

Volume 13  
Number 18  
1 May 2003

# CDR WEEKLY

Health  
Protection  
Agency

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOONOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

## Main stories this week:

**Use of human organs and tissue for public health surveillance, quality assurance and research**

**Avian influenza in The Netherlands – human death reported**

**Severe Acute Respiratory Syndrome – update**

## Respiratory:

**Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales**

## Travel Health:

**The National Travel Health Network and Centre (NaTHNaC)**

## Zoonoses:

**Common animal associated infections, England and Wales: laboratory reports, weeks 14 - 17/03**

**Common imported infections, England and Wales: laboratory reports, weeks 14-17/03**

Published by:  
Health Protection Agency  
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

## News

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZONOOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

**Last updated: 1 May 2003****Next update due: 8 May 2003**

### Contents

[Use of human organs and tissue for public health surveillance, quality assurance and research](#)

[Avian influenza in The Netherlands – human death reported](#)

[Severe Acute Respiratory Syndrome – update](#)

---

[Top](#) |

### **Use of human organs and tissue for public health surveillance, quality assurance and research**

The law in England and Wales on the removal, retention, and use of organs and tissue has been reviewed, following reports on past practice in various parts of the National Health Service (NHS). The consultation document *Human bodies, human choices* was published in July 2002 (1), and new legislation is being proposed. Meanwhile, the Department of Health (DoH) has issued best practice guidance on the use of human organs and tissue in the form of a statement that offers advice while new legislation is pending (2).

The statement reflects the DoH's understanding of the current law on the removal, retention, and use of human organs and tissue. In its introduction the Chief Medical Officers for England and Wales emphasise the benefits that have been gained through testing recent and historic tissue for our understanding of HIV infection, variant-Creutzfeldt Jakob disease (variant-CJD), and influenza. The general principle that human tissue should be removed, retained, or used only for purposes for which patients have had the opportunity to give valid consent is central to the new guidance. Additional requirements for research uses of tissue are heavily based on the operational and ethical guidelines issued by the Medical Research Council (MRC) in 2001 (3).

The DoH recommends, however, particular approaches to consent for such uses of tissue (including sera, and other clinical microbiology specimens) collected from living patients for use in quality assurance, in-service training, formal education, public health surveillance, and investigation of the performance of laboratory test kits. In the majority of circumstances, specific patient consent is not required, provided there are 'active local arrangements' for informing patients about the uses to which their tissue may be put, opportunities for them to ask questions, mechanisms in place for respecting any individual patient objections when they arise, prior to use the samples are anonymised or pseudonymised (*ie*, with identifying attributes restricted to a controlled set of individuals). The earlier MRC guidelines also stated that it is acceptable to use human material surplus to clinical requirements for research without consent if the material is anonymous and unlinked (3).

In 2001, the DoH advised NHS organisations that by 1 October 2002 procedures must be in place to ensure that patients have the opportunity to refuse permission for tissue taken from them during surgery

or other procedure to be used for education or research purposes (4,5). These procedures must be well-publicised and transparent, and make provision for patients to record their consent or objection to such tissue uses, and for this to be notified to the laboratory (5). In the new guidance the CMOs note that implementation should be possible, in part, through building on these central consent initiatives that are already underway.

1. Department of Health and Welsh Assembly Government. *Human bodies, human choices: The law on human organs and tissue in England and Wales*. London: Department of Health and Welsh Assembly Government, 2002. Available at <<http://www.doh.gov.uk/tissue>>
  2. Department of Health, Welsh Assembly Government, and Central Office for Research Ethics Committees. *The use of human organs and tissue, an interim statement*. London: Department of Health, Welsh Assembly Government, 2003. Available at <<http://www.doh.gov.uk/tissue/interimstatement.pdf>>
  3. Medical Research Council. *Human tissue and biological samples for use in research: Operational and ethical guidelines*, 2001. Available at <[http://www.mrc.ac.uk/pdf-tissue\\_guide\\_fin.pdf](http://www.mrc.ac.uk/pdf-tissue_guide_fin.pdf)>
  4. Department of Health. Good practice in consent. Achieving the NHS Plan commitment to a patient-centred consent practice. Health Service Circular (HSC 2001/023). London: Department of Health, 2001. Available at <<http://www.doh.gov.uk/consent/goodpractice.htm>>
  5. Department of Health. *Model policy for consent to examination or treatment*. London: Department of Health, 2001. Available at <<http://www.doh.gov.uk/consent/modelconsentpolicy.doc>>
- 

