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- Surveillance of *Clostridium difficile* associated disease: report of the national standards group
- Hong Kong SARS expert committee report - *SARS in Hong Kong: from experience to action*



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

- Bacteraemia**
Clostridium difficile, England, Wales, and Northern Ireland: 2000 to 2002

News

Last updated: **2 October 2003**
Next update due: **9 October 2003**

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Influenza update - winter 2003/2004

Health Protection Agency weekly influenza report

Reporting of influenza surveillance information for the United Kingdom (UK) will begin in week 40 for the 2003/04 season. This will be through the weekly influenza report, which is published on the Health Protection Agency (HPA) website at

<http://www.hpa.org.uk/infections/topics_az/influenza/fluactivity0304.htm>.

Initially, this will be produced bi-weekly starting Wednesday 1 October 2003, switching to weekly reporting for the duration of the influenza season (October to May) when influenza activity levels begin to increase. The aim is to provide a timely summary, along with comments and interpretation, of clinical and virological indicators of influenza activity in the (UK). Reports of influenza activity in Europe and other parts of the world will also be included. Graphs and maps on the influenza web page will also be updated on a weekly basis to provide more comprehensive information on influenza activity. This also includes information from NHS Direct a telephone service run by nurses, which covers England and Wales and provides medical advice to the public. Call rates are compiled for a number of clinical algorithms such as fever calls.

Graphs for data represented during the 2003/04 winter are available at

<http://www.hpa.org.uk/infections/topics_az/influenza/graphmenutemp0304.htm>.

NHS Direct web site available at <<http://www.nhsdirect.nhs.uk/>>.

Outbreaks of acute respiratory illness

Following the severe acute respiratory (SARS) epidemic from March to July 2003, there will be heightened interest in reports of outbreaks of respiratory illness in the winter of 2003. Guidance on surveillance and reporting for potential cases or clusters of SARS have been published on the HPA website at

<http://www.hpa.org.uk/infections/topics_az/SARS/casedef.htm>.

Reports have already been received of an outbreak of influenza like illness in a boarding school in the Republic of Ireland at the start of the new term. Influenza A (H3N2) has been detected in specimens obtained from some affected pupils. Confirmation of the virological cause of outbreaks of influenza-like illness, and other outbreaks of acute respiratory illness, will be of value in the management of the local outbreak. This also contributes to the surveillance of influenza virus strains that may be relevant for future vaccine composition. CDSC Colindale would be pleased to hear about outbreaks, including the results of investigation of such outbreaks in collaboration with local microbiological laboratories. The Respiratory Virus Unit at SRMD (specialist reference microbiology division) Colindale also has the capacity for rapid and sensitive detection of respiratory virus using PCR, and can supply kits for sample taking and direct submission to anyone requesting them. Any positive virus culture isolations should be referred to the Enteric, Respiratory, and Neurological Virus Laboratory (ERNVL) for further characterisation as soon as possible.

Influenza immunisation programme 2003-2004

The Department of Health (DoH) has recently launched the influenza immunisation programme for the winter 2003/2004. The DoH recommends that all those aged 65 years and over together with people of any age (over six months) at increased risk of the complications of influenza infection (at risk groups) and those living in long-stay residential and nursing homes be vaccinated. At-risk groups include those with a chronic respiratory disease (including asthma), chronic heart disease, chronic renal disease, diabetes, or those who are immunosuppressed. In addition, all NHS employers should offer immunisation to employees directly involved in patient care. Social care employers should consider similar action for social care staff. The influenza vaccination is available free of charge to the above groups.

Further information on the DoH influenza immunisation campaign is available at

<<http://www.doh.gov.uk/flu/campaign.htm>>. Further information on the influenza immunisation programme is available at

<<http://www.doh.gov.uk/cmo/letters/cmo0306.htm>>.

Vaccine composition

The strains of influenza virus recommended by the World Health Organization (WHO) to be included in the components for the 2003/04 vaccine are:

- an A/New Caledonia/20/99(H1N1)-like virus
- an A/Moscow/10/99(H3N2)-like virus*
- A B/Hong Kong/330/2001-like virus†

*The widely used vaccine strain is A/Panama/2007/99

† Currently used vaccine strains include B/Shandong/7/97, B/Hong Kong/330/2001, and B/Hong Kong/1434/2002.

