



NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOONOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

## Main stories this week:

**Syphilis in England, Wales, and Northern Ireland**

## Immunisation

**Virus infections, England and Wales: laboratory reports, weeks 52/02-03/03**

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

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

## Immunisation contd...

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

**Invasive meningococcal infections, England and Wales: laboratory reports, weeks 37-41/02**

**Laboratory confirmed cases of pertussis infection in England and Wales January to September 2002**

**COVER programme : July to September 2002**

## Primary Care

**Reporting respiratory illness in the Weekly Returns Service**

Published by: PHLS  
Communicable  
Disease Surveillance  
Centre

*If you have any comments or encounter any problems with this website, please contact [cdr@phls.org.uk](mailto:cdr@phls.org.uk)*



NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

## News

Last updated: 23 January 2003  
Next update due: 30 January 2003

### Contents

#### Syphilis in England, Wales, and Northern Ireland

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

### Syphilis in England, Wales, and Northern Ireland

After two decades of consistent decline in the United Kingdom, diagnoses of infectious syphilis started to increase in 1998, largely driven by a series of focal outbreaks across England (1,2). In London, diagnoses of infectious syphilis rose from 54 in 1998 to 336 in 2001, largely due to rapid and substantial increases in diagnoses among homosexual men. These increases have continued unabated. Data collected from genitourinary medicine (GUM) clinics (KC60 dataset) indicate that between 2000 and 2001 diagnoses of infectious syphilis rose by 118%, and a rise of 187% was seen in men who have sex with men (MSM) (3). In 2001, 715 new diagnoses of primary and secondary infectious syphilis (613 male, 102 female) were made in GUM clinics. Of the 613 cases seen in males, 57% (352) were seen in MSM.

As the KC60 return provides limited epidemiological data to inform targeted prevention and outbreak control measures, (4) enhanced surveillance programmes for infectious syphilis have been established across outbreak sites in England. The London programme was established in April 2001 (5) and subsequently extended to the rest of England in June 2002, in partnership with enhanced syphilis surveillance programmes in other outbreak sites.

By December 2002, 770 diagnoses of infectious syphilis had been reported (690 males, 80 females) since the inception of the London programme, 81% of whom were MSM. Over 50% of syphilis cases reported among MSM in London were co-infected with HIV infection, reflecting the concentration of this disease within subgroups with high rates of partner change (6,7), the sustained increases in unsafe sex amongst MSM in London (8), overlapping transmission networks, and epidemiological synergy between these diseases (9). Targeted prevention efforts aimed at improving the education, screening, and treatment of HIV positive MSM for infectious syphilis continue to form the core of prevention activities in outbreak sites across England (1).

1. Fenton K, Nicoll A, Kinghorn G. Resurgence of syphilis in England: time for more radical and nationally co-ordinated approaches. *Sex Transm Infect* 2001; **77**: 309-10.
2. Doherty L, Fenton KA, Jones J, Paine TC, Higgins SP, Williams D *et al*. Syphilis: old problem, new strategy. *BMJ* 2002; **325**:153-6.
3. PHLS. *Sexually transmitted infections in the UK: new episodes seen at genitourinary medicine clinics, 1991 to 2001*. London: Public Health Laboratory Service, 2002.
4. Hughes G, Paine T, Thomas D. Surveillance of sexually transmitted infections in England and Wales. *Eurosurveillance* 2001; **6**: 71-81.
5. Crook PD, Paine TC, Davis M, Fenton KA. London- – the next battleground for syphilis? *Commun Dis Public Health* 2002; **5** (2): 163-4.
6. Garnett G, Aral S, Hoyle D, Cates W, Anderson R. The natural history of syphilis – implications for the transmission dynamics and control of infection. *Sex Transm Dis* 1997; **24**: 185-200.
7. Wasserheit J, Aral S. The dynamic topology of sexually transmitted disease epidemics: implication for prevention strategies. *J Infect Dis* 1996; **174**: 201-13.
8. Dodds J, Nardone A, Mercey D, Johnson A. Increase in high risk sexual behaviour among homosexual men, London 1996-8: cross sectional, questionnaire study. *BMJ* 2000; **320**: 1510-1.
9. Fenton KA. Sexual health and HIV positive individuals: emerging lessons from the recent outbreaks of infectious syphilis in England. *Commun Dis Public Health* 2002; **5** (1): 4-6.

[NEWS](#)
[ENTERIC](#)
[RESPIRATORY](#)
[IMMUNISATION](#)
[HIV/STIs](#)
[BACTERAEMIA](#)
[ZOOSES](#)
[TRAVEL HEALTH](#)
[PRIMARY CARE](#)
[DIARY](#)
[BACK ISSUES](#)
[SEARCH](#)

## Immunisation

Last updated: 23 January 2003  
Next update due: 27 February 2003

### Contents

[Virus infections, England and Wales: laboratory reports, weeks 52/02-03/03](#)

[Laboratory reports of hepatitis A in England and Wales: third quarter 2002](#)

[Laboratory reports of acute hepatitis B infection by age group and sex England and Wales: third quarter 2002](#)

[Laboratory reports of hepatitis C infection in England and Wales: third quarter 2002](#)

