

Volume 13
Number 06
6 February 2003

CDR WEEKLY



NEWS

Main stories this week:

ENTERIC

[Increasing Influenza B activity](#)

RESPIRATORY

[Training fellowships for intervention epidemiology in Europe](#)

IMMUNISATION

HIV/STIs

HIV/STIs

BACTERAEMIA

[AIDS and HIV infection in the United Kingdom: monthly report January 2003](#)

ZOONOSES

Respiratory

TRAVEL HEALTH

[Laboratory reports of respiratory infections made to CDSC from PHLS and NHS laboratories in England and Wales](#)

PRIMARY CARE

DIARY

Travel

[Schistosomiasis in Travellers](#)

Zoonoses

[Common animal associated infections, England and Wales: laboratory reports, weeks 01 - 05/03](#)

[Common imported infections, England and Wales: laboratory reports, weeks 01 - 05/03](#)

Diary

[Immunisation theory and practice](#)

[Epidemiology and control of communicable diseases and environmental hazards Monday](#)

BACK ISSUES

SEARCH

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Disease Surveillance
Centre

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NEWS

News

Last updated: 6 February 2003

Next update due: 13 February

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

Contents

BACTERAEMIA

[Increasing Influenza B activity](#)

ZOONOSES

[Training fellowships for intervention epidemiology in Europe](#)

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

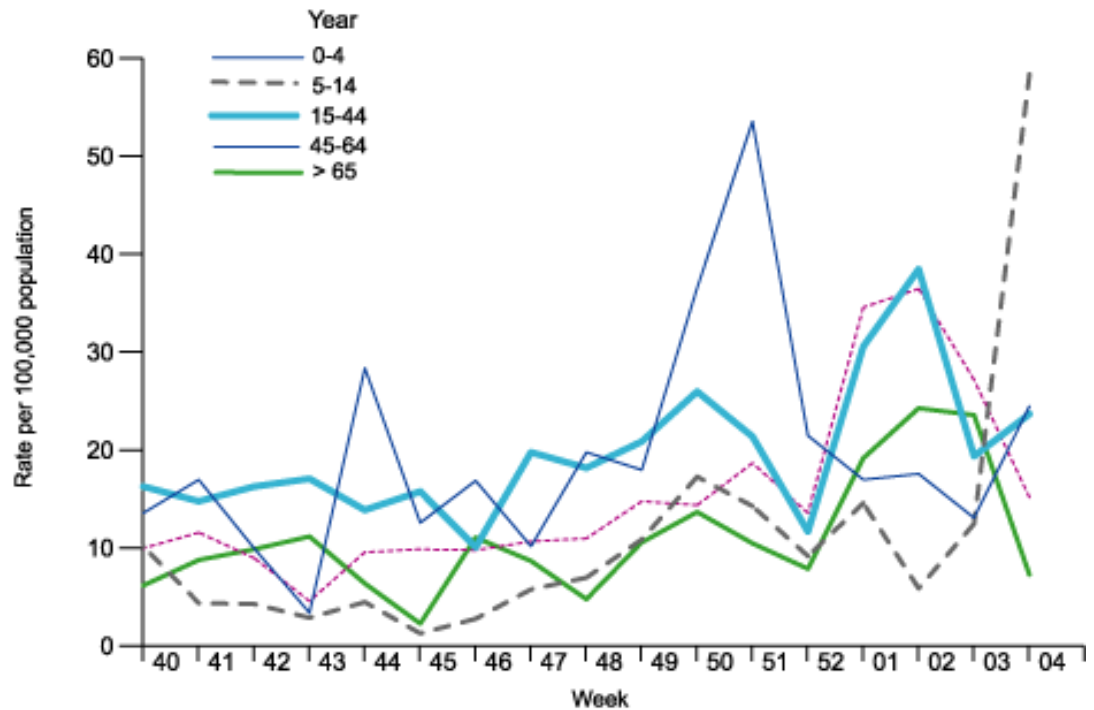
[Top](#) |

Increasing Influenza B activity

The Communicable Disease Surveillance Centre (CDSC) has received the first reports for the 2002-3 season, of outbreaks of influenza-like illness, all of which have occurred in schools. Three outbreaks were reported from schools in the south of England during weeks four and five (week ending 2 February 2003) and influenza B virus has been laboratory confirmed in all three outbreaks. Attack rates have ranged from 15% to 58%. Additional reports of outbreaks have since been received from the north of England where influenza activity has been detected in several schools through the monitoring of school sickness absence rates.

Overall this season in the United Kingdom (UK), both laboratory detections and clinical indicators for influenza have been low, with influenza B comprising the majority of laboratory reports. Indicators in England, however, in the last few weeks from both the Royal College of General Practitioners (RCGP) weekly returns sentinel service for consultation rates for influenza-like illness (figure 1) and calls to NHS Direct for "cold/flu", have shown an increase in the 5 to 14 year age group for week four, suggesting rising influenza B activity in children. Influenza B traditionally causes milder symptoms than influenza A and commonly affects the younger age groups.