In recent years the strains in the vaccine have shown a good match with circulating strains and have offered good protection.

Influenza vaccine uptake monitoring

The DoH vaccination uptake target remains 70% for those aged 65 years and over. As in previous years, vaccine uptake will be monitored in a national surveillance programme during the winter months. This data is collected through immunisation co-ordinators in Primary Care Trusts (PCTs). Monitoring of vaccination uptake will continue to be undertaken by CDSC Colindale on behalf of the DoH.

No target has been set relating to vaccine uptake in those aged under 65 years in the at-risk groups and there will be no monitoring for this group during this winter. On 18 September 2003, in line with Item of Service payments for those aged 65 years and over, the DoH introduced such payments for those aged under 65 years in the at-risk groups for whom influenza immunisation is indicated. General practitioner practices can only claim payments for patients aged 65 years and over and those aged under 65 years in the at-risk groups who are on an appropriate disease register.

This winter, there will also be monitoring of influenza vaccine uptake among health care workers in NHS acute hospital trusts. This data will be collected monthly through immunisation co-ordinators in strategic health authorities. The monitoring will focus on full-time and part-time staff working in four specialties with high-risk patients including accident and emergency departments, neonatal, paediatric, and adult intensive care units.

NICE guidance on neuraminidase inhibitors and amantadine for prophylaxis of influenza

In July 2003 the National Institute of Clinical Excellence (NICE) published final guidance (subject to appeal) on the use of oseltamivir and amantadine for the prophylaxis of influenza

<http://www.nice.org.uk/pdf/Influenza_FAD.pdf>. Oseltamivir is recommended for the post-exposure

prophylaxis of influenza in at-risk individuals aged 13 years or over who are not effectively protected by vaccination, and have been exposed to someone with influenza-like illness (ILI) in the same household and are able to begin prophylaxis within 48 hours of exposure. This includes those who have not yet been vaccinated, in whom vaccination has been contraindicated (*ie*, not recommended), has not yet taken effect, or where the vaccine is not well matched to the circulating strain of influenza. At-risk individuals include those aged 65 years

or over, or those aged under 65 years with chronic respiratory, cardiovascular, renal disease, diabetes, or those who are immuno-compromised.

In addition, oseltamivir is recommended for the post-exposure prophylaxis of influenza in at-risk individuals aged 13 years or over, who are able to begin prophylaxis within 48 hours of exposure, whether or not they have been vaccinated, if they live in residential care establishments where a resident or staff member has influenza-like illness.

Oseltamivir is not recommended for post-exposure prophylaxis in healthy people under 65 years of age, or for seasonal prophylaxis, while amantadine is not recommended for either post-exposure or seasonal prophylaxis. Zanamivir is not licensed for prophylaxis of influenza in the UK.

Surveillance of *Clostridium difficile* associated disease: report of the national standards group

As reported in the *CDR Weekly*, Volume 13, Number 24 (1), the Department of Health (DoH) announced forthcoming developments in healthcare-associated infection surveillance (2,3). Amongst other developments, mandatory surveillance of *Clostridium difficile* associated disease (CDAD) is due to start early in 2004. This represents an extension of the national healthcare-associated infection surveillance initiative that includes mandatory *Staphylococcus aureus* bacteraemia surveillance, results of which are published quarterly in the *CDR Weekly*.

Given the potential for a variety of different approaches to the selection and examination of stools for *C. difficile*, an expert group was established to review current approaches in England and make recommendations on standard methods to ensure a consistent approach nationally to underpin the forthcoming mandatory surveillance. The group included experts in *C. difficile*, as well as representation from relevant national organisations, such as the Hospital Infection Society. The report of the group has now been approved by the DoH, (4). It includes the findings of a review of laboratory practice across England, as well as recommendations on a national approach to *C. difficile* identification and surveillance and a literature review on interventions to prevent and control CDAD.

