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Legionnaires' disease associated with a hotel and leisure centre in Somerset

Seven cases of legionnaires' disease, including one death, have been associated with an outbreak at a hotel and leisure centre in Somerset. The spa pool is the suspected source of infection. The cases, six females and one male, range in age from 53 to 70 years and one 66 year old woman has died. Diagnosis was made by culture of the organism from one case, and detection of urinary antigen in the other cases. Three of the cases have been confirmed as Legionella pneumophila sg1 by the PHLS Respiratory and Systemic Infections Laboratory (RSIL) based at Colindale, London. The cases visited or stayed at the hotel between 3 and 28 February 2003 and came from all over England. All are known to have used the leisure centre facilities. Onset of illness ranges from 13 February to 3 March 2003. The spa pool was closed on 27 February when the outbreak was recognised and the hotel is closing on 14 March 2003, while further control measures and investigations into the source of the outbreak are carried out.

About 4000 people who used the hotel or leisure centre in the month before the outbreak have been contacted, and asked to inform the outbreak control team if they have had a respiratory illness following their visit. Twenty-eight out of more than 1000 people who have replied, so far, have reported a compatible illness and are now being investigated for legionella infection.

The Somerset Health Protection Unit (tel: 01823 344267) or the Communicable Disease Surveillance Centre (CDSC) Colindale (tel: 020 8200 6868 ext 4497) would be grateful for any information on cases of legionnaires' disease that might be associated with this outbreak. The RSIL (tel: 020 8200 4400 ext 3906) would be pleased to receive any specimens for confirmation of diagnosis.

Acute respiratory syndrome in Vietnam and southern China

The World Health Organization (WHO) is currently investigating outbreaks of pneumonic illness in the Guangdong province of southern China, Hanoi (Vietnam), and Hong Kong Special Administrative Region (SAR). The outbreak in Guangdong began in November 2002 where 305 cases of atypical pneumonia were reported; two of the cases were diagnosed with *Chlamydia pneumoniae* infection, but no cause has been confirmed in the other cases. Investigation of this outbreak continues.

In late February 2003, a Hong Kong resident became ill with a pneumonic illness shortly after arriving in Hanoi. He was initially cared for in a hospital in Hanoi and was then evacuated to a hospital in Hong Kong. Approximately twenty hospital staff involved in his care, in Hanoi, have subsequently developed a similar illness. In Hong Kong, an outbreak of a similar respiratory illness has occurred among hospital workers in another hospital (not the hospital in which the Hong Kong resident from Hanoi was cared for). Despite intensive investigation, no cause for these outbreaks has, so far, been determined other than the two cases of *C. pneumoniae* infection in the Guangdong outbreak. Influenza virus infection has not been demonstrated. No clear epidemiological link between these three separate outbreaks has been identified, nor any link with the earlier outbreak of influenza due to the avian influenza A H5N1 in Hong Kong reported in the *CDR weekly* in February 2003 (1).

The signs and symptoms of the illness in Hanoi, most commonly, include an initial influenza-like illness (rapid onset of high fever followed by muscle aches, headache, and sore throat). In some cases, but not all, this is followed by bilateral pneumonia and occasionally acute respiratory distress requiring assisted breathing on a respirator. Some patients are recovering but others remain critically ill. Laboratory findings may include thrombocytopenia(low platelet count) and leucopenia(low white cell count).

WHO is recommending that, until more is known about the cause of these outbreaks, patients with atypical pneumonia who may be related to these outbreaks be isolated with barrier nursing techniques and that any suspect cases be reported to national health authorities. WHO has provided the following case definitions for international hospital based surveillance:Suspected case

Suspected case

A person presenting to a health care facility after 23 February 2003 with all of the following:

- sudden onset of high fever (>38 ^{o}C)
- myalgia
- one or more respiratory symptoms (cough, sore throat, shortness of breath, or difficulty breathing)

And one or more of the following:

- history of travel to mainland China, Hong Kong (SAR), or Hanoi within two week of symptom onset
- history of caring for, living with, face-to-face contact, or contact with respiratory secretions of a probable case

Probable case

- a suspect case with,chest x-ray findings of pneumonia or adult respiratory distress syndrome

Action for England and Wales

The PHLS recommends the following approach in England and Wales:

Suspected or probable cases based on the WHO definitions (above) should be considered to have possible links to these outbreaks. They should be isolated and cared for using barrier nursing techniques. They should be investigated for viral and bacterial causes for their illness. Treatment should include anti-microbials active against both typical and atypical organisms. Hospital laboratories should liaise with local PHLS laboratories to ensure that a comprehensive range of microbiological investigations are carried out. These should include investigations (including cultures) for typical and atypical bacteria as well as a broad range of respiratory viruses. Laboratories are asked to discuss the investigation of such cases with the influenza Laboratory, Enteric, Respiratory, and Neurological Virus Laboratory, and the Respiratory and Systemic Infection Laboratory of the Central Public Health Laboratory (CPHL) (tel: 020 8200 4400). In addition, all such cases should be reported to the Respiratory Diseases Division or duty doctor of the PHLS Communicable Disease Surveillance Centre (CDSC), Colindale (tel: 020 8200 6868).