RCGP consultation rate for influenza and influenza-like illness by age, England 2002/03



This season, In Europe and the United States, influenza B has also been the major influenza virus in circulation. Confirmation of the virological cause of outbreaks of influenza-like illness, and other outbreaks of acute respiratory illness, may be of value in the management of the local outbreak, while contributing to the surveillance of influenza virus strains that may be relevant for future vaccine composition. CDSC would be pleased to hear about outbreaks, including the results of investigations of such outbreaks in collaboration with local microbiological laboratories (please contact Jonathon Crofts: 020 8200 1295 ext 4649, email: jcrofts@phls.org.uk). The PHLS Influenza Reference Laboratory, also has the capacity for rapid and sensitive detection of respiratory virus' using PCR and can supply kits for sample taking and direct submission to anyone requesting them. Any positive isolations should be referred to the Enteric, Respiratory and Neurological Virus Laboratory (ERNVL) for further characterisation. (Please contact: Kelly Batey: 020 8200 4400 ext 3258, email: kbatey@phls.org.uk).

[Top |](#)

Training fellowships for intervention epidemiology in Europe

Applications are being invited for places on the European Programme for Intervention Epidemiology Training (EPIET). Applicants for the 2003 cohort must be nationals of a European Union (EU) member country or Norway, and should have experience in public health, a keen interest in fieldwork, and be pursuing a career involving public health infectious disease epidemiology. They should have a good knowledge of English and of at least one other EU language, and be prepared to live abroad for 24 months.

The aim of the training is to enable the fellow to assume service responsibilities in communicable disease epidemiology. The in-service training will focus on outbreak investigations, disease surveillance, applied research, and communications with decision makers, the media, the public and the scientific community.

Fellows will attend a three-week intensive introductory course and then be located in a host institute in one of the 15 participating European countries or Norway. Further training modules are organised during the two-year programme, normally in one of the participating national institutes with responsibility for communicable disease surveillance.

The programme, which started in 1995, is funded by the European Commission and by various EU member states as well as Norway and the World Health Organization. The ninth cohort of fellows is planned, starting in October 2003, subject to agreement for another round of funding.

Detailed information can be obtained from the EPIET programme office at the address below. Letters of application accompanied by a curriculum vitae should be submitted by 28 February 2003 to: EPIET Programme Office, Swedish Institute for Infectious Disease Control (SMI) / EPI, SE-171 82 Solna, Sweden; tel: +46 8 457 23 70; Fax: +46 8 30 06 26; email carole.desmoulins@smi.ki.se. Further information can be found on the EPIET website at <http://www.EPIET.org>.

[Back to top](#)

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

HIV/STIs

Last updated: 6 February 2003
Next update due: 27 February 2003

Contents

[AIDS and HIV infection in the United Kingdom: monthly report January 2003](#)

[PDF |](#)

AIDS and HIV infection in the United Kingdom: monthly report January 2003

United Kingdom (UK) data from the PHLS HIV and STI Division, Scottish Centre for Infection and Environmental Health, Institute of Child Health, London, and Oxford Haemophilia Centre (on behalf of UK Haemophilia Centre Doctors' Organisation)

One thousand five hundred and thirty-two reports of new HIV diagnoses were received in the last quarter of 2002. This brings the total for the United Kingdom (UK) HIV data set to 54,261 since AIDS reporting began in 1982. Thirty-five percent (19,166) of the total have been diagnosed with an AIDS defining condition, of which 12,544 (65%) have died. A further 2455 (4.5%) of the total have died without having had a report of an AIDS defining condition. Some of the individuals reported may have left the country, and there may also be some multiple reports of individuals due to transcription errors, incomplete reports, and name changes. This means that it has not been possible to match all related reports

The total number of reports received for 2001 now stands at 4,909, which is the highest for any year of reporting since reporting began (table 1). Fifty-six percent (2749) of the reports for 2001 showed the probable route of infection to be sex between men and women; this is the highest proportion of reports infected via this route in any year. Sex between men accounted for 34% (1662) of reports of new infections. The number of reports for 2002 is 4202 and this figure is likely to rise substantially due to reporting delay. The equivalent figure for 2001 at the same time last year was 3342. Two thousand one hundred and ninety-nine (52%) reports in 2002 were from individuals infected through sex between men and women and 1,195 (28%) were infected through sex between men. The proportion of those infected through sex between men and women is likely to rise as follow up occurs on those whose route of infection was undetermined in 2002 and as new reports of infections diagnosed in 2002 are received. The proportion of those infected through injecting drug use (IDU) has fallen each year since 1995. In 2001 there were 123 (2.5%) reports of new diagnoses infected through IDU. Sixty-four new diagnoses were reported in 2002, of those infected through IDU was 64, which accounts for 1.5% of the total infections reported. Mother-to-infant transmission accounted for less than 2% (57) of reports of new diagnoses in 2002.

Table 1 HIV infected individuals* by year of first reported UK† diagnosis: UK data to end of December 2002

How infection was probably acquired	<1992	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Total
Sex between men ‡	12,782	1639	1497	1483	1467	1542	1399	1349	1337	1483	1662	1195	28,835
Sex between men and women	2255	780	766	796	850	836	1006	1157	1422	1974	2749	2199	16,790
Injecting drug use	2304	187	205	167	181	172	167	130	111	106	123	64	3917
Blood factor	1333	4	4	2	–	2	2	2	1	1	2	2	1355
Blood/tissue transfer	163	20	13	15	20	18	25	8	18	22	22	8	352
Mother to infant	117	57	66	63	60	61	82	93	82	101	81	57	920
Other/undetermined	527	53	63	48	65	56	49	67	83	132	270	679	2092
Total	19,481	2740	2614	2574	2643	2687	2730	2806	3054	3819	4909	4204	54,261

*Individuals with laboratory reports of infection, or with AIDS or death reported but no matching laboratory report, numbers, particularly for recent years, will rise as further reports are received.