[Invasive meningococcal infections, England and Wales: laboratory reports, weeks 37-41/02](#)

[Laboratory confirmed cases of pertussis infection in England and Wales January to September 2002](#)

[COVER programme : July to September 2002](#)

[Next|Top| PDF |](#)

### Virus infections, England and Wales: laboratory reports, weeks 52/02-03/03

Laboratory reports	Number of reports received				Total reports 52/02 -03/03	Cumulative total 2002	Cumulative total 2003
	52/02	01/03	02/03	03/03			
Coxsackie A	–	–	1	2	3	27	3
Coxsackie B	–	2	3	2	7	105	7
Cytomegalovirus	2	23	41	20	86	983	84
Echovirus	2	–	5	2	9	268	7
Parvovirus B19	2	6	41	18	67	1442	65
Varicella zoster virus	1	3	13	5	22	478	21

[Next|Top| PDF |](#)

### Laboratory reports of hepatitis A in England and Wales: third quarter 2002\*

During the third quarter of 2002, 357 laboratory reports of hepatitis A were made to the PHLS, 49% (174) more than in the equivalent quarter of 2001. Forty-nine per cent (175) were men aged between 15 and 44 years (table 1) and the majority of cases occurred in the Yorkshire and Humberside region. Five people acquired their infection abroad (country not stated) and 19 infections were reported to be in injecting drug users (IDUs). The number in the latter group decreased by 39% since the previous quarter. The overall number of cases of hepatitis A in the third quarter increased by 11% (41) compared with the second quarter. Unlike last quarter, this was mainly attributable to the 39% increase seen in females aged between 15 and

44 years (figure 1). Male cases in this age group decreased by 9% this quarter compared to last.

Risk factor information is incomplete making the trends difficult to interpret. The increase in female cases in the July to September quarter could be secondary cases acquired from men. Alternatively, a different exposure, such as travel abroad, could have led to a different underlying trend that is seen, most clearly, in females aged between 15 and 44.

Regional reporting variation continues to present a challenge to surveillance. A total of 397 cases of hepatitis A were formally notified in the third quarter of 2002, 10% more than laboratory confirmed. This represents a change from last quarter, where more laboratory confirmations were made than formal notifications. In the South East region, 11 laboratory reports were made, while 30 cases were formally notified. Similarly in London, 19 cases were formally notified while only seven laboratory reports were made. Under-reporting by London laboratories continues to impede surveillance, and potentially control measures, in the capital, although populations at high risk are concentrated in the city. Although the number of notifications exceeded the number of laboratory reports for most regions, in the North East, South West, and West Midlands the number of laboratory confirmations remained higher. As in the previous quarter, the greatest disparity occurred in the South West region with 59 laboratory reports made and 34 cases formally notified. This discrepancy is probably due to under-notification by GPs in the area.

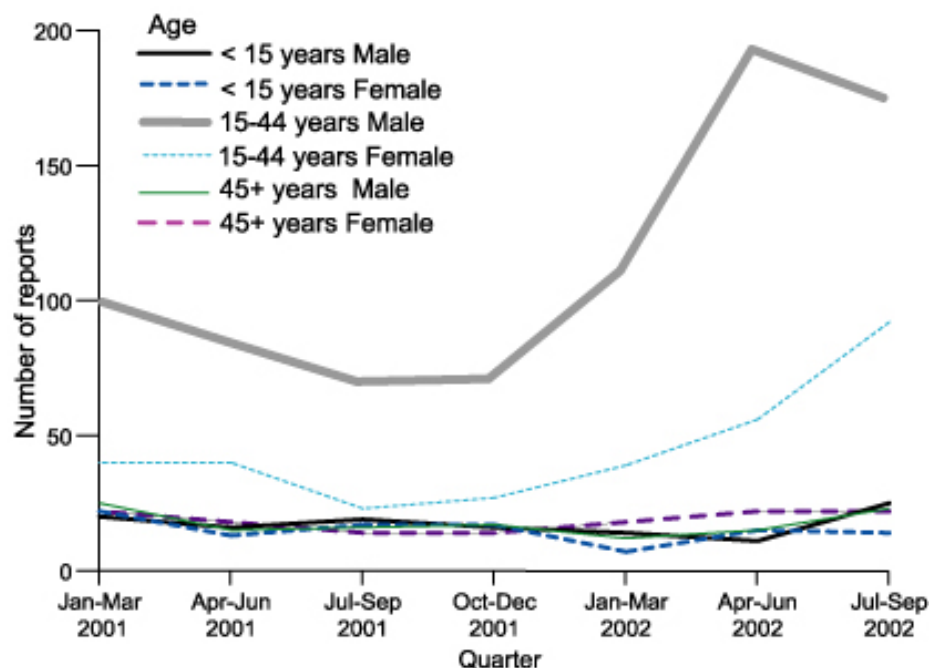
**Table 1 Laboratory reports of hepatitis A in England and Wales: third quarter 2002\***

Age Group (years)	Jul-Sep 2002			
	Male	Female	Not known	Total
<1	–	–	–	–
1-4	4	3	–	7
5-9	12	5	–	17
10-14	7	6	–	13
15-24	75	46	–	121
25-34	84	34	1	119
35-44	16	12	–	28
45-54	7	4	–	11
55-64	8	9	–	17
≥65	10	9	–	19
NK†	–	3	2	5
<b>Total</b>	<b>223</b>	<b>131</b>	<b>3</b>	<b>357</b>

†NK = not known

\* All data are provisional

**Figure 1 Laboratory reports of hepatitis A by age group and sex: January 2001- September 2002**



## Laboratory reports of acute hepatitis B infection by age group and sex in England and Wales: third quarter 2002\*

A total of 158 reports of acute hepatitis B infection were reported to the end of the third quarter of 2002 (table 1). Twenty-six per cent (41/158) occurred in those aged between 15 and 34 years. The majority of cases were in males (72%; 113/158).

