



NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEamia

ZONOSSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

Main stories this week:

Norovirus (Norwalk-like virus) increase in 2002

London public health investigation of *Salmonella* Enteritidis in raw shell eggs

Glycopeptide-intermediate *Staphylococcus aureus* (GISA)

Enhanced surveillance of invasive group A streptococcal infections

Bacteraemia

***Staphylococcus aureus* bacteraemia: England, Wales, and Northern Ireland, July to September 2002**

Immunisation

Laboratory reports of hepatitis A in England and Wales: second quarter 2002

Laboratory reports of acute hepatitis B infection by age group and sex England and Wales: second quarter 2002

Laboratory reports of hepatitis C infection in England and Wales: second quarter 2002

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NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

News

Last updated: 19 December 2002

Next update due: 3 January 2003

Contents

[Norovirus \(Norwalk-like virus\) increase in 2002](#)[London public health investigation of *Salmonella* Enteritidis in raw shell eggs](#)[Glycopeptide-intermediate *Staphylococcus aureus* \(GISA\)](#)[Enhanced surveillance of invasive group A streptococcal infections](#)

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

Norovirus (Norwalk-like virus) increase in 2002

Three thousand and twenty-nine laboratory confirmed reports of norovirus (Norwalk-like virus) infection were reported to the PHLS Communicable Disease Surveillance Centre (CDSC) in the first ten months of 2002. This represents a substantial increase from preceding years. The previous peak in reporting was in 1996, when 2437 cases were reported for the whole 12-month period. In 2002 reports did not decline during summer months as they typically have in previous years. The bulk of the recent increase was in the elderly. Sixty-eight per cent of all cases reported in the first ten months of 2002 were aged 65 years or above. Laboratory reporting of norovirus-positive results provides a timely source of trend data although noroviruses are substantially underreported by this method of surveillance because not all patients seek medical care, and of those who do, only a minority have relevant tests.

The rise in reports does not necessarily mean that the incidence has increased. Factors potentially influencing the number of reports include increased ascertainment due to awareness and improvements in diagnostic capability. A commercial ELISA for the detection of noroviruses in faecal samples is now being marketed (Dako Cytomation, Ely, UK) so testing is more readily available. Guidance on the ELISA as a preliminary screening tool for outbreaks of gastroenteritis will be published shortly (1).

The impact of noroviruses on healthcare facilities is increasingly recognised both in the medical and popular press (2-4). Since 1992, over three-quarters of norovirus outbreaks reported to the PHLS Communicable Disease Surveillance Centre occurred in either hospitals or residential homes (5). Guidance on the control of hospital outbreaks of viral gastroenteritis has been issued (6). Understanding of the epidemiology, in particular the incidence and impact of norovirus outbreaks in healthcare institutions, is, however, incomplete. For this reason, a collaborative team including the Avon Health Protection Unit, Bristol Public Health Laboratory, and CDSC Gastrointestinal Diseases Division have introduced active, enhanced surveillance in hospitals and nursing homes (7).

Noroviruses are the group of viruses formerly known as Norwalk-like viruses (NLV) or small round structured viruses (SRSV) (8,9). These viruses have long been associated with outbreaks of a relatively mild and short-lived form of gastroenteritis, often referred to as "winter vomiting disease". A prominent symptom is projectile vomiting that can lead to widespread environmental contamination, resulting in indirect but rapid person-to-person spread.

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3. Virus patient numbers rise at hospital. BBC News [online]. London: British Broadcasting Corporation, 23 October 2002.

Available at <<http://news.bbc.co.uk/1/hi/england/2353623.stm>>.

4. Viral gastroenteritis update 2002 - UK and Ireland (04) In *ProMed Mail* [online]. Boston US: International Society for Infectious Diseases, 16 November 2002 [cited 19 December 2002]. Available at <<http://www.promedmail.org>>
5. Lopman BA, Reacher M, Brown DW, Adak GK. Two epidemiological patterns of Norwalk-like virus outbreaks: England and Wales, 1992 - 2000. *Emerg Infect Dis* In press 2002.
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[Top](#) | [PDF](#)

London public health investigation of *Salmonella* Enteritidis in raw shell eggs

In response to the recent outbreaks and increased incidence of *Salmonella enterica* serotype Enteritidis thought to be associated with raw shell eggs (1), the London local authorities' environmental health departments within the London Food Co-ordinating Group have sampled eggs from large catering outlets, hospitals, and suppliers/distributors. Samples are being examined for *Salmonella spp.* by the PHLS London Food Water and Environmental Microbiology Laboratory and isolates sent to the PHLS Laboratory of Enteric Pathogens (LEP) for confirmation and typing. Further to the results of investigations reported in *CDR Weekly* of 12 December 2002 (2), the following additional results are now available (table 1).