Further information about these incidents can be found at: http://www.who.int/en/

1. PHLS. H5N1 avian influenza virus: human cases reported in southern China. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 13 March 2003]; **13** (9); news. Available at <http://www.phls.org.uk/publications/cdr/PDFfiles/2003/CDR0903.pdf>

Measles outbreak in Cardiff

A linked cluster of 17 probable and confirmed cases of measles have recently been identified in Cardiff, three of whom have been admitted to hospital. The first two cases presented to a local accident and emergency department on the 22 February 2003. All the cases are linked to a travelling community and range in age from 7 months to 18 years. Five cases have been confirmed; two by serum and three by oral fluid IgM antibody testing. The 12 remaining cases have a clinical presentation that is compatible with measles (rash and fever with cough, coryza, or conjunctivitis) and an epidemiological link to a confirmed case. All caseshave been in unvaccinated individuals. Measles, mumps, and rubella (MMR) coverage (one dose) is around 65% in children in this travelling community.

Bro Taf Health Authority is leading the investigation and has alerted all General Practitioners (GPs) and schools in the area. A public health team is visiting local travelling-communities to undertake surveillance for new cases and offer MMR immunisation. Families have been advised to keep ill children or their unimmunised siblings confined to home. Children require two doses of MMR before school entry. A review of immunisation records of 1260 children attending seven primary schools in the catchment area has found MMR coverage to be 96% for one dose and 85% for two doses. Parents of children who have missed immunisation are being urged to contact their GP to get their child fully immunised.

New *Prison health handbook* summarises responsibilities and contact details

Following the re-organisation of the Prison Health Task Force and Policy Unit, into one central unit (Prison Health) a revised version of *the Prison health handbook* was published in January 2003. Copies of the Handbook are available free of charge from the NHS Response line (tel:08701 555455) or

alternatively an electronic copy can be obtained from the Prison Health website at <http://www.doh.gov.uk/prisonhealth>

The Handbook contains information on the prison health management team structure. It also includes the names of key contacts for the national control of communicable diseases and the development of harm minimisation measures, aimed at ensuring that every prison has in place a range of, previously identified, measures designed to reduce the risks to prisoners their families and the wider community from blood-borne diseases, such as hepatitis B virus (HBV), hepatitis C virus (HCV), and HIV. Chapter 11 contains a list of key publications including prison service orders, instructions, and 'dear doctor' letters on subjects such as: dealing with communicable diseases, HIV, HCV, HBV vaccination, the diagnosis and treatment of Tuberculosis in a prison setting, and influenza vaccination.

At any time, approximately 72,000 people are held in one of 137 prisons in England and Wales. Over 150,000 people will pass through prison annually, impacting on an estimated 1.5 million family and friends. Most prisoners come from socially excluded sections of the community, and a recent survey showed that 90% of those entering prison had a mental health or substance misuse problem. In 1999 Ministers at the Department of Health (DoH) and the Home Office agreed the establishment of a formal partnership between HM Prison Service and the NHS in an effort to improve healthcare in prisons, resulting in the creation of the Prison Health Policy Unit and Task Force. In 2002, in line with the transfer of funding for prison healthcare from the prison service to the DoH, these two groups were reorganized into one central unit – Prison Health.

The chief objective of the prison health department is to improve the health of prisoners and tackle health inequalities nationally. This is done by improving the standard of prison health services through greater integration with the wider NHS, reducing or mitigating the effects of unhealthy or high-risk behaviours, and promoting effective links with health and related services in the community to improve through-care.

Integral to the work of the prison health department are the nine regional prison health development teams. These teams are responsible for coordinating the development of partnership, between the Government Offices of the Regions and the area managers, and between establishments and their local primary care trust (PCT). They are also responsible for performance monitoring and supporting the development of NHS approaches on a local level. The handbook contains a list of all regional teams and their staff. It also includes a list of all the PCTs and the prisons they include.

