individual water providers within England and Wales. Overall compliance with regulatory standards for drinking water have improved from 98.65% in 1992 to 99.86% of samples in 2001, with reductions in breaches of the total coliform and faecal coliform standards at treatment works and service reservoirs, as well as improvements in compliance for iron, trihalomethanes (THM), and lead.

Under the *Water Supply (Water Quality) (Amendment) Regulations 1999* a treatment standard of less than one *Cryptosporidium* oocyst per 10L of water was established for water treatment works, where there is a significant risk of the standard being contravened. There were 51,168 regulatory samples taken from 166 sites up to the end of 2001. Low numbers of oocysts were detected in 1,676 (3.8%) samples taken from 117 (70.5%) sites. Most of the detections were in the range 0.01 to 0.1 oocysts per 10L. The regulatory standard was not contravened at any site during 2001, and no outbreaks linked to mains drinking water were detected. This monitoring enables both the DWI and the water industry to be confident that well operated conventional coagulation and filtration treatment methods can ensure safe drinking water. There are 16 companies undertaking 199 programmes to improve water treatment work, 50 of which were completed during 2001. Two water companies gave undertakings to build new treatment works for the removal of *Cryptosporidium* at 18 sites, two of which have been completed.

The advice produced at the start of *Cryptosporidium* monitoring (2) <http://www.phls.co.uk/publications/cdph/issues/CDPHVol3/no1/crypto.pdf> has proved useful in preventing unnecessary boil water notices while allowing measured responses to changing water quality information.

1. Chief Inspector, DWI. *Drinking water 2001*. London: Drinking Water Inspectorate, 2002. Available at <http://www.dwi.gov.uk/pubs/annrep01/index.htm>
2. Hunter PA. Advice on the response from public and environmental health to the detection of cryptosporidial oocysts in treated drinking water. *Commun Dis Public Health* 2000; **3** (1): 24-7.

---

[Top](#) |

## Dengue Fever in the Galapagos Islands

The Directorate of Health on the island of Santa Cruz in the Galapagos Islands, has reported six laboratory confirmed and approximately 100 suspected cases of dengue fever as of 8 August 2002 (1). There have so far been no reported cases of dengue haemorrhagic fever, which is a potentially fatal form of the disease. This is the first report of dengue activity on the islands, which attract approximately 80,000 tourists a year. It is not yet clear whether the cases are imported or indigenous. The Ministry of Health have sent a team to investigate the outbreak and carry out entomological studies.

As of 2 August 2002, the Ministry of Health on mainland Ecuador had reported 344 laboratory confirmed and 5833 suspected cases of dengue fever, including 11 laboratory confirmed and 158 suspected cases of dengue haemorrhagic fever (2). Dengue serotypes 2 and 3 have both been reported in Ecuador.

Further information on dengue fever can be found in the [travel health](#) section.

1. Dengue – Ecuador (Galapagos Islands). Galapagos Islands: 6 cases of classical dengue fever reported. In ProMed mail [online]. Boston US: International Society for Infectious Diseases, 13 August 2002 [cited 21 august 2002]. Available at <<http://www.promedmail.org>>

2. World Health Organization. Dengue/dengue haemorrhagic fever in Ecuador. Geneva: World Health Organisation, 16 August 2002. Available from <<http://www.who.int/disease-outbreak-news/n2002/august/16august2002.html>>.

[Back to top](#)

- NEWS
- ENTERIC
- RESPIRATORY
- IMMUNISATION
- HIV/STIs
- BACTERAEMIA
- ZOONOSES
- TRAVEL HEALTH
- PRIMARY CARE
- DIARY
- BACK ISSUES
- SEARCH

## Immunisation

Last updated: 22 August 2002  
Next update due: 26 September 2002

### Contents

[Virus infections, England and Wales: laboratory reports, weeks 30-33/02](#)

[Invasive meningococcal infections, England and Wales: laboratory reports, weeks 21-24/02](#)

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

### Virus infections, England and Wales: laboratory reports, weeks 30-33/02

Laboratory reports	Number of reports received				Total reports 30/02	Cumulative total 2002
	30/02	31/02	32/02	33/02		
Coxsackie A	–	–	–	–	–	11
Coxsackie B	4	11	6	2	23	70
Cytomegalovirus	11	20	17	6	54	617
Echovirus	6	3	2	10	21	210
Parvovirus B19	36	57	69	42	168	980
Varicella zoster virus	2	2	4	19	52	361

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

### Invasive meningococcal infections, England and Wales: laboratory reports, weeks 21-24/02

	Method of diagnosis			Total reports 21-24/02	Cumulative total* 2002
	CSF and blood		Other sites		
	culture	non-culture**			
Group A	–	–	–	–	1
Group B	35	42	5	82	830
Group C	6	3	–	9	108
Group W135	2	–	–	2	51
Group X	–	–	–	–	2
Group Y	1	2	–	3	17
Group Z	–	–	–	–	–
Group 29E	–	–	–	–	–
Ungroupable	–	–	–	–	–
Ungrouped	–	–	–	–	1
<b>Total</b>	<b>44</b>	<b>55</b>	<b>6</b>	<b>105</b>	<b>1083</b>

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

[Back to top](#)