Table 1 *Salmonella* Enteritidis in eggs: contamination rates based on pooled samples of six eggs (Samples tested up to 9 December 2002)

Total number of eggs	Total number of samples	Origin	Lion marked	Salmonella detected
1926	321	Britain/UK	Yes	Not detected
120	20	Britain/UK	Not Known	One sample positive for <i>S. Enteritidis</i> PT4
330	55	Not known	No	One sample positive for <i>S. Enteritidis</i> PT4
480	80	Britain/UK	No	Not detected

Between the 27 November and 9 December 2002, 25 batches of eggs, comprising 476 pooled samples of six whole eggs (2856 eggs in total) in the pan London investigation. Salmonellas have been recovered from two (0.4%) of the 476 pools. Notably, no salmonellas were isolated from ten of the 25 batches of eggs investigated. Twenty-two of the batches tested were labelled as of British or United Kingdom origin. Seventeen of these batches, (321 samples, 1926 eggs) were labelled of British/UK origin with the Lion Quality mark, and no salmonellae were recovered from any of these samples. *Salmonella enterica* serotype Enteritidis phage type (PT) PT4 was recovered from eggs sampled from hospital kitchens, one of three batches of non-Lion quality British/UK eggs (55 samples, 330 eggs) (1.8%) and one batch (20 samples, 120 eggs) where the details are not known. In these circumstances hospitals may wish to

consider not using raw shell eggs.

1. PHLS. *Salmonella* Enteritidis outbreaks in England and Wales, September to November 2002. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 19 December 2002]; 12 (49): news. Available at <<http://www.phls.co.uk/publications/cdr/pages/news.html#salm>>.

2. PHLS. Public health investigation of *Salmonella* Enteritidis in raw shell eggs. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 19 December 2002]; 12 (50): news. Available at <<http://www.phls.org.uk/publications/cdr/pages/news.html#eggs>>.

[Top](#) |

Glycopeptide-intermediate *Staphylococcus aureus* (GISA)

The first known patient death in the United Kingdom (UK) following an infection with vancomycin – intermediate resistant *Staphylococcus aureus* has been reported in Monklands Hospital, Lanarkshire (1). Glycopeptide Intermediate resistant *S. aureus* (GISA) was first described in Japan (2) and has increased resistance to both of the glycopeptide antibiotics – vancomycin and teicoplanin – that are used for the empirical treatment of suspected infections caused by methicillin-resistant *Staphylococcus aureus* (MRSA).

GISA is very rare, though MRSA with resistance only to teicoplanin is encountered more frequently. In the UK, GISAs were first reported in Scotland (3) although there have been a few subsequent reports, and none have been found among over 40000 MRSA isolates submitted to the PHLS Laboratory of Hospital Infection (LHI) for typing during the past three to four years. The genetic and phenotypic mechanisms that confer the GISA phenotypes are not fully understood (nor those that confer resistance only to teicoplanin). They do not contain the *vanA* resistance genes described recently in MRSA isolates with higher levels of glycopeptide resistance (4).

In the recent GISA report from Scotland, the patient contracted MRSA while on the intensive therapy unit and, despite aggressive and appropriate antibiotic therapy, the MRSA persisted and eventually developed resistance to glycopeptide antibiotics (vancomycin MIC 8 mg/L). Post-mortem findings confirmed tricuspid endocarditis with metastatic lung abscesses. Ongoing investigations are exploring the possibility of cross infection, although there has been little evidence of this so far (5). The unit was closed, deep-cleaned, and screened before re-opening.