1. Department of Health, HM Prison Service, Welsh Assembly Government. Prison health handbook, London: Department of Health, 2003. Available at <http://www.doh.gov.uk/prisonhealth/handbook.pdf

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United Kingdom Zoonoses Report 2001

The report, *Zoonoses Report United Kingdom 2001*, has been published by the Department of Agriculture and Rural Affairs (DEFRA) on behalf of UK Health and agriculture departments. It is the fourth in a series of reports on zoonoses and pulls together data on the prevalence of zoonoses in humans, animals, and food. The report should be useful for professionals who deal with zoonotic diseases. It also gives the non-specialist an insight into the prevalence and importance of zooneses. The report is available on the DEFRA website in pdf format at: <http://www.defra.gov.uk/animalh/diseases/zoonoses/zoonoses_reports/zoonoses2001.pdf>

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Last updated: 27 February 2003

For information about other conferences, courses, and events visit http://www.phls.org.uk/conferences/index.htm

International symposium on severe group A streptococcal (GAS) infections

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International symposium on severe group A streptococcal (GAS) infections

An international symposium on severe group A streptococcal infections will be held on Thursday 15 May at the Central Public Health Laboratory (CPHL) in Colindale, London, featuring the European Commission's fifth framework programme, **strep-EURO** (1). The Symposium will be officially opened by Dr Pat Troop, acting Chief Executive, Health Protection Agency. The aim of **strep-EURO** is to

aimed at all healthcare professionals in particular: clinicians, microbiologists, public health specialists, infection control specialists, epidemiologists, and anyone who has a professional interest in these infections. A range of topics focusing upon clinical, epidemiological, and microbiological aspects will be presented by national and international speakers .

For registration forms and further information, contact Ian Hunter, CPHL Training Coordinator, at CPHL, 61 Colindale Avenue, London, NW9 5HT (tel: 0208200 4400, extension 3868; email: iahunter@phls.org.uk). As space is limited, **the deadline for registration is 15 April 2003**.

1. Schalen C. European surveillance of severe group A streptococcal disease. *Eurosurveillance weekly* [serial online] 2002; [cited 10 March 2003] **6** (35) 020829. Available at <http://www.eurosurveillance.org/ew/2002/020829.asp>

Enteric

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General outbreaks of foodborne illness, England and Wales: weeks 06-09/03*

DHA	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
National	*S.*Braenderup	Community	February	>40	>40	none	–
Dorset	*S.*Enteritidis PT 1	Public House	February	8	8	None	–

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

Salmonella infections: England and Wales, reports to the PHLS(salmonella data set*) January 2003

Details of serotypes of the 677*salmonella* infections reported in January 2003 are given in the table below. In February 2003, 432 salmonella infections were recorded and preliminary information was received about two outbreaks.

	January 2003
***Salmonella* (provisional data)**	677
S. Enteritidis (PT4)	122
S. Enteritidis (other PTs)	207
S. Typhimurium	119
S. Virchow	14
Other (typed)	215

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Common gastrointestinal infections, England and Wales: laboratory reports, weeks 06-09/03

Laboratory reports	Number of reports received				**Total reports**	**Cumulative total to**	
	06/03	***07/03***	***08/03***	***09/03***	*06-09/03*	***09/03***	***09/02***
Campylobacter	669	400	534	549	**2152**	**5667**	**5479**
Escherichia coli* O157	1	3	3	2	**9**	**19**	**23**
Salmonella†	96	111	133	125	**465**	**1349**	**1306**
Shigella sonnei	10	6	18	12	**46**	**93**	**79**
Rotavirus	227	206	489	582	**1504**	**2409**	**2239**
Norovirus	95	25	57	149	**326**	**1082**	**577**
Cryptosporidium	60	22	24	47	**153**	**382**	**445**
Giardia	53	33	34	41	**161**	**464**	**507**

* Vero cytotoxin producing isolates (data from LEP)
† Data from PHLS LEP

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General outbreaks of foodborne illness in humans, England and Wales, quarterly report: July to September 2002

Table 1 Final information on general outbreaks of foodborne illness: July to September 2002

Local Authority	Organism	Location of Food Prepared or Served	Number ill	Cases Positive	Suspect Vehicle	Evidence
Milton Keynes	*S.* Braenderup	Restaurant	7	5	None	–
Enfield and Haringey	*S.* Enteritidis PT4	Residential Home	8	5	None	–
Birmingham	*S.* Enteritidis PT4	Restaurant	8	7	None	–
Suffolk Coastal	*S.* Enteritidis PT4	Nursing Home	11	6	Queens pudding	D
Kingston upon Hull	*S.*Enteritidis PT4	Restaurant	8	6	None	–
Enfield and Haringey	*S* .Enteritidis PT4 & 21	Restaurant	3	3	Fish balls	–
Cornwall	*S.* Eenteritidis PT6	Restaurant	7	7	None	–
Lambeth, Southwark, and Lewisham	*S.* Enteritidis PT6a	Party	3	3	None	–
National	*S.* Enteritidis PT14B	National	381	381	Bakery products made with imported eggs	M, S
Milton Keynes	*S.* Enteritidis PT21	Restaurant	51	27	None	–
Gwynedd	*S.* Enteritidis PT21	Hotel	58	27	Chocolate terrine	M
Suffolk Coastal	*S.*Enteritidis PT34	Restaurant	38	29	Egg/Chicken/ Special Fried Rice	S
Breckland	*S.*Typhimurium DT104	Restaurant	5	4	Chicken	D
Tyneside	Campylobacter	Farm	3	3	Unpasteurised Milk	M
Cardiff	*C.*Jejuni HS50PT5	Restaurant	3	3	None	–