†includes 68 individuals first reported from the Isle of Man or the Channel Islands.

‡includes 694 men who also injected drugs

In 2001 new regional boundaries came into force in the NHS. The number of HIV diagnoses by year of diagnosis and region of report are shown in table 2. The regions have been ‘mapped’ so the data are shown using the ‘new’ boundaries. The focus of the HIV epidemic is mainly in London and the South East, with 69% of all new diagnoses occurring in these regions. London accounts for 60% of all new diagnoses overall. There has been a slight reduction in the proportion of diagnoses overall in London from 61% in 1992 to 53% in 2002. In the same period the proportion of new diagnoses overall in the South East region has risen from 8% to 12% and in the Eastern region there has been an increase from 3% to 9% during the same period. The North West region has the third largest number of diagnoses in the UK, accounting for 6% overall diagnoses. The number in this region, however, is lower than expected for 2002 due to reporting delay as the numbers are collated locally in this region before reporting to the UK database, and numbers are therefore expected to rise considerably. The number of reports in England has risen by 54% from 2544 in 1992 to 3937 in 2002. The largest proportional rise has occurred in the Eastern region, where new diagnoses have increased from 90 in 1992 to 375 in 2002, a rise of 316%. The numbers in Scotland have increased from 132 in 1992 to 202 in 2002, a rise of 53%.

Table 2 HIV infected individuals* by year of first reported UK diagnoses and region or country of report: U.K. data to end of December 2002

Country/region of report	<1992	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Total
North East	330	38	21	32	20	23	35	21	28	33	47	51	679
Yorkshire & Humberside	633	86	80	66	80	90	81	85	91	99	179	190	1760
East Midlands	351	69	68	57	51	47	44	60	80	101	193	185	1306
Eastern	461	90	83	61	76	55	77	85	94	185	305	375	1947
London	11,709	1695	1623	1584	1680	1703	1715	1760	1950	2332	2706	2236	32,693

South East	1577	226	221	232	168	227	215	203	214	351	494	524	4652
South West	640	85	68	108	86	77	91	104	101	103	132	140	1735
West Midlands	609	83	83	75	98	62	98	106	100	177	211	194	1896
North West	1094	172	146	146	179	186	147	185	203	225	394	42	3119
England (total)	17,397	2544	2393	2361	2438	2469	2503	2609	2861	3606	4661	3937	49,779
Wales	276	51	40	46	46	36	44	30	34	46	64	48	761
Northern Ireland	97	12	12	14	12	16	9	9	14	19	19	17	250
Scotland	1676	132	167	145	146	159	166	153	144	147	158	202	3395
UK Total	19,453	2739	2612	2566	2642	2681	2722	2801	3053	3818	4902	4204	54,193
Channel Islands/Isle of Man	28	1	2	8	1	6	8	5	1	1	7	-	68

*Individuals with laboratory reports of infection, or with AIDS or death reported but no matching laboratory report, numbers, particularly for recent years, will rise as further reports are received.

[Back to top](#)



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

Respiratory

Last updated: 6 February 2003

Next update due: 6 March 2003

Contents

[Laboratory reports of respiratory infections made to CDSC from PHLS and NHS laboratories in England and Wales](#)

[PDF](#) |

Laboratory reports of respiratory infections made to CDSC from PHLS and NHS laboratories in England and Wales

Data are recorded by week of report, but include only specimens taken since 11 November 2002, *ie* recent specimens.

Table 1 Reports of influenza infection made to CDSC, by week of report, weeks 01-05/03

Week	01/03	02/03	03/03	04/03	05/03	Total
Week ending	05/01/03	12/01/03	19/01/03	26/01/03	02/02/03	
Influenza A	2	7	6	1	4	20
Isolation	–	–	–	–	–	–
DIF	1	2	1	–	1	5
Four-fold rise in paired sera	1	–	–	–	–	1
PCR	–	–	–	–	–	–
Other	–	5	5	1	3	14
Influenza B	1	14	11	14	18	58
Isolation	1	5	6	3	7	22
DIF	–	5	2	5	2	14

Four-fold rise in paired sera	-	-	-	-	-	-
PCR	-	0	-	-	-	-
Other	-	4	3	6	9	22
Influenza (untyped)	-	-	-	-	-	-
Isolation	-	-	-	-	-	-
DIF	-	-	-	-	-	-
Four-fold rise in paired sera	-	-	-	-	-	-
PCR	-	-	-	-	-	-
Other	-	-	-	-	-	-

DIF = Direct Immunofluorescence.

