

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOONOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

Main stories this week:

Rise in heterosexual cases of syphilis in south London

Hepatitis A outbreak in Weymouth, Dorset

Updated guidance on reporting Creutzfeldt-Jakob disease

Guidelines for water quality on board merchant ships including passenger vessels

HIV/STIs:

Recent developments in syphilis epidemiology

Diary:

Recent advances with hepatitis C virus

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[About CDR Weekly](#) | [Home](#) | [FAQs](#) | [Links](#) | [PHLS Home](#) | [CDPH](#) | [Eurosurveillance](#)

NEWS

ENTERIC

RESPIRATORY

IMMUNISATION

HIV/STIs

BACTERAEMIA

ZOOSES

TRAVEL HEALTH

PRIMARY CARE

DIARY

BACK ISSUES

SEARCH

News

Last updated: 31 July 2003
Next update due: 7 August 2003

Contents

[Rise in heterosexual cases of syphilis in south London](#)

[Hepatitis A outbreak in Weymouth, Dorset](#)

[Updated guidance on reporting Creutzfeldt-Jakob disease](#)

[Guidelines for water quality on board merchant ships including passenger vessels](#)

[Top](#) |

Rise in heterosexual cases of syphilis in south London

Over the last year, there has been almost three times the number of heterosexual cases of syphilis in south London than were diagnosed in 2001 (25 in 2001, 72 in 2002 and over 40 cases in the first five months of this year). Cases are occurring among those who have had unprotected oral or vaginal sex with casual partners/ strangers and people buying or selling sex. Of 73 cases diagnosed between July 2002 and May 2003, 17 cases had documented links with the commercial sex industry. Twenty cases admitted to unprotected oral sex and 48 cases to unprotected vaginal sex.

An incident control team, has been set up in South London involving public health and genitourinary medicine (GUM) healthcare professionals. Current intervention activities being undertaken to tackle this problem include:

- Enhanced surveillance to monitor the outbreak
- General health advice to people raising awareness and highlighting that syphilis can be easily diagnosed with a blood test and effectively treated with antibiotics. People with symptoms, or who consider themselves or their regular partners at risk, are being advised to go to GUM clinics for assessment. In addition, people are being reminded to practise safer sex by using condoms.
- Specific work targeted at commercial sex workers including outreach work giving health advice and a fast track referral system in GUM clinics
- Communication to raise awareness amongst local healthcare professionals and relevant voluntary agencies.

Other initiatives are planned including the appointment of a specialist health advisor and the piloting of a new test to facilitate case finding.

The increase in heterosexual syphilis is an important reminder that the rise in syphilis infection has not been confined to men who have sex with men. Neither has this rise been exclusive to south London, as heterosexual cases have also been reported in other parts of London, some of which have been linked with the commercial sex industry.

[Top](#) |

Hepatitis A outbreak in Weymouth, Dorset

An outbreak of hepatitis A involving intravenous drug users (IDUs), has been identified in Weymouth, Dorset. Seven hepatitis A virus (HAV) IgM positive cases of acute hepatitis A were notified between 2 July 2003 and 27 July 2003. Two further cases of acute hepatitis A have been identified retrospectively from stored sera from household contacts of the recently notified cases. These two cases had recently been hospitalised with conditions linked to their drug use.

All nine cases use heroin and gave histories that indicate the regular sharing of drugs, drug paraphernalia, and the sharing of household accommodation. There is also some sharing of sexual partners within the group of cases and contacts. Two of the cases have links to the local travelling communities and two other cases have at times been homeless and abused alcohol as well as drugs. The cases and the contacts are from socially marginalized groups living transient and often chaotic lives and contact tracing and vaccination has been hampered by their mistrust of most statutory services.

Many of the Weymouth intravenous drug using community have already been immunised against hepatitis B and this is documented by the local services for drug users. As it is unlikely that all contacts of cases will be identified and that only a proportion of those identified will be vaccinated in time to prevent transmission of hepatitis A, a decision has been taken to opportunistically offer single dose vaccine to as many drug users in the Weymouth population as possible, as well as to contacts. Hepatitis A immunoglobulin is also being offered to particularly vulnerable contacts. Two contacts are known to have been admitted to hospital in the last 12 months with compromised hepatic function.