The laboratory detection of GISA is difficult since disc diffusion tests are unsatisfactory. Suspicions of such infections should be aroused when patients infected with *S. aureus* (usually MRSA) infections do not responding clinically to glycopeptides (2). Isolates should be tested using inocula matched to the opacity of a 2 McFarland on brain heart infusion agar, with either vancomycin (and teicoplanin) E-test strips. GISA isolates are those requiring vancomycin minimum inhibitory concentrations (MICs) of 8-16 mg/L and are invariably cross-resistant to teicoplanin. Screening can also be performed by a breakpoint dilution method using 5 mg/L vancomycin incorporated into Mueller Hinton agar or 6 mg/L vancomycin in brain heart infusion agar (6). The Antibiotic Resistance Monitoring and Reference Laboratory and the Laboratory of Healthcare Associated Infection, at the PHLS Central Public Health Laboratory would be happy to receive any suspicious isolates isolated from patients in England or Wales for MIC confirmation and typing.

1. SCIEH. Glycopeptide-intermediate *Staphylococcus aureus* (GISA). *SCIEH Weekly Report* 2002; **36** (50): 321.
 2. Hiramatsu K, Hanaki H, Ino T, Yabuta K, Oguri T, Tenover, FC. Methicillin-resistant *Staphylococcus aureus* clinical strain with reduced vancomycin susceptibility. *J Antimicrob Chemother* 1997; **40**: 135-6.
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Enhanced surveillance of invasive group A streptococcal infections

A two-year enhanced surveillance of invasive group A streptococcal infections in the United Kingdom (UK) will commence on 1 January 2003 as part of an important European surveillance programme (Strep-EURO) (1). The UK component of this programme will be led by the PHLS Respiratory and Systemic Infection Laboratory (Streptococcus and Diphtheria Reference Unit, [SDRU]) in collaboration with the Healthcare Associated Infections and Antimicrobial Resistance Division of the Communicable Disease Surveillance Centre.

Cases will be ascertained in two ways: by isolate submissions to SDRU, and by routine laboratory reports made to CDSC. Laboratories will be sent a short questionnaire requesting basic isolate and patient information. Microbiologists are requested to submit all isolates from cases of severe group A streptococcal infection, for typing. Severe infection is indicated by the isolation of group A *Streptococcus* from a site that is normally sterile (blood, cerebrospinal fluid, joint aspirates, abscesses, pericardial/peritoneal fluid, deep tissue at operation or necropsy, and bone).

This surveillance forms an essential component of the pan-European surveillance programme supported by the European Commission, Fifth Framework Programme (QLK2.CT-2002-01398) on 'Severe *Streptococcus pyogenes* invasive disease in Europe'. The project will provide a unique opportunity to measure and compare the overall burden of these infections, as well as serotype distributions, antimicrobial susceptibility patterns, and clinical manifestations among participating countries. A one day symposium entitled *Group A streptococcal infections; clinical, epidemiological and microbiological aspects* is planned for 15 May 2003, at the Central Public Health Laboratory – all contributions are welcome. Further information on this symposium will be available at the beginning of the year.

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[Back to top](#)

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

Bacteraemia

Last updated: 19 December 2002
Next update due: 16 January 2003

[PDF](#)

***Staphylococcus aureus* bacteraemia: England, Wales, and Northern Ireland, July to September 2002**

Key points

- Laboratories in England reported 2950 *Staphylococcus aureus* bacteraemia isolates through the voluntary reporting scheme and 4713 isolates through the mandatory reporting scheme between July and September 2002.
- There have been 172 and 105 voluntary reports of *S. aureus* bacteraemia isolates from laboratories in Wales and Northern Ireland for the same time period.
- This is the first time that data for Northern Ireland have been included in the report.
- Overall, 91% of voluntary reports contained information on susceptibility to methicillin. This is similar to the level (93%) in the previous report (1).
- In England, 42% of *S. aureus* bacteraemias were due to MRSA under the voluntary scheme and 39% MRSA attributable to the mandatory scheme.
- Methicillin resistance in Wales and Northern Ireland (voluntary reporting) was noted in 47% and 38% of *S. aureus* bacteraemia reports respectively.

