

Volume 13  
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# CDR WEEKLY



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Published by: PHLS  
Communicable  
Disease Surveillance  
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## News

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### Severe Acute Respiratory Syndrome – update

Cases of Severe Acute Respiratory Syndrome (SARS) reported last week from Hong Kong, Hanoi, and Vietnam (1), have now been observed from other countries, including: Canada, Germany, Singapore, Slovenia, Taiwan, Thailand, and the United Kingdom (UK). Local transmission, however, has only been reported from Canada, Hanoi, Hong Kong, Singapore, and Taiwan (2). From 1 February to 19 March 2003, 219 suspect or probable cases have been reported to the World Health Organization (WHO), including 9 cases that have died (2).

Two probable cases in the United Kingdom (UK) had been reported to the PHLS Communicable Disease Surveillance Centre (CDSC) by 20 March 2003. The first is a man aged 65 years who was returning from Hong Kong to Manchester via Amsterdam on the 15 March. He is in hospital under strict isolation measures. His condition is reported to be improving (3). The second case is a man aged 30 years from London, who flew back from Taiwan on 16 March after visiting his family for three days. He is in hospital and his condition is stable. Both cases have abnormal signs on chest X-ray, a compatible respiratory infection, and fulfil the WHO case definition for SARS. Neither is known to have been in contact with any probable or suspect cases. Passengers travelling on the same flights as the two cases have been advised to seek medical assistance if they develop high fever and respiratory symptoms within ten days of their return. The same advice is given to all people visiting places where local transmission has been reported. The flight details of the two UK probable cases have been released by the Department of Health (DoH) – press statements are available on the PHLS website at [http://www.phls.org.uk/topics\\_az/SARS/menu.htm](http://www.phls.org.uk/topics_az/SARS/menu.htm).

A wide range of laboratory tests have been undertaken for specimens from cases in a number of laboratories worldwide, coordinated by WHO. There are reports, from a number of laboratories, of a virus of the Paramyxoviridae family, having been observed by electron microscopy, in samples from some of the cases outside the UK (4). It would be premature, however, to attribute the outbreak to this source.

The DoH and the PHLS have issued a joint press release, presenting the key points of the UK specific response to this international threat (5):

- All doctors have been alerted to identify any illness in returning travellers that may be associated with this outbreak
- Travellers returning to the UK from any of the affected countries and presenting symptoms compatible with the case definition should seek medical advice

- People from the UK are not restricted from travelling to any of the affected countries.

Guidance on microbiological investigations has been developed by the Influenza Laboratory, and the Respiratory and Systemic Infection Laboratory of the PHLS Central Public Health Laboratory. In addition, the PHLS Communicable Disease Surveillance Centre has coordinated the development of general guidance for public health professionals, and more specific guidance for general practitioners, working in infection control and management in hospital. Advice for travellers from the UK is also provided. A surveillance form for reporting suspect and probable cases to CDSC can also be downloaded. All information is available at from the PHLS website available at <[http://www.phls.co.uk/topics\\_az/SARS/menu.htm](http://www.phls.co.uk/topics_az/SARS/menu.htm)>

1. PHLS. Acute respiratory syndrome in Vietnam and southern China. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 20 March 2003]; **13** (11): news. Available at <<http://www.phls.co.uk/publications/cdr/PDFfiles/2003/cdr1103.pdf>>
2. World Health Organization. Cumulative number of reported suspect and probable. Geneva: WHO, 2003, 19 March 2003. Available at <[http://www.who.int/csr/sars/2003\\_19\\_03/en/](http://www.who.int/csr/sars/2003_19_03/en/)>
3. PHLS/Department of Health. *Severe Acute Respiratory Syndrome in people returning from east and south east Asia (press release)*. London: PHLS/DoH, 16 March 2003. Available at <[http://www.phls.org.uk/press\\_media/press\\_releases/archive/03pr/030317pr.htm](http://www.phls.org.uk/press_media/press_releases/archive/03pr/030317pr.htm)>
4. Hong Kong: Severe Acute Respiratory Syndrome – Worldwide. *Promed-edr Severe Acute Respiratory Syndrome (08)*: 18 March 2003. In *Promed Mail* [online]. Boston US: International Society for Infectious Diseases, 18 March 2003 [cited 20 March 2003]. Available at <<http://www.Promedmail.org>>
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## Update on Legionnaires' disease associated with a hotel and leisure centre in Somerset