Injecting drug use was the main risk factor associated with acute hepatitis B infection, accounting for 48% (31/64) of individuals with known risk factors (table 2). Acquisition through heterosexual sex accounted for 28% (18/64).

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

Age group (years)	Female	Male	NK	Total
<1	1	–	–	1
1-4	–	–	–	–
5-9	–	–	–	–
10-14	–	2	–	2
15-24	22	17	1	40
25-34	35	4	2	41
35-44	27	10	–	37
45-54	16	3	1	20
55-64	8	–	1	9
≥ 65	1	2	–	3
NK†	3	–	2	5
<b>Total</b>	<b>113</b>	<b>38</b>	<b>7</b>	<b>158</b>

\*All data are provisional

†NK = not known

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

Summary	Total
Intravenous drug users	31
Sex between men & women	18
Sex between men	7
Other identified risk	8
No risk information	94
<b>Total</b>	<b>158</b>

\* All data are provisional

## Laboratory reports of hepatitis C infection in England and Wales: third quarter 2002\*

A total of 1554 reports of hepatitis C infection were reported to the end of the third quarter of 2002 (table 1). The majority of cases (63%; 976/1554) were in those aged between 35 and 44 years. The number of cases in males was greater than those in females.

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

Age group (years)	Female	Male	NK	Total
<1	–	–	–	–
1-4	8	8	–	16
5-9	2	1	–	3
10-14	4	1	–	5
15-24	103	72	7	182
25-34	359	170	10	539
35-44	319	111	7	437
45-54	160	56	1	217
55-64	30	26	–	56
≥ 65	19	19	–	38
NK^	38	20	3	61
<b>Total</b>	<b>1042</b>	<b>484</b>	<b>28</b>	<b>1554</b>

\* All data are provisional

^ NK = not known

## Invasive meningococcal infections, England and Wales: laboratory reports, weeks 37-41/02

	Method of diagnosis			Total reports 37-41/02	Cumulative total* 2002
	CSF and blood		Other sites		
	culture	non-culture**	culture		
Group A	–	–	–	–	1
Group B	34	36	3	73	1090
Group C	7	1	–	8	137
Group W135	–	–	–	–	68
Group X	–	–	–	–	3
Group Y	4	–	–	4	21
Group Z	–	–	–	–	–
Group 29E	–	–	–	–	–
Ungroupable	–	–	–	–	1
Ungrouped	–	3	–	3	96
<b>Total</b>	<b>45</b>	<b>40</b>	<b>3</b>	<b>88</b>	<b>1417</b>

## Laboratory confirmed cases of pertussis infection in England and Wales: January to September 2002

**Table 1 Laboratory confirmed cases of pertussis infection in England and Wales by Age Group: January to September 2002**

Age group (years)	PCR and or serology	Culture	Total	Percentage increase in case ascertainment through PCR and/or Serology
< 3 months	11	98	109	11%
3-5 months	4	35	39	11%
6-11 months	–	6	6	0%
1-4 years	13	30	43	43%
5-9 years	23	21	44	109%
10-14 years	14	7	21	200%
≥ 15 years	52	12	64	433%
NK†	–	9	9	0%
<b>Grand Total</b>	<b>117</b>	<b>218</b>	<b>335</b>	<b>53%</b>

Since January 2002, infants ≤ 6months of age with suspected pertussis have been offered PCR testing through RSIL. Adults with a cough persisting for > 21 days and children with a cough persisting for > 14 days, have been offered serology testing through RSIL. These cases are likely to have been culture negative, and testing with PCR and/or serology have increased case ascertainment.

†NK = not known

**Table 2 Laboratory confirmed cases of pertussis infection in England and Wales January to September 2002 by quarter**

Quarter	Method of Diagnosis			Total
	PCR and /or Serology only	Culture	proportion of pcr/serology reports	
Q1	11	63	15%	74
Q2	57	78	42%	135
Q3	49	77	39%	126
<b>Total</b>	<b>117</b>	<b>218</b>	<b>35%</b>	<b>335</b>

The apparent increase particularly in adult cases is explained by the availability of enhanced diagnostic methods which have been increasingly used during the three quarters, as illustrated by the increasing proportion of reports diagnosed by PCR and or serology