The recommendations include:


- Standardisation of the diagnosis and reporting of CDAD, in order to compare its impact across different populations.
- Faecal samples should be sent for microbiological investigation whenever patients present with diarrhoea of potentially infectious aetiology.
- For surveillance purposes, microbiology laboratories should test diarrhoeal specimens for evidence of CDAD from all patients aged 65 years and over who have not been diagnosed with CDAD in the preceding four weeks. Non-diarrhoeal stools should not be tested and it is recommended that specimens from children below the age of one year, in whom *C. difficile* can be regarded as a commensal organism, should not be tested.
- Laboratories should use either an immunoassay for both toxin A and toxin B or a neutralised cell cytotoxicity assay in order to ensure the detection of all cases of CDAD.
- Positive toxin results should be reported to CDSC via routine laboratory reporting. Results will be filtered at destination, so there is no requirement to remove those pertaining to patients outside the surveillance system (*ie*, those aged under 65 years).
- The surveillance scheme envisaged will also encompass strain typing and antimicrobial sensitivity data. Although the details have yet to be finalised, it is expected that specimens associated with outbreaks, plus a representative sample of other specimens, will be cultured at designated regional facilities and isolates sent for typing susceptibility testing at a designated national laboratory.

As indicated above, the recommendations distinguish between those groups in the population in which *C. difficile* should be looked for and identified (age groups over one year), and those groups in which *C. difficile* should also be reported in the forthcoming mandatory surveillance scheme (those aged over 65 years). Infection Control Teams are encouraged to liaise with their regional epidemiologists if they have queries about the implementation of this surveillance.

Previously there has been little consensus in laboratory diagnosis of *C. difficile*. Various criteria derived from proven or perceived risk factors for CDAD have traditionally been used to screen specimens. Although this approach provides economic benefits by limiting the number of tests performed, it restricts diagnosis and hampers epidemiological understanding. It is intended that the establishment of the national surveillance system will go hand in hand with improved standardisation of the diagnostic approach.

This edition of *CDR Weekly* (Volume 13, Number 40) also includes a review of *C. difficile* reports from

laboratories for 2000, 2001, and 2002, which can provide a baseline for future mandatory reporting.

1. Health Protection Agency. Activation of next phase of the healthcare-associated infection surveillance. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 15 August 2003]; **13** (24): news. Available at <<http://www.hpa.org.uk/cdr/archive03/news/news2403.htm#hcai>>.
2. Department of Health. *CMO to step up fight against hospital infection. (press release) 2003/0222*. London: Department of Health, 9 June 2003. Available at <<http://www.info.doh.gov.uk/doh/intpress.nsf/page/2003-0222?OpenDocument>>.
3. Donaldson L, Mullally S. Letter from the Chief Medical Officer: Surveillance of Healthcare Associated Infections. PLCMO2003/4; PLCNO2003/4. 9-6-2003. London: Department of Health, 2003.
4. (4) Health Protection Agency. *National Clostridium difficile standards group report to the Department of Health February 2003*. London: Health Protection Agency, 2003. Available at <http://www.hpa.org.uk/infections/topics_az/clostridium_difficile/FINALCdiffreport.pdf>. 

Hong Kong SARS expert committee report - SARS in Hong Kong: from experience to action



The Hong Kong SARS expert committee has released a report containing a detailed chronology of events during the SARS epidemic in Hong Kong. The report, SARS in Hong Kong: from experience to action discusses the effectiveness and shortcomings of the Hong Kong health system in dealing with the outbreak.

The report is available at <http://www.sars-expertcom.gov.hk/english/reports/reports/reports_fullrpt.html>.