Ten cases of legionnaires' disease, including one death, are now known to be associated with the outbreak at a hotel and leisure centre in Somerset (1). The cases, six females and four males, range in age from 53 to 78 years, and a 66 year old woman has died. Diagnosis was made by culture of the organism from one case, detection of urinary antigen in six cases, and by serological evidence of raised antibodies in three cases. Nine

of the cases have been confirmed by the PHLS Respiratory and Systemic Infections Laboratory (RSIL) based at Colindale, London, seven of which are proven *Legionella pneumophila* sg1. The cases, who came from all over England, visited or stayed at the hotel between 3 and 28 February 2003 and onset of illness occurred from 13 February to 3 March 2003. So far, 3200 of the 5400 people contacted who used the hotel or leisure centre in February have returned a follow up questionnaire. Around 30 people have reported a compatible illness and are being investigated for legionella infection.

All cases are known to have used the leisure centre facilities. The spa pool in the leisure centre was closed on 27 February when the outbreak was recognised and the hotel was closed on 14 March 2003 to implement control measures and investigations into the source of the outbreak. Environmental tests

on samples taken at the hotel and leisure centre have failed to grow any legionella, but further tests are being carried out on the samples.

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. RSIL (tel: 020 8200 4400 ext 3906) would be pleased to receive any specimens for confirmation of diagnosis.

1. PHLS. Legionnaires' disease associated with a leisure centre in Somerset. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 20 March 2003]; **13** (11): news. Available at <<http://www.phls.co.uk/publications/cdr/PDFfiles/2003/cdr1103.pdf>>
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## World TB day – 24 March 2003

World TB day on 24 March marks the 10th anniversary of the declaration by the World Health Organization of tuberculosis as a global health emergency. 24 March is significant as it was on that day in 1882 that Robert Koch announced in Berlin the discovery of the tuberculosis bacillus. More information is available at <<http://www.stoptb.org/world.tb.day/default.asp>>

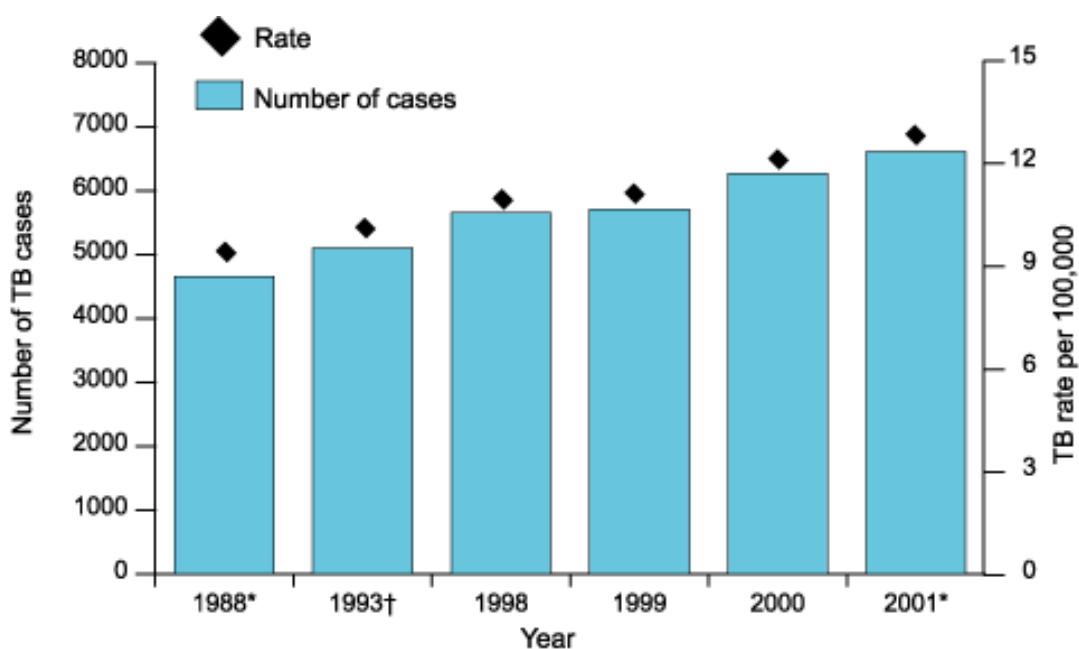
It is likely that in 2003 tuberculosis will kill more people than any previous year in history. While the vast majority (98%) of the estimated 2 million tuberculosis related deaths will occur in resource poor countries, few countries in the world are now unaffected by the global resurgence of the disease. Tuberculosis disproportionately affects the most vulnerable in any society: children, the elderly, the poor, the homeless, immigrants, and the immunocompromised.