## COVER programme : July to September 2002

### Vaccination coverage statistics for children up to five years of age in the United Kingdom

This report of the COVER programme presents coverage data for children in the United Kingdom (UK) who reached their first, second, or fifth birthday during the evaluation quarter, between July and September 2002. This is the ninth quarter to include coverage data on Meningococcal conjugate Group C vaccine (MenC) following its introduction in the UK vaccination programme in November 1999 (1). Children who reached their first birthdays in the quarter would have been scheduled to receive their third dose primary vaccinations (third dose diphtheria, tetanus, pertussis (DTP vaccine), *Haemophilus influenzae* type b (Hib vaccine), polio vaccine, and MenC vaccine) during the period between November 2001 and January 2002. Children who reached their second birthdays would have been scheduled to receive their third dose primary vaccinations during the period between November 2000 and January 2001 as well as their first measles, mumps and rubella (MMR) vaccination during the period between July 2001 and January 2002. Children who reached their fifth birthdays would have been scheduled to receive their third dose primary vaccinations during the period between November 1997 and January 1998; their first MMR during the period between July 1998 and January 2000; their pre-school booster DT; polio; and their second dose MMR from November 2000 onwards. One catch-up dose of MenC would have been scheduled from April 2000 onwards.

### Methods

Data from computerised child-health information systems were submitted in November and December 2002 for children resident in UK health authorities, health boards, and British Forces Germany (BFG) on 30 September 2002 reaching their first, second or fifth birthdays during the evaluation quarter, *ie* from July to September 2002. The numbers were requested of children completing a primary course of each antigen (three doses of diphtheria (D3), tetanus (T3), pertussis (P3), polio (Pol3), *Haemophilus influenzae* type b (Hib3), Meningococcal conjugate Group C (MenC3) vaccines, and one dose of measles, mumps and rubella (MMR1) vaccine any time up to their first or second birthdays. Numbers were also requested for resident children who had received a primary course of each antigen (DTPol3, P3, and Hib3), a preschool booster dose (DTPol4), at least one MMR (MMR1), and two doses of MMR (MMR2) at any time up to their fifth birthdays.

Up to April 2002, COVER data were collected by the Communicable Disease Surveillance Centre (CDSC) for each health authority. Health authorities were dissolved in April 2002 and immunisation coverage is now being collected for Primary Care Trusts (PCTs), which have different boundaries and populations to health authorities. New regional health authority boundaries also came into effect at the same time. To allow comparisons to be made and for continuity, data will continue to be collected for old health authority boundaries and populations for as long as is practicable and will be published in the *CDR Weekly* using the

pre-April 2002 regional health authorities definitions until April 2003. Quarterly data from April 2003 will be published for PCT relevant populations. The data are evaluated against World Health Organization (WHO) targets of 95% coverage for each antigen (except MenC) by two years of age at the national level and of at least 90% coverage in each health authority (2).

## Results

### Coverage at 12 and 24 months

Data were received from all health authorities/health boards in the UK (tables 1 and 2), however, two trusts serving parts of two health authorities were unable to submit data for this quarter. Twenty of the participating health authorities/boards (16.8%) achieved the 95% target at 12 months for three doses of diphtheria, tetanus and polio vaccine (DTPol3), 15 (12.6%) for three doses of pertussis vaccine (P3), and 18 (15.1%) for three doses of Hib vaccine (Hib3). Fifty-seven health authorities/boards (47.9%) achieved 95% coverage at 24 months for DTPol3, 47 (39.5%) for P3, and 52 (43.7%) for Hib3 and all countries/regions, except for London, achieved at least 90% coverage for these antigens. No health authorities/boards achieved 95% coverage for MMR at 24 months. Coverage for the UK was either the same or slightly lower (0.1-0.3%) for all antigens at 12 and 24 months compared to that reported in the previous quarter (3), except for MMR1 at 24 months which fell by 1.3% from 84.3% between April and June 2002 to 83.0% this quarter, and MenC which rose by 0.3%.

The country specific 12 month coverage for MenC vaccine was 89.6% in England, 92.5% in Wales, 94.5% in Northern Ireland, and 94.5% in Scotland. Coverage for the 24 month cohort was 91.8% in England, 94.2% in Wales, 96.3% in Northern Ireland, and 95.5% in Scotland. This is the fourth 24 month cohort to be entirely routinely scheduled for three doses of MenC vaccine.

**Table 1 Completed primary immunisations (all antigens) by 12 months: July to September 2002**

Region/Country	HA* (total)	DTPol3 %	P3 %	Hib3 %	MenC %
Northern & Yorkshire	13 (13)	91.2	90.7	90.9	90.5
Trent	11 (11)	91.1	90.8	91.1	90.7
Eastern	7 (7)	92.2	91.7	92.1	91.6
London	14 (14)	84.1	83.4	83.7	83
South East	13 (13)	92	91.6	91.9	91
South West	8 (8)	93.2	92.6	93.1	92.2
West Midlands	13 (13)	90.9	90.4	91.8	90.9
North West	16 (16)	90.1	89.5	90	90
England (Total)	95 (95)	90.2	89.7	90.1	89.6
Wales	5 (5)	92.9	91.7	92.5	92.5
Northern Ireland	4 (4)	94.6	94.1	94.5	94.5
Scotland	15 (15)	95.5	95.2	95.3	94.5
United Kingdom	119 (119)	90.9	90.4	90.8	89.9

