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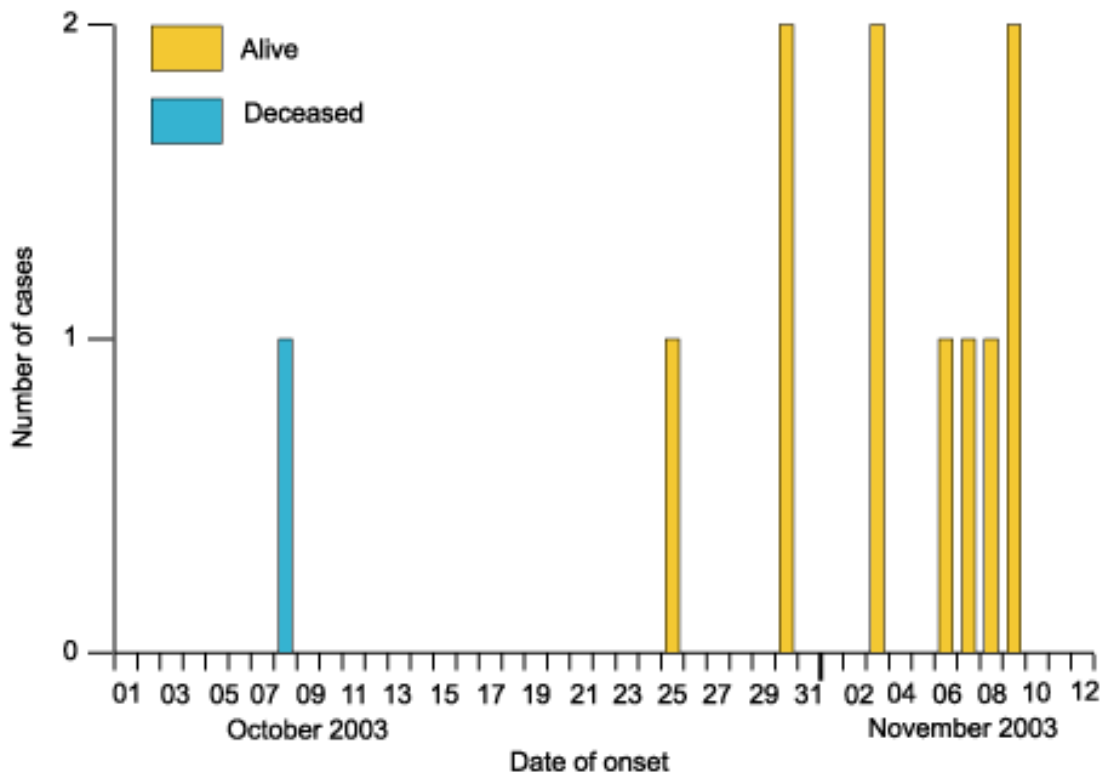
Outbreak of legionnaires' disease in Hereford

There are 12 confirmed cases legionnaires' disease (eight males, four females) aged from 36 to 76 years (median age 55 years) associated with an outbreak in Hereford. Dates of onset of illness range from 8 October to 9 November, 2003. One 76 year old man has died. Cooling towers and other aerosol generating equipment are being sampled and treated.

The outbreak is being investigated by the Hereford and Worcestershire Health Protection Unit, in association with environmental health officers of Herefordshire Council, the Hereford Hospitals NHS Trust, and the Specialist and Reference Microbiology Division of the Health Protection Agency.

Any cases of legionnaires' disease with onset since 1 October 2003 who have visited Hereford in the 14 days before onset should be reported to David Kirrage: tel 01432 344 344, as well as to the Health Protection Agency's Communicable Disease Surveillance Centre.

Figure Outbreak of legionnaires' disease in Hereford : number of cases by date of onset*



*1 case of unknown onset date

Meningococcal meningitis in Moscow



There has been a rise in the number of cases of meningococcal meningitis in Moscow, Russia. There have been 268 cases (including 22 deaths) up to the end of October 2003, mostly in children, which is approximately twice the average number of cases reported (1). Unusually, many of the cases have been reported at the end of the summer and in early autumn; the usual season is in February and March. Meningococcal serogroup A has been identified in 90% of the strains isolated. The city health authorities in Moscow have initiated a mass vaccination campaign in order to prevent further cases occurring during the coming peak transmission season.

Cases of meningococcal serogroup A infection are rare in the United Kingdom (UK), and it is uncommon to have infections even associated with travel to those endemic areas where serogroup A is most frequent, such as the meningitis belt in Africa. It is not, therefore, anticipated that many cases will be imported from Russia into the UK. There have been no cases of meningococcal meningitis serogroup A reported in the UK so far in 2003, and the risk to the individual traveller, believed to be low, appears related to the degree in which they are in close contact with the local population.

The National Travel Health Network and Centre (NaTHNaC) in England has issued some guidance for health professionals in the UK who may be advising travellers to Moscow (2). It is recommended that meningococcal vaccine should only be considered for travellers to Moscow who will be teaching in schools, attending university or other courses, frequenting crowded bars and clubs, or working in a medical setting.

