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Provisional national data released for 2002 on sexually transmitted infection

Data released on 3 July 2003 (1) by the Health Protection Agency Communicable Disease Surveillance Centre showed that there were 1.5 million attendances (diagnoses and workload) at genitourinary medicine clinics (GUM) in England, Wales, and Northern Ireland in 2002, a 15% increase on 2001. Diagnoses of sexually transmitted infections (STIs) rose by 5% between 2001 and 2002, whereas workload, (that is other sexual health services provided by GUM clinics), increased by 23%.

Within the overall increase in attendances there were marked differences in the changes in diagnoses of STIs. Diagnoses of **syphilis** increased substantially by 67% and 33% in males and females respectively, and there was a 68% increase in diagnoses made in men who have sex with men (MSM). The largest increases were seen in London and Manchester, where substantial outbreaks have occurred in recent years. The 1193 diagnoses of syphilis seen in 2002 were the highest number seen since 1984, before the time of widespread awareness of HIV/AIDS in the UK (2). The 607 diagnoses in MSM and the high proportion of co-infections with HIV seen in the enhanced surveillance for infectious syphilis initiative is consistent with a core group of men who continue to be at risk of transmitting or acquiring syphilis.

Diagnoses of **gonorrhoea** increased by 8% in males and 10% in females, but decreased by 5% in MSM. In London, where 51% of gonorrhoea diagnoses in MSM are made, diagnoses decreased by 11%. Decreases in diagnoses were seen in all age groups apart from men aged between 16 and 24 years. In contrast, diagnoses of gonorrhoea in females increased in all age groups and all regions apart from the West Midlands. Young women were particularly affected, 40% of diagnoses in women were seen in those aged 20 years or under.

Genital chlamydial infection is the most commonly diagnosed STI seen in GUM clinics with a total of 81,680 diagnoses made in 2002, a 14% increase on 2001. Increases in diagnoses were seen in all regions and all age groups. This may either reflect increased prevalence or increasing opportunistic, as well as demand-led, screening.

Diagnoses of **genital herpes simplex virus** infection increased by only 1% in males and 4% in females between 2001 and 2002, a slight overall increase similar to trends over recent years. There was little variation in the distribution between age groups and regions for males and females, although diagnoses in the distribution of MSM increased in most regions. Diagnoses of genital warts increased by 3% in males (10% in MSM) and 1% in females with substantial increases in London and the South East region, as well as Northern Ireland. There was little change in diagnoses of genital warts by age group.

These data suggest that the increase in STIs diagnoses that began in the mid-1990s is continuing (3). There are indications that the rate of increase in diagnoses of gonorrhoea, genital herpes simplex infection, and genital warts has slowed in some groups. The decreases in diagnoses of gonorrhoea in MSM seen in London and the South East, coupled with the reductions in the rate of rise in infectious syphilis in these areas, are encouraging and may reflect a positive impact of recent targeted sexual health promotion campaigns (4).

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Methicillin-resistant *Staphylococcus aureus* (MRSA) in injecting drug users

Two centres in England are encountering cases of methicillin-resistant *Staphylococcus aureus* (MRSA) in injecting drug users (IDUs) in the community. Cases have groin abscesses with or without septicaemia, and there are also a number with endocarditis. These MRSA isolates can be heterogeneously resistant to oxacillin/methicillin. They may appear mastalex negative but become positive after induction with cefoxitin. They have an unusual antibiogram, being also resistant to fusidic acid, but sensitive to ciprofloxacin. One centre has examined a limited number and they appear clonal by pulsed field gel electrophoresis (PFGE) and accessory gene regulator (agr) allele typing. Indications, so far, are that these strains are Panton-Valentine leukocidin (PVL) negative (1).

Further microbiological investigations and epidemiological studies are underway, but in the interim can any other centres encountering MRSA infections in IDUs please contact, and send strains to Angela Kearns at the Staphylococcal Reference Unit (SRU), Laboratory of Healthcare Associated Infection, Specialist and Reference Microbiology Division, Health Protection Agency, 61 Colindale Avenue, London NW9 5HT: tel 020 8200 4400 (ext: 4249); fax 020 8200 7449.