In such a transient and chaotic population, it is an advantage that only one dose of hepatitis A vaccine is highly immunogenic. It would, however, be good practice to offer a booster in approximately six months, as this will stimulate immunity for ten years. Continued long-term efforts will also be made to ensure that as many intravenous drug users as possible are fully immunised against hepatitis B.

[Top](#) |

Updated guidance on reporting Creutzfeldt-Jakob disease

Updated guidance for the local reporting of Creutzfeldt-Jakob disease (CJD) by clinicians to Consultants in Communicable Disease Control (CCDCs), and public health action to be taken on receipt of such information has been issued (1). The guidance, which replaces that published in 2001, relates to possible, probable, or definite cases of all types of CJD, including variant and sporadic cases, and is aimed primarily at clinicians caring for cases of CJD, and CCDCs and their equivalents in the UK.

The guidance advises that a local response to CJD may be required with respect to the potential secondary transmission, infection control, and any issues that may arise concerning the protection of the wider community. The new document is similar to the 2001 edition, but is explicit in the guidance given to clinicians for local reporting to CCDCs and clarifies the public health action to be taken by CCDCs. These actions are summarized below, with expansions to the previous edition highlighted in bold:

- Clinicians suspecting a diagnosis of CJD are encouraged to refer patients to the National Creutzfeldt Jakob Disease Surveillance Unit (NCJDSU); a neurologist from the NCJDSU will visit the patient for confirmation of diagnosis and further investigation. Following this visit the NCJDSU neurologist will ask the local clinician to share sufficient information on the case with the relevant CCDC to enable public health follow-up; **this information should include the NCJDSU patient number. A form for reporting possible, probable and confirmed cases of CJD to the local CCDC will be provided for this purpose.**
- CCDCs' action on receipt of such information will concern control of a communicable disease, infection control, care of the patient and informing responses for the appropriate authorities. CCDCs should refer to the secretariat of the National CJD Incidents Panel, at the Health Protection Agency Communicable Disease Surveillance Centre (tel: 020 8200 6868 ext 3411) for advice on investigating and managing the potential public health risk from invasive medical and dental procedures carried on patients who develop CJD and of incidents involving blood. **A CCDC will also need to establish if other CCDCs need to be aware of patients because of contact with different hospitals or other places where invasive procedures may have taken place.**

1. National Creutzfeldt Jakob Disease Surveillance Unit. *Guidance on local reporting by clinicians of Creutzfeldt-Jakob disease and local action by Consultants in Communicable Disease Control*. Edinburgh: NCJDSU, 2003. Available at <<http://www.cjd.ed.ac.uk/guidance.htm>> .

[Top](#) |

Guidelines for water quality on board merchant ships including passenger vessels

The Health Protection Agency has recently published the first national guidelines on the microbiological quality of water on board ships in the UK. These joint water quality guidelines are the result of collaboration between the Health Protection Agency and the Chartered Institute of Environmental Health Port Health Centre (through the Association of Port Health Authorities). The guidelines are intended to foster high standards of environmental sanitation critical for protecting public health, by providing guidance to ship owners and operators, responsible officers, port health officers, and environmental health officers. The guidelines, which cover microbiological guidelines, water sampling, disinfection and storage, swimming pool and spa pool water quality, and the control of legionella on board ships, encourage consistency of laboratory testing and interpretation or reporting of microbiological results for water samples taken from vessels.

Guidelines for water quality on board merchant ships including passenger vessels is available from the Publications Officer, Communications Unit, Health Protection agency, Corporate Services Colindale, 61 Colindale Avenue, London, NW9 5DF; tel: 020 8200 1295 ext 3055; email publications@hpa.org.uk, price £6.00 (+p&p); 36 pages, ISBN 0 901144 65 7

- NEWS
- ENTERIC
- RESPIRATORY
- IMMUNISATION
- HIV/STIs
- BACTERAEMIA
- ZOOSES
- TRAVEL HEALTH
- PRIMARY CARE
- DIARY
- BACK ISSUES
- SEARCH

