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Two suspected cases of foodborne botulism coincident in time

The Health Protection Agency's Food Safety Microbiology Laboratory (FSML) received two requests for botulinum toxin testing in the week ending 8 August 2003. The first request was from the Eastern Region where a woman aged 51 years (Patient A) had been admitted to an intensive therapy unit (ITU) in a state of collapse on 4 August. The second request came from the South East Region where a woman aged 23 years (Patient B) had been admitted to ITU on 1 August with a history of weakness, blurred vision, hoarse voice, and slurred speech. Both patients required artificial ventilation. Neither patient has a history of intravenous drug use, but both had suffered a diarrhoeal illness prior to the onset of neurological symptoms. The differential diagnosis in both patients included Guillain-Barré syndrome (GBS) and botulism. This is a common combination of differential diagnoses.

In GBS, the initial presentation is frequently of sensory complaints, followed rapidly by loss of tendon reflex activity. It rarely begins with cranial nerve dysfunction and does not alter pupillary reactivity (1). *Campylobacter jejuni* infection is estimated to account for approximately 15% of GBS cases in England (2).

By contrast the classic picture of botulism is a patient in whom acute, bilateral cranial neuropathies develop in association with symmetrical descending weakness. Pupillary dilatation occurs and patients with botulism do not exhibit areflexia until the affected muscle group is completely paralysed (1). A good clinical history may, however, be difficult to obtain if the patient presents with paralysis, or in a collapsed state. The other differential diagnoses for botulism include myasthenia gravis, Eaton-Lambert myasthenic syndrome, tick paralysis, the Miller-Fisher variant of acute inflammatory polyneuropathy, poliomyelitis, and magnesium intoxication (1).

Suspected botulism is a public health emergency. Urgent investigations by the consultants in communicable disease control serving the areas concerned ruled out any possible link between the two cases. These investigations included completing a questionnaire containing detailed clinical and exposure histories (questionnaire available from the Gastrointestinal Diseases Division; (email: gisection@hpa.org.uk), food sampling by environmental health officers and microbiological examinations. Detailed guidance on the investigation of suspected botulism is available on the website of the former PHLS, available at http://www.phls.co.uk/topics_az/botulism/botulism_guidelines.pdf.

Botulinum toxin was not detected in a faecal specimen and a single food sample from Patient A. Tests for botulinum toxin on serum samples from both cases are continuing. In the United Kingdom, tests for botulinum toxin are performed by the Food Safety Microbiology Laboratory (FSML)

The Health Protection Agency's Laboratory of Enteric Pathogens (LEP) has detected serum antibodies that bound to *C. jejuni* flagellar preparations in Patient A, and *C. jejuni* DNA has been detected by PCR in her faecal sample. Further confirmatory work is required.

For further information, or to discuss the investigation of cases please ring Moira Brett, FSML (tel: 020 8200 4400 ext 4933) if botulism is suspected, or Jenny Frost, LEP (ext 3772) if GBS is suspected.

1. Bleck TP. *Clostridium botulinum* (Botulism). In Mandell GL, Bennett JE, Dolin R (Eds) Mandell, Douglas and Bennett's Principles and Practice of Infectious Diseases (5th ed.) London: Churchill Livingstone, 2000. pp2543-8.
2. Tam CC, Rodrigues LC, O'Brien SJ. Guillain-Barré syndrome associated with *Campylobacter jejuni* infection in England, 2000-2001. *Clin Infect Dis* 2003; **37**: 307-10.

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Adult immunisation update

The Chief Medical Officer has issued an *Adult immunisation update* on a pneumococcal immunisation programme for those aged 80 years and over, and on the influenza immunisation programme for 2003/04 (1).

Pneumococcal immunisation for older people

From August 2003 a pneumococcal immunisation programme for older people will be introduced. All those aged 80 years or over, who have not previously been immunised, should be offered pneumococcal polysaccharide vaccine. From 1 April 2004, this programme will be extended to include all people aged 75 years and over, and from 1 April 2005 all those aged 65 years and over will be offered the vaccine.