Malvern Hills	*C.*Jejuni HS13PT1	Nursing Home	20	4	Chicken casserole	D
Wigan and Bolton	*E.* coli O157 PT21/28	Community	6	6	Milk	D

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

Table 2 Outbreaks of salmonella infection: October to December 2002

Outbreak type	*S.* Enteritidis		*S.* Typhimurium	Other serotypes	**Total**
	Phage type 4	Other phage types			
General	3	16	–	1	**20**
Household	21	31	8	9	**69**
Acquired abroad	6	6	1	1	**14**
Total	**30**	**53**	**9**	**11**	**103**

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Salmonella serotypes recorded in the PHLS salmonella data set: October to December 2002

All serotypes recorded in the PHLS salmonella data set, in the fourth quarter of 2002, are listed below. There were more than ten reports of 19 serotypes, between two and ten reports of 60 serotypes, and one report of 50 serotypes.

	October to December 2002 (provisional)
S. Agona	65
S. Anatum	21
S. Blockley	11
S. Braenderup	48
S. Chester	11
S. Enteritidis	2904
S. Hadar	39
S. Heidelberg	17
S. Infantis	51
S. Java	28
S Livingstone	16
S. Mbandaka	12
S. Montevideo	12
S. Newport	21
S. Saint-Paul	11
S. Stanley	28
S. Typhimurium	445
S. Unnamed	42
S. Virchow	64

Between two and ten reports of each of the following serotypes were received:

S. Abony	3
S. Adelaide	2
S. Agama	6
S. Ajiobo	2
S. Albany	6
S. Arizonae	7
S. Bardo	3
S. Bareilly	9
*S.*Berta	2
S. Bovis-morbificans	2
S. Brandenburg	8
S. Bredeney	10
S. Cerro	4
*S.*Colindale	2
S. Concord	3
S. Corvallis	7
S. Cubana	2
S. Derby	8
S. Drypool	3
S. Dublin	7
S. Durham	2
S. Ealing	2
S. Give	4
S. Gold-Coast	7
S. Haifa	5
S. Havana	2
S. Indiana	4
S. Iruma	2
S. Javiana	3
S. Jukestown	2
S. Kedougou	4
S. Kentucky	10
S. Kinondoni	2
S. Kottbus	10
S. London	6
S. Mikawasima	3
S. Mississippi	7
S. Muenchen	5
S. New-Haw	2
S. Newington	2
S. Ohio	4
S. Oranienburg	2
S. Oslo	3
S. Panama	8
S. Poona	10
S. Potsdam	3
S. Richmond	3

S. Rissen	5
S. Rubislaw	2
S. Senftenberg	10
S. Sofia	2
S. Stanleyville	6
S. Tel-El-Kebir	2
S. Tennessee	4
S. Thompson	7
S. Tyresoe	7
S. Uganda	3
S. Wangata	2
S. Weltevreden	6
S. Zanzibar	2

One report of each of the following serotypes were received:

S. Agoueve	*S.* Hartford	*S.* Mount-pleasant	*S.* Tado
S. Altona	*S.* Hillbrow	*S.* Muenster	*S.* Tel-Hashomer
S. Amager	*S.* Hvittingfoss	*S.* Nagoya	*S.* Tilene
S. Arechavaleta	*S.* Ibadan	*S.* Napoli	*S.* Tudu
S. Baildon	*S.* Jangwani	*S.* Ness-Ziona	*S.* Uphill
S. Bonarienis	*S.* Johannesburg	*S.* Neukoelln	*S.* Uzaramo
S. Chameleon	*S.* Kenya	*S.* New Brunswick	*S.* Veneziana
S. Chandans	*S.* Koketime	*S.* Nima	*S.* Wien
S. Emek	*S.* Konstanz	*S.* Orion	
S. Galiema	*S.* Lamin	*S.* Oxford	
S. Gaminara	*S.* Lansing	*S.* Reading	
S. Glostrup	*S.* Liverpool	*S.* Saarbruecken	
S. Haardt	*S.* Manhattan	*S.* San-Diego	
S. Halle	*S.* Monschaui	*S.* Singapore	

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