\*Health authorities/health boards participating

**Table 2 Completed primary immunisations (all antigens) by 24 months: July to September 2002**

Region/Country	HA* (total)	DTPol3 %	P3 %	Hib3 %	MenC %	MMR1%
Northern & Yorkshire	13 (13)	94.3	93.5	93.5	92.9	84.9
Trent	11 (11)	95.4	94.9	95.2	94.2	86.7
Eastern	7 (7)	94.6	94	94.5	93.8	83.7
London	14 (14)	87.4	86.9	86.9	84.2	72.9

South East	13 (13)	93.7	93.1	93.3	91.4	83.1
South West	8 (8)	95.5	94.8	95.1	93.9	84
West Midlands	13 (13)	94.7	94	94.3	94.1	85.4
North West	16 (16)	94.4	93.6	93.9	94	84.9
England (Total)	95 (95)	93.3	92.7	92.9	91.8	82.5
Wales	5 (5)	94.6	93.3	94.2	94.2	82
Northern Ireland	4 (4)	96.7	96.2	96.5	96.3	88.5
Scotland	15 (15)	96.9	96.5	96.4	95.5	87.3
United Kingdom	119 (119)	93.7	93	93.2	92.2	83

\*Health authorities/health boards participating

## Coverage at 5 years

Data were received from all health authorities/health boards in England, Wales, and Northern Ireland, although four English trusts were unable to supply data. Coverage at five years increased by 0.1% for DTPol3, 0.2% for P3, 0.8% for MenC, and 0.1% for DTPol4 compared with the previous quarter, while Hib3 fell by 0.3%. Also, MMR1 increased by 0.6% to 90.6% and MMR2 increased by 0.1% to 74.0% (table 3) (3). Country specific data for MenC catch-up coverage at five years was 83.9% in England, 89.5% in Wales, and 91.9% in Northern Ireland (table 3). Data for children reaching their sixth birthday in Scottish health boards were also received for DTPol4 and MMR2; coverage was 95.4% and 91.0% respectively.

**Table 3 Completed primary immunisations (all antigens) by 5 years: July to September 2002**

Region/Country	HA* (total)	DTPol3 %	P3 %	Hib3 %	MenC %	MMR1 %	MMR2 %	DTPol4 %
Northern&Yorkshire	13 (13)	95.4	94.2	94.6	87.3	92.9	79.3	82.3
Trent	11 (11)	96.1	95.3	95.7	87.6	93.7	77.6	81.6
Eastern	7 (7)	94.3	92.4	93.8	87.1	90	77	77.4
London	14 (14)	87.6	86.6	86.6	66.2	82.6	58.9	64.5
South East	13 (13)	93.4	92.6	92.6	85.3	90	74.7	81.1
South West	8 (8)	96.3	95.2	95.5	88.3	92.7	80.2	86.8
West Midlands	13 (13)	95.8	94.4	94.6	88.1	93.4	78.6	84
North West	16 (16)	95.2	93.6	94.4	87.4	92.4	74.9	80.1
England (Total)	95 (95)	93.8	92.7	93.1	83.9	90.5	74.4	79.1
Wales	5 (5)	95.2	92.7	94.6	89.5	89.5	71.1	86.3
Northern Ireland	4 (4)	97.9	96.2	97	91.9	96.3	86.1	88.3
Scotland 6 years†	15 (15)	–	–	–	–	–	91	95.4
England, Wales, and Northern Ireland	104 (104)	94.1	92.8	93.1	84.5	90.6	74	79.2

\*Health authorities/health boards

† No data available at 5 years

## British Forces Germany Health Service

Comparable COVER data have been received from the regions across British Forces Germany (BFG). The BFG child population is approximately 1500 and is spread over five separate geographical regions throughout Germany. The average coverage at 12 months (n = 192) was 98.6% for all antigens; average coverage at 24 months (n = 202) was 96.4% for DTPol3, P3, Hib3, MenC, and 95.1% for MMR1. Average coverage at five years (n = 212) was 95.5% for DTPol3, P3, Hib3, MenC, and MMR, while for MMR2 and DTPol4 the figures were 93.9% and 95.0% respectively.

## MMR sentinel surveillance scheme coverage

In order to give a more timely indication of trends in MMR coverage a sentinel surveillance scheme has monitored MMR coverage in a sample of children becoming 16 and 24 months of age in a particular month was initiated in England from April 1999 . Since March 2002 this information has been routinely collected every month and was recently extended to include coverage at 20 and 36 months of age to help determine whether there is further improvement in coverage due to parents delaying MMR vaccination.

This sentinel scheme is based on a sample of trusts/health authorities in England and represents approximately 20% of the population, although monthly reporting is not always complete for the whole sample. This means that these data are not sufficiently detailed to allow us to compare different regions, and will be subject to greater variability than the national data due to varying monthly sample size. Data collected from October to December 2002 for children in the four age cohorts is summarised in table 4 (range for the three months was 67.7 to 68.8% at 16 months, 76.2 to 76.4% at 20 months, 81.5 to 83.0% at 24 months, and 88.0 to 88.5% at 36 months).