Pneumococcal vaccine uptake in older people will be monitored to evaluate the effectiveness of the programme and for planning purposes. As the vaccine is available throughout the year this information will be collected on an annual basis. A target is not being applied to individual primary care trusts (PCT).

Pneumococcal vaccine is already recommended for all those in whom pneumococcal infection is likely to be more common and/or serious. The at-risk groups are defined in paragraph 25.3 of the new pneumococcal chapter of *Immunisation Against Infectious Disease 2003* (The Green Book) (2). Re-immunisation is not currently recommended except for people whose antibody levels are likely to have declined rapidly, *ie*, asplenic patients, and those with splenic dysfunction or nephrotic syndrome. In such cases reimmunisation after five years is indicated.

Influenza immunisation programme 2003/04

The groups recommended for influenza vaccine by The Department of Health (DoH) remain the same as 2002/03, *ie*, all people aged 65 years or over, all people less than 65 years in clinical risk groups, and those in long-stay residential, nursing homes or other long-stay facilities. National Health Service (NHS) and social care employers should also offer influenza vaccine to their employees, especially those directly involved in patient care.

For the past three winters, the DoH has set targets for influenza vaccine uptake in people aged 65 years or over. These targets have been monitored through a timely and comprehensive surveillance programme during the winter months when immunisation should have been carried out. Last winter an uptake rate of 68.5% was achieved nationally against a target of 70%, although 51% of primary care trusts (PCTs) achieved the DoH target at the local level. For the coming winter of 2003/04, the DoH target remains at 70% and the Health Protection Agency Communicable Disease Surveillance Centre will again be monitoring its implementation through the nominated influenza immunisation co-ordinators in each PCT.

The number of healthcare workers in NHS acute hospital trusts who are vaccinated against influenza this winter will also be monitored monthly through immunisation co-ordinators in each strategic health authority. Attention this year will be focussed on uptake rates among full or part time staff working in accident and emergency departments, or neonatal, paediatric or adult intensive care units.

1. Chief Medical Officer. *Adult immunisation update*. London: Department of Health, 6 August 2003. Available at <<http://www.doh.gov.uk/cmo/letters/cmo0306.htm>>

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Screening standards for infectious diseases in pregnancy

New standards have been issued to reinforce existing policy that all pregnant women in the United Kingdom (UK) should be offered screening for rubella antibody, syphilis, HIV, and hepatitis B as an integral part of their antenatal care during their first and all subsequent pregnancies (1). The new generic and disease-specific standards for antenatal screening for infectious diseases have been developed and agreed by the Department of Health expert advisory committees (Advisory Group on Hepatitis, Joint Committee on vaccines and immunisation and Expert Advisory Group on AIDS), and the UK National Screening Committee.

The standards cover the four infections that are currently included in the UK antenatal screening programme and they are sub-divided according to the setting in which the activity takes place (trust, clinic and laboratory). Details of the systems required for monitoring the quality of the programmes are included along with the reporting required for public health purposes. The Health Protection Agency has a role in the reporting and monitoring aspect of the standards.

The standards are part of a wider initiative to establish a quality-assured national screening programme and will provide a standardised tool for local audit and performance management. This document will be relevant to commissioners and providers of screening services and for those with performance management responsibilities.

Paper copies of the document are available on request from: Ruth Hickson, Department of Health, Room 631B Skipton House, 80 London Road, London SE1 6LH; email: Ruth.Hickson@doh.gsi.gov.uk.

Feedback and policy-related queries should be addressed to: Linda Lazarus, Department of Health, Room 631B Skipton House, 80 London Road, London SE1 6LH; email: Linda.Lazarus@doh.gsi.gov.uk.

1. Department of Health. *Screening for infectious diseases in pregnancy: standards to support the UK antenatal screening programme*. London: Department of Health, August 2003. Available at <<http://www.doh.gov.uk/antenatalscreening>>.