This report covers *Staphylococcus aureus* bacteraemias over the third quarter of 2002 (July to September) under the voluntary (routine *CDR Weekly* reporting by laboratories) and mandatory bacteraemia reporting schemes. These bacteria were isolated from blood cultures with or without cerebrospinal fluid, by laboratories across England, Wales, and Northern Ireland. This is the first *CDR Weekly* report to include data on *S. aureus* bacteraemias from Northern Ireland. Wales and Northern Ireland do not participate in the Department of Health's (DoH) mandatory *S. aureus* surveillance scheme. The DoH, Social Services, and Public Safety (DHSSPS) in Northern Ireland have made reporting mandatory through a similar scheme.

Rates were calculated using 2000 resident population denominators for each region. Regional analyses were performed using the English regional boundaries introduced in April 2002.

Reporting of *S. aureus* bacteraemias

In the three month period between July and September 2002, 3227 reports of *S. aureus* bacteraemia were received in England (2950), Wales (172), and Northern Ireland (105) through the voluntary reporting scheme (table 1 and figure 1). Under the mandatory surveillance scheme, there were 4713 *S. aureus* bacteraemia reports in England. Among the English regions, the South East (471) had the highest number of reports under the voluntary scheme and London (947) had the highest number of reports under the mandatory scheme. The least number of reports under both schemes were received from the North East (166 for the voluntary and 229 for the mandatory scheme). Regional variations in the total number of reports received between the two reporting schemes were observed. London had the greatest discrepancy in the number of reports (592), and the West Midlands the least (37).

The overall reporting rate of *S. aureus* bacteraemia for England, Wales, and Northern Ireland was 5.9 per 100,000 for the three month period, based on voluntary reporting (figure 2). Northern Ireland had the highest

rate (6.2 per 100,000 population) followed by England (5.9 per 100,000 population), and Wales (5.8 per 100,000 population). Reporting rates within England ranged from 4.0 per 100,000 population in the North West to 7.8 per 100,000 in the West Midlands.

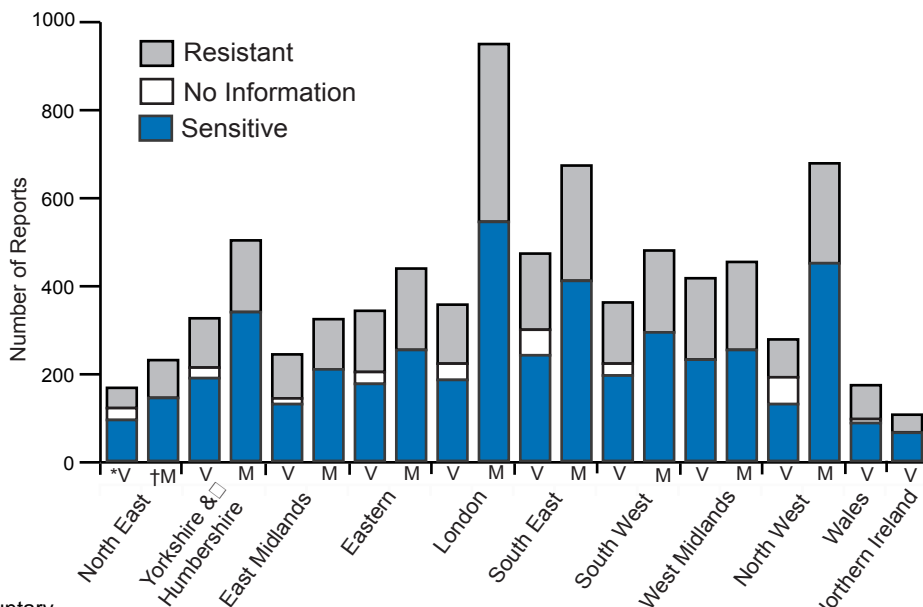
Table 1 *Staphylococcus aureus* bacteraemia reports and methicillin susceptibility data*, England, Wales, and Northern Ireland: July to September 2002