Numbers of cases of tuberculosis reported in England and Wales have been increasing since 1988 (see figure). In response to increasing case reports a system for enhanced tuberculosis surveillance was launched in 1999. Preliminary results for tuberculosis cases reported through this system in England, Wales, and Northern Ireland in 2001 are now available. A final report will be made available later in 2003 following matching of enhanced surveillance data with data on mycobacterial isolates collected through the MycobNet system.

A total of 6669 tuberculosis cases were reported in 2001, a rate of 12.4 per 100,000 (12.7/100,000 in England and Wales and 3.3/100,000 in Northern Ireland). This represents a 6% increase in both tuberculosis case reports and rates of disease between 2000 and 2001. In 2001, nearly two-thirds (63%) of tuberculosis patients were born outside the United Kingdom (UK) compared to almost half (49%) of cases reported in 1993. In 2001, the tuberculosis rate in people born outside the UK was 74.9/100,000, and 4.3/100,000 for those born in the UK. Fifty-three per cent of the cases were reported in young adults aged between 15 and 44 years, for both males and females.

A new tuberculosis update (a newsletter on tuberculosis surveillance in England and Wales) has been issued to mark World TB Day 2003. The PHLS has published two new TB reports: *A final annual report on tuberculosis cases reported in 2000 in England, Wales, and Northern Ireland*, and the *2001 preliminary Enhanced Tuberculosis Surveillance report*. Both of these reports can now be downloaded in pdf format from the PHLS website, available at <[http://www.phls.org.uk/topics\\_az/tb/tbfrontpage.htm](http://www.phls.org.uk/topics_az/tb/tbfrontpage.htm)>

**Figure Tuberculosis case reports, England and Wales, 1988, 1993, and 1998 – 2001\***



\* Preliminary results

† Number of TB cases multiplied by scaling factors as follows; 1.9348 for 1988; 1.886 for 1993

Sources: Tuberculosis cases: 1988, 1993, 1998 National TB survey, 1999, 2000, 2001 Enhanced Tuberculosis Surveillance



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## Bacteraemia

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Next update due: 17 April 2003

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### ***Staphylococcus aureus* bacteraemia: England, Wales, and Northern Ireland, January to December 2002**

#### Key points:

- In 2002, 13,325 *Staphylococcus aureus* bacteraemia reports were received from England (12,284), Wales (644), and Northern Ireland (397) under the voluntary laboratory reporting scheme\*.
- In 2002, 18,075 *S. aureus* reports were received from England under the mandatory reporting scheme†.
- Methicillin resistance as a proportion of *S. aureus* bacteraemias with susceptibility information was 42%, 47% and 38% for England, Wales, and Northern Ireland respectively (voluntary reporting). Under the English mandatory scheme, the proportion of methicillin resistant *Staphylococcus aureus* (MRSA) was 39%.
- Regional differences in the proportion of *S. aureus* bacteraemia reported as methicillin resistant between the voluntary and mandatory reporting schemes in England ranged from 1% to 6%.
- Methicillin resistance as a proportion of *S. aureus* bacteraemias with susceptibility information appears to be stabilising at about 42%, after increasing throughout the 1990s.
- Numbers of reports of both MRSA and methicillin sensitive *S. aureus* (MSSA) bacteraemia increased again in 2002 over the previous year.
- There has been a continuing improvement in the reporting of methicillin susceptibility under the voluntary scheme, this information having been provided in 92% of reports in 2002.
- One vancomycin intermediate resistant *S. aureus* bacteraemia isolate was reported in 2002.