If consultants in communicable disease control are aware of an increase of MRSA in IDUs in their locality, they should encourage local laboratories to send strains to the SRU, and should also contact Fortune Ncube or Viv Hope at the HIV/STI Division, Health Protection Agency Communicable Disease Surveillance Centre to pass on epidemiological details: tel 020 8200 6868 (ext 3424) and 4930.

1. Health Protection Agency. Emergence of PVL-producing strains of *Staphylococcus aureus*. *Comm Dis Rep CDR Wkly* [serial online] 2003 [cited 3 July 2003]; **13** (15): news. Available at <<http://www.phls.org.uk/publications/cdr/archive03/News/news1503.htm#pvl>>

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National increases in salmonellosis

The Health Protection Agency's Laboratory of Enteric Pathogens (LEP) in Colindale, London, has reported simultaneous increases in two salmonella strains. These are *S. Enteritidis* PT14b and *S. Typhimurium* U277, both fully sensitive to the panel of antimicrobial agents used by LEP for epidemiological typing.

***S. Typhimurium* U277**

Since 1 June 2003, LEP has confirmed 40 isolates of *S. Typhimurium* U277 infection compared with

none last year. Those affected range in age from one year to 57 years (median 29 years) with both genders being represented in approximately equal proportions. Cases are distributed in most regions of England and Wales with most living in central England.

S. Enteritidis PT14b

Since 1 June 2003, LEP has confirmed 51 human isolates of *S. Enteritidis* PT 14b sensitive to antibiotics compared with 20 in 2002. Forty per cent of the cases report recent foreign travel to destinations in the Mediterranean. A majority of the cases identified, so far, are male and the ages range from three to 75 years (median 31 years). Infection is distributed throughout England and Wales. There was an upsurge in cases infected with *S. Enteritidis* PT 14b sensitive to antibiotics in England and Wales in the autumn of 2002. Investigations demonstrated a link between infection and the consumption of bakery products made with imported shell eggs.

Investigations

Epidemiological and microbiological investigations into the increase in illness due to these two strains of salmonella have been initiated. Patients with laboratory confirmed infection are being interviewed in order to identify common factors which might be linked to disease transmission.

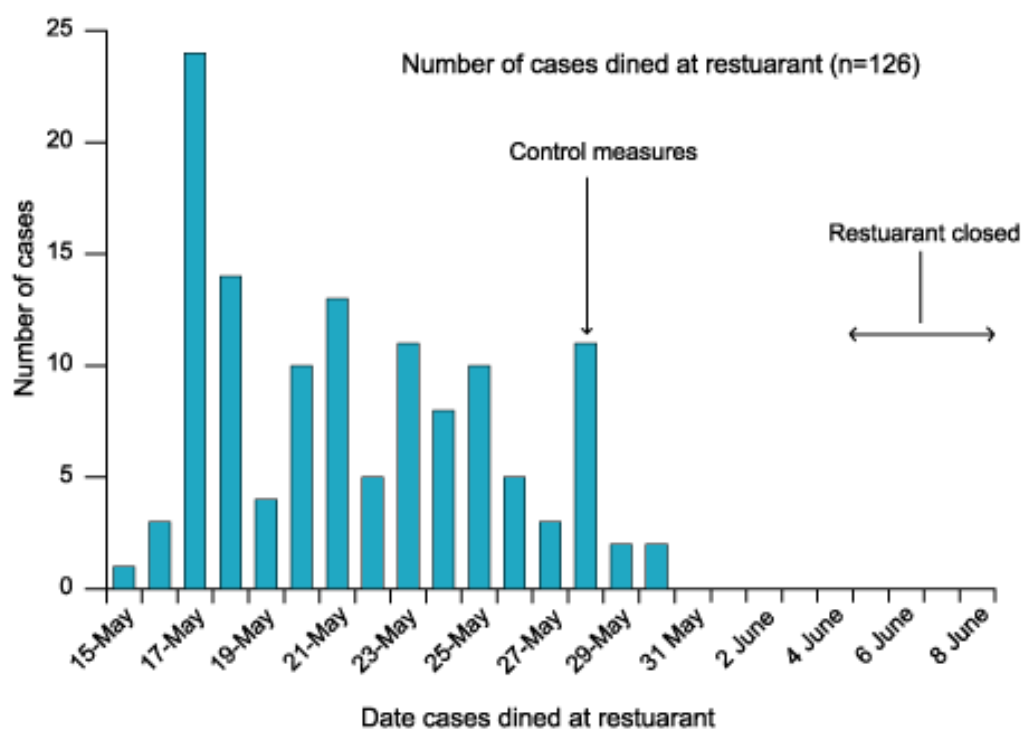
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Outbreak of *Salmonella* Enteritidis Phage Type 56 in Durham