Region	Reporting scheme	Resistant	(%#)	Sensitive	No information	(%)	Total
North East	Voluntary	46	33%	93	27	16%	166
	Mandatory	86	38%	143	0	0%	229
Yorkshire & Humberside	Voluntary	112	37%	188	24	7%	324
	Mandatory	163	33%	338	0	0%	501
East Midlands	Voluntary	100	44%	129	13	5%	242
	Mandatory	114	35%	208	0	0%	322
Eastern	Voluntary	139	44%	175	27	8%	341
	Mandatory	185	42%	252	0	0%	437
London	Voluntary	134	42%	184	37	10%	355
	Mandatory	404	43%	543	0	0%	947
South East	Voluntary	173	42%	240	58	12%	471
	Mandatory	262	39%	409	0	0%	671
South West	Voluntary	139	42%	194	27	8%	360
	Mandatory	186	39%	292	0	0%	478
West Midlands	Voluntary	185	45%	230	0	0%	415
	Mandatory	200	44%	252	0	0%	452
North West	Voluntary	86	40%	129	61	22%	276
	Mandatory	227	34%	449	0	0%	676
England	Voluntary	1114	42%	1562	274	9%	2950
	Mandatory	1827	39%	2886	0	0%	4713
Wales†	Voluntary	77	47%	86	9	5%	172
Northern Ireland†	Voluntary	40	38%	64	1	1%	105
England, Wales & NI	Voluntary	1231	42%	1712	284	9%	3227

* provisional data; #R as a percentage of R+S

† Wales & Northern Ireland do not take part in the DoH mandatory surveillance scheme

Figure 1 *Staphylococcus aureus* bacteraemia reports and methicillin susceptibility data, England, Wales, and Northern Ireland: July to September 2002



*V = Voluntary

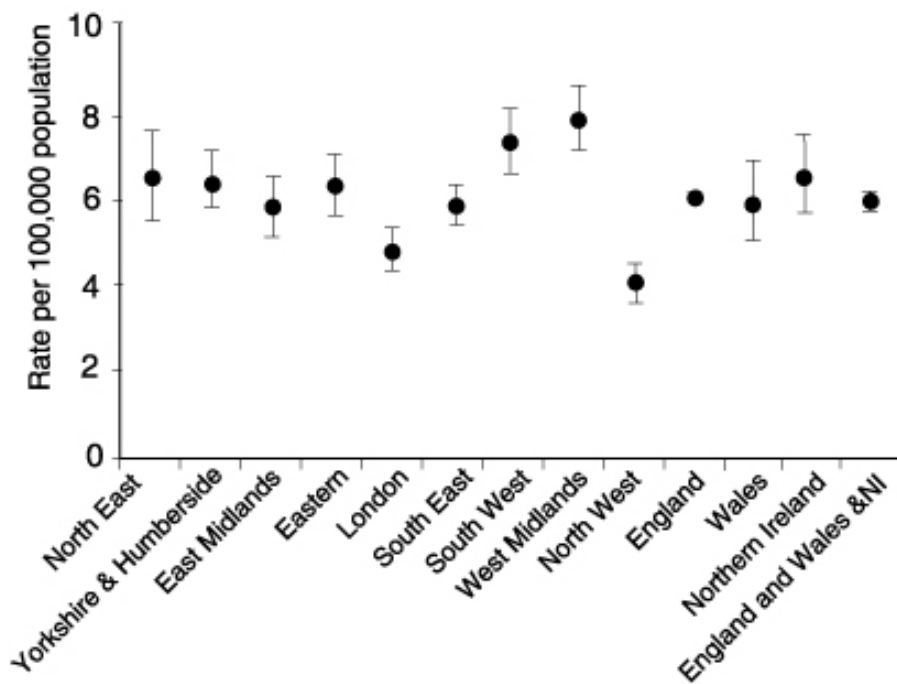
†M = Mandatory

Wales and Northern Ireland do not take part in the DoH mandatory surveillance scheme

Table 2 *Staphylococcus aureus* bacteraemia reports (voluntary reporting) and susceptibility data, England, Wales, and Northern Ireland: July to September 2002