This report covers *Staphylococcus aureus* bacteraemias diagnosed between January and December 2002 under the voluntary laboratory reporting scheme in England, Wales, and Northern Ireland‡. These reports comprise bacteria isolated from blood cultures with or without cerebrospinal fluid. In England, a mandatory bacteraemia reporting scheme was established in 2001. These data are also included here. Northern Ireland(1) and Wales have their own mandatory MRSA bacteraemia reporting schemes, which are not covered in this report .

Rates were calculated using 2001 resident population denominators for England and Wales. Resident population denominators from 2000 were used for Northern Ireland, as 2001 resident population denominators were unavailable during the preparation of this report. Regional analyses were performed using the English regional boundaries introduced in April 2002.

\* Voluntary reporting: undertaken by many laboratories in England and Wales for many years. Laboratories report individual clinically significant infections on a regular basis, usually weekly. Data include information on the patient's age and the antimicrobial susceptibilities of the reported pathogen.

† Mandatory reporting: established in England in April 2001. Acute NHS Trusts send quarterly aggregate reports of total numbers of *S. aureus* bacteraemias, including MRSA. No information on individual cases.

‡ The first contribution of Northern Ireland to the CDR report was in 2002 (2) and therefore their data cannot be compared to previous years.

#### Reporting of *Staphylococcus aureus* bacteraemias

A total of 13,325 *S. aureus* bacteraemias were reported – England (12,284), Wales (644), and Northern Ireland (397) – through the voluntary reporting scheme in 2002 (table 1). This compares to 18,075 reports under the mandatory scheme in England, a 32% deficit (table 1). Among the English regions, the South East had the highest number of reports (1745) under the voluntary scheme and London (3605) the highest number under the mandatory scheme. The least number of reports were received from the North East under both schemes (682 for the voluntary and 913 for the mandatory scheme). All regions reported higher numbers of *S. aureus* bacteraemias under the mandatory than the voluntary scheme. The greatest discrepancy in reporting between the schemes was noted for London and the North West, where more than double the number of reports were reported under the mandatory scheme. The smallest discrepancy was in the West Midlands.

The voluntary *S. aureus* bacteraemia reporting rate for England, Wales, and Northern Ireland overall was 24.8 per 100,000 population in 2002. This comprised rates of 25.0 for England, 21.9 for Wales, and 23.4/100,000 for Northern Ireland respectively (figure 2). Within England, reporting rates (figure 2) ranged from 18.8/100,000 in the North West to 31.9/100,000 in the West Midlands. Using the mandatory scheme data, the *S. aureus* bacteraemia reporting rate for England would be 36.8/100,000.

**Table 1 *Staphylococcus aureus* bacteraemia reports and methicillin susceptibility data\*, England, Wales, and Northern Ireland: January to December 2002**