HIV/STIs

Last updated: 31 July 2003
Next update due: 29 August 2003

Contents

Recent developments in syphilis epidemiology

[PDF](#) | [Archive](#)

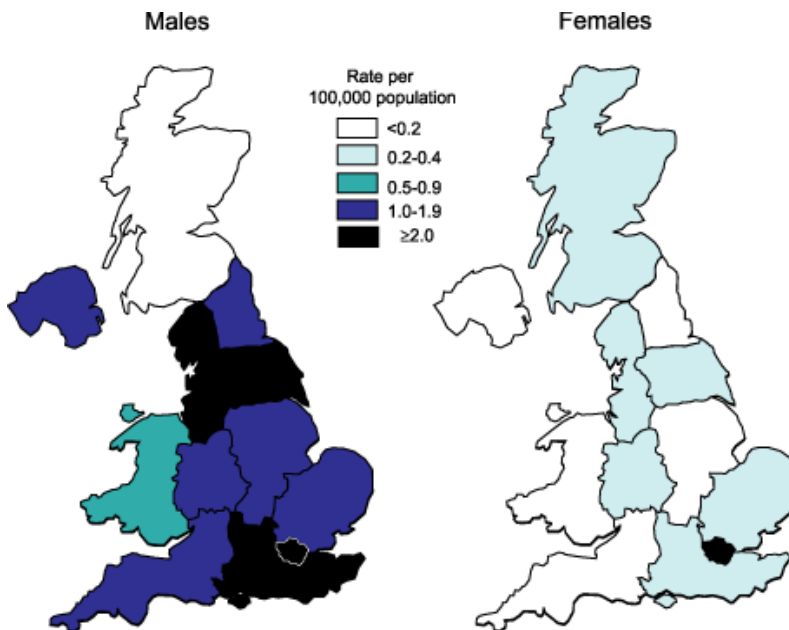
Recent developments in syphilis epidemiology

This update summarises the recent epidemiology of syphilis in England, Wales, and Northern Ireland using information from two data sources: diagnoses made in genitourinary medicine (GUM) clinics reported on the KC60 return, and information collected through the Enhanced Surveillance Programmes for Infectious Syphilis co-ordinated by the Health Protection Agency (HPA) North West and the Communicable Disease Surveillance Centre (CDSC), Colindale, together with their associated partners.

Data from genitourinary medicine clinics

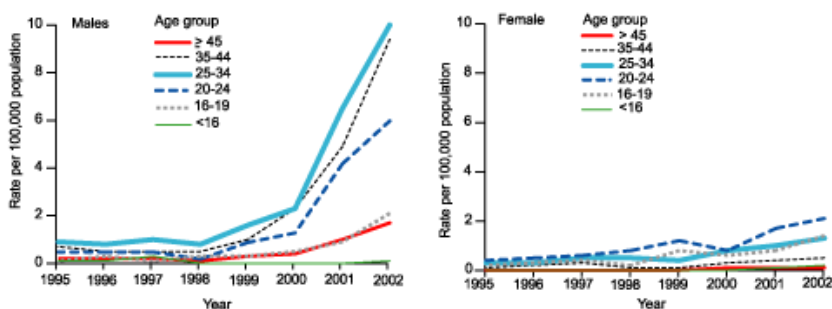
Between 2001 and 2002, overall diagnoses of infectious syphilis rose by 67% in males and 33% in females, with a rise of 68% in men who have sex with men (MSM). In 2002, 1163 new diagnoses of primary and secondary infectious syphilis (1056 male, 137 female) were made in (GUM) clinics (1). Fifty-seven per cent of the male cases, (607) were seen in MSM. Fifty-three per cent of male diagnoses were made in London, and 19% in the North West (figure 1). A similar pattern was seen for both MSM and females and reflects the outbreaks of syphilis seen in these regions over recent years. In London, diagnoses of infectious syphilis rose from 129 in 2000 to 626 in 2002. Unlike other bacterial STIs, the burden of syphilis does not fall upon teenagers: increased rates have been seen in most age groups (figure 2).