## Comments

Coverage for most antigens at 12 and 24 months of ages is similar to or slightly lower than the previous quarter (3). The exceptions are MenC at 24 months, which increased by 0.3% to 92.2% , and MMR1 at 24 months, which decreased by 1.3% to 83%. MenC also increased at five years and coverage at both 24 months and five years is rapidly approaching levels achieved for other antigens evaluated at these ages. Improvement in coverage of MMR1 at five years was also observed increasing by 0.6% to 90.6%; MMR2 at the same age remained similar compared to the previous quarter at 74%.

The London region continues to report the lowest coverage for all childhood vaccines. At 24 months this is greatest for MMR and MenC. MMR is 10% lower than the UK average and up to 15% lower than the highest achieving English regions/countries, and MenC is 8% lower than the UK average and up to 11% lower than the highest achieving regions/countries. The London Assembly's Health Committee has recently produced a report *Infant immunisation* regarding these issues (4).

Children who reached their second birthdays in this quarter would have been scheduled to receive their MMR during the period between July 2001 and January 2002. There was considerable adverse publicity in relation to MMR vaccine at the end of 2001 and early in 2002, probably resulting in the drop of 1.3% to 83% in MMR1 coverage at 24 months. This decrease was observed across the UK, in all countries, and in each English region (except West Midlands which increased marginally by 0.1%) indicating that the effect was widespread. A survey conducted in May 2002 by Immunisation Information\* showed that the media has an important influence on mothers' attitudes to immunisation with mothers being negatively influenced when media reporting about MMR vaccine was negative (5) and sentinel surveillance of MMR coverage at 16 months shows similar trends to the proportion of mothers who believe MMR is safe (6). The monthly sentinel estimates of MMR coverage at 16 months from September to November 2002 (representing children born between April and June 2001) suggests that routine MMR coverage at 24 months may not improve in the near future (table 4).

Action taken in the last year to improve coverage includes local action plans with additional resources for the health authorities with the lowest coverage, and information provided through the internet (<http://www.mmrthefacts.nhs.uk>). Any improvement in coverage that might result from these initiatives might not be reflected in the 24 month coverage data until the next quarter's evaluation (October to December 2002).

**Table 4 Monthly sentinel estimates of measles, mumps rubella (MMR) coverage at 16, 20, 24, and 36 months: September to November 2002**

Evaluation month	Number of HA/trusts	Age at vaccination			
		16 months	20 months	24 months	36 months
Sep 02	39	68.8%	76.4%	83.0%	88.5%
Oct 02	40	68.5%	76.2%	82.2%	88.3%
Nov 02	39	67.7%	76.2%	81.5%	88.0%

\*Immunisation Information is part of the communicable disease and immunisation team at the Department of Health,

previously at Health Promotion England and the Health Education Authority.

## Links to PHLS website

<[http://www.phls.org.uk/topics\\_az/vaccination/vacc\\_menu.htm](http://www.phls.org.uk/topics_az/vaccination/vacc_menu.htm)>

## Links to other websites

<<http://www.mmrthefacts.nhs.uk>>

<<http://www.doh.gov.uk/public/sb0218.htm>>

## References:

1. Chief Medical Officer, Chief Nursing Officer, Chief Pharmaceutical Officer. *Introduction of immunisation against group C meningococcal infection* (PL/CMO/99/2, PL/CNO/99/4, PL/CPHO/99/1). London: Department of Health, 1999 .
2. WHO Regional Office for Europe. Operational targets for EPI diseases. EUR/ICP/CMDS 01 01 12 Rev.1
3. PHLS. *COVER programme: April to June 2002*. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 21 January 2002]; **12**: immunisation. Available online at <http://www.phls.org.uk/publications/cdr/PDFfiles/2002/cdr3902.pdf>>
4. London Assembly Health Committee. *Infant immunisation*. London: Greater London Authority, 2003
5. PHLS. Effects of media reporting on MMR coverage. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 21 January 2002]; **12**: immunisation Available online at <http://www.phls.org.uk/publications/cdr/PDFfiles/2002/cdr3502.pdf>
6. Ramsay ME, Yarwood J, Lewis D, Campbell H, White JM. Parental confidence in MMR vaccine: evidence from vaccine coverage and attitudinal surveys. *Br J of Gen Prac* 2002; **52**: 912-16.

[Back to top](#)

## Primary care

Last updated: 23 January 2003



### Reporting respiratory illness in the Weekly Returns Service

The RCGP Weekly Returns Service (WRS) collate data on all episodes of illness diagnosed in a sample of general practices well distributed throughout England and Wales, covering 1.2% of the national population. The incidence of influenza/influenza-like illness (ILI) is reported via the CDSC twice weekly during the winter but data on all other respiratory conditions split by age group and gender are also available. This report focuses covers respiratory illnesses in 2001/02 to provide a review against which the incidence for the 2002/03 season can be compared. The RCGP Research Unit based in Birmingham hold data for up to 30 years on some conditions, which have been used to monitor secular trends and to calculate average and baseline incidence levels of common infectious diseases. These data can be made available to scientific researchers on request.