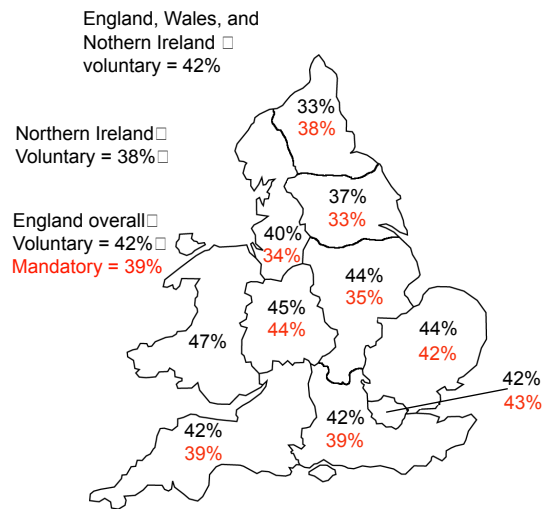
	Resistant	(%)	Sensitive	No information	(%)
Ciprofloxacin	423	53%	373	2431	75%
Erythromycin	906	39%	1395	926	29%
Fusidic acid	151	7%	1944	1132	35%
Gentamicin	71	4%	1684	1472	46%
Mupirocin	42	4%	1064	2121	66%
Rifampicin	23	2%	1325	1879	58%
Vancomycin	0	0%	1582	1645	51%

Figure 2 *Staphylococcus aureus* bacteraemia voluntary reporting rates* per 100,000 population (95% confidence intervals), England, Wales, and Northern Ireland: July to September 2002



*rates calculated using 2000 mid-year resident population estimates

Figure 3 Methicillin resistance in *Staphylococcus aureus* bacteraemia reports*, England, Wales, and Northern Ireland: July to September 2002. MRSA as a percentage of isolates whose susceptibilities were reported



Antimicrobial susceptibility

Comparing mandatory and voluntary reporting in England (table 1 and figure 3), complete information on methicillin susceptibility was received for the mandatory reporting scheme, whereas only 91% of voluntary reports had this information. There was little variation in the proportion of *S. aureus* bacteraemias resistant to methicillin between the two schemes in the West Midlands (1%), London (1%), and Eastern regions (2%), whereas in the East Midlands voluntary reporting indicated a higher rate of methicillin resistance than mandatory reporting - 9% higher.

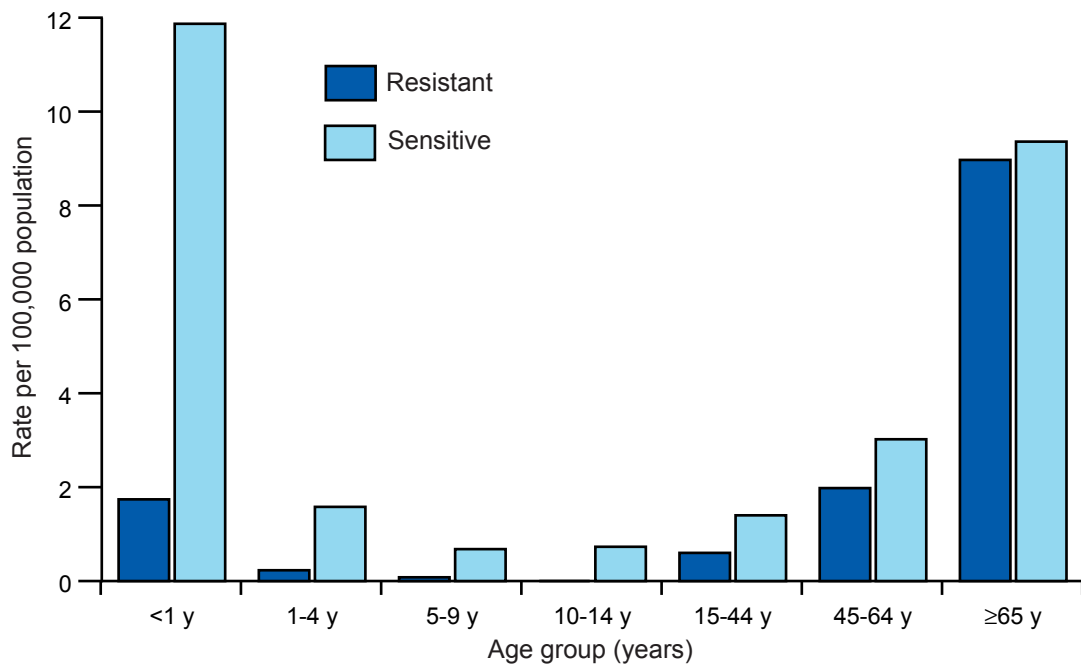
There was a significant lack of information on methicillin susceptibility under the voluntary reporting scheme in the North West (22%), North East (16%), and South East regions (12%). Only the West Midlands had complete information on methicillin susceptibility for the July to September 2002 quarter under the voluntary scheme.