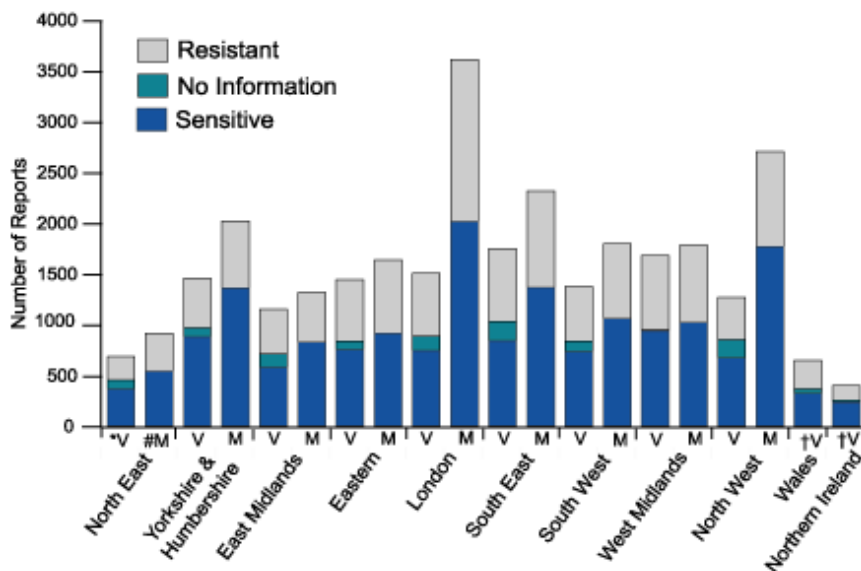
Region	Reporting scheme	Resistant	(%#)	Sensitive	No information	(%)	Total	% difference between the two schemes‡
North East	Voluntary	233	39%	366	83	12%	<b>682</b>	25
	Mandatory	376	41%	537	–	–%	<b>913</b>	–
Yorkshire and Humberside	Voluntary	490	36%	877	86	6%	<b>1453</b>	28
	Mandatory	662	33%	1357	–	–%	<b>2019</b>	–
East Midlands	Voluntary	442	43%	576	130	11%	<b>1148</b>	13
	Mandatory	489	37%	826	–	–%	<b>1315</b>	–
Eastern	Voluntary	606	45%	752	82	6%	<b>1440</b>	12
	Mandatory	720	44%	914	–	–%	<b>1634</b>	–
London	Voluntary	620	46%	740	141	9%	<b>1501</b>	58
	Mandatory	1593	44%	2012	–	–%	<b>3605</b>	–
South East	Voluntary	716	46%	840	189	11%	<b>1745</b>	25
	Mandatory	950	41%	1364	–	–%	<b>2314</b>	–
South West	Voluntary	539	42%	734	99	7%	<b>1372</b>	24
	Mandatory	741	41%	1055	–	–%	<b>1796</b>	–
West Midlands	Voluntary	733	44%	938	7	–%	<b>1678</b>	6
	Mandatory	760	43%	1020	–	–%	<b>1780</b>	–
North West	Voluntary	414	38%	669	182	14%	<b>1265</b>	53
	Mandatory	936	35%	1763	–	–%	<b>2699</b>	–
England	Voluntary	4793	42%	6492	999	8%	<b>12,284</b>	32
	Mandatory	7227	39%	10848	–	–%	<b>18,075</b>	–
Wales†	Voluntary	282	47%	318	44	7%	<b>644</b>	–
Northern Ireland†	Voluntary	144	38%	234	19	5%	<b>397</b>	–
England, Wales, and Northern Ireland	Voluntary	5219	43%	7044	1062	8%	<b>13,325</b>	–

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

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

‡ % difference = 1 - (voluntary/mandatory) \* 100

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



\*V = Voluntary

#M = Mandatory

† = Wales and Northern Ireland do not take part in the English mandatory surveillance scheme

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

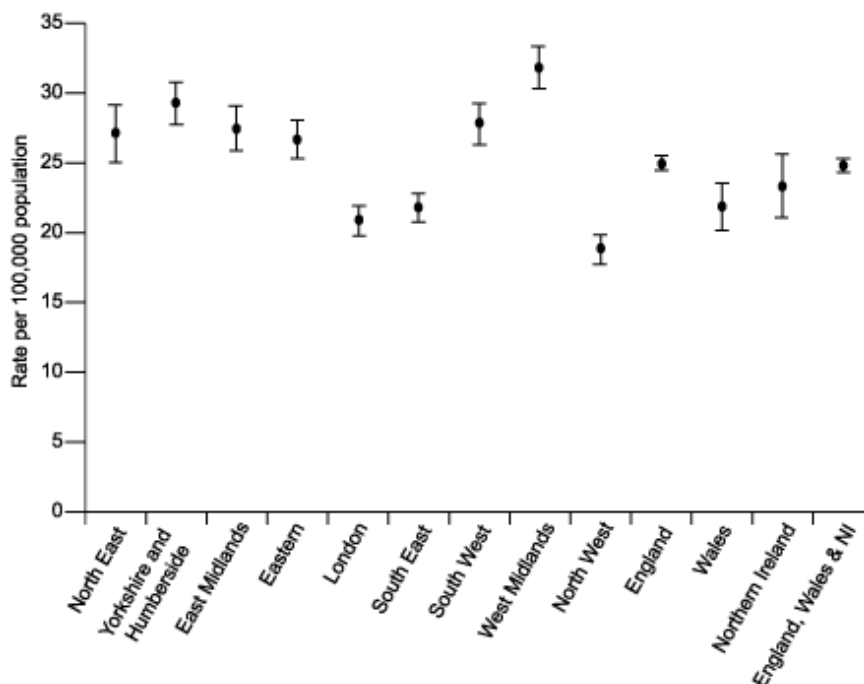
	Resistant	(%)#	Sensitive	No information	(%)‡
Ciprofloxacin	1800	53%	1578	9947	75%
Erythromycin	3905	41%	5692	3728	28%
Fusidic acid	733	8%	8249	4343	33%
Gentamicin	355	5%	6954	6016	45%
Mupirocin	201	4%	4290	8834	66%
Rifampicin	114	2%	5621	7590	57%
Vancomycin	1	0.02%	6482	6842	51%