[Top](#) |

## Avian influenza in The Netherlands - human death reported

A human fatality linked to the current epidemic of the highly pathogenic avian influenza (HPAI) A H7N7 has been reported. The same virus has been affecting poultry flocks in The Netherlands since the end of February 2003 (1). On Thursday 17 April 2003, a 57 year old veterinarian who had visited an affected farm died of pneumonia (1). The patient first suffered from an influenza-like illness (ILI) on 4 April. Throat and eye swabs taken on 8 April proved negative by genomic testing. The patient was admitted to hospital on the 14 April where his condition deteriorated, and he eventually died. A bronchoalveolar lavage (BAL) was performed on the patient and a positive detection of influenza A (H7N7) was made using genomic testing methods. Influenza A (H7N7) virus was also detected in post-mortem lung biopsy samples. Further tests are also needed to confirm whether the virus detected is similar to the HPAI H7N7 virus currently circulating in domestic poultry flocks in The Netherlands.

There have been reports of human cases infected with HPAI among workers involved in the culling of chickens to control the outbreak (2, 3). Eighty-three confirmed human cases of H7N7 influenza virus infections have been recorded, the majority of have presented as conjunctivitis, with a limited number reporting symptoms of ILI. Strong evidence of person-to-person transmission has been reported in three instances, through contacts with infected poultry workers in the home environment (1). None of the detected human cases of avian influenza have been found to have any co-infections of the influenza A viruses that regularly infect humans (4). Current control measures for those involved in the culling of chickens on affected farms or anyone in contact with such farms include protective clothing, disinfection procedures, influenza vaccination, and prophylaxis with the influenza antiviral oseltamivir (5).

Two hundred and twelve outbreaks have been confirmed and 13.6 million birds have been destroyed on more than 800 holdings in the established protection, surveillance, and buffer zones (6). This outbreak has now spread across the border to Belgium and antibodies against avian influenza have also been detected in pigs in five mixed farms (chicken and pig rearing) in The Netherlands. A decision has been taken by the Dutch authorities to cull pigs on infected mixed farms (7)

There is concern about the potential for co-infection in humans with the avian influenza virus and any of the currently circulating human influenza viruses, with the possibility of recombination occurring to produce a virus more adapted for human-to-human transmission. Pigs have also been suggested as

intermediate hosts or a 'mixing vessel' between human and avian influenza viruses for such recombination events (8). Another possibility would be the mutation of an existing avian influenza virus more adapted for human-to-human transmission.

## UK measures

The Department for Environment, Food, and Rural Affairs (DEFRA) has recently updated information on its website about the avian influenza outbreak in The Netherlands available at <http://www.defra.gov.uk/animalh/diseases/notifiable/disease/avianinfluenza.htm>. DEFRA has banned the imports of live poultry and hatching eggs from The Netherlands and Belgium, but considers that the risk of this highly pathogenic strain of avian influenza becoming established in the United Kingdom (UK) flock is low. As a precautionary measure, however, DEFRA has prepared a biosecurity code for poultry owners to minimise the introduction of disease into their birds. DEFRA also considers that the most likely way the infection could get to the UK from The Netherlands, would be via migrating wildfowl, such as ducks, that would have acquired the HPAI virus from the ongoing outbreak in The Netherlands. The UK is not considered to be at risk from airborne infection of virus from The Netherlands as any airborne spread would probably be limited to a few hundred metres. Preventing contact between domestic flocks and wild fowl populations is an important preventative measure. According to DEFRA the last outbreak of avian influenza in the UK was confirmed in a flock of Turkeys in Norfolk in 1992 and affected only one set of premises. [http://www.who.int/csr/don/2003\\_04\\_24/en/](http://www.who.int/csr/don/2003_04_24/en/).

WHO concluded that the death was an isolated occurrence, as no efficient human-to-human transmission of the avian H7N7 influenza virus strain has been detected. Detailed investigation, including tracing of the veterinarians contacts, has not revealed any transmission of the disease (in its severest form) to other people. In accordance with WHO's pandemic preparedness plan for influenza, it recommends that in countries where initial cases of H7N7 infection were detected, surveillance and diagnosis of the avian H7N7 virus should be enhanced for humans and susceptible animals (including chickens, turkeys, and pigs). The WHO global influenza surveillance network is currently assembling a test kit for H7N7 that will be ready for use in three weeks. As a precautionary measure, the network is also working on the development of a vaccine for H7N7.