During a three-week period from 18 May, 129 cases of *Salmonella* Enteritidis Phage Type (PT) 56 were reported in the north east of England, associated with eating in a Chinese restaurant in Durham City. The buffet-style restaurant serves over 2000 meals each week, for a 12-hour period each day, and there are typically over 60 different dishes on offer, with the choice varying according to the time of day.

One hundred cases were residents of County Durham and Darlington, 25 were from elsewhere in the North East, and four from other parts of the United Kingdom.

The known dates of onset (for 126 of the cases) ranged from 18 May to 8 June. Eleven cases were admitted to hospital and there have been no deaths associated with this outbreak. The average age was 28 years (range 1 to 76 years). The period of exposure to the restaurant ranged from 15 to 30 May (Figure).



The outbreak came to light on 27 May and initial control measures at the restaurant were implemented on 28 May. The restaurant was closed to business from 5 to 8 June. An outbreak control team, including representatives from Durham and Chester le Street PCT, County Durham and Darlington Local Health

Protection Unit and environmental health officers for City of Durham and other local authorities, investigated and managed the outbreak. The outbreak has now been declared closed. No specific food vehicle has been identified.

This is the first outbreak of *S. Enteritidis* PT56 infection since the phage type was first identified by the Health Protection Agency Laboratory of Enteric Pathogens (LEP) in autumn 2002. Between September and December 2002, LEP reported on 51 human isolates of this strain, with the majority of cases occurring in October and November. No common link was found, although four patients had a recent history of foreign travel (Portugal two, Canary Islands and United States one each). There have been no non-human isolates of *S. Enteritidis* PT56 to date.

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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 23-26/03**

Week	23/03	24/03	25/03	26/03	
Week ending	08/06/03	15/06/03	22/06/03	29/06/03	Total
Influenza A	6	4	11	3	24
Isolation	1	3	4	–	8
DIF	–	–	–	–	–
Four-fold rise in paired sera	1	–	–	–	1
PCR	–	–	–	–	–
Other	4	1	7	3	15
Influenza B	4	–	2	1	7
Isolation	–	–	–	–	–
DIF	–	–	–	–	–
Four-fold rise in paired sera	1	–	–	–	1
PCR	–	–	–	–	–
Other	3	–	2	1	6
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 23-26/03

Week	23/03	24/03	25/03	26/03	
Week ending	08/06/03	15/06/03	22/06/03	29/06/03	Total
Adenovirus*	18	34	40	43	135
Coronavirus	–	–	–	–	–

Parainfluenza†	18	20	20	18	76
Rhinovirus	7	1	2	3	13
Respiratory Syncytial Virus (RSV)‡	15	11	16	4	46

*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 23-26/03

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥ 65 years	Unknown	Total
Adenovirus*	13	10	8	82	16	4	2	135
Coronavirus	–	–	–	–	–	–	–	–
Influenza A	1	2	1	6	9	3	2	24
Influenza B	–	–	2	3	–	2	–	7
Parainfluenza†	39	10	2	10	8	6	1	76
Rhinovirus	9	1	1	–	–	1	1	13
Respiratory Syncytial Virus (RSV) ‡	9	2	3	10	12	9	1	46

*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	Total
Week ending	04/05/03	11/05/03	18/05/03	25/05/03	
<i>Coxiella burnetii</i>	–	1	–	3	4
Respiratory <i>Chlamydia</i> sp.*	2	2	4	2	10
<i>Mycoplasma pneumoniae</i>	18	15	21	18	72
<i>Legionella</i> sp.	4	9	–	3	16

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

Table 5 Reports of legionnaires' disease cases in England and Wales, by week of report

Week	18/03	19/03	20/03	21/03	Total
Week ending	04/05/03	11/05/03	18/05/03	25/05/03	
Nosocomial	1	–	–	1	2
Community	2	3	–	1	6
Travel abroad	1	6	–	1	8
Travel UK	–	–	–	–	–
Total	4	9	–	3	16
Male	4	7	–	2	13
Female	–	2	–	1	3

Sixteen cases were reported with pneumonia. Thirteen cases were males aged between 47 and 78 years and three were females aged between 47 and 59 years. F 47y died. Eight cases were associated with travel: France (2), Greece (2), Italy (1), Spain (1), Spain and UK (1), Turkey (1). One case who visited France was associated with a cluster. Six cases had community-acquired infection, and two were hospital acquired.