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National increases in salmonellosis – update

The Health Protection Agency's Laboratory of Enteric Pathogens (LEP) continues to confirm human isolates of *Salmonella* Enteritidis phage type (PT) 14b and *S. Typhimurium* PT U277 (1,2). After excluding cases that were reported to have travelled abroad during the incubation period, LEP has confirmed 79 cases of *S. Enteritidis* PT 14b and 70 cases of *S. Typhimurium* PT U277 since 1 June 2003.

On 21 July 2003, following hypothesis-generating studies, national case-control studies were instigated – a joint venture between the Local and Regional Services Division, the Specialist and Reference Microbiology Division and the Communicable Disease Surveillance Centre (CDSC). So far, four of 12 completed sets of case-control study questionnaires have been returned to CDSC in the *S. Enteritidis* PT14b investigation and six of 16 in the *S. Typhimurium* PT U277 investigation.

1. Health Protection Agency. National increases in salmonellosis. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 14 August 2003]; **13** (27): news. Available at <<http://www.phls.co.uk/publications/cdr/PDFfiles/2003/cdr2703.pdf>>.

2. Health Protection Agency. National increases in salmonellosis. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 14 August 2003]; **13** (30): news. Available at <<http://www.phls.co.uk/publications/cdr/PDFfiles/2003/cdr3003.pdf>>.

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General outbreaks of foodborne illness, England and Wales: weeks 27-31/03*

DHA	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
Berkshire	S. Enteritidis PT1	School	July	24	24	None	–
Plymouth	S. Enteritidis PT4	College	July	11	11	Rice salad/coleslaw	M
North Lincolnshire	S. Enteritidis PT6	Retailer	July	6	6	Custard slice	M
Berkshire	S. Enteritidis PT6A	Restaurant	July	2	2	None	–
Suffolk	S. Enteritidis PT8	Hospital	July	9	9	None	–
Tees	S. Enteritidis PT24	Restaurant	July	4	4	None	–

* Preliminary data. Final information will be published in the quarterly report.

M (microbiological): identification of an organism of the same type from cases and in the suspect vehicle, or vehicle ingredient(s), or detection of toxin in faeces or food.

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Salmonella infections: England and Wales, reports to the Health Protection Agency (salmonella data set*) June 2003

Details of serotypes of 1504 salmonella infections recorded in June 2003 are given in the table below. In July 2003, 1477 salmonella infections were recorded and preliminary information was received about six outbreaks (see table above).

Salmonella (provisional data)	June 2003
	1504
S. Enteritidis (PT4)	201
S. Enteritidis (other PTs)	907
S. Typhimurium	193
S. Virchow	18

Other (typed)	185
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* Data provisional

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Common gastrointestinal infections, England and Wales: laboratory reports, weeks 27-31/03

Laboratory reports	Number of reports received					Total reports	Cumulative total to	
	27/03	28/03	29/03	30/03	31/03	27-31/03	27/03	31/02
<i>Campylobacter</i>	1073	969	898	758	572	4270	22,721	26,145
<i>E.coli</i> O157*	13	11	20	33	21	98	192	290
Salmonella†	398	372	343	349	263	1725	6440	6168
<i>Shigella sonnei</i>	8	7	7	5	1	28	306	394
Rotavirus	34	43	41	18	16	152	13,810	13,306
Norovirus	8	4	2	1	6	21	1666	1768
<i>Cryptosporidium</i>	23	46	49	57	135	310	1431	1429
<i>Giardia</i>	44	36	46	30	23	179	1455	1761

* Vero cytotoxin producing isolates (data from Laboratory of Enteric Pathogens (LEP))

† Data from the Health Protection Agency's LEP

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Typhoid and paratyphoid, England and Wales: laboratory reports, January to March 2003

