Health Protection Agency

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MAIN STORIES THIS WEEK:

REPORTS BY INFECTION:

Enteric

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News

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Cluster of pregnancy-associated listeria cases in the Swindon area

A cluster of four cases of pregnancy-associated *Listeria monocytogenes* infection have been reported in the Swindon area, and a further case in a neighbouring county over the past two months. All mothers and babies remain healthy, on or following treatment. The source has not been identified and investigations continue.

L. monocytogenes from all five share the same serotype, phage type, and genotype (amplified fragment length polymorphism [AFLP] pattern), which is different from all isolates analysed during 2002 and 2003, including that identified earlier this year in an outbreak in the Yorkshire and Humberside region. The strain from the Swindon cluster was serotype 1/2, phage type Y, AFLP type III. Isolates from four of the five cases were indistinguishable by pulsed field gel electrophoresis (PFGE); results from the final case are not complete.

Three of the five cases are known to have eaten chicken sandwiches (two definitely with mayonnaise) from the same retail outlet. Samples from the sandwich manufacturers, have to date, tested positive for the presence of *L. monocytogenes* in only a brie and cranberry sandwich. Further food and environmental samples from these suppliers have been collected for culture and molecular typing if positive. The retail outlet have recently changed sandwich suppliers due to problems with packaging, and *L. monocytogenes* has also been detected at low levels in a turkey and stuffing roll from the new suppliers. Isolates from both food products are currently being analysed and are of the same serotype as the isolates from the infected patients. Environmental sampling of the retail outlet itself is also planned.

Pregnant women are routinely advised to avoid foods classically associated with listeriosis, such as mould ripened soft cheeses such as camembert and blue veined varieties, pate, and ready cooked meals until they are piping hot. Most of the infected pregnant women, associated with this cluster had strictly adhered to this advice.

Once it was confirmed there was a small cluster, an outbreak control meeting was called and an alert notice was sent out to health care workers working with pregnant women and neonates in Swindon and the surrounding area. Microbiologists in the south west, and consultants in communicable disease control nationally were asked to report any recent listeriosis cases and send isolates the Health Protection Agency's Food Safety Microbiology Laboratory (FSML), Colindale, for further analysis.
The Food Standards Agency was informed, and it was decided to inform the local media. This led to newspaper, radio, and television coverage re-emphasising advice about particular food avoidance in pregnancy and highlighting the nature of the non-specific symptoms (1) of listeriosis in pregnancy, fever, and 'flu-like illness. Advice was given that anyone presenting with these symptoms should contact the on-call antenatal services at the Great Western Hospital, Swindon.

References

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Report from the Chief Medical Officer – *Winning ways: working together to reduce healthcare associated infection in England*

The Chief Medical Officer (CMO) for England published *Winning ways: working together to reduce healthcare associated infection in England* on 5 December 2003, (available at <http://www.doh.gov.uk/cmo/index.htm>). Until recently, healthcare associated infection (HCAI) had a relatively low profile compared with other areas of the health service, although it was one of the key areas identified in the CMO's infectious diseases strategy for England *Getting ahead of the curve* in 2002 (1). The latest report sets out the actions necessary to reduce certain healthcare associated infections and to curtail the rise of antibiotic resistant organisms in England.

Advances in medicine have led to a huge number of benefits to patients including increased survival and enhanced quality of life. Several of these advances increase the risk of HCAI and because of this HCAI cannot be completely eliminated. This does not mean, however, that we cannot make progress in the prevention and control of HCAI. The report outlines seven action areas to be addressed.

The seven action areas identified in *Winning ways: working together to reduce healthcare associated infection in England* are:

(1) Active surveillance and investigation
(2) Reducing the infection risk from use of catheters, tubes, cannulae, instruments, and other devices
(3) Reducing reservoirs of infection
(4) High standards of hygiene in clinical practice
(5) Prudent use of antibiotics
(6) Management and organisation
(7) Research and development

In addition to a reiteration of best practice for the management of medical devices, hospital cleanliness and the design of infection control into healthcare premises (2-5), the report includes a number of new measures. These include:

- The appointment of a Director of Infection Prevention, and control in each organisation providing NHS services. This director will report directly to the chief executive and the Trust Board, and be responsible for the infection control team within the healthcare organisation
- An assurance that chief executives will be aware of their legal duties to identify, assess, and control risks of infection in the workplace
- An obligation for NHS Trust chief executives to ensure that, over time, there is an appropriate provision of isolation facilities within their healthcare facilities.
- Further development of the mandatory surveillance system for HCAI. This will include:
    - Bloodstream infections. Including, but not limited to methicillin-resistant *Staphylococcus aureus* (MRSA);
    - Surgical site infections;
    - *Clostridium difficile* infections;
    - Glycopeptide resistant enterococci (GRE) infections;
    - Post-discharge infections;
    - Serious incidents associated with infection.

- Support for prudent antibiotic prescribing by clinical pharmacists, medical microbiologists, and infectious diseases physicians. Narrow spectrum antibiotics will be preferred to broad spectrum and the choice of antibiotic will be governed

- An investigation of new systems to control HCAI, such as collaborative links between the Inspector of Microbiology and the National Patient Safety Authority to ensure that root cause analysis and hazard analysis and critical control point (HACCP) are used.
- The publication of rates of HCAI in each area of the country on the CMO's website. A national audit of deaths from HCAI will be established. Some of these deaths will be investigated to identify 'lessons learned'.
- The implementation of a national research strategy to underpin effective action and ensure that new developments in the understanding of HCAI are rapidly translated into benefits for patients. Three million pounds has been allocated to this new research programme. This will include an exploration of the potential for epidemiological modelling and molecular methods to improve infection control, and the feasibility of vaccines.
- Reporting of serious outbreaks of infection in healthcare settings to the Health Protection Agency, which will provide advice and support for the management and control of the incident.
- Keeping the appropriate healthcare staff up-to-date with immunisation for hepatitis B, TB, influenza, and chickenpox.
- The publication of the Department of Health's additional guidance on the roles and responsibilities of infection control teams, while ensuring that its expertise and specialist agencies are made available to facilitate change and improvement in local NHS facilities. The Department will also ensure up-to-date information is provided to the public and patients on infection control and prevention.
- The Commission for Healthcare Audit and Inspection (CHAI) will be asked to give priority in assessing NHS performance in reducing HCAI.