1. Netherlands: H7N7 in The Netherlands; first fatal human case. Archive no 20030419.0959. In *Promed Mail* [online]. Boston US: International Society for Infectious Diseases, 19 April 2003 [cited 1 May 2003]. Available at <http://www.Promedmail.org>.
  2. At least five workers infected with highly pathogenic avian influenza (HPAI) during outbreak of avian influenza in poultry farms in Holland - update 14 March. *Eurosurveillance Weekly* [serial online] 2003 [cited 1 May 2003]; 7 (11). Available at <http://www.eurosurveillance.org/ew/2003/030313.asp>.
  3. Outbreak of fowl plague (avian influenza) leads to secondary human cases, March 2002, The Netherlands. *Eurosurveillance Weekly* [serial online] 2003 [cited 1 May 2003] 2003; 7 (12). Available at <http://www.eurosurveillance.org/ew/2003/030320.asp>.
  4. Human infection associated with outbreak of fowl plague (avian influenza) in The Netherlands - update 27 March. *Eurosurveillance Weekly* [serial online] 2003 [cited 1 May 2003]; 7 (13). Available at <http://www.eurosurveillance.org/ew/2003/030327.asp>.
  5. Netherlands: Avian influenza, – Netherlands. Archive no 20030310.0583. In *Promed Mail* [online]. Boston US: International Society for Infectious Diseases, 10 March 2003 [cited 1 May 2003]. Available at <http://www.Promedmail.org>.
  6. Highly pathogenic avian influenza in the Netherlands - follow-up report No 7. World Health Organization for Animal Health website, 15 April 2003. OIE: Paris, [cited 1 May 2003]. Available at [http://www.oie.int/eng/info/hebd/AIS\\_23.HTM#Sec3](http://www.oie.int/eng/info/hebd/AIS_23.HTM#Sec3)
  7. Belgium: Belgium reports 2 new suspected bird flu cases. Archive 20030420.0971. In *Promed Mail* [online]. Boston US: International Society for Infectious Diseases, 20 April 2003 [cited 1 May 2003]. Available at <http://www.Promedmail.org>
  8. Brown IH. *The pig as an intermediate host for influenza A viruses between birds and humans*. In: Osterhaus A, Cox N, Hampson A, editors. Options for the control of influenza IV. International Congress Series. Amsterdam: Elsevier, 2001; p173-8.
-

## Severe Acute Respiratory Syndrome – update

By 30 April 2003, 5663 probable cases of severe acute respiratory syndrome (SARS) and 372 deaths had been reported to the World Health Organization (WHO) from 27 countries. As a result of ongoing local transmission in Beijing, Hong Kong Special Administrative Region, and Guangdong, and Shanxi provinces, China, WHO recommends that all but *essential travel* to these destinations should be postponed. As of 30 April the advice to postpone travel to Toronto is rescinded. Travel advice in the United Kingdom (UK) (published on the former PHLS and the Foreign and Commonwealth Office websites) follows WHO recommendations.

The World Health Organization maintains a current list of SARS affected areas countries which it defines as “a region where the country is reporting local transmission of SARS, within the last 20 days.” <[http://www.who.int/csr/sarsareas/2003\\_05\\_01/en/](http://www.who.int/csr/sarsareas/2003_05_01/en/)>. On 1 May London was removed from the list as it was more than 20 days (two incubation periods) since a single possible transmission was reported for the UK. The case was reported to WHO on 11 April and followed exposure to a man with what turned out to be confirmed (with laboratory confirmation) SARS on 3 April (1). London has not, however, been considered by WHO to be an area with more extensive transmission as despite comprehensive surveillance there had been no evidence of further transmission and no evidence of international spread from London. Hanoi, Vietnam was removed from the WHO list on 28 April (1), while Ulanbaatar City, Mongolia, and Tianjin Province in China have been added <[http://www.who.int/csr/sarsareas/2003\\_05\\_01/en/](http://www.who.int/csr/sarsareas/2003_05_01/en/)>. Although a travel advisory for Toronto, Canada was withdrawn by WHO on 29 April <[http://www.who.int/csr/sarsareas/2003\\_05\\_01/en/](http://www.who.int/csr/sarsareas/2003_05_01/en/)>, that area remains on the current list of affected areas as it not yet 20 days since the last recorded transmission for Toronto.

China continues to report the majority of cases and now accounts for more probable cases than the rest of the world combined. Beijing has reported the highest number of probable cases (1,440) and deaths (75). Nine hospitals in the Chinese capital now deal exclusively with SARS patients. Just outside Beijing, a new 1000-bed complex has been built to accommodate SARS patients.