The unit has traditionally reported respiratory illnesses by disease and in groups as follows:

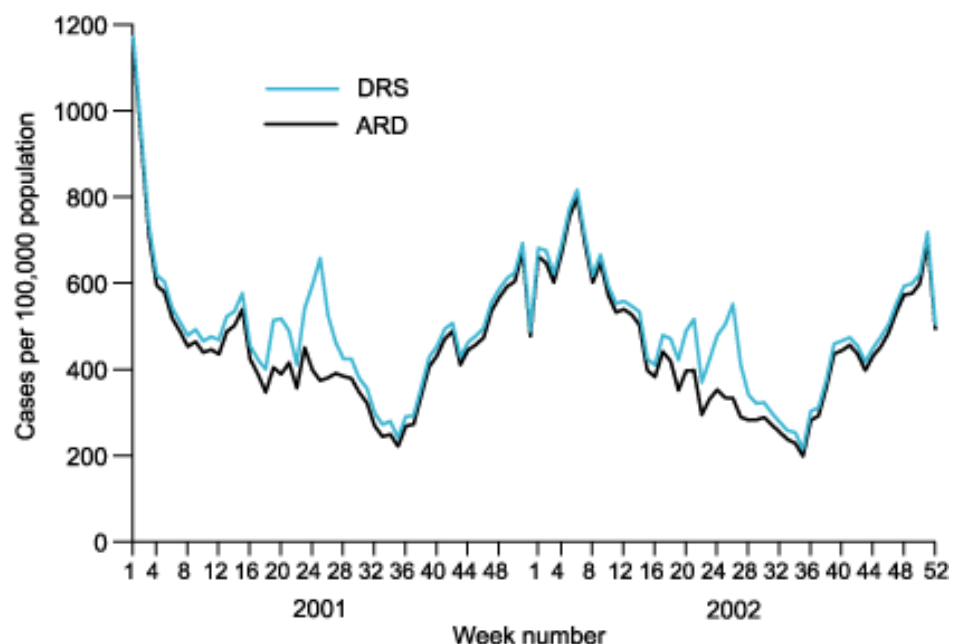
**Upper respiratory tract infection (URTI):** common cold, acute otitis media, sinusitis and tonsillitis

**Lower respiratory tract infection (LRTI):** laryngitis, acute bronchitis, influenza / influenza-like illness (ILI), pleurisy and pneumonia.

**Aggregated respiratory disease (ARD):** URTI but excluding otitis media (which is not classified as a respiratory disorder within the ICD classification), plus LRTI, plus selected codes in the range ICD 472-519 indicative of a new episode of infection.

In future, instead of presenting data on aggregated respiratory disease (ARD), data for respiratory diseases will be grouped in accordance with the entire ICD Chapter Diseases of the Respiratory System, abbreviated DRS. This decision has been taken for two reasons: firstly because ARD represents about 95% of the total DRS rate; and secondly, because the rate for DRS is directly comparable with mortality and hospital episode data published from other sources. A comparison of incident data for DRS with ARD is presented graphically for the 104 weeks of 2000 and 2001 in the figure below. The rates were very similar during the winter, two additional peaks were seen in DRS in the summer due to the inclusion of hay fever (allergic rhinitis) which is not included in ARD. The ability to review historical data using ARD as opposed to DRS will be retained.

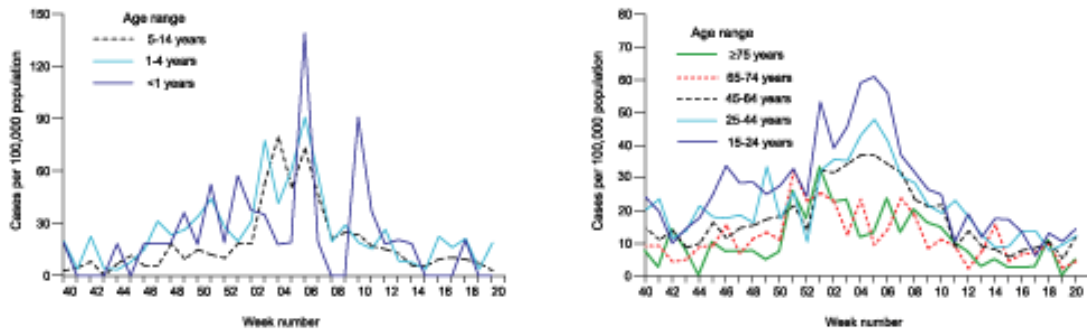
**Figure Diseases of the respiratory system (DRS) vs aggregated respiratory diseases (ARD), England and Wales: 2001 to 2002**