Of the 2676 English voluntary laboratory reports of *S. aureus* bacteraemia with information on methicillin susceptibility, 1114 isolates (42%) were reported as resistant to methicillin. In Wales and Northern Ireland, methicillin resistance in *S. aureus* bacteraemias was reported in 47% and 38% of isolates respectively.

From the 4713 mandatory reports in England, 1827 (39%) isolates were reported as resistant to methicillin. The West Midlands had the highest percentage of methicillin resistant *S. aureus* (MRSA) isolates (45% voluntary and 44% mandatory) in England (table 1). The North East (33% voluntary and 38% mandatory) and Yorkshire and Humberside regions (37% voluntary and 33% mandatory) had the lowest proportion of methicillin resistant isolates.

Although the susceptibility of *S. aureus* to other antimicrobials (table 2) was also reported under the voluntary scheme, overall no more than half of the isolates contained such information. Of the reports that included susceptibility data, 53% of isolates were reported as resistant to ciprofloxacin, and 39% as resistant to erythromycin. Less than 10% resistance was reported to the remaining antibiotics listed in table 2. No reports of vancomycin resistance in *S. aureus* bacteraemia were received during this period.

Figure 4 Age-specific *Staphylococcus aureus* bacteraemia voluntary reporting *rates and methicillin susceptibility per 100,000 population, England, Wales, and Northern Ireland: July to September 2002



Rates calculated using 2000 mid-year resident population estimates

Age distribution

The age-specific rate of MRSA (figure 4) was highest in those aged 65 years and over (9.0 per 100,000 population). This information is only obtainable from the voluntary reporting scheme and it is not included in the mandatory dataset. The proportion of methicillin sensitive *S. aureus* (MSSA) was higher than MRSA for all age-groups, with the highest rate reported for under one-year olds (11.9 per 100,000 population) followed by the 65 years and over (9.4 per 100,000 population).

Discussion

Three months of data (July to September 2002) from both the voluntary and mandatory reporting schemes for *S. aureus* bacteraemia are presented here, to allow comparison with earlier reports. Caution must be exercised when interpreting data from such a short time period. The data obtained under the two schemes (voluntary and mandatory) that have been analysed here as the voluntary scheme provides continuity with historic data and brings in added information, for instance on age and gender. It is also important to assess how the two systems compare, as the mandatory reporting system is likely to become disaggregate in the future (*ie*, based on routine reporting rather than quarterly aggregate reports). There were no substantial differences in the overall proportion of *S. aureus* bacteraemias due to MRSA in England under the two schemes: 42% methicillin resistance under the voluntary reporting scheme and 39% methicillin resistance under the mandatory reporting scheme.

Although methicillin susceptibility information was missing from 9% of reports from the voluntary scheme in England, this did not appear to strongly bias the results. For example, in London, there was a difference of

592 reports between the mandatory and voluntary schemes, although the proportion that were methicillin resistant was 43% and 42% respectively.

Compared to data from the previous report (1), where methicillin resistance of 41% and 44% from the mandatory and voluntary schemes respectively were observed, this quarter the percentage of MRSA was lower from both schemes (39% and 42%). Compared to voluntary data reported the quarter between January and June 2002 (1), there was a slight increase in the proportion that was methicillin resistant in the South West, West Midlands, and North West regions, whereas other regions showed a decrease in methicillin resistance. The results should be interpreted with care, as technical problems were encountered with reporting from the North West, and no information on susceptibility to methicillin for 61 isolates (22%) from the North West was available.

There were also problems with reporting from the Eastern region; it is likely that when the complete 2002 summary is published next year there may be some additional reports for this quarter.

Overall, susceptibility data for other antimicrobials was weak as there was a lack of information on more than 50% of the isolates. The incomplete information makes both comparisons and analyses with previous data difficult. The pattern of age-specific reporting rates of *S. aureus* bacteraemia is similar to the previous report (1), with the highest rates of MRSA in those aged 65 years and older.

