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CDR WEEKLY

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Severe Acute Respiratory Syndrome – update

Severe Acute Respiratory Syndrome – update

UK situation

As of 4 June 2003, the United Kingdom (UK) is currently reporting four probable cases of severe acute respiratory syndrome (SARS) all of whom have recovered and been discharged from hospital. A further 159 reports of possible cases of SARS in residents of the UK have been assessed by the Health Protection Agency (HPA) and none have been classified as probable cases.

UK information updates

Since 29 May 2003, the following information has been made available on the internet:

Information on face masks and respirators - frequently asked questions - available at
<http://www.phls.co.uk/topics_az/SARS/facemaskFAQs.htm>

Updates to primary care and hospital guidance, incorporating new guidance in relation to masks. Health care workers in both hospital and community settings are now recommended to wear masks conforming to the European standard EN149: 2001 FFP2 or the US-approved N95 when seeing suspect or probable SARS patients. If a respirator is not immediately available, a surgical face mask should be worn. More information is available at

<http://www.phls.co.uk/topics_az/SARS/GP_guidance.htm> and
<http://www.phls.co.uk/topics_az/SARS/hospital_guidance.htm>

Updated travel advice incorporating the latest world Health Organization (WHO) recommendations is available at <http://www.phls.co.uk/topics_az/SARS/travel_guidance.htm> and
<http://www.phls.co.uk/topics_az/SARS/traveller_health_alert.pdf>.

A new web page, *Frequently asked questions about coronaviruses* for the public is at
<http://www.phls.co.uk/topics_az/SARS/virus_FAQs.htm>.

Frequently-asked questions about SARS and *Advice for travellers* are also available in Chinese from
<http://www.phls.org.uk/topics_az/SARS/public_page.htm>.

Status of diagnostic tests

The World Health Organization (WHO) is currently coordinating a series of training courses in Beijing to establish an efficient laboratory infrastructure for SARS diagnosis throughout China. More information is available at <http://www.who.int/csr/don/2003_06_02a/en/>. Trainers will be provided from the United States, UK, and Hong Kong to give the best possible experience the world has to offer in the laboratory detection of SARS infection. China has already developed an enzyme-linked immunosorbent assay (ELISA) for SARS, which WHO considers to be promising. One of the problems faced by researchers around the world in developing diagnostic tests has been that viral shedding is

comparatively low during the initial phase of illness, requiring the need for tests with a particularly high sensitivity to detect for the presence of the SARS virus. Detectable immune responses do not begin until day five or six, and current reliable antibody tests can only detect antibodies to the SARS virus around day ten following onset of symptoms. WHO continues to recommend use of its case definitions based on clinical ascertainment together with patient travel and contact history to detect suspect and probable SARS cases. Current UK case definitions are available at http://www.phls.co.uk/topics_az/SARS/case_definition.htm.

Global news

The WHO reports 8402 cases and 772 deaths globally, up to 4 June 2003.

Toronto, Canada reported 54 probable cases to WHO between 31 May and 03 June. Of these, 20 had been reclassified according to Health Canada's revised case definition for probable cases, and the remaining 34 are newly identified probable cases. The case definition was revised on 30 May and was applied retrospectively to the recent resurgence in SARS cases linked to healthcare settings in Toronto, which were first reported to Health Canada on 22 May 2003. Further details are available on the Health Canada website at

http://www.hc-sc.gc.ca/pphb-dgspssp/sars-sras/sarscasedef-0529_e.html

China

China has seen a decline the number of newly reported cases. In the six days up to 3 June there has been a daily average of 2.5 cases compared to 166, during the first week of May

http://www.who.int/csr/don/2003_06_03/en/. WHO advocates caution over the interpretation of this downward trend, since they are concerned about the sensitivity of case detection in some provinces, and about the capacity of the health infrastructure to cope with the challenge that SARS presents.

Approximately half of the new cases reported do not have information on the source or setting of exposure, making it difficult to assess the extent of local transmission. WHO still considers China to be at the epicentre of SARS and believes attempts to control SARS worldwide will depend on whether the disease can be controlled in China, which has a large migrant populations and porous borders. The recent experience in Toronto demonstrates the difficulty a country can experience in bringing SARS under control, and the need to maintain vigilance and preparedness for the prevention and control of potential outbreaks from imported or previously undetected cases.

Singapore

Singapore was removed from the list of areas with recent local transmission of SARS on 31 May 2003. Over twenty days had passed since the last reported probable on 11 May. This is twice the maximum incubation period and indicates that the chain of transmission has been broken. Exit screening is no longer recommended for Singapore by WHO, and neither residents nor travellers are considered to be at risk of acquiring SARS in Singapore. WHO praised Singapore's handling of its SARS outbreak as "exemplary" and highlighted a number of measures that Singapore used in bringing the outbreak under control:

- A highly sensitive case definition (picking up anybody with symptoms that might possibly indicate SARS, with or without previous contact history).
- An independent hospital-based surveillance system, which monitors cases of pneumonia outside the hospital setting.
- Vigorous contact tracing and enforcement of home quarantine measures assisted by the Singaporean military forces.

More information is available on the WHO website at http://www.who.int/csr/don/2003_05_30a/en/.