Respiratory

Last updated: 2 October 2003
Next update due 6 November 2003

 [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 36-39/03

Week Week ending	36/03 07/09/03	37/03 14/09/03	38/03 21/09/03	39/03 28/09/03	Total
Influenza A	4	2	1	3	10
Isolation	–	–	–	–	–
DIF	–	2	1	–	3
Four-fold rise in paired sera	1	–	–	–	1
PCR	–	–	–	–	–
Other	3	–	–	3	6
Influenza B	–	–	–	–	–
Isolation	–	–	–	–	–
DIF	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–
PCR	–	–	–	–	–
Other	–	–	–	–	–
Influenza (untyped)	–	–	–	–	–
Isolation	–	–	–	–	–
DIF	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–
PCR	–	–	–	–	–

Other

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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 36-39/03

Week Week ending	36/03 07/09/03	37/03 14/09/03	38/03 21/09/03	39/03 28/09/03	Total
Adenovirus*	22	37	11	30	100
Coronavirus	-	-	-	-	-
Parainfluenza†	4	4	3	6	17
Rhinovirus	-	2	3	1	6
Respiratory Syncytial Virus (RSV)‡	3	8	2	6	19

*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 36-39/03

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥ 65 years	Unknown	Total
Adenovirus*	5	5	5	61	15	8	1	100
Coronavirus	-	-	-	-	-	-	-	-
Influenza A	-	-	1	6	-	3	-	10
Influenza B	-	-	-	-	-	-	-	-
Parainfluenza†	4	3	3	1	6	-	-	17
Rhinovirus	4	1	1	-	-	-	-	6
Respiratory Syncytial Virus (RSV)‡	9	1	-	4	3	2	-	19

*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 Week ending	36/03 07/09/03	37/03 14/09/03	38/03 21/09/03	39/03 28/09/03	Total
<i>Coxiella burnettii</i>	-	-	-	1	1
Respiratory <i>Chlamydia</i> sp.*	2	1	2	9	14
<i>Mycoplasma pneumoniae</i>	9	11	7	14	41
<i>Legionella</i> sp.†	-	-	-	-	-

*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 Week ending	36/03 07/09/03	37/03 14/09/03	38/03 21/09/03	39/03 28/09/03	Total
Nosocomial	–	–	–	–	–
Community	–	2	4	2	8
Travel abroad	8	5 (1)	4	8	26
Travel UK	–	1	1	–	2
Total	8	9	9	10	36
Male	6	8	7	7	28
Female	2	1	2	3	8

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

Thirty-five cases were reported with pneumonia and one with non-pneumonic illness, 28 males aged between 38 and 82 years and 8 females aged between 24 and 68 years. One death, F 68y was reported. Eight cases were due to community-acquired infection. Twenty-eight cases were travel associated: Spain (7), Cyprus (3), Italy (3), Bulgaria (1 non-pneumonic case and 1 cluster case), England (2), Mediterranean cruise (1 and 1 cluster case), Belgium (1), Bermuda (1), France (1), France and Italy (1), Hong Kong (1), Malta (1), New Zealand, Portugal (1), and Singapore and Thailand (1).

Bacteraemia

Last updated: **2 October 2003**
Next update due: **16 October 2003**

Clostridium difficile, England, Wales, and Northern Ireland: 2000 to 2002

Clostridium difficile, England, Wales, and Northern Ireland: 2000 to 2002

Key points:

- The number of reports of *Clostridium difficile* infections diagnosed from faecal specimens increased from 20,556 reports in 2000 to 28,819 in 2002, although it is not clear what proportion could be due to improved reporting.
- Both Wales and Northern Ireland had rates above the English average; within England, rates of *C. difficile* varied widely among the regions.
- Few antibiotic susceptibility results were reported; all reports where this information was included were sensitive to metronidazole and vancomycin.
- Eighty-two per cent of reports concerned patients aged 65 years or over.

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Clostridium difficile, England, Wales, and Northern Ireland: 2000 to 2002

Key points:

- The number of reports of *Clostridium difficile* infections diagnosed from faecal specimens increased from 20,556 reports in 2000 to 28,819 in 2002, although it is not clear what proportion could be due to improved reporting.
- Both Wales and Northern Ireland had rates above the English average; within England, rates of *C. difficile* varied widely among the regions.
- Few antibiotic susceptibility results were reported; all reports where this information was included were sensitive to metronidazole and vancomycin.
- Eighty-two per cent of reports concerned patients aged 65 years or over.

This review covers reports of *Clostridium difficile* made to CDSC in 2000, 2001, and 2002 from laboratories in England, Wales, and reports made in 2001 and 2002 from Northern Ireland. Only reports concerning faecal or lower gastro-intestinal tract specimens were included. Where rates were calculated according to age or geographical area, 2001 mid-year resident population estimates were used. Data were analysed and displayed according to current regional boundaries.