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Travel health

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Dengue fever – worldwide update 2002/03

Introduction

Dengue Fever is recognised in over 100 countries throughout the tropical and sub-tropical areas of the world putting over 2.5 billion people at risk of infection – equivalent to approximately 40% of the world’s population. It is also estimated that there are 100,000 cases of the more severe (and often fatal) form of dengue fever, dengue haemorrhagic fever (DHF). The endemic areas are Asia, the Pacific Islands, the Americas, Africa, and the Eastern Mediterranean. The highest burden of disease occurs in south east Asia and the western Pacific, but over the last few years there has also been a rising trend in South America and the Caribbean. It is difficult to obtain accurate data on dengue outbreaks and trends as there seems to be great variation in quality of information between data sources. The World Health Organization (WHO) is in the process of addressing this and has created DengueNet (1) in order to overcome this problem and standardise the reporting of dengue. This article will highlight recent trends in conjunction with current outbreaks of dengue fever in the endemic areas as reported by Promed and various news agencies (tables 1 to 3). It will then look at the reported travel-associated cases in England and Wales in 2002.

Asia

Dengue fever usually has a cyclical pattern in south east Asia, which is illustrated by figure 1. The figures in DengueNet are not yet complete for 2002, but WHO reported a general increase in dengue activity in this region in 2002, which has been supported by various Promed reports of increased dengue activity in Asian countries (2). Thailand is suffering from its third consecutive year of high dengue numbers. In 2002, there were 108,905 reports of dengue fever with 172 deaths and in 2001 there were 100,653 with 216 deaths. The public health ministry in Thailand, so far, this year has reported 30,645 cases up to June 2003 (3).