'Other' = 'Antibody detection - Single high titre' or 'method not specified'

Table 2 Respiratory viral detections by any method (culture, direct immunofluorescence, PCR, four-fold rise in paired sera, single high serology titre), by week of report), weeks 01-05/03

Week	01/03	02/03	03/03	04/03	05/03	Total
Week ending	05/01/03	12/01/03	19/01/03	26/01/03	02/02/03	
Adenovirus*	5	45	22	31	53	156
Coronavirus	-	-	-	-	-	-
Parainfluenza **	5	10	4	-	8	27
Rhinovirus	3	13	2	1	16	35
Respiratory Syncytial Virus (RSV)	389	818	429	165	294	2095

Note: 277 (48%) out of the 608 reports

*Respiratory samples only. Excludes diagnoses made by electron microscopy (EM)

**includes parainfluenza types 1, 2, 3, 4, and untyped

Table 3 Respiratory viral detections by age group, weeks 01-05/03

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	65+ years	Unknown	Total
Adenovirus*	22	29	12	62	21	2	8	156
Coronavirus	-	-	-	-	-	-	-	-
Influenza A	1	2	3	3	7	3	1	20
Influenza B	9	7	19	15	6	2	0	58
Parainfluenza**	11	6	1	2	3	3	1	27

Rhinovirus	24	4	1	-	2	-	4	35
Respiratory Syncytial Virus (RSV)	1711	194	21	20	19	18	112	2095

*Respiratory samples only. Excludes diagnoses made by electron microscopy (EM)

**includes parainfluenza types 1, 2, 3, 4, and untyped

Table 4 Laboratory reports of infections associated with atypical pneumonia by week of report

Week	01/03	02/03	03/03	04/03	05/03	Total
Week ending	05/01/03	12/01/03	19/01/03	26/01/03	02/02/03	
<i>Coxiella burnettii</i>	-	-	1	-	1	2
respiratory <i>Chlamydia</i> sp.*	3	7	1	-	3	14
<i>Mycoplasma pneumoniae</i>	29	32	37	29	77	204
<i>Legionella</i> sp.	2	3	3	5	2	15

*includes *Chlamydia psittaci*, *Chlamydia pneumoniae* and *Chlamydia* sp detected from blood, serum and respiratory specimens

Table 5 Reports of legionnaires' disease (pneumonic and non-pneumonic*) cases in England and Wales, by week of report

Week	01/03	02/03	03/03	04/03	05/03	Total
Week ending	05/01/03	12/01/03	19/01/03	26/01/03	02/02/03	
Nosocomial	-	-	-	1	-	1
Community	2 (1)	-	1	2 (1)	2	7 (2)
Travel abroad	-	3	2	2	-	7
Travel UK	-	-	-	-	-	-
Total	2 (1)	3	3	5 (1)	2	15 (2)
Male	2 (1)	3	2	4 (1)	1	12 (2)
Female	0	0	1	1	1	3

* non-pneumonic cases in brackets

Fifteen cases were reported with pneumonia and two as non-pneumonic cases. Fourteen were male aged between 40 and 75 years and three were female aged 26, 51, and 54 years. One F 54y died. Seven cases were associated with travel: China (2), France (1), Holland (1),

Spain (1), USA (1) and one case travelled to both the UK and Spain (1). The case who travelled to France is associated with a cluster. Nine cases, eight males aged between 40 and 75 years and One F 26y had community acquired infection. One F 54y had a possible nosocomial infection.

[Back to top](#)



NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

Travel health

Last updated: 6 February 2003

Next update due: 6 March 2003

Schistosomiasis in travellers

Introduction

Schistosomiasis is a parasitic infection caused by blood flukes (trematodes) of the genus *Schistosoma*. The intermediate host is an aquatic or amphibious snail. Humans become infected when the skin is penetrated directly by the cercaria larvae found in fresh water inhabited by infected snails. It is also known as Bilharziasis in some endemic countries after Theodore Bilharz, who described the infection in 1851 (1). The World Health Organization (WHO) describes schistosomiasis as 'the second most important (tropical disease) in terms of public health importance' after malaria. It is endemic in 76 developing countries, putting over 600 million people at risk of infection. Over 200 million people have been estimated to be infected worldwide, with 20,000 deaths annually; visitors from non-endemic countries such as the United Kingdom (UK) may also be at risk from being infected (2).