In 2000, 20,556 reports of *C. difficile* diagnosed from stool specimens from England and Wales (table 1) were received at CDSC. In 2001, this increased to 22,008 reports, including 345 reports from Northern Ireland. In 2002, a further increase of 31% was seen compared to the previous year, to 28,819 reports.

In six of the nine English regions (Yorkshire and Humberside, Eastern, London, South East, South West, and West Midlands), year-on-year increases in the number of reports were seen (figure 1). In Wales, the

number of reports fluctuated between 2000 and 2002, but decreased overall (1744 reports in 2000 to 1706 in 2002). The number of reports from Northern Ireland more than doubled between 2001 and 2002, from 345 to 930 reports. Data from Northern Ireland have been incorporated into this dataset from 2001.

Figure 1 Laboratory reports of *Clostridium difficile*, England, Wales, and Northern Ireland: 2000 to 2002

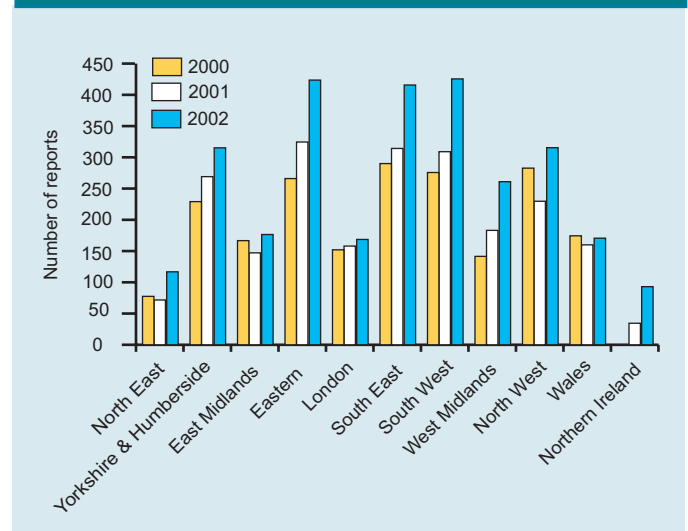


Table 1 Laboratory reports of *Clostridium difficile*, England, Wales, and Northern Ireland: 2000 to 2002

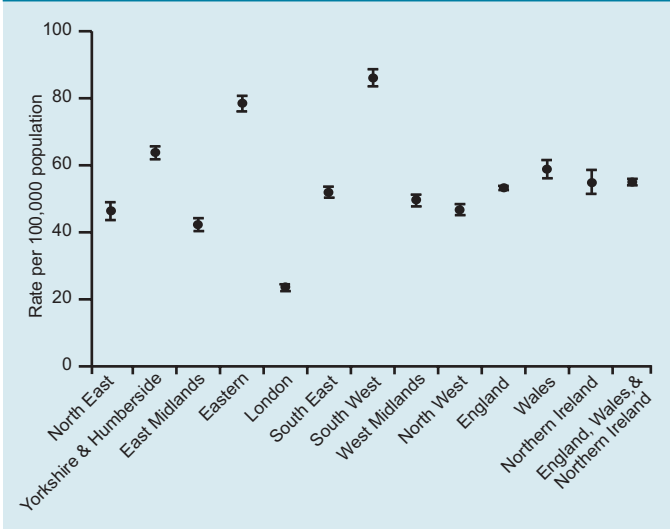
	2000	2001	2002
North East	775	717	1168
Yorkshire & Humberside	2291	2691	3152
East Midlands	1667	1471	1765
Eastern	2660	3245	4236
London	1520	1580	1686
South East	2900	3142	4157
South West	2757	3090	4255
West Midlands	1415	1831	2610
North West	2827	2297	3154
England	18,812	20,064	26,183
Wales	1744	1599	1706
Northern Ireland	NA*	345	930
England, Wales and Northern Ireland	20,556	22,008	28,819

*Not available, data imported at national level from 2001.