Figure 1 Dengue fever reports for south east Asia and the far east 1980 to 2001

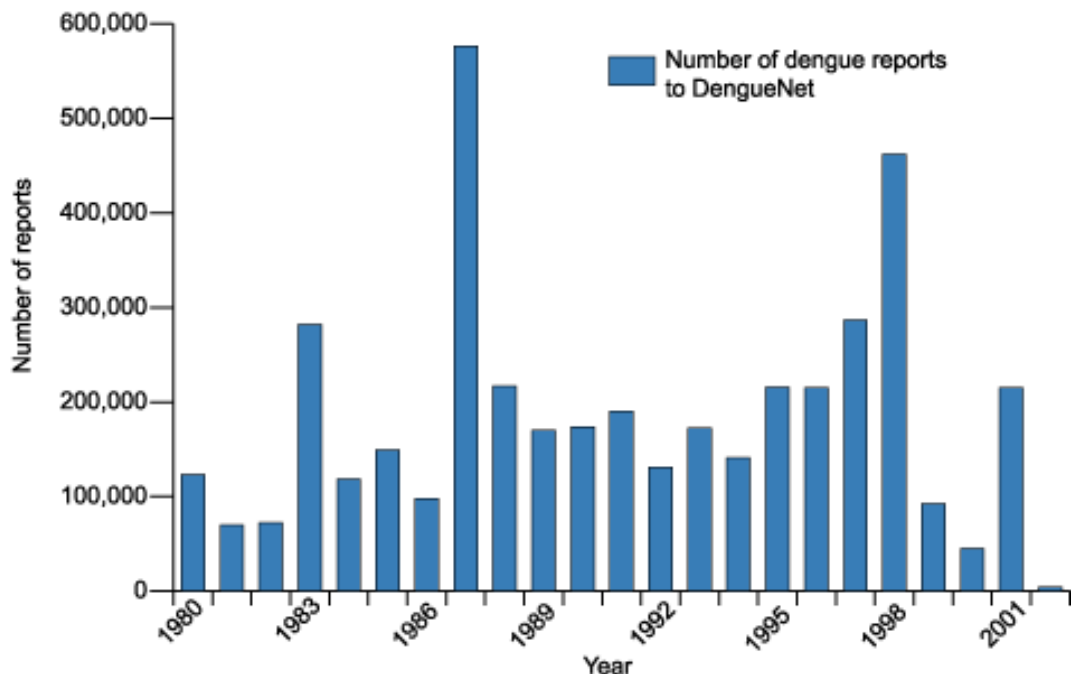


Table 1 Current outbreaks of dengue fever in Asia

Country	Date	*Numbers DF/DHF/(Deaths)	Source	Additional comments
Philippines	From June 2002 to 02 June 2003	4026/-(54)	(4)	In 2002, there were 12,670 DF cases recorded by the health department with 153 deaths.
Vietnam	Jan to May 2003	8000/-(16)	(5)	Fifty per cent increase on same period in 2002. Ninety per cent of cases from southern Mekong Delta region.
Cambodia	Jan to Apr 2003	1644/-(–)	(6)	Unusually high number of cases reported during the dry season.
India (Kerala)	2003 to date	78/-(4)	(7)	Outbreak centred on Thiruvananthapuram.

*These figures are unofficial reports, please interpret with caution.

DF – Dengue Fever,

DHF – Dengue Haemorrhagic Fever

Figure 2 shows the dengue reports from the Indian sub-continent. The majority of the reports to DengueNet in this region are from India, but figures are incomplete and do not include any data for Pakistan or Bangladesh, which are also endemic for dengue fever.

Figure 2 Dengue reports from the Indian sub-continent 1988 – 2001

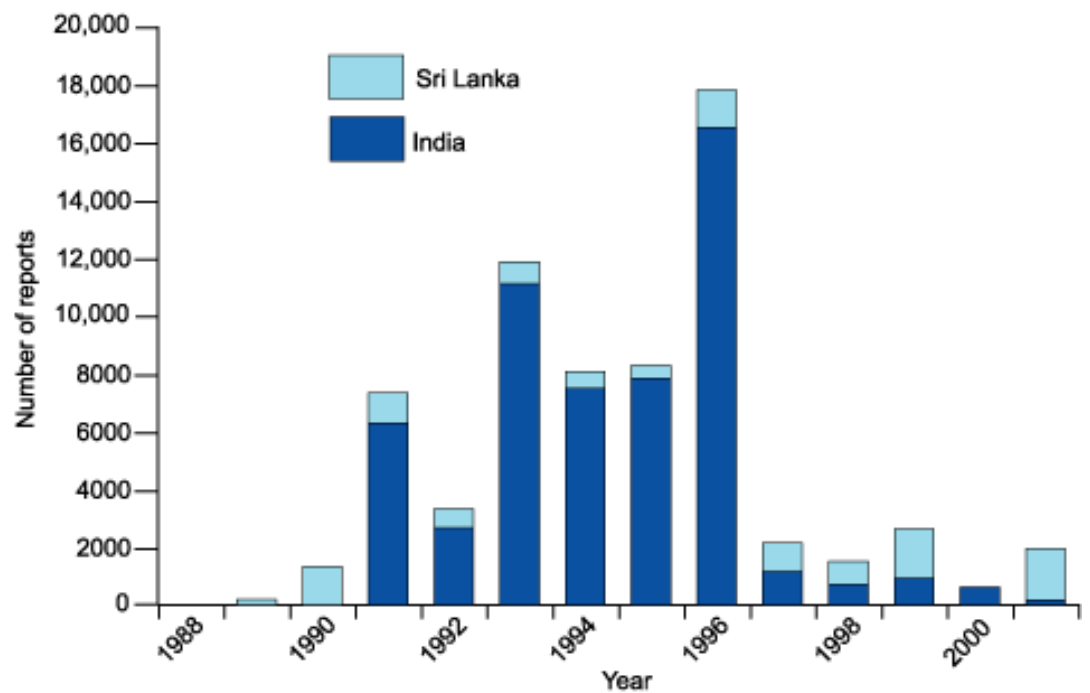


Table 2 Current outbreaks of dengue fever in the Pacific

Country	Date	*Numbers DF/DHF/(Deaths)	Source	Additional Comments
New Caledonia (French Pacific Territory)	01/01/03 to 12/05/03	4500/–/(14)	(8)	There were 98 cases (71 Dengue sero-type 1) in 2002.