A preliminary report on the surveillance of MRSA bacteraemia in Northern Ireland, from April 2001 to March 2002 has recently been published (2). The surveillance of *S. aureus* bacteraemias in Northern Ireland follows a similar strategy to that in England. The percentage of *S. aureus* blood cultures and patient episodes that were due to MRSA was 41.8% and 39.3% respectively for that period (2). Unpublished data received from Communicable Disease Surveillance Centre (CDSC) Northern Ireland (from this scheme) for the period July to September 2002, showed that 43% of *S. aureus* bacteraemias were resistant to methicillin. This is higher than the voluntary reporting rate for methicillin resistance of 38% shown in this report.

Acknowledgements

These reports would not be possible without the enduring weekly contributions from microbiology colleagues in laboratories across England, Wales, and Northern Ireland without which there would be no surveillance data. Feedback is welcome, and should be addressed to Georgia Duckworth email: gduckworth@phls.org.uk. In addition, the support from colleagues within the PHLS, CPHL in particular, is valued in the preparation of the reports. These contributions are greatly appreciated.

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[Back to top](#)

[Next](#)

Laboratory reports of acute hepatitis B infection by age group and sex England and Wales: second quarter 2002*

A total of 190 reports of acute hepatitis B infection were reported in the second quarter of 2002. The majority of cases (80%) occurred in the ±15 to 44 year olds table 1.

During the second quarter of 2002 injecting drug use was the main risk factor associated with hepatitis B infection, accounting for 20% (38/190) of individuals with known risk factors table 2. Hepatitis B infection associated with heterosexual exposure accounted for 12.6% (24/190), 4.7% in sex between men, and 7.9% in individuals with other risk exposures.

Table 1 Laboratory reports of acute hepatitis B infection by age group and sex England and Wales: second quarter 2002*

Age group (years)	Female	Male	NK	Total
< 15	–	–	–	–
15-24	27	24	–	51
25-34	19	40	–	59
35-44	14	28	1	43
45-54	1	15	–	16
55-64	–	11	1	12
> 65	–	5	–	5
NK	2	2	–	4
Total	63	125	2	190

* All data are provisional

Table 2 Laboratory reports of acute hepatitis B infection by exposure category in England and Wales Second quarter 2002*

Summary	Total
IVDU	38
Sex between men & women	24
Sex between men	9
Other identified risk	15
NRI	104
Total	190

* All data are provisional

Laboratory reports of hepatitis C infection in England and Wales: second quarter 2002*

A total of 1622 reports of hepatitis C infection were reported in the second quarter of 2002 table 1. Sixty-five percent (1053/1622) of the cases occurred in 25 to 44 year olds. Cases in males exceeded those in females.

Table 1 Laboratory reports of hepatitis C infection in England and Wales: second quarter 2002*

Group	Female	Male	NK	Total
<1	1	2	–	3
01-04	3	3	–	6
05-09	1	1	–	2
10-14	2	1	–	3
15-24	64	118	8	190
25-34	178	402	9	589
35-44	138	335	8	481
45-54	55	154	1	210
55-64	11	45	3	59
> 65	25	27	1	53
NK	8	15	3	26
Total	486	1103	33	1622

* All data are provisional

[Next|](#)

Virus infections, England and Wales: laboratory reports, weeks 43-47/02

Laboratory reports	Number of reports received					Total reports 43 -47/02	Cumulative total 2002
	43/02	44/02	45/02	46/02	47/02		
Coxsackie A	–	2	1	1	2	6	24
Coxsackie B	1	1	–	2	4	9	98
Cytomegalovirus	8	27	16	13	22	86	897
Echovirus	–	–	–	1	14	15	259
Parvovirus B19	8	9	18	5	23	63	1375
Varicella zoster virus	1	4	6	4	11	26	456

Invasive meningococcal infections, England and Wales: laboratory reports, weeks 33-36/02

	Method of diagnosis			Total reports 33-36/02	Cumulative total* 2002
	CSF and blood		Other sites		
	culture	non-culture**	culture		
Group A	–	–	–	–	1
Group B	27	18	3	48	1020
Group C	3	3	1	7	129
Group W135	4	–	–	4	68
Group X	–	–	–	–	3
Group Y	–	–	–	–	17
Group Z	–	–	–	–	0
Group 29E	–	–	–	–	0
Ungroupable	–	–	–	–	1
Ungrouped	–	2	–	2	95
Total	34	23	4	61	1334

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