## Review of respiratory illness during winter 2001-02

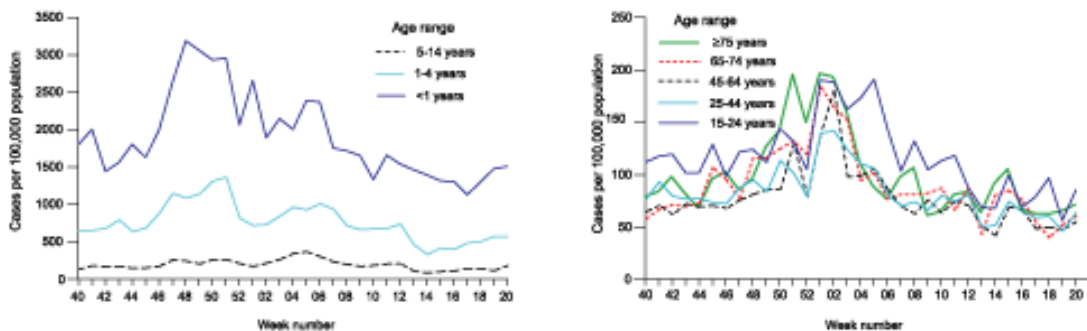
For reporting purposes, winter is defined commencing with week 40/2001 and ending week 20/2002. This arbitrary definition retains comparability with other European sentinel practice surveillance systems. The graphs presented summarize the data separately for children (0 to 14 years) and adults (15 years and over). The y axes are necessarily different because the incidence in children is usually much higher than in adults, though where possible the y axis for children is a multiple of that of adults to allow easy comparison.

### Influenza / influenza - like illness



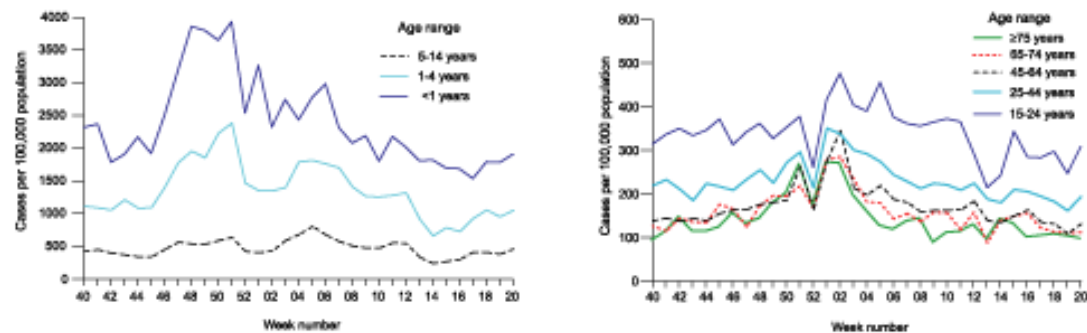
Levels of ILI were very low last winter with the highest activity occurring during the first few weeks of 2002. The peak for all ages was seen in week 6 with a mean weekly incidence of 45 per 100,000. The highest incidence levels were seen in children and young adults with very little activity in the elderly.

### Common cold



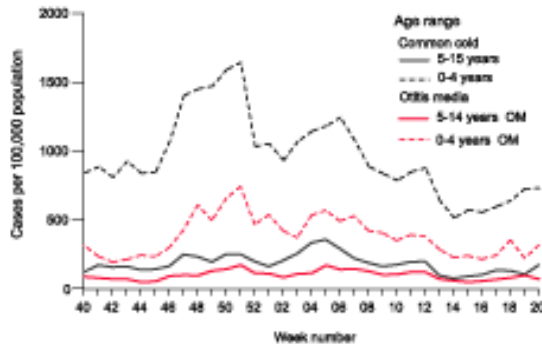
Levels of common cold were highest in children, peaking before Christmas. The main peaks in adults occurred at the start of the new year.

### Upper respiratory tract infections



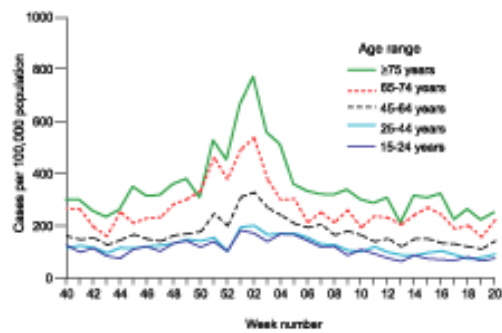
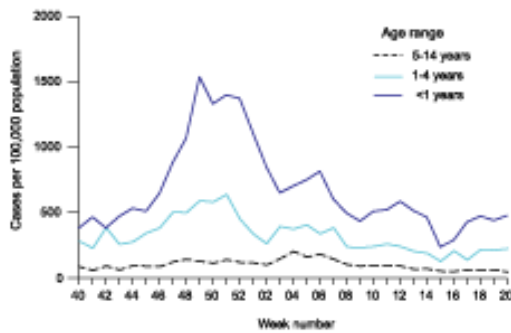
The general pattern of the timing of URTI peaks followed that of common cold (which is its largest component). However, in adults the age-specific pattern was slightly different with higher levels of URTI seen in young adults, this was due to a higher incidence of tonsillitis in these groups.

## Acute otitis media



Acute otitis media is seen mainly in children (incidence was around 20 fold higher than adults for the winter 2001-02). The peak in acute otitis media (OM) occurred at the same time of the year as the peak in common cold (CC), this mirror image between the two diseases is seen each winter.

## Lower respiratory tract infection



Levels of LRTI were highest in the under 1 year and over 75 year age groups, the major contributor to LRTI is acute bronchitis (the graphs for acute bronchitis alone appear very similar to these and are not shown separately). Last winter followed the traditional pattern with a peak in acute bronchitis in children just before Christmas and a peak in the elderly in the new year.

## Diseases of the respiratory system