*These figures are unofficial reports, please interpret with caution.

DF – Dengue Fever,

DHF – Dengue Haemorrhagic Fever

Pacific

Dengue fever occurs at a low level in most countries in the Pacific, however, every few years, larger outbreaks occur (figure 3). In 2001 and 1989, outbreaks in French Polynesia accounted for the majority of cases; in 1998 there was a large outbreak in Fiji, and Tonga accounted for the majority of cases in 1980.

Figure 3 Dengue reports from the Pacific Islands 1980 to 2001

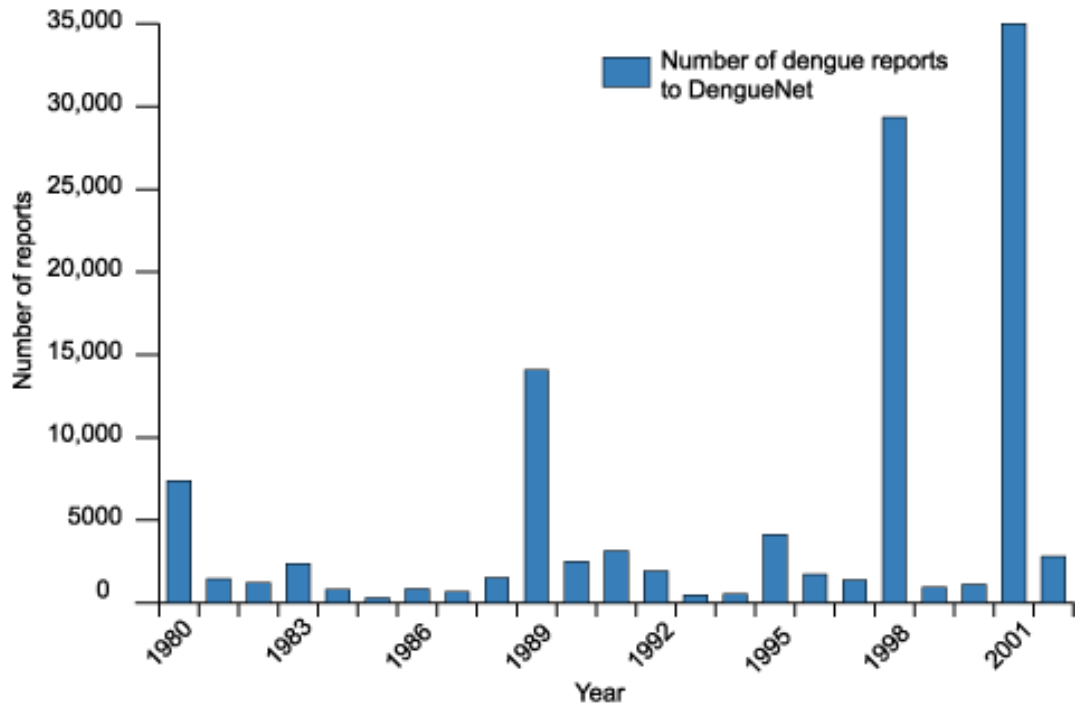


Table 3 Current outbreaks of dengue fever in the Americas

Country	Date	*NumbersDF/DHF/(Deaths)	Source	Additional Comments
Costa Rica	Up to first week in May 2003	2163/-/(-)	(11)	Forty-four per cent of cases in Guanacaste, Thirty-five per cent in Puntarenas. As of week 19, there were six cases of DHF and no deaths (9).
Brazil				
Ceara	Jan to May 2003	23674/272/(12)	(12)	Dengue sero-type 3 has been confirmed.
Minas Gerais	As of 21 May 2003	11348/19/(3)	(12)	
Sao Paulo (City)	As of 26 May 2003	929/-/(-)	(12)	This total is higher than for the same period last year.
Peru (northern city of Sullana)	Feb to 3 May 2003	1124/-/(-)	(13)	