\* This information is not available under the mandatory surveillance scheme

# R as a percentage of R+S

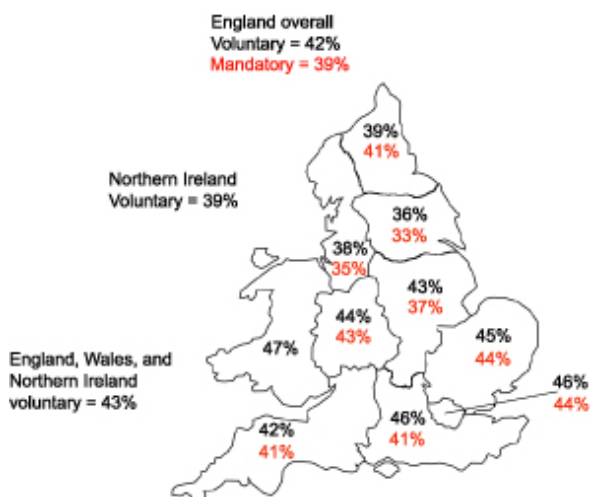
‡ Reports without susceptibility information as a percentage of the total number of reports

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



\*rates calculated using 2001 mid-year resident population estimates for England & Wales, and 2000 mid-year resident population estimates for Northern Ireland

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



### Antimicrobial susceptibility

Methicillin susceptibility data for *S. aureus* bacteraemia reports received under the voluntary and mandatory schemes in 2002 are shown in table 1, and figures 1 and 3. By definition, information on methicillin susceptibility is complete under the mandatory scheme. This information, however, is not always given under the voluntary laboratory reporting scheme. Ninety-two per cent of voluntary reports of *S. aureus* bacteraemias (11,285/12,284) included this information in 2002, an improvement of 2% on 2001 (3). In Wales and Northern Ireland, 93% and 95% respectively of *S. aureus* bacteraemia reports included methicillin susceptibility information.

Under the voluntary scheme, the North West region had the highest proportion and number of reports lacking methicillin susceptibility information (14%, 182 reports), followed by the North East (12%, 83), the East Midlands (11%, 130), and the South East (11%, 189). Nearly all reports from the West Midlands (<1% missing) included methicillin susceptibility information.

In England, methicillin resistance was reported in 42% (4793/11,285) of *S. aureus* bacteraemias with susceptibility information under the voluntary scheme and in 39% (7227/18,075) of *S. aureus* bacteraemia isolates under the mandatory scheme. This compares to 41% and 40% respectively from these schemes for April to December 2001 (mandatory surveillance began in April 2001) (3). In Wales and Northern Ireland, methicillin resistance was reported in 47% (45% in 2001) and 38% of *S. aureus* bacteraemia reports respectively (3). Within England, there has been an increase in the total number of *S. aureus* reports: 10,338 in 2000 (4), 11,852 in 2001(3), and 12,284 in 2002. During this period there has been an increase in the proportion of reports with information on susceptibility to methicillin, from 84%, to 90%, and then to 92% respectively. An increase in the number of both MRSA and MSSA bacteraemia was seen during this period.