There are currently six probable cases of SARS in the UK. One probable case was declassified and removed on 29 April 2003 following a diagnosis of influenza. A previously reported case, with onset date of 1 March 2003, has been reviewed and retrospectively classified as a probable case. All contacts were followed-up and none reported illness.

Convalescent sera and other biological samples are being collected from reported cases and are being tested in the Enteric, Respiratory and Neurological Virus Laboratory at Colindale. A significant proportion of these samples are testing positive for influenza A. These results are being reported through the normal system to requesting clinicians and their patients, and in addition, through regional epidemiologists to health protection units.

A study aimed at identifying risk factors and possible mechanisms for transmission of SARS associated with a hotel in Hong Kong is underway. Interviewing of UK nationals who stayed at the hotel between 20 and 22 February 2003 has commenced.

1. Health Protection Agency. Possible transmission of SARS within the UK – update. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 2 May 2003]; **13** (16): news. Available at <<http://www.phls.org.uk/publications/cdr/PDFfiles/2003/CDR1603.pdf>>

---

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZONOSEs

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

## Respiratory

Last updated: 1 May 2003

Next update due: 5 June 2003

### Contents

Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales

### Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales

Data are recorded by week of report, but only include specimens taken in the last eight weeks (*ie*, recent specimens)

**Table 1 Reports of influenza infection made to CDSC, by week of report, weeks 14-17/03**

Week	14/03	15/03	16/03	17/03	
<i>Week ending</i>	06/04/03	13/04/03	20/04/03	27/04/03	Total
<b>Influenza A</b>	<b>19</b>	<b>29</b>	<b>35</b>	<b>28</b>	<b>111</b>
Isolation	5	7	14	4	30
DIF	11	13	1	5	30
Four-fold rise in paired sera	–	2	1	–	3
PCR	–	–	–	–	–
Other	3	7	19	19	48

<b>Influenza B</b>	<b>12</b>	<b>13</b>	<b>12</b>	<b>11</b>	<b>48</b>
Isolation	4	–	2	1	7
DIF	–	4	1	2	7
Four-fold rise in paired sera	6	2	1	1	10
PCR	–	–	–	–	–
Other	2	7	8	7	24
<b>Influenza (untyped)</b>	<b>–</b>	<b>–</b>	<b>–</b>	<b>–</b>	<b>–</b>
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, genomic, electron microscopy, other method, other method unknown), by week of report, weeks 14-17/03**

<b>Week</b>	<b>14/03</b>	<b>15/03</b>	<b>16/03</b>	<b>17/03</b>	
<i>Week ending</i>	<b>06/04/03</b>	<b>13/04/03</b>	<b>20/04/03</b>	<b>27/04/03</b>	<b>Total</b>
Adenovirus*	46	26	38	30	<b>140</b>
Coronavirus	–	–	–	–	–
Parainfluenza†	6	4	16	12	<b>38</b>
Rhinovirus	1	6	9	3	<b>19</b>
Respiratory Syncytial Virus (RSV)‡	22	22	32	17	<b>93</b>

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

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

‡ excludes diagnosis made by electron microscopy (EM)

**Table 3 Respiratory viral detections by age group, weeks 14-17/03**

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥ 65 years	Unknown	Total
Adenovirus*	20	23	11	71	9	5	1	140
Coronavirus	–	–	–	–	–	–	–	–
Influenza A	23	20	5	25	13	23	2	111
Influenza B	5	4	16	16	6	1	–	48
Parainfluenza†	22	8	1	1	4	1	1	38
Rhinovirus	12	1	1	1	3	1	–	19
Respiratory Syncytial Virus (RSV) ‡	65	9	1	3	6	6	3	93

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

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

‡ excludes diagnosis made by electron microscopy (EM)

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

Week	14/03	15/03	16/03	17/03	
Week ending	06/04/03	13/04/03	20/04/03	27/04/03	Total
<i>Coxiella burnetii</i>	2	–	–	–	2
Respiratory <i>Chlamydia</i> sp.*	3	1	1	2	7
<i>Mycoplasma pneumoniae</i>	10	49	11	9	79
<i>Legionella</i> sp.†	2	4(2)	3	2	11(2)