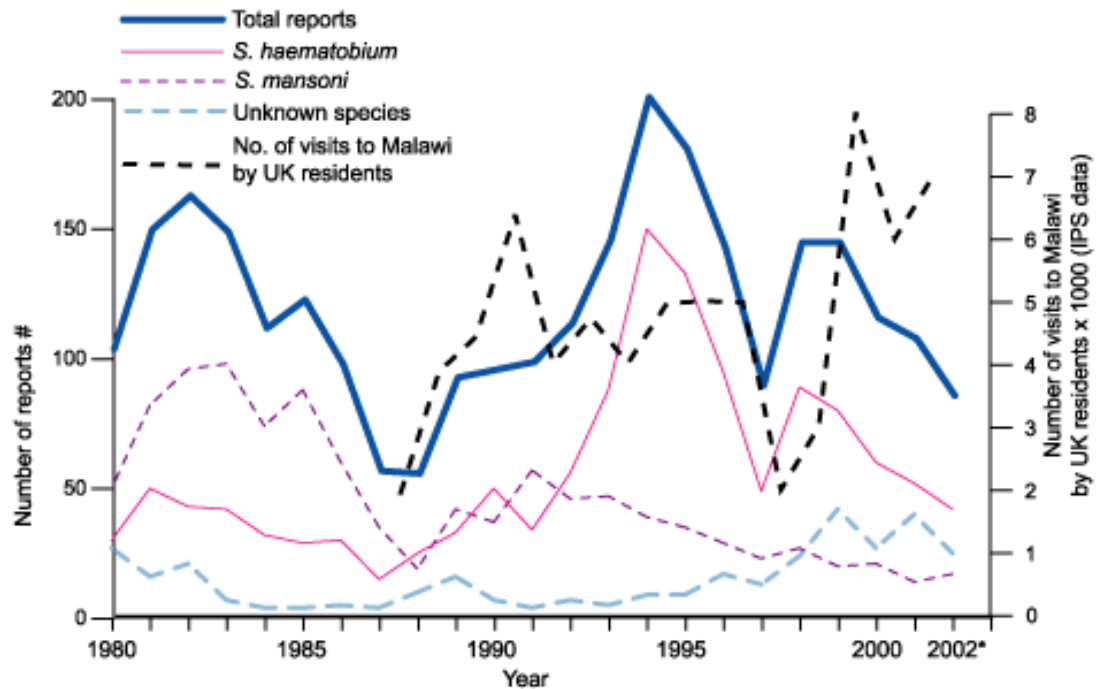
Epidemiology

Most of the pathology of schistosome infections is caused by fibro-obstructive lesions associated with eggs trapped in the tissues, but because the adult worms do not multiply in the human host, many infections are light. Eggs are the main cause of the two clinical forms of the disease; urinary schistosomiasis caused by *S. haematobium* and intestinal schistosomiasis caused by other species. *S. haematobium*, *S. mansoni*, and *S. japonicum* are the three major species of schistosome that cause human disease; they predominate in different areas of the world. Other species causing human infection include *S. intercalatum*, *S. mekongi*, *S. malayensis*, and *S. mattheei* but these occur in limited foci.

S. haematobium occurs in 53 African countries (particularly prevalent in East Africa and Lake Malawi), including the islands of Madagascar and Mauritius and the Middle East. It is also known to occur in a few small areas of India. *S. mansoni* has a similar distribution throughout sub-Saharan Africa and the Middle East, but it is also found in some Caribbean islands, Brazil, Venezuela and the coast of Suriname. *S. japonicum* is found only in Southeast Asia and the western Pacific. *S. intercalata* is found in jungle areas of central and western Africa. The epidemiology of schistosomiasis can be affected by environmental changes, and construction of water control projects can lead to shifts in snail vector populations (3). For example, intestinal schistosomiasis increased in Ghana after the construction of the Akosombo Dam and other smaller dams (2). Population movements have also extended the disease's range in some areas.

Cases in the UK

Figure 1. Laboratory reports of schistosomiasis to CDSC England and Wales: 1980 to 2002*



*All data for 2002 are provisional
 # Before 1998 data extracted using year of report to CDSC, 1998 onwards year of first specimen date
 Source: annual computer printouts 1975 -88 (form 20s); Oracle database from 1989

There has been a shift in the predominant species identified in returning travellers over the last 20 years (figure 1); *S. mansoni* was predominant during the 1980s with *S. haematobium* achieving dominance during the 1990s. There has been a decline in the number of reports to the Communicable Disease Surveillance Centre (CDSC) since a peak of nearly 200 reports in 1994 although the data are not yet complete for 2002, due to reporting delays. These changes may be in part, accounted for by reporting artefacts and changes in the travel patterns of UK residents. For example, there are similarities between the patterns of laboratory reports and the number of visits to Malawi by UK residents (4).

Travel history in general is under-reported; table 1 shows travel details for reports over the last five years.

Table 1 Number of laboratory reports to CDSC with Travel History

	1998	1999	2000	2001	2002*
Africa (% Malawi/Lake Malawi)	68 (45)	60 (50)	56 (41)	22 (45)	20 (10)
Middle East	1	–	4	–	–
India	–	1	–	–	–
Far East/Asia	–	2	–	–	–
South America	–	–	1	–	–
Country unspecified	2	3	2	1	2
Travel history unknown (% of total)	72 (50)	77 (54)	51 (45)	83 (78)	62 (74)
Total reports	143	143	114	106	84