Figure 1 Regional distribution of diagnoses of infectious syphilis (primary and secondary) infection by sex, UK: 2002*



* 1999 data used for Scotland

Figure 2 Diagnoses of infectious syphilis (primary and secondary) in GUM clinics by sex and age group, UK: 1995-2002*



* Data are currently unavailable from Scotland for 2000, 2001 and 2002

Outbreaks of syphilis

Diagnoses of syphilis made in GUM clinics are the highest seen since 1984, before the time of widespread awareness to HIV/AIDS in the United Kingdom (UK). The resurgence in syphilis seen in the past five years has been punctuated by a number of outbreaks the first of which occurred in Bristol in 1997. Further outbreaks have now been documented in Newcastle-upon-Tyne, Edinburgh, Glasgow, Nottingham, and Northern Ireland, together with a number of clusters (3,4). The outbreaks give an insight into factors underlying the change in syphilis epidemiology in the UK. The Bristol outbreak was associated with heterosexually acquired infection, commercial sex work, and 'crack' cocaine use, whereas the outbreaks in Brighton, Manchester and London were among MSM, some of whom had concurrent HIV infection (5,6,7).

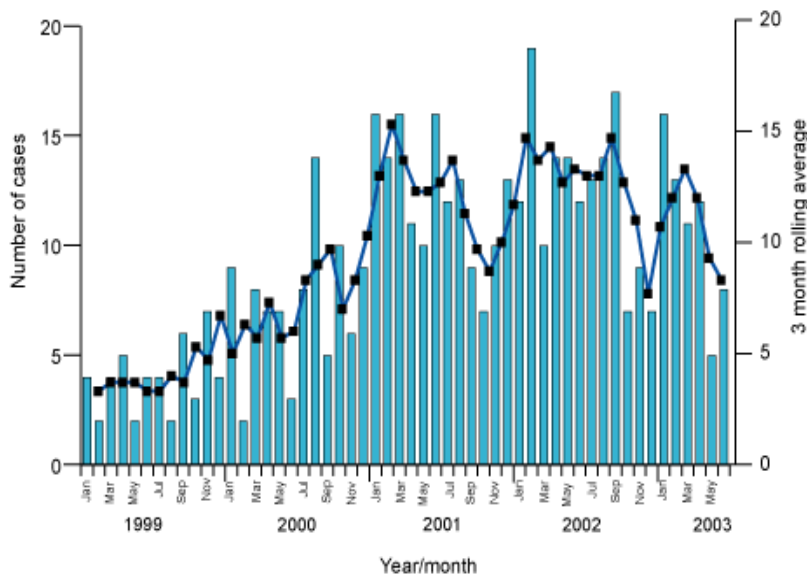
The characteristics of the UK syphilis outbreaks are very similar to those seen in Western Europe and the United States (US), infection being associated with high incidence areas, high rates of partner change within risk groups, and concurrent HIV infection (8). A number of other factors may also have influenced the increase in syphilis and co-infection with HIV. Anti-retroviral therapies have increased the prevalence of HIV infected individuals. At the same time, reporting of unsafe sex amongst MSM, particularly occurring with a partner of unknown HIV status, has increased in London since 1996 (9). In addition, the recent growth in traditional (such as saunas and cruising grounds) and new (internet chat rooms) 'sexual market' places has increased the opportunity to acquire new sexual partners.

The Manchester Syphilis outbreak

Between January 1999 and the end of June 2003, 495 cases of syphilis were detected in Greater Manchester (figure 3). Around 80% of the cases were seen in MSM and half of all cases had previously had a sexually transmitted infection. A quarter of the MSM who had syphilis were also HIV positive. Oral sex was a key transmission route, 90% of the MSM with syphilis never used a condom for oral sex compared to over 75% who regularly used a condom for anal sex.

The rapid identification of infection, prompt management of cases by GUM services, and increased awareness to syphilis are key to the control of the outbreak. Awareness to syphilis has been promoted through the 'Spreads Easily' campaign at social venues in Manchester. A barrier, however, to infection control has been the limited access to clinical services: patients have had to wait six to 12 weeks for an appointment, although the waiting time is shorter for symptomatic cases.