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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 18-22/03

Week	18/03	19/03	20/03	21/03	22/03	
Week ending	04/05/03	11/05/03	18/05/03	25/05/03	01/06/03	Total
Influenza A	16	29	30	15	4	94
Isolation	2	8	5	–	1	16
DIF	7	3	7	4	–	21

Four-fold rise in paired sera	3	7	3	–	–	13
PCR	–	–	–	–	–	–
Other	4	11	15	11	3	44
Influenza B	1	4	2	1	–	8
Isolation	–	–	–	–	–	–
DIF	1	–	1	–	–	2
Four-fold rise in paired sera	–	–	1	–	–	1
PCR	–	–	–	–	–	–
Other	–	4	–	1	–	5
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, genomic, electron microscopy, other method, other method unknown), by week of report, weeks 18-22/03

Week	18/03	19/03	20/03	21/03	22/03	
<i>Week ending</i>	04/05/03	11/05/03	18/05/03	25/05/03	01/06/03	Total
Adenovirus*	23	34	56	32	20	165
Coronavirus	–	–	–	–	–	–
Parainfluenza†	8	21	21	19	12	81

Rhinovirus	5	6	8	1	2	22
Respiratory Syncytial Virus (RSV) ‡	12	27	14	14	9	76

*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 18-22/03

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥ 65 years	Unknown	Total
Adenovirus*	16	25	10	75	26	8	5	165
Coronavirus	–	–	–	–	–	–	–	–
Influenza A	14	8	7	27	20	13	5	94
Influenza B	-	-	3	3	2	–	–	8
Parainfluenza †	48	14	2	6	8	2	1	81
Rhinovirus	9	5	2	2	1	–	3	22
Respiratory Syncytial Virus (RSV) ‡	31	5	2	15	13	6	4	76

*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	18/03	19/03	20/03	21/03	22/03	
Week ending	04/05/03	11/05/03	18/05/03	25/05/03	01/06/03	Total
<i>Coxiella burnettii</i>	–	–	1	–	–	1
Respiratory <i>Chlamydia</i> sp.*	–	3	1	6	2	12
<i>Mycoplasma pneumoniae</i>	5	14	18	17	10	64
<i>Legionella</i> sp. †	4	5	2	4	2	17

*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

Week	18/03	19/03	20/03	21/03	22/03	
Week ending	04/05/03	11/05/03	18/05/03	25/05/03	01/06/03	Total
Nosocomial	–	–	1	1	1	3
Community	3	1	1	1	–	6
Travel abroad	1	1	–	2	–	4
Travel UK	–	3	–	–	1	4
Total	4	5	2	4	2	17
Male	2	4	2	3	1	12
Female	2	1	–	1	1	5

* non-pneumonic cases in brackets 17 cases were reported with pneumonia.

Twelve cases were males aged between 34 and 69 years and five were females aged between 47 and 85 years. M 66y died. Eight cases were associated with travel: England (4), Spain (1), Tenerife (1), Turkey (2). One travel case in England was linked to an outbreak at a hotel and leisure complex in Somerset. Six cases had community acquired infection, and three were hospital acquired.

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Common animal associated infections, England and Wales: laboratory reports, weeks 18 - 22/03

Organism	Total reports for weeks 18-22		Cumulative totals for weeks 18-22	
	2003*	2002	2003*	2002
<i>Borrelia burgdorferi</i> *‡	3	19	10	46
<i>Leptospira hardjo</i> †§	–	1	–	1
<i>Leptospira icterohaemorrhagiae</i> †§	–	2	4	5
<i>Leptospira other</i> †§	4	–	13	4
<i>Pasteurella haemolytica</i>	–	–	1	1
<i>Pasteurella multocida</i>	11	17	69	61
<i>Pasteurella pneumotropica</i>	–	1	2	1
<i>Pasteurella</i> spp	3	2	16	11
<i>Toxocara canis</i>	–	–	–	–
<i>Toxocara cati</i>	–	–	–	–
<i>Toxocara</i> spp	–	–	–	–
<i>Toxoplasma gondii</i>	2	3	11	12
<i>Toxoplasma</i> spp	6	3	12	14

* 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 18- 22/03

Organism	Cumulative total reports for weeks 06-09		Cumulative totals for weeks 01-09	
	2003*	2002	2003*	2002
Arbovirus	–	–	–	–
Dengue virus	1	4	2	5
<i>Ascaris</i> spp	15	8	36	47
Hookworms (unspecified)	35	2	39	103
<i>Leptospira</i> spp†	–	–	–	1
<i>Ancylostoma duodenale</i>	–	–	–	–
<i>Necator americanus</i>	–	–	–	–
<i>Hymenolepis diminuta</i>	–	–	–	–
<i>Hymenolepis nana</i>	3	2	6	13
<i>Hymenolepis</i> spp	–	–	–	–
<i>Schistosoma haematobium</i>	–	4	12	21
<i>Schistosoma intercalatum</i>	–	–	–	–
<i>Schistosoma mansoni</i>	–	2	3	13
<i>Schistosoma</i> spp	–	3	–	9
<i>Strongyloides stercoralis</i>	2	2	4	7
<i>Strongyloides</i> spp	–	2	1	2

* Provisional data

† Leptospira Reference Laboratory and CDSC

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