Any changes to this guidance will be posted on the NaTHNaC website <<http://www.nathnac.org>> and health professionals are advised to view the NaTHNaC website for regular updates on this and other issues related to vaccinations for travel.

References

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2. National Travel Health Network and Centre (NaTHNaC). Meningococcal meningitis in Moscow - clinical updates for health professionals. London: NaTHNaC, November 2003. Available at <http://www.nathnac.org/healthprofessionals/clinical/meningitis_moscow.html>.

Health protection in Scotland



The Health Department of the Scottish Executive consulted major stakeholders in public agencies and representative bodies about the scope and possible organisational arrangements for health protection in Scotland. The consultation document outlined six options. The consultation paper was circulated in November 2002, and the deadline for responses was 31 January 2003.






On Wednesday 29 October, the Executive released a research report presenting findings from analysis of written responses to the consultation paper. This report provides a profile of respondents, describes the content of responses to the central questions of the consultation and discusses the nature of the support for the preferred option.

The option most favoured by respondents, and which the Executive accepts, envisages the Health Protection Agency (HPA), now established in England and Wales, assuming responsibility in Scotland for the functions at present discharged by the National Radiological Protection Board, the services provided hitherto by the National Focus for Chemical Incidents and for the commissioning of an integrated United Kingdom (UK) poisons service which will include the Scottish Poisons Information Bureau. Delivering these specialised functions on this basis is intended to facilitate common standards of efficiency and performance across the UK and promote the sharing of expertise and concerted working.

In Scotland, the functions of the Scottish Centre for Infection and Environmental Health, the health surveillance elements of the Information and Statistics Division of the Common Services Agency (CSA), and the current responsibilities of the National Services Division of CSA in relation to the Scottish National Reference Laboratories will be brought together into a new Scottish health protection organization, which will form a discrete Division within the CSA. The health protection functions of NHS boards and local authorities will be unaffected, but it is intended that strong administrative functions will be put in place to ensure collaborative working.

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EntericLast updated: **13 November 2003**Next update due: **11 December 2003**

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General outbreaks of foodborne illness, England and Wales: laboratory reports, weeks 40-44/03

	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	*Evidence
Wales	S. Enteritidis PT8	Restaurant	October	4	4	None	-
Sunderland East & North	S. Enteritidis PT8	Function	October	4	4	None	-
Herts	S. Enteritidis PT14B	Restaurant	October	4	4	None	-
Barnet	S. Enteritidis PT14B	Function	October	40	26	Dessert (egg based)	M
Bradford	S. Enteritidis PT56	Retailer	October	150	16	None	-
Essex	S. Typhimurium DT49	Function	October	17	17	Dessert (egg based)	M

* 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; S (statistical): a significant statistical association between consumption of the suspect vehicle(s) and being a case; D (descriptive): other evidence, usually descriptive, reported by local investigators as indicating the suspect vehicle.



Salmonella infections (faecal specimens): England and Wales, reports to the HPA (salmonella data set) September 2003

Details of serotypes of the 2272 salmonella infections recorded in September 2003 are given in the adjacent table. In October 2003, 1061 salmonella infections were recorded and preliminary information was received about six outbreaks (see table above).

Total <i>Salmonella</i> (provisional data)	Sep-03
	2272
S. Enteritidis (PT 4)	528
S. Enteritidis (other PTs)	1223
S. Typhimurium	202
S. Virchow	33
Others (typed)	286

* Data provisional



Common gastrointestinal infections, England and Wales: laboratory reports, weeks 40-44/03

Laboratory reports	Number of reports received					Total reports 40-44/03	Cumulative total to	
	40/03	41/03	42/03	43/03	44/03		44/03	44/02
<i>Campylobacter</i>	744	612	569	423	226	2574	35,770	37,965
<i>Escherichia coli</i> O157*	5	24	5	19	19	72	541	498
<i>Salmonella</i> †	333	316	283	210	85	1227	12,718	12,431
<i>Shigella sonnei</i>	10	3	–	6	3	22	478	619
Rotavirus	28	20	17	19	12	96	14,388	13,927
Norovirus	26	27	17	13	2	85	1851	2807
<i>Cryptosporidium</i>	150	148	112	47	40	497	4274	2385
<i>Giardia</i>	66	60	52	47	19	244	2467	2714

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

† Data from Health Protection Agency's Laboratory of Enteric Pathogens



Typhoid and paratyphoid, England and Wales: laboratory reports, July to September 2003

Organism and phage type	Number of cases	Infection acquired abroad			Excretors and carriers
		Yes	No	Not reported	