In 2002, the overall rate of *C. difficile* reports for England, Wales, and Northern Ireland was 53.59 per 100,000 population (figure 2). The rates in Wales and Northern Ireland (58.76/100,000 and 55.05/100,000 respectively) were higher than in England (53.24/100,000). The English region with the highest rate was the South West with 86.24/100,000 population, over three times the lowest rate (23.46/100,000), which was in London.

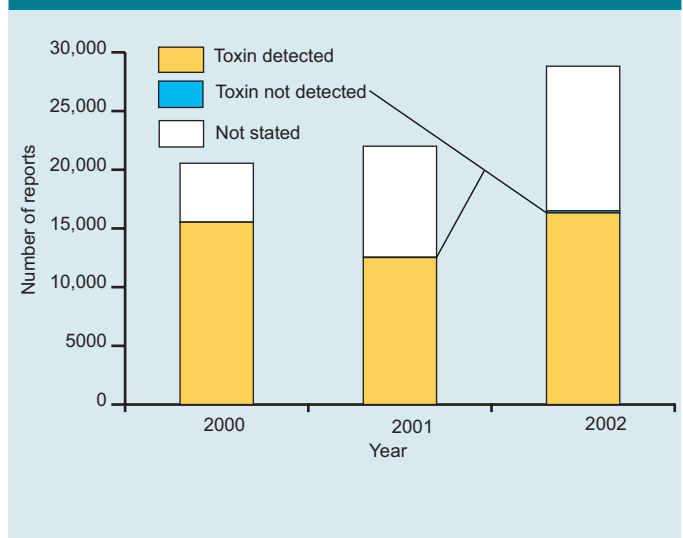
Reports of *C. difficile* can include information on the method(s) used to identify this bacterium, including whether *C. difficile* toxin was detected. In 2000, 76% (15,530/20,556 reports) of reports indicated that toxin

Figure 2 Region-specific rates* of *Clostridium difficile*, England, Wales and Northern Ireland: 2002



* rates calculated using 2001 mid-year resident population estimates

Figure 3 *Clostridium difficile* reports and toxin detection, England, Wales, and Northern Ireland: 2000 to 2002



had been detected, and the remainder did not contain this information (figure 3). In 2001, fewer reports (12,521 reports, 57%) indicated that toxin had been detected. Twenty reports (0.1%) indicated that toxin had not been detected and in the remainder it was not stated.

In 2002, the proportion of reports that indicated that toxin was detected remained unchanged from 2001 (57%, 16,326 reports) although the number of reports that indicated that toxin had not been detected increased slightly (to 0.6% of the total, 182 reports). Of the reports that indicated toxin had not been detected, 71 (39%) indicated that *C. difficile* had been diagnosed by isolation; for the remainder (111; 61%) it was not clear on what the basis the diagnosis was made. Forty-three per cent of reports from 2002 did not contain information on whether toxin had been detected. Of these, 19% (2311 reports) indicated that culture was used to identify *C. difficile*. This does not necessarily mean that toxin detection did not take place; of the 16,326 reports from 2002 that indicated that toxin had been detected, 14% (2322 reports) indicated that *C. difficile* had also been cultured. Between 2000 and 2002 a decreasing proportion of reports indicated that *C. difficile* had been diagnosed by isolation, from 33% of reports (6746 reports) in 2000 to 16% (4674 reports) in 2002.

Antimicrobial resistance

In 2000 and 2001 very few reports contained information on antimicrobial susceptibility (seven and four reports respectively). In 2002, 115 reports included antimicrobial susceptibility information, although the majority (71 reports) came from a single laboratory in the East Midlands over a six-month period. Of the remaining 44 reports, 39 came from the North West region. Of the 115 reports, 20 isolates were reported as having been tested for susceptibility to vancomycin, all of which were sensitive, and four isolates were tested for susceptibility to metronidazole. Again all were sensitive. Susceptibility to a wide range of other antibiotics was also reported.