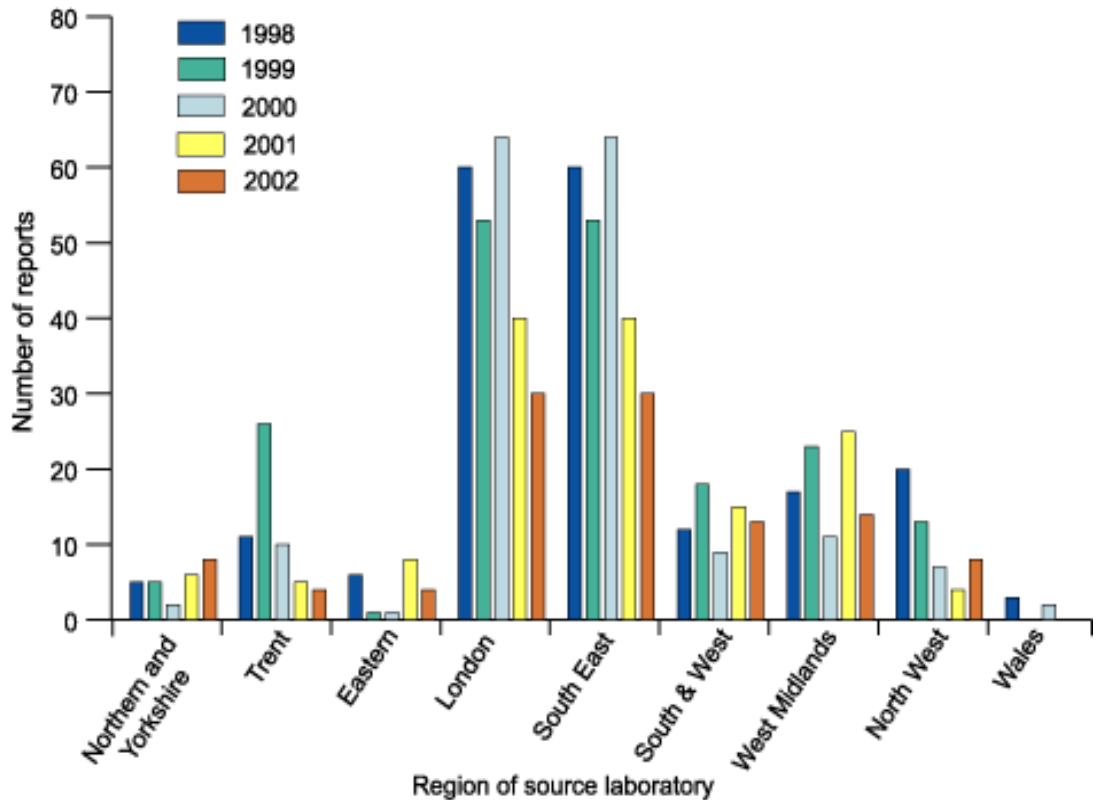
*All data for 2002 are provisional

Total reports

A high proportion of the total reports, have not had any travel details included. Since schistosomiasis is not endemic in the UK, it is reasonable to assume that all the cases will be associated with travel to, or migration from endemic countries. (Only a small proportion of reports have been received from residents of endemic countries – personal communication, Dr Robert Smith, Zoonoses Unit, CDSC Wales).

Those who have lived in endemic countries for a long time may often have asymptomatic infections. Of those reports with recorded travel details, the majority are associated with travel to Africa, 40 to 50% of these to Malawi or Lake Malawi. These figures should be interpreted with some caution, however, as some reports may list more than one country per case.

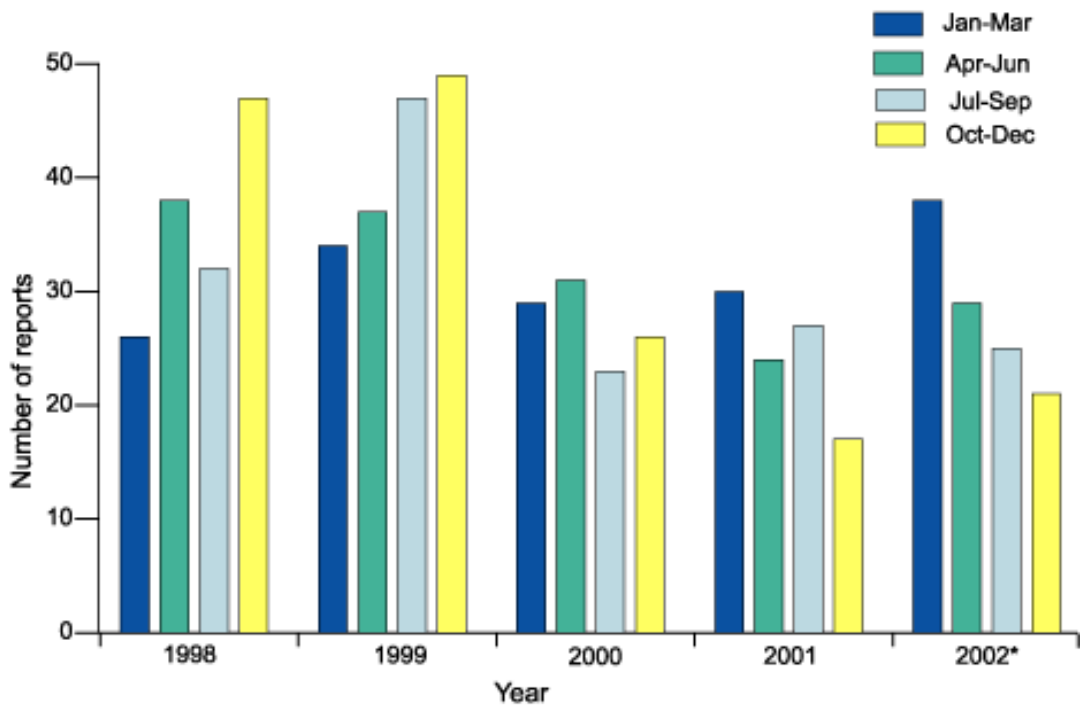
Figure 2 Schistosomiasis (all species) reports to CDSC by region of source laboratory: 1998-2002*



*All data for 2002 are provisional

In the last five years, the majority of reports have been from London laboratories (figure 2), which may in part be a reporting artefact, reflecting the presence of the PHLS Parasitology Reference Laboratory, as well as differences in regional travel patterns..

Figure 3 Schistosomiasis (all species) reports to CDSC by specimen quarter #: 1998-2002*



*All data for 2002 are provisional

Reports per quarter worked out by using specimen month data

Prior to 2000 more cases were reported towards the end of the calendar year, in more recent years most reports have been received at the beginning of the calendar year. This may reflect reporting artefacts or a change in travel patterns (figure 3).