Figure 3 Number of diagnoses of syphilis, Greater Manchester: January 1999 to June 2003



The London Syphilis outbreak

The London outbreak has been the largest outbreak reported so far, *ie*, as of July 2003. Between April 2001 and May 2003, 980 diagnoses have been reported, 684 in MSM, and 191 and 105 diagnoses in heterosexual males and females respectively (figures 4 and 5). The median age of MSM was 35 years (range 18 to 75) and the median age for heterosexual males was 35 (range 17 to 92). The median age for heterosexual females was 30 (range 16 to 64) (figure 6). Most cases had been identified through routine health service screening or because the patient was symptomatic (figure 7). Few cases were identified through contact tracing or antenatal screening. There was little reported contact with other UK outbreak sites, most infections in MSM having been acquired in London, although 66 heterosexual cases had been acquired outside the UK.

Figure 4 Diagnoses of syphilis in men who have sex with men: 2001 to 31 May 2003

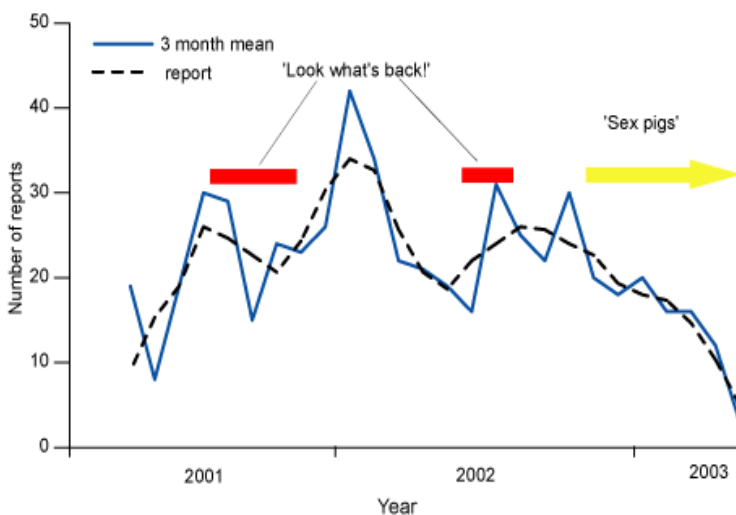


Figure 5 Diagnoses of syphilis in heterosexual men and women: 2001 to 31 May 2003