Total Salmonella Typhi						
A	2	–	–	2	–	–
B1	1	–	–	1	–	–
B2	1	1	–	–	–	–
C1	2	1	–	1	–	–
C3	1	1	–	–	–	–
C4	1	–	–	1	–	–
D1	2	1	–	1	–	–
E1	16	10	–	6	–	–
E9	1	–	–	1	–	–
E14	1	1	–	–	–	–
M1	1	1	–	–	–	–
O	4	3	–	1	–	–
28	1	–	–	1	–	–
Degraded	1	–	–	1	–	–
Untypable	7	4	–	3	–	–
Untypable Vi-2	1	1	–	–	–	–
Total Salmonella Paratyphi A						
1	13	6	–	7	–	–
1A	15	8	–	7	–	–
2	1	1	–	–	–	–
4	7	5	–	2	–	–
6A	2	–	–	2	–	–
13	15	10	–	5	–	–
RDNC	5	2	–	3	–	–
Total Salmonella Paratyphi B						
Beccles var 1	1	–	–	1	–	–
Taunton	5	3	–	2	–	–

Forty-three cases of *Salmonella* Typhi infection were reported in the third quarter of 2003. Twenty-four cases were infected abroad (Indian subcontinent 20, Nigeria 2, Hong Kong 1, and abroad (unspecified) 1). In 19 cases the country of infection was not stated.

Fifty-eight cases of *S. Paratyphi A* infection were reported. Thirty-two cases were infected abroad (Indian subcontinent 31, Nigeria 1). In 26 cases the country of infection was not stated.

Six cases of *S. Paratyphi B* infection were reported. Three cases were infected abroad (Morocco 2, Peru 1) and in three cases the country of infection was not stated.



Treatment of cryptosporidiosis

Infection with *Cryptosporidium* spp. is associated with illness characterised by diarrhoea, abdominal cramps, loss of appetite, low grade fever, and vomiting. Symptoms can vary in severity, and although diarrhoea is often prolonged, it is usually self-limiting in patients with an intact immune system. Patients with severe immunodeficiency can present with prolonged or life-threatening disease. In HIV-infected patients this is substantially reduced where highly active anti-retroviral treatment (HAART) is available, since adequate T cell function is critical in clearing *Cryptosporidium* infection. There is, however, an increasingly recognised burden of disease in patients with primary and secondary immunodeficiencies (1). Unfortunately, no drugs have had proven efficacy in the management of cryptosporidiosis, particularly in patients who are severely immunocompromised (HIV patients with CD4 count $<50 \times 10^6/L$) and/or those with cryptosporidial cholangitis. Paromomycin is increasingly being used to treat other intestinal protozoal infections (2), but initial enthusiasm for its use in cryptosporidiosis, taken alone or with azithromycin, has been tempered by failure to demonstrate effectiveness in placebo-controlled studies in late stage HIV (3).

Recently, a nitrothiazolyl-salicylamide derivative, nitazoxanide, has been shown to provide significant improvement in adults and children with mild illness (4) and clinical and parasitological improvement and improved survival in malnourished children with chronic cryptosporidiosis in Zambia (5). Earlier studies showed poor results in patients with advanced HIV infection although it was effective in patients with higher CD4 counts (6). New studies are underway to further investigate treatment regimens, and to clarify the role of nitazoxanide in the treatment of patients with severely depleted CD4 counts.

On the evidence of the double-blind placebo-controlled trials, the US Food and Drug Administration has approved the use of nitazoxanide, in suspension, for the treatment of cryptosporidiosis and giardiasis in children aged between 1 and 11 years. The drug is given orally at a dose of 100mg twice daily for three days for children aged between 12 and 47 months, and 200mg twice daily for three days for those aged between 4 and 11 years. Nitazoxanide is marketed in the United States (US) as Alinia by Romark Laboratories, Tampa, Florida, but does not currently possess a British product licence. It is, however, available as an imported medicine on a named patient basis with a delivery time of between 10 and 12 working days. It is likely that the main use of anti-*Cryptosporidium* therapy will be in patients who have unusually prolonged diarrhoea and for treating cryptosporidiosis in those suffering from immunodeficiency states. Further studies are still required to establish the dose and duration of treatment with nitazoxanide in immunodeficient patients. Interactions have not been specifically studied and there have been no studies in subjects aged under 1 year of age, patients with hepatic or renal impairment, or investigations for use during pregnancy or breast-feeding. Nitazoxanide is generally well tolerated and reported side effects are mild, but include abdominal pain, diarrhoea, vomiting, and headache. Nitazoxanide is a broad-spectrum antimicrobial agent with *in vitro* activity against a variety of parasites, including other protozoa, some intestinal helminths, anaerobic and microaerophilic bacteria including *Helicobacter pylori*, and may prove to have wider applications in human medicine in due course.

Diagnosis by confirmation of the presence of *Cryptosporidium* oocysts in stool samples and investigation of subsequent reduction or eradication following treatment may require specialised tests offering greater sensitivity than those routinely offered in primary testing laboratories. Pre and post treatment faecal specimens can be referred to the Cryptosporidium Reference Unit, NPHS Microbiology Swansea, Singleton Hospital, Swansea SA2 8QA for specialist testing following discussion with the Head of the Unit (telephone 01792 285341).

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