Reservoir and Transmission

Schistosomiasis is acquired from fresh water containing free-living, larval forms of the parasite (cercariae) that develop in some snail genera. The cercaria shed by the snail pierces the epidermis of a definitive host entering the water (man or animal), and, depending on the species of the organism, sheds its tail to become an invasive schistosomulum. The invasive schistosomula enter the bloodstream via the lymphatic system and reach the lungs where they remain for a short time, after which they localise in the hepatic-portal system where blood feeding begins and they reach sexual maturity. The male and female mate and migrate to sites of oviposition in either the blood vessels lining the intestine (*S. mansoni* and *S. japonicum*) or the bladder (*S. haematobium*). Between 200 and 2000 eggs may be laid by the female each day; these may be excreted in the faeces or urine, reinitiating the cycle, or remain trapped in body tissues causing damage to vital organs such as the liver or the bladder.

Once the eggs are excreted via the faeces or urine, they may contaminate fresh water sources and infect the snail host where new parasites will develop and be released into the surrounding water. The cycle starts again by infecting humans who may be using the water for work, recreation, or hygiene purposes.

Clinical Features

Most of the pathology of schistosome infections is caused by the eggs. The disease can vary in severity; the intensity of infection depends on the amount of exposure to cercariae. The majority of people harbour relatively few parasites. Slight infections may be asymptomatic; repeated exposure in endemic areas is an important cause of severe chronic illness. Children between 10 and 19 years, fishermen, and those who enter the water frequently are most at risk in endemic areas (2).

The symptomatology of schistosomiasis can be thought of in four phases. The first phase corresponds to penetration by cercariae, and sometimes presents as dermatitis. The second phase corresponds to invasion by the schistosomula; where they enter the bloodstream and are carried to the blood vessels of

the lungs. This stage may be asymptomatic or there may be a dry cough as the parasite passes through the pulmonary capillaries. The third phase, the acute or toxæmic stage, occurring after 15 to 20 days (Katayama syndrome), corresponds to maturing infections of *S. mansoni* or *S. japonicum* and may be accompanied by fever, lymphadenopathy, splenomegaly, eosinophilia, and diarrhoea. This can be particularly severe in non-immune travellers. Acute bowel disease may occur after six to eight weeks with a dysentery-like diarrhoea and weight loss and may persist for six to 12 months. In infections caused by *S. haematobium*, the lesions and symptoms mainly involve the urogenital tract, and to a lesser extent, the intestine. Fourth or chronic phase manifestations may occur if the infection is left untreated and/or after repeated exposure. This corresponds to proliferation of the parasites and tissue inflammation caused by egg deposition in different organs. This may result in liver fibrosis, portal hypertension and possible colorectal cancer in the intestinal form or, in the urinary form, obstructive uropathy, infertility and possibly bladder cancer (5).

Larval forms of the schistosomes are also involved in the disease process. Repeated penetrations of the skin by cercariae (particularly of non-human species of schistosomes which die in the epidermis) can cause a severe form of dermatitis ('swimmers' itch'), which may last for 24 to 48 hours). (Over the years, there have been a few epidemics of 'swimmers' itch' in the UK due to bird schistosomes – personal communication, Professor David Bradley, London School of Hygiene and Tropical Medicine). The first signs and symptoms appear between 10 and 30 minutes after exposure when the infected person feels a transitory itching. This corresponds to migration of larvae in the skin; macules appear but vanish within 10 to 24 hours. Between 5 and 14 days after initial infection, small papules appear, accompanied by temporary itching where the macules had been; these constitute an allergic reaction to the dead parasite. Individuals sensitised by previous exposures suffer a more accelerated and intense response.

Diagnosis

The PHLS Parasitology Reference Laboratory at the Hospital for Tropical Diseases offer screening to all patients who have been exposed to fresh water in an endemic area, regardless of whether or not they have symptoms. This involves microscopy of stool and terminal urine; eosinophil count, and schistosome ELISA (6). (If looking for schistosome eggs in urine, the largest number are shed in the middle of the day – personal communication, Professor David Bradley, London School of Hygiene and Tropical Medicine).

Clinical diagnosis is important up to the acute stage of Katayama syndrome if symptomatic, or between two and three weeks after. Following this period, eggs are increasingly produced allowing diagnosis by examination of stool or urine samples. If ova are not detected in the stool, a biopsy specimen of the rectum may be obtained and examined. Antibodies appear relatively early in the infection permitting serodiagnosis and may persist for a long time.

Treatment

Praziquantel is the mainstay treatment for all forms of schistosomiasis and is effective in a single oral dose against all species of schistosomes. Oxamniquine is only effective against *S. mansoni* and is used in Africa and South America to treat intestinal schistosomiasis, and metrifonate has been shown to be effective against *S. haematobium* and is used in treating urinary schistosomiasis. These three drugs are included in the WHO Model List of Essential Drugs (7).

Prevention

Praziquantel can be used to treat populations for all three common species in endemic areas in order to reduce egg excretion from the human reservoir and has been successful in Egypt (2). There is currently no vaccine or prophylactic drug as yet for the prevention of schistosomiasis in travellers. Travellers to areas where schistosomiasis is endemic should avoid activities that involve contact with freshwater.