*These figures are unofficial reports, please interpret with caution

DF – Dengue Fever,

DHF – Dengue Haemorrhagic Fever

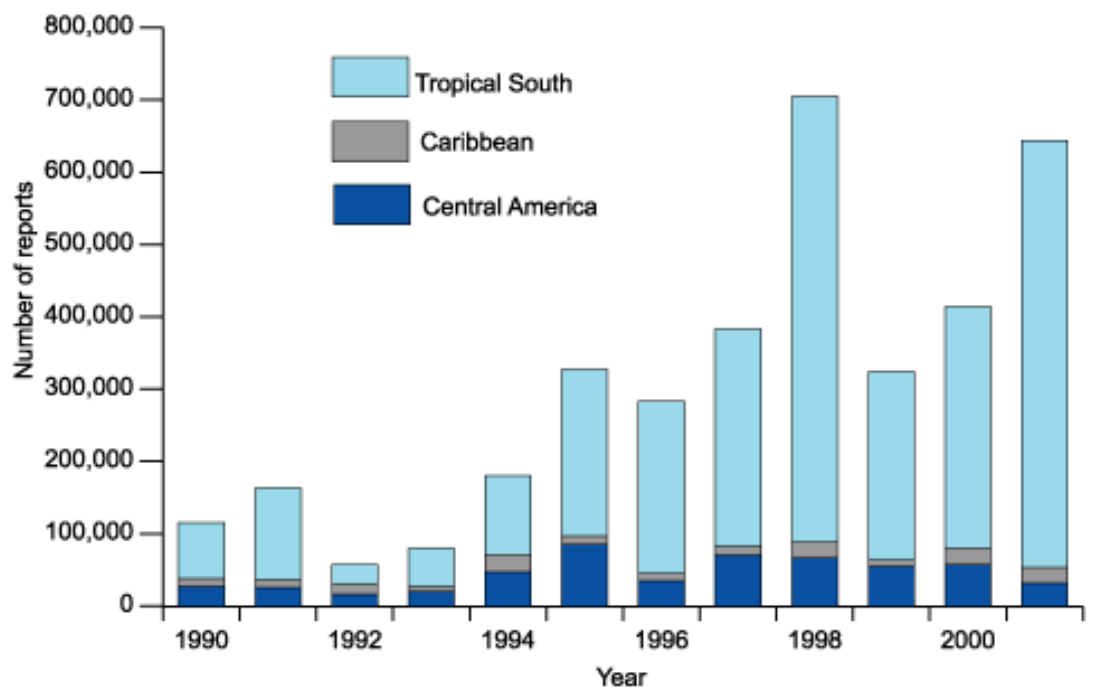
Americas

In 2002, the largest outbreak of dengue in this part of the world occurred in Brazil severely affecting the state of Rio de Janeiro, in particular. There were 780, 644 cases including 2607 cases of dengue haemorrhagic fever (DHF) and 145 deaths in Brazil in total. In the first quarter of 2003 there were 123,948 cases including 181 cases of DHF and 13 deaths (9). Figure 4 shows the number of cases of dengue fever in the Americas by region. Tropical South America accounts for the majority of the reports, which may reflect the size and population of that area. Central America and the Caribbean account for the rest of the cases. Reports from Bermuda and temperate South America have been rare, but these figures are incomplete. The Americas seems to have a cyclical pattern of dengue reporting. There were two large peaks, one in 1998 and the other in 2001; Brazil accounted for the majority of these, but this may reflect the fact that Brazil is the largest country in South America.

The numbers of dengue fever reports for the Caribbean have not changed a great deal over the last ten years. In 1992, they represented about 20% of the total reports from the Americas, but since 1995 they have remained at around 5% of the total. The Caribbean Epidemiology Centre (CAREC) have reported that during the first 3 months of 2003, there have been 574 cases of dengue fever including 20 cases of

DHF. In 2002, there were 1488 cases of dengue fever and 42 cases of DHF, this represents a 50% decrease, which may be due to the unusually dry weather during this period (10).