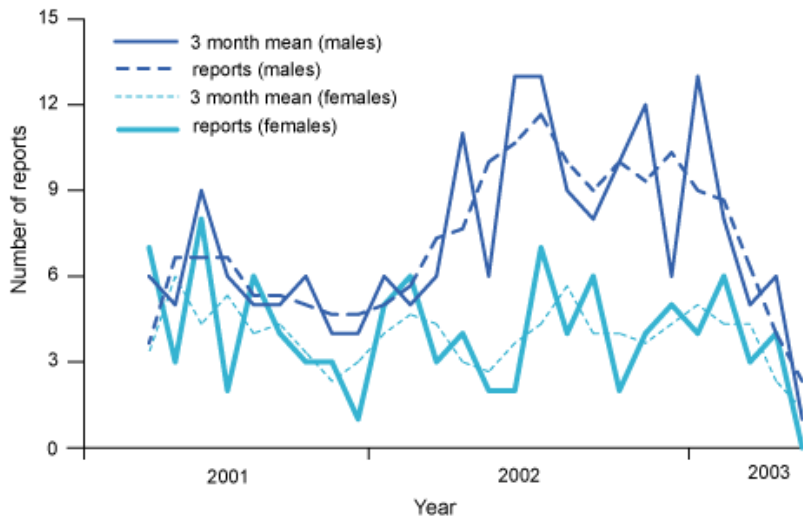


Figure 6 Diagnoses of syphilis by age group and sexual orientation, London

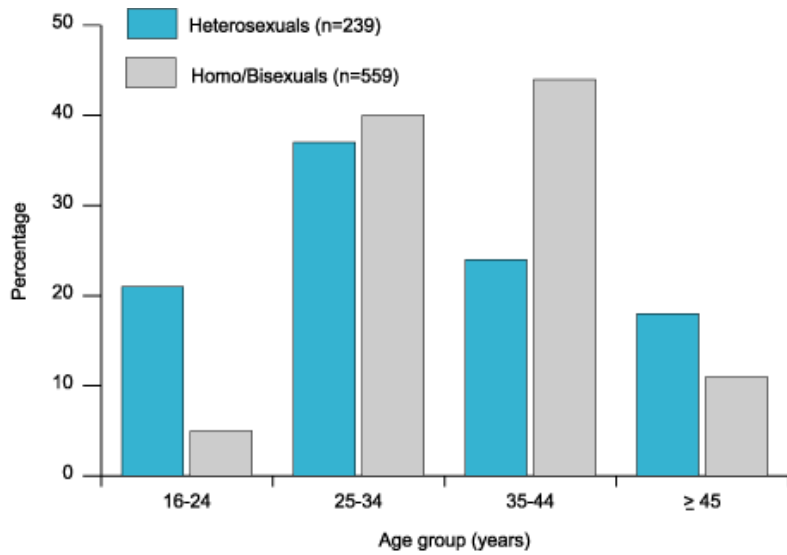
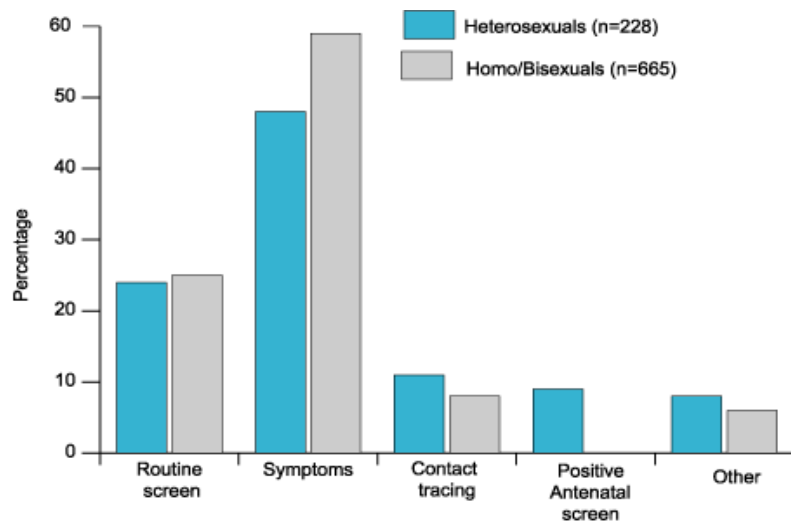


Figure 7 Diagnoses of syphilis: reason for clinic attendance by sexual orientation



Most MSM diagnosed with syphilis were of white ethnic origin and had been born in the UK, whereas heterosexuals were more likely to be either white, black, or black British, and born outside the UK (figure 8). Social venues such as, cruising grounds, saunas, bars and the internet, were identified as important to the spread of infection amongst MSM (figure 9).