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[Back to top](#)



NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

Zoonoses

Last updated: 6 February 2003

Next update due: 6 March 2003

Contents

[Common animal associated infections, England and Wales: laboratory reports, weeks 01 - 05/03](#)[Common imported infections, England and Wales: laboratory reports, weeks 01 - 05/03](#)[PDF](#)

Common animal associated infections, England and Wales: laboratory reports, weeks 01 - 05/03

Organism	Total reports for weeks 01-05		Cumulative totals for weeks 01-05	
	2003*	2002	2003*	2002
<i>Borrelia burgdorferi</i> **#	–	5	–	5
<i>Leptospira hardjo</i> **##	–	–	–	–
<i>Leptospira icterohaemorrhagiae</i> **##	3	–	3	–
<i>Leptospira other</i> **##	5	1	5	1
<i>Pasteurella haemolytica</i>	1	1	1	1
<i>Pasteurella multocida</i>	16	13	16	13
<i>Pasteurella pneumotropica</i>	–	–	–	–
<i>Pasteurella</i> spp	–	3	–	3
<i>Toxocara canis</i>	–	–	–	–
<i>Toxocara cati</i>	–	–	–	–
<i>Toxocara</i> spp	–	–	–	–
<i>Toxoplasma gondii</i>	1	4	1	4
<i>Toxoplasma</i> spp	–	5	–	5

* provisional data; ** by specimen date; # Lyme Disease Reference Laboratory and CDSC;

Leptospira Reference Laboratory and CDSC.

Common imported infections, England and Wales: laboratory reports,

weeks 01- 05/03

Organism	Cumulative total reports for weeks 01-05		Cumulative totals for weeks 01-05	
	2003*	2002	2003*	2002
Arbovirus	–	–	–	--
Dengue virus	1	2	1	2
<i>Ascaris</i> spp	5	6	5	5
Hookworms (unspecified)	--	6	–	6
<i>Leptospira</i> spp	–	–	–	--
<i>Ancylostoma duodenale</i>	–	–	–	–
<i>Necator americanus</i>	–	–	–	–
<i>Hymenolepis diminuta</i>	–	--	–	–
<i>Hymenolepis nana</i>	1	4	1	4
<i>Hymenolepis</i> spp	--	–	–	–
<i>Schistosoma haematobium</i>	4	7	4	7
<i>Schistosoma intercalatum</i>	–	–	–	–
<i>Schistosoma mansoni</i>	–	5	–	5
<i>Schistosoma</i> spp	–	3	–	3
<i>Strongyloides stercoralis</i>	–	2	–	2
<i>Strongyloides</i> spp	–	–	–	–

* Provisional data

Archive

2002:

[01-05/03](#)

2002:

[01-05/02](#); [06-09](#); [10-13](#); [14-17](#); [18-22](#); [23-26](#); [27-30](#); [31-35](#); [36-39](#); [40-44](#); [45-48](#); [49-52](#);

2001:

[01-04/01](#); [05-08](#); [09-13](#); [14-17](#); [18-21](#); [27-30](#); [31-35](#); [36-39](#); [40-43](#); [44-48](#); [49-52](#)

[Back to top](#)



NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

Diary

Last updated: 6 February 2003

Immunisation theory and practice

Epidemiology and control of communicable diseases and environmental hazards

Monday



Immunisation theory and practice

The annual *Immunisation theory and practice introductory day* will take place on Wednesday 2 April 2003 at PHLS Colindale. This study day is aimed primarily at DICs, but is also suitable for CCDCs and PCT immunisation leads. Nurse educators, practice nurses, health visitors, school nurses and other professionals involved with immunisation may also find the day beneficial.

Following the success of the previous study day it has been decided to run very similar sessions to last year. The day will therefore cover: immunology of response to vaccines, surveillance of vaccine preventable diseases, coverage and herd immunity, BCG and influenza and the roles of the DIC and PCT Immunisation co-ordinator. The Social Affairs Editor at the BBC, Niall Dickson, will be speaking about the media response to immunisation controversies.

Those who have already attended the introductory day may be interested in attending the *Update day* on Thursday 3 April 2003 which will consist of two lectures: immunisation of the immunocompromised child and the Immunisation Information England tracking project and two practical sessions: media training and critical incident management. Numbers are limited for this second day to the first fifty people who apply.

Registration is £80 for doctors and £50 for nurses and professions allied to health for the Introductory day on Wednesday 2 April, and £50 for doctors and £30 for nurses and professions allied to health for the update day on Thursday 3 April 2003. For further details and registration, contact Vivienne Fitch, CDSC Colindale on 020 8200 6868 ext 4569; email vfitch@phls.org.uk or Laura Lane, Immunisation Training and Advice Nurse, on 020 8200 6868 ext 4680; email llane@phls.org.uk.



Epidemiology and control of communicable diseases and environmental hazards

This annual conference will be held at The Royal Concert Hall, Glasgow, from 3 to 5 November 2003. It will address a wide range of health protection issues that have arisen in the past year and provide fresh perspectives on established areas of disease prevention and communicable disease control, dealing with non-communicable environmental threats and health emergencies *ie* the health protection agenda. Short papers on recent outbreaks and surveillance initiatives will also be presented. The conference organizing committee is drawn from CDSC in England, Wales, and Northern Ireland, the Scottish Centre for Infection and Environmental Health, the National Disease Surveillance Centre in Dublin, the Public Health Medicine Environmental Group, Consultants in Communicable Disease Control and Consultants in Public Health Medicine (Communicable Diseases/Environmental Health).

Further details will be available at the end of March 2003 from Vivienne Fitch, email vfitch@phls.org.uk or Rebecca Flanagan, email Rebecca.Flanagan@scieh.csa.scot.nhs.uk

[Back to top](#)