Organism and Phage type	Number of cases	Infection acquired abroad			Excretors and carriers
		Yes	No	Not reported	
S.Typhi					
A	5	4	-	1	-
B1	1	-	-	1	-
D1	3	2	-	1	-
E1	17	10	-	7	-
E9	1	-	-	1	-
E14	1	-	-	1	-
M1	1	-	-	1	-
O	3	1	-	2	-
28	2	-	-	2	-
46	1	1	-	-	-
50	1	-	-	1	-
51	1	-	-	1	-
Degraded	3	1	-	2	-
Degraded Vi-23	1	1	-	-	-
Vi-negative	1	-	-	1	-
Untypable	1	1	-	-	-
Total	43	21	-	21	-
S.Paratyphi A					
1	3	2	-	1	-
1A	2	-	-	2	-

2	2	1	-	1	-
4	10	2	-	8	-
6A	1	-	-	1	-
13	14	10	-	4	-
S.Paratyphi B					
Taunton	2	1	-	1	-
1 var 1	1	-	-	1	-
S.Paratyphi C	1	-	-	1	-

Forty-three cases of *Salmonella* Typhi infection were reported in the first quarter of 2003. Twenty-one cases were infected abroad (Indian subcontinent 16, abroad 2 (unspecified), Nigeria 2, Africa 1). In 22 cases the country of infection was not stated. Thirty-two of *S. Paratyphi A* infection were reported. Fifteen cases were infected abroad (all Indian subcontinent). In 17 cases the country of infection was not stated. Three cases of *S. paratyphi B* infection were reported. One case was infected abroad (Indian subcontinent). In two cases the country of infection was not stated. One case of *S. Paratyphi C* infection was reported, the country of infection was not stated.

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Typhoid and paratyphoid, England and Wales: laboratory reports, April to June 2003

Organism and Phage type	Number of cases	Infection acquired abroad			Excreters and carriers
		Yes	No	Not reported	
S.Typhi					
A	4	2	-	2	-
B1	1	-	-	1	-
E1	39	20	-	19	-
E14	1	1	-	-	-
E7	1	-	-	1	-
M3	1	1	-	-	-
O	6	4	-	2	-
Degraded	3	1	-	2	-
Degraded Vi-15	4	3	-	1	-
Untypable	8	7	-	1	-
Untypable Vi-1	1	-	-	1	-
Untypable Vi-2	1	-	-	1	-
Vi-negative	2	1	-	1	-
36	1	-	-	1	-
40	1	1	-	-	-
46	1	-	-	1	-
Total	75	41	41	34	-
S.Paratyphi A					
1	10	6	-	4	-
1A	10	7	-	3	-
2	3	2	-	1	-
3	1	1	-	-	-
4	11	7	-	4	-
6A	1	1	-	-	-
13	18	11	-	7	-
RDNC	1	1	-	-	-
S.Paratyphi B					
Taunton	5	3	-	2	-

Seventy-five cases of *S. Typhi* infection were reported. Forty-one cases were infected abroad (Indian subcontinent 40, Africa 1). In 34 cases the country of infection was not stated.

Fifty-five cases of *Salmonella* Paratyphi A infection were reported in the second quarter of 2003. Thirty-six cases were infected abroad (Indian subcontinent 32, abroad 2, Central America 1, more than 1 country 1). In 19 cases the country of infection was not stated.

Five cases of *S. Paratyphi* B infection were reported. Three cases was infected abroad (Indian subcontinent.). In two cases the country of infection was not stated.

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Medical guide to bioterrorist and related threats

Medical guide to bioterrorist and related threats

Would you recognise a victim of bioterrorism in your hospital? The concept of biological agents being used as weapons is currently in the public eye, but just how much do you know? The Medical Guide to Bioterrorist and Related Threats, Royal Armouries Museum, Leeds, 26 November 2003, is a **FREE** course that will focus on potential biological weapons agents and their clinical presentation and treatment.

The content of this course is designed for medical microbiologists and infection control specialists. The course is provided free of charge to Health Protection Agency (HPA) and NHS employees. Places will, however, be limited and will be allocated on a first come first served basis.

To register for this course please contact Steve North by email (src.training@hpa.org.uk), by telephone or fax (tel: 01980 612898, fax: 01980 610848), or by post: SRC Training, Special Pathogens, HPA Porton Down, Salisbury, Wiltshire, SP4 0JG.