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

† non-pneumonic cases in brackets

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

<b>Week</b>	<b>14/03</b>	<b>15/03</b>	<b>16/03</b>	<b>17/03</b>	
<b>Week ending</b>	<b>06/04/03</b>	<b>13/04/03</b>	<b>20/04/03</b>	<b>27/04/03</b>	<b>Total</b>
Nosocomial	–	–	–	–	–
Community	2	1	1	–	4
Travel UK	–	3(2)	2	–	5(2)
<b>Total</b>	<b>2</b>	<b>4(2)</b>	<b>3</b>	<b>2</b>	<b>11(2)</b>
Male	1	2(2)	2	1	6(2)
Female	1	2	1	1	5

\* non-pneumonic cases in brackets

Eleven cases were reported with pneumonia and there were two non-pneumonic cases. Eight were male aged between 53 and 79 years and five were female aged between 45 and 71 years. M 76y died. Nine cases were associated with travel: England (7), Australia (1), and Sri Lanka (1). Eight cases, seven of which were travel cases in England and one community acquired case, are linked to an outbreak at a hotel and leisure complex in Somerset. Four cases had community acquired infection.

[Back to top](#)

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

## Travel health

Last updated: 1 May 2003

Next update due: 5 June 2003

[Click here for links to travel health websites](#)

### The National Travel Health Network and Centre (NaTHNaC)

#### Rationale

The number of people travelling overseas from the United Kingdom (UK) is increasing at an average rate of about 8% a year with just over 59 million visits abroad in 2002. In particular, the annual increase in the number of travellers going to more distant and exotic locations in developing countries is also by about 5% a year (1). As a result, more travellers are exposed to new and potentially serious diseases that do not ordinarily occur in the UK. Diseases such as malaria, yellow fever, dengue fever, hepatitis A, typhoid, and Japanese encephalitis are endemic in many developing countries, and therefore appropriate pre-travel advice is essential to protect travellers from infections and other non-infectious hazards associated with their travel. Travel-associated illness may also have public health implications for the UK, as there may be a risk of ongoing transmission to other people. There are also costs associated with treatment of returning travellers who are ill. There are an increasing number of more vulnerable groups of travellers such as children, the elderly, chronically ill, and immune-suppressed individuals travelling, whose health-risks and pre-travel preparations are difficult and complex, and therefore requires more specialist advice and expertise. Several organisations both in the public sector and private sector provide pre-travel expertise and advice to health professionals and the public; this is evidence-based where possible, although the evidence base needs to be improved as more data becomes available.

#### Who are NaTHNaC?

The National Travel Health Network and Centre (NaTHNaC) is a government funded initiative, developed by the London School of Hygiene and Tropical Medicine, the Hospital for Tropical Diseases, the Communicable Disease Surveillance Centre (CDSC) (now part of the Health Protection Agency), the Liverpool School of Tropical Medicine, and the Defence Medical Services. These organisations have brought together expert knowledge in the field of travel medicine in order to achieve the key goal of NaTHNaC, which is **'to protect the health of British travellers'**. It is envisaged that this will be achieved using an agreed set of core objectives.

#### Aims and objectives of NaTHNaC:

- To develop consistent and authoritative national guidance on general health matters for health professionals who advise the public on travelling abroad, and to disseminate this information widely
- To provide guidance on specific situations relating to health of travellers
- To carry out surveillance of infectious and non-infectious hazards abroad, producing accessible

- regular outputs of such surveillance
- To administer the yellow fever vaccination centres
- To engage the major stakeholders concerned with travel health especially the travel industry, insurance industry, and other government bodies, to assist both in sentinel surveillance and to engage in constructive dialogue towards a unified prevention approach
- To facilitate, in collaboration with other training providers, the training of health care and other personnel in the provision of best quality travel health advice, based on such evidence as is available
- To define short-term and long-term research priorities in relation to the above

### **The NaTHNaC Team**

NaTHNaC is based at the Hospital for Tropical Diseases in London where most of the staff are located. This team, consists of a part-time medical consultant, three full time nurses, an administrator, and an information officer. In addition, one nurse is based at the Liverpool School of Tropical Medicine, and the surveillance team (a part-time consultant epidemiologist and full time scientist) is based at the Communicable Disease Surveillance Centre (CDSC), Colindale, London. Most of the staff began work with NaTHNaC in December 2002, and a medical director of international standing has been interviewed and is expected to start in June 2003, pending formalities.

### **Progress so far**

#### **Telephone service**

One of the first priorities for the centre has been to set up the telephone advice line service for health professionals and to develop more detailed guidelines for travellers with special needs. The advice service began at the end of March 2003 and is currently operating in the mornings between the hours of 09.00 and 12.00, Monday to Friday. The queries are answered by the team of specialist nurses, with medical cover provided. The service is available to health professionals only on: (020 7380 9234). Individual members of the public should seek advice from their general practitioner or specialist travel clinic.