Age distribution

In 2002, 607 reports (2% of the total) did not contain information on the age of the patient. The highest age-specific rate of *C. difficile* was in those aged 75 years and over, and the rate for females was slightly higher than that for males in this age group (figure 4). The second highest rate was in the 65 to 74 age group, although this time the rate was slightly higher among males than in females. Overall, 82% of *C. difficile* reports

Figure 4 Age-specific rates* of *Clostridium difficile* reports, England, Wales, and Northern Ireland: 2002



* rates calculated using 2001 mid-year resident population estimates

concerned patients aged 65 years or over.

Discussion

The data presented in this report show that the number of reports of *C. difficile* has increased between 2000 and 2002. The 20,556 reports from England and Wales in 2000 were an increase compared to 1999, for which 18,354 reports were received(1). This increase, however,

has not been reported evenly across the country; certain regions (North East, Eastern, South West, and West Midlands) reported increases of over 50% in the number of reports received over the three years reported here, whereas other regions reported smaller increases. This geographic variation was also reflected in the region-specific rates of *C. difficile*. It is not clear how much of this increase is related to improved reporting of cases.

Although only 57% of reports in 2002 indicated that toxin had been detected, virtually all laboratories that perform *C. difficile* testing (that responded to the national survey of current practice carried out on behalf of the National *Clostridium difficile* Standards Group(2)) indicated that they used toxin testing to diagnose *C. difficile* disease. It is, therefore, likely that *C. difficile* was diagnosed by toxin testing in most of the cases where the report did not have this information.

As the majority of cases of *C. difficile* are diagnosed using toxin testing, little culture is undertaken (16% of reports in 2002 indicated culture as the method of identification) removing the opportunity for antibiotic susceptibility testing to be carried out; less than 1% of reports from 2002 included information on antimicrobial susceptibility. The susceptibility testing results available indicate the need for more representative sampling across the regions. No metronidazole or vancomycin resistance was reported in any of the years examined here, although an isolate with reduced susceptibility to metronidazole was identified by the Anaerobe Reference Unit and reported in 2001(3).

The increase in laboratory reports of *C. difficile* indicates the need for increased vigilance in the surveillance of this pathogen. The figures used for this report are based on voluntary laboratory reporting, but following the recent announcement of the Chief Medical Officer(4), surveillance of *C. difficile* will become mandatory from January 2004. Details of this and the report of the National *Clostridium difficile* Standards Group (which recommends standard methods to

ensure a consistent approach) are given in Volume 13 Number 40 of *CDR Weekly* (5).

Acknowledgements

These reports would not be possible without the enduring weekly contributions from microbiology colleagues in laboratories across England, Wales, and Northern Ireland, without which there would be no surveillance data. Laboratory reporting is the bedrock of national surveillance. This is your data, so please tell us what you would like done with it. We are always pleased to hear your views. Please send your comments/feedback to <georgia.duckworth@hpa.org.uk>. In addition, the support from colleagues within the Health Protection Agency, the Anaerobe Reference Unit in particular, is valued in the preparation of the reports. These contributions are greatly appreciated.

References

- (1) CDSC. *Clostridium difficile* in England and Wales: 1999. *Commun Dis Rep CDR Wkly* [serial online] 2000 [cited 15 August 2003]; **10**(15). Available at <<http://www.hpa.org.uk/cdr/CDR00/cdr1500.pdf>>
- (2) Health Protection Agency. *National Clostridium difficile standards group report to the Department of Health February 2003*. London: Health Protection Agency, 2003. Available at <http://www.hpa.org.uk/infections/topics_az/clostridium_difficile/FINALCdifreport.pdf>.
- (3) Brazier JS, Warren F, Freeman J, Wilcox MH. Reduced susceptibility of *Clostridium difficile* to metronidazole. *J Antimicrob Chemother* 2001; **48**: 741-2.
- (4) Donaldson L, Mullally S. Letter from the Chief Medical Officer: Surveillance of Healthcare Associated Infections. PLCMO2003/4; PLCNO2003/4. 9-6-2003. London: Department of Health, 2003.
- (5) Health Protection Agency. Surveillance of *Clostridium difficile* associated disease: report of the National Standards Group. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 15 August 2003]; **13** (40): news. Available at <<http://www.hpa.org.uk/cdr/PDFfiles/2003/cdr4003.pdf>>.