Figure 8 Diagnoses of syphilis by Ethnicity and sexual orientation

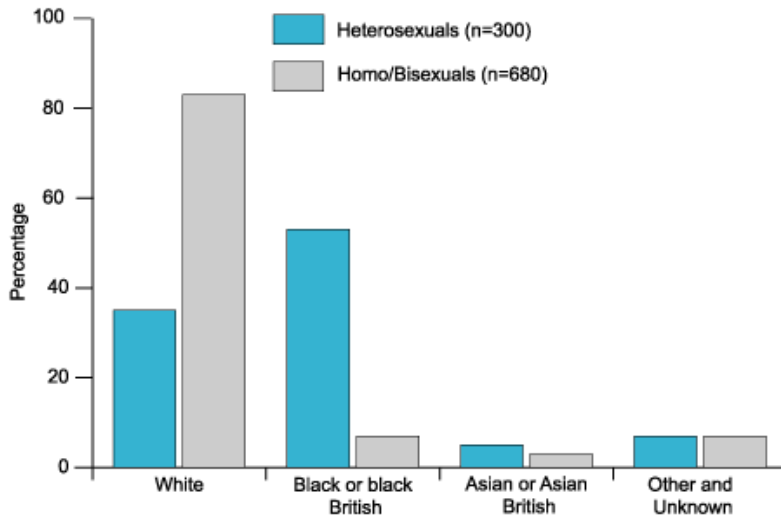
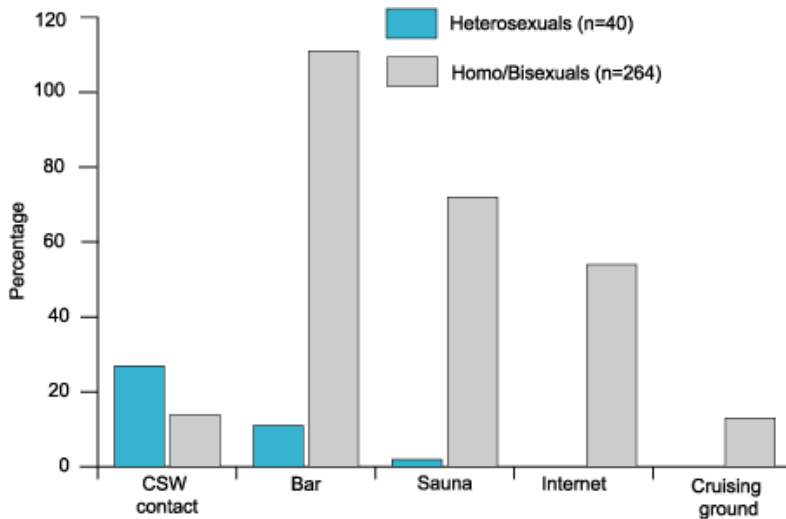
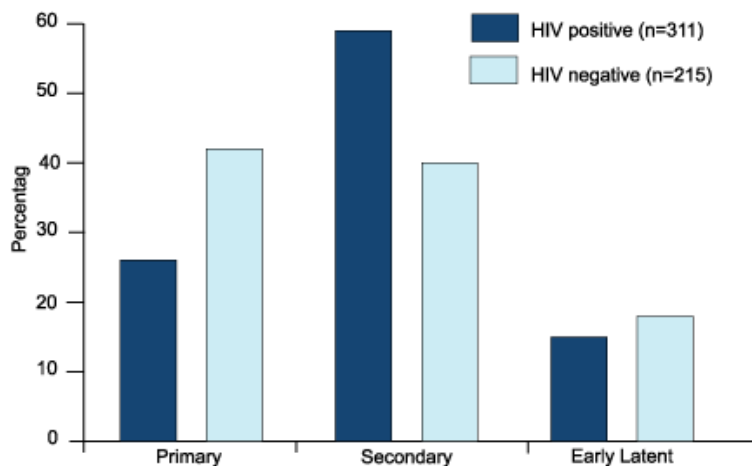


Figure 9 Diagnoses of syphilis by relevant social venues/networks and sexual orientation



The enhanced surveillance initiatives were introduced to give a detailed insight into the course of syphilis outbreaks and inform control and intervention strategies. Raising awareness to syphilis through targeted campaigns, such as the Manchester 'Spreads easily' and Terrance Higgins Trust's 'Look what's back!' and 'Sex Pigs' campaigns, has been well received and promoted knowledge about syphilis within the general gay community (figure 4). The initiatives have aimed at informing the decision making process and choice in sexual relationships but there had been no evaluation of whether the campaigns have brought about behavioural change.

Figure 10 Diagnoses of syphilis in men who have sex with men by stage of Infection by HIV Status



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Diary

Last updated: 31 July 2003

Recent advances with hepatitis C virus

Recent advances with hepatitis C virus

The pathology section of the Royal Society of Medicine is holding an afternoon meeting on recent advances with hepatitis C virus on Tuesday 2 December 2003 at the Royal Society of Medicine in London. The meeting will include sessions on the genetic evolution of the hepatitis C virus, its epidemiology, clinical presentations and complications, diagnosis and treatment. For further information contact, Claire Bowen, Academic Department, Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE; Tel: (+44) (0) 20 7290 3859; Fax: 0 20 7290 2989; email: pathology@rsm.ac.uk.