#### **Surveillance**

Surveillance of travel-related illness will contribute to the evidence-base for the travel advice given by the nurses and medical staff at NaTHNaC. The surveillance function of NaTHNaC is to be undertaken by the consultant and scientist in the travel health surveillance section (part of the respiratory division) at CDSC, which has been operational since January 2003. As well as monitoring global disease burdens, the immediate aims of the travel surveillance section are to co-ordinate and collate the travel-related disease surveillance that is currently being undertaken within the different divisions of CDSC, to produce regular outputs of this information, and to develop other innovative approaches to the surveillance of travel-related illness in England. In this regard CDSC is already collaborating with the Scottish Centre for Infection and Environmental Health (SCIEH) and also hopes to work on surveillance issues with colleagues in CDSC Wales, CDSC Northern Ireland, and the National Disease Surveillance Centre (NDSC) in the Republic of Ireland.

#### **Yellow fever vaccination centres**

Administration of the yellow fever vaccination centres is due to be transferred from the Department of Health to NaTHNaC during 2003. The aim is to provide a more comprehensive service to designated centres, with proposals underway for extended training programmes, improved standards, and fluent communication lines.

#### **Official launch**

An official launch of NaTHNaC will take place in July 2003 and will be attended by Her Royal Highness The Princess Royal who is the patron of the Hospital for Tropical Diseases Foundation, where the NaTHNaC Centre is based.

Further information about the aims and current activities of NaTHNaC is available at <http://www.nathnac.org>

## References

1. Office for National Statistics. *MQ6 Transport and Tourism. Overseas travel and tourism, Quarter 4, 2002*. HMSO: London; 2003 Available at <[http://www.statistics.gov.uk/downloads/theme\\_transport/MQ6\\_Q4\\_2002.pdf](http://www.statistics.gov.uk/downloads/theme_transport/MQ6_Q4_2002.pdf)>

[Back to top](#)

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOONOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

## Zoonoses

Last updated: 6 March 2003  
Next update due: 3 April 2003

### Contents

[Common animal associated infections, England and Wales: laboratory reports, weeks 14 - 17/03](#)

[Common imported infections, England and Wales: laboratory reports, weeks 14-17/03](#)

### Common animal associated infections, England and Wales: laboratory reports, weeks 14 - 17/03

Organism	Total reports for weeks 14-17		Cumulative totals for weeks 14-17	
	2003*	2002	2003*	2002
<i>Borrelia burgdorferi</i> *‡	2	9	7	28
<i>Leptospira hardjo</i> †§	–	–	–	–
<i>Leptospira icterohaemorrhagiae</i> †§	–	2	4	3
<i>Leptospira other</i> †§	1	1	9	4
<i>Pasteurella haemolytica</i>	–	–	1	1
<i>Pasteurella multocida</i>	15	11	58	44
<i>Pasteurella pneumotropica</i>	–	–	2	–
<i>Pasteurella</i> spp	7	2	13	9
<i>Toxocara canis</i>	–	–	–	–
<i>Toxocara cati</i>	–	–	–	–
<i>Toxocara</i> spp	–	–	–	–
<i>Toxoplasma gondii</i>	6	2	9	9
<i>Toxoplasma</i> spp	1	4	6	11

\* 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 14- 17/03

Organism	Cumulative total reports for weeks 06-09		Cumulative totals for weeks 01-09	
	2003*	2002	2003*	2002
Arbovirus	–	–	–	–
Dengue virus	–	–	1	1
<i>Ascaris</i> spp	6	19	21	39
Hookworms (unspecified)	2	51	4	101
<i>Leptospira</i> spp†	–	1	–	1
<i>Ancylostoma duodenale</i>	–	–	–	–
<i>Necator americanus</i>	–	–	–	–
<i>Hymenolepis diminuta</i>	–	–	–	–
<i>Hymenolepis nana</i>	2	6	3	11
<i>Hymenolepis</i> spp	–	–	–	–
<i>Schistosoma haematobium</i>	1	7	12	17
<i>Schistosoma intercalatum</i>	–	–	–	–
<i>Schistosoma mansoni</i>	–	4	3	11
<i>Schistosoma</i> spp	–	–	–	6
<i>Strongyloides stercoralis</i>	2	2	2	5
<i>Strongyloides</i> spp	1	–	1	–

\* Provisional data

† *Leptospira* Reference Laboratory and CDSC

[Back to top](#)