Figure 4 Dengue reports from the Americas 1990 - 2001



Other areas

This year there has been an outbreak of dengue fever in northern Queensland, Australia, that is still ongoing. Since 1990, there have been eight outbreaks of dengue fever reported in northern Queensland; the largest was in 1992/93 in Townsville and Charters Towers where 900 cases were reported. The current outbreak started in Cairns in February 2003, where there have been 444 confirmed cases as of 19 June 2003. The outbreak has now spread to Townsville where there have been 19 confirmed cases; seven of those imported from Cairns [Sonya Clarson, communications officer, Queensland Health - personal communication, 19 June 2003]. Dengue is not endemic in Queensland but the mosquito vector *Aedes aegypti*, is common in north Queensland. Sporadic outbreaks occur when the virus is introduced via international travellers or residents returning from endemic countries, most typically, Asia and the south Pacific.

Travel-associated cases in England and Wales 2002

In 2002, there were 44 laboratory reports of dengue fever in England and Wales. Dengue fever is not endemic in the United Kingdom, so it may be assumed that all of the reports were related to travel to an endemic area. Table 4 shows the travel history of 15 of the cases reported, 29 had no travel history stated at all. Of the reports that specified a travel history, just over 50% had travelled to south east Asia. Improved reporting of travel history would improve the quality of assessments on the risks of dengue to travellers to various countries.

Table 4 Laboratory reports of dengue in England and Wales 2002

Country of recent travel	Number of laboratory reports
Barbados	1
Cambodia/Thailand	1
Caribbean	2
India	3
Indonesia	1

Malaysia	1
Malaysia and Qatar	1
Thailand	4
Vietnam/Cambodia	1
Travel history not taken	29
Total	44

These figures may underestimate the true number of dengue cases in travellers from England and Wales. The dengue virus is difficult to isolate, and can be difficult to diagnose clinically and many people may be asymptomatic or only suffer mild flu-like symptoms. A detailed travel history could help with a clinical diagnosis.

Dengue can be a debilitating illness and there is evidence to suggest that subsequent infection with a heterologous dengue sero-type may result in dengue haemorrhagic fever (14). Information about the sero-types circulating in endemic countries would help to advise intending travellers who have already had a laboratory confirmed dengue infection. Such information is being sought with the development of DengueNet. It is essential that travellers to dengue endemic countries continue to reduce their risk of contracting dengue and other mosquito-borne diseases, by avoiding mosquito bites during the day and at night.

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Common animal associated infections, England and Wales: laboratory reports, weeks 23 - 26/03

Organism	Total reports for weeks 23-26		Cumulative totals for weeks 01-26	
	2003*	2002	2003*	2002
<i>Borrelia burgdorferi</i> *‡	3	21	13	67
<i>Leptospira hardjo</i> †§	--	-	-	1
<i>Leptospira icterohaemorrhagiae</i> †§	-	1	4	6
<i>Leptospira other</i> †§	-	1	13	5
<i>Pasteurella haemolytica</i>	-	1	1	2
<i>Pasteurella multocida</i>	16	24	85	85
<i>Pasteurella pneumotropica</i>	-	-	2	1
<i>Pasteurella spp</i>	8	6	24	17
<i>Toxocara canis</i>	-	--	-	-
<i>Toxocara cati</i>	-	-	--	-
<i>Toxocara spp</i>	-	-	-	-
<i>Toxoplasma gondii</i>	-	1	11	13
<i>Toxoplasma spp</i>	3	6	15	20

* 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 23- 26/03

Organism	Cumulative total reports for weeks 23-26		Cumulative totals for weeks 01-26	
	2003*	2002	2003*	2002
Arbovirus	–	–	–	–
Dengue virus	–	5	2	6
<i>Ascaris</i> spp	7	8	43	55
Hookworms (unspecified)	3	2	42	105
<i>Leptospira</i> spp†	–	–	–	1
<i>Ancylostoma duodenale</i>	–	–	–	–
<i>Necator americanus</i>	–	–	–	–
<i>Hymenolepis diminuta</i>	–	–	–	–
<i>Hymenolepis nana</i>	1	1	7	14
<i>Hymenolepis</i> spp	–	–	–	–
<i>Schistosoma haematobium</i>	5	3	17	24
<i>Schistosoma intercalatum</i>	–	–	–	–
<i>Schistosoma mansoni</i>	2	–	5	13
<i>Schistosoma</i> spp	–	1	–	10
<i>Strongyloides stercoralis</i>	5	1	9	8
<i>Strongyloides</i> spp	1	–	2	2

* Provisional data

† *Leptospira* Reference Laboratory and CDSC

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