The highest proportion of *S. aureus* methicillin-resistant bacteraemia reports in England were in London (46% voluntary and 44% mandatory), South East (46% and 41%), and Eastern (45% and 44%) (table 1, and figures 1 and 3). Conversely, the lowest proportion of *S. aureus* methicillin-resistant bacteraemia was seen in Yorkshire and Humberside (36% voluntary and 33% mandatory) (table 1 and figures 1 and 3). All regions with the exception of the North East reported slightly higher proportions of *S. aureus* bacteraemia under the voluntary scheme as methicillin resistant than under the mandatory scheme. Within English regions, the difference in the proportions of *S. aureus* bacteraemias reported as methicillin resistant under the voluntary and mandatory schemes ranged from 1% to 3% for most regions. Exceptions to this were the East Midlands (6%) and South East (5%).

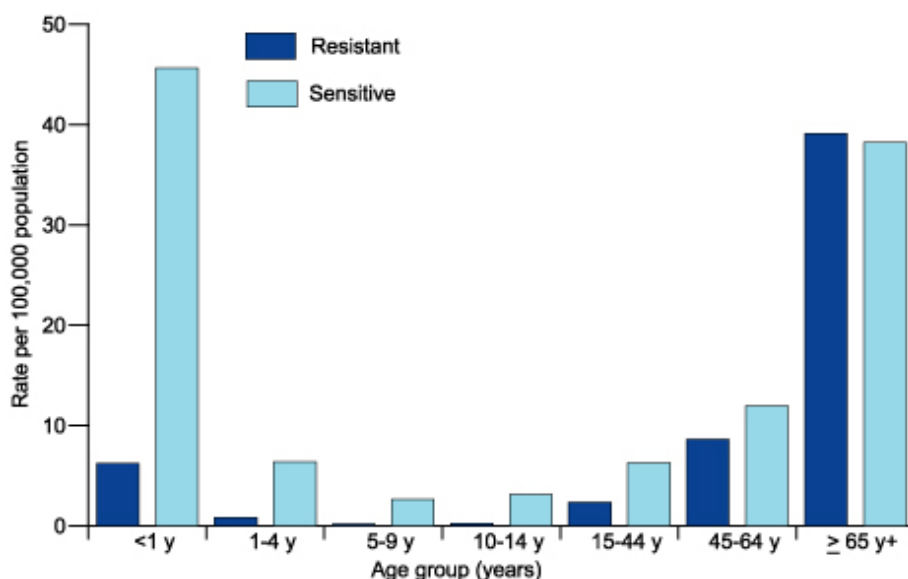
Eighty percent (10,702/13,325) of *S. aureus* bacteraemias reported under the voluntary scheme in 2002 (England, Wales, and Northern Ireland) contained information on susceptibility to any antimicrobial other than methicillin. The region reporting the most information on susceptibility of *S. aureus* bacteraemia isolates to any antimicrobial, other than methicillin, was the Eastern region (97%), with the least susceptibility information from London (72%). Susceptibility to erythromycin was included in nearly three-quarters of the *S. aureus* bacteraemia reports (72%), fusidic acid in two-thirds (67%), and gentamicin in over half (55%). There was no information reported for ciprofloxacin, mupirocin, rifampicin, and vancomycin susceptibilities in 75%, 66%, 57%, and 51% of reports respectively (table 2).

Although three reports were initially made of vancomycin intermediate resistance in *S. aureus* bacteraemias in 2002 (glycopeptide-intermediate *S. aureus* [GISA]), only one of these was eventually confirmed. Resistance to other non-methicillin antimicrobials can be found in table 3.

### Age distribution

This information is only obtainable from the voluntary reporting scheme as it is not included in the mandatory dataset currently. For MSSA the highest age-specific rate was noted in those aged under one year (45.7 per 100,000 population), followed by those aged 65 years and above (38.2/100,000) (figure 4). The MSSA rates were higher than MRSA for all the age groups except in those aged 65 years and above. The highest age-specific rate for MRSA was in those aged 65 years and above (39.1/100,000), followed by those aged between 45 and 64 (8.6/100,000).

**Figure 4 Age-specific *Staphylococcus aureus* bacteraemia \*rates and methicillin susceptibility per 100,000 population: England, Wales, and Northern Ireland: January to December 2002 (voluntary reporting)**



\* rates calculated using 2001 mid-year resident population estimates for England and Wales, and 2000 mid-year resident population estimates for Northern Ireland

### Discussion

In 2002, the numbers of *S. aureus* bacteraemia reports increased under the voluntary reporting scheme in England compared to 2000(4) and 2001(3), with both MRSA and MSSA increasing during this period (3,4). Almost a third more reports of *S. aureus* bacteraemia were received under the mandatory scheme in England. Regional differences in the number of *S. aureus* reports between the two schemes ranged from 6% to 58% in 2002. These differences will need to be addressed in light of the anticipated change in the method for reporting the mandatory *S. aureus* bacteraemia data, from the quarterly aggregate reporting of total numbers of bacteraemias, to the regular reporting of individual bacteraemias through the voluntary scheme. The voluntary scheme is also useful in allowing comparison with previous years and brings in additional information about affected age groups and other antimicrobial susceptibilities, but has the drawback that information on methicillin susceptibility is not always complete. The year 2002, however, marked another improvement in this, from 90% (3) to 92% of *S. aureus* bacteraemia reports having information on methicillin susceptibility compared to 2001. Regional changes in the proportion of reports without methicillin susceptibility information ranged from 1% to 12% between the two years (3).

Comparison with previous years under the voluntary scheme suggests that the proportion of *S. aureus* bacteraemias due to

MRSA may be stabilising at around 42%. In Wales, the proportion of *S. aureus* bacteraemias due to MRSA appears to have stabilised between 45% and 47% (3,4). The highest population rates of *S. aureus* bacteraemia reports in 2002 were in England (25.0/100,000) compared to (21.9/100,000) for Wales, and (23.4/100,000) for Northern Ireland. The rate for England under the mandatory scheme was 36.8/100,000. The reporting rate under the mandatory scheme probably gives a reasonable idea of the true rate of *S. aureus* bacteraemias in the population.

Despite these general improvements in reporting, some regions still have large discrepancies in terms of numbers of bacteraemias reported under the voluntary and mandatory schemes and there is clearly an urgent need to remedy this situation. It is notable that despite these discrepancies, the proportion of *S. aureus* bacteraemias due to MRSA are remarkably similar in each region between the two schemes, only a 1% to 3% difference in all but two regions. For most regions, the proportion of MRSA is slightly lower under the mandatory scheme, indicating a slight bias towards reporting MRSA in the voluntary scheme.

One vancomycin intermediate resistant *S. aureus* bacteraemia report (GISA) was confirmed in 2002. This was the first reported GISA in England (5). The isolate, which was also methicillin resistant, was identified as phage type EMRSA 16-variant A12 (5). Laboratories are asked to send any isolates suspected to have full or intermediate glycopeptide resistance or resistance to newer anti-staphylococcal agents, such as linezolid, to the Antimicrobial Resistant Monitoring Reference Laboratory (ARMRL) at the Central Public Health Laboratory (CPHL) in London. Suspected isolates will also be typed at the Laboratory of Health Care Associated Infection (LHCAI) to explore the evolution and spread of new strains.

## Acknowledgements

These reports would not be possible without the 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](mailto:gduckworth@phls.org.uk)). In addition, the support from colleagues within the PHLS, CPHL in particular, is valued in the preparation of the reports.

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## Diary

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### Infection control - Don't panic!

#### Infection control - Don't panic!

Sheffield Teaching Hospitals are to run the sixth, *Don't panic!* meeting on 23rd and 24th June 2003 looking at current issues and practical aspects of infection control. It would be of interest to microbiologists and infection control nurses, public health staff and biomedical scientists. The meeting is recognised for CPD.

The programme includes lectures on: iInfection control in the renal unit, Infection control and estates management, bioterrorism, how to manage an outbreak, the Leicester TB outbreak, the Cumbria legionella outbreak, strategies for reducing foodborne infection, infection control in primary dental care, epidemiology of nosocomial fungal infection, IV device related infections, pets in healthcare settings, and preparing for an influenza pandemic.

The attendance fee is £50 per day which includes refreshments. Accommodation is available in local hotels or University hall of residence. Further information may be obtained from Jan Waddingham, tel: 0114 271 3129; fax: 0114 278 9376; email: [Jan.Waddingham@sth.nhs.uk](mailto:Jan.Waddingham@sth.nhs.uk).