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Chickenpox (varicella) immunisation for healthcare workers

The Chief Medical Officer (CMO) for England has announced a new varicella vaccination policy for healthcare workers. Following advice from the Joint Committee on Vaccination and Immunisation, chickenpox (varicella) vaccination is now recommended for non-immune healthcare workers who work in primary care and in hospitals (both NHS and private). This recommendation covers all non-immune staff, including ambulance drivers, ward cleaners, catering staff, and general practitioner receptionists, who have direct patient contact. Those without a previous history of chickenpox or shingles infection and who are then found to be seronegative to varicella following antibody testing should be offered varicella vaccine.

Full details of this policy can be found in Annex 1 of the CMO letter (available at <http://www.doh.gov.uk/cmo/letters/cmo0312.htm>, and in the new varicella chapter of *Immunisation against infectious*

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General outbreaks of foodborne illness, England and Wales laboratory reports: weeks 45-48/03

	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	*Evidence
County Durham	*S*. Enteritidis PT1	Restaurant	November	18	18	None	–
County Durham	*S*. Enteritidis PT1	Canteen	November	5	5	Roast pork	–

* 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): October 2003

Details of serotypes of 1399 salmonella infections recorded in October 2003 are given in the adjacent table. In November 2003, 780 Salmonella infections were recorded and preliminary information was received about two outbreaks (see above table)

Total *Salmonella* (provisional data)	Oct-03
	1399
S. Enteritidis (PT 4)	257
S. Enteritidis (other PTs)	742
S.Typhimurium	176
S. Virchow	14
Others (typed)	210

* Data provisional

Common gastrointestinal infections, England and Wales, laboratory reports: weeks 45-48/03

Laboratory reports	Number of reports received				Total reports	Cumulative total to	
	45/03	46/03	47/03	48/03	45-48/03	48/03	48/02
Campylobacter	648	552	484	301	1985	38,991	43,449
Escherichia coli* O157	7	10	5	3	25	613	546
***Salmonella*†**	362	230	119	61	772	13,775	13,527
Shigella sonnei	5	3	5	–	13	511	658
Rotavirus	30	17	27	20	94	14,411	14,257
Norovirus	17	21	12	5	55	2003	3297
Cryptosporidium	74	89	63	46	272	4861	2620
Giardia	50	53	32	45	180	2742	2942

* Vero cytotoxin producing isolates (data from Laboratory of Enteric Pathogens (LEP))
† Data from Health Protection Agency's Laboratory of Enteric Pathogens

General outbreaks of foodborne illness in humans, England and Wales quarterly report: April to June 2003

Table 1 Final information on general outbreaks of foodborne illness: April to June 2003

Local authority	Organism	Location of food prepared or served	Number ill	Cases positive	Suspect vehicle	*Evidence
Rushcliffe	*S*. Enteritidis PT4	Hotel	15	27	Cheesecake	M
Swansea	*S*. Enteritidis PT4	Restaurant	7	7	None	–
Milton Keynes	*S*. Enteritidis PT21	Restaurant	8	19	None	–
Durham	*S*. Enteritidis PT56	Restaurant	142	142	None	–
Leeds	*Campylobacter jejuni* HS 67 PT1 HS 13 PT1	Restaurant	12	5	Chicken liver pate	D

* 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 serotypes recorded in the HPA salmonella data set: July to September 2003

All serotypes recorded in the Health Protection Agency salmonella data set in the third quarter of 2003 are listed below. There were more than ten reports of 26 serotypes, two to ten reports were 58 serotypes and one report of 51 serotypes.

	July to September 2003 (provisional)
S. Agona	49
S. Anatum	11
S. Bareilly	169
S. Blockley	24
S. Braenderup	51
S. Bredeney	12
S. Corvallis	11
S. Derby	16
S. Enteritidis	4906
S. Hadar	58
S. Infantis	44
S. Java	27
S. Kentucky	17
S. Kottbus	21
S. Livingstone	15
S. London	11
S. Mbandaka	22
S. Montevideo	18
S. Newport	40
S. Oranienburg	18
S. Saint-Paul	11
S. Stanley	29
S. Thompson	21
S. Typhimurium	657
S. Unnamed	58
S. Virchow	93

Between two and ten reports of each of the following serotypes were received:

S. Aba	2
S. Abony	3
S. Adelaide	2
S. Agama	6
S. Ajiobo	5
S. Altona	2
S. Arizonae	6
S. Bovismorbificans	9
S. Brandenburg	8
S. Butantan	2
S. Cerro	2
S. Chester	7
S. Coeln	8
S. Colindale	4
S. Cubana	2
S. Dublin	4
S. Duesseldorf	6
S. Durham	10
S. Gaminara	2
S. Give	4
S. Emek	2
S. Gold-Coast	3
S. Heidelberg	7
S. Haifa	5
S. Hull	2
S. Hvittingfoss	6
S. Ibadan	4
S. Indiana	6
S. Istanbul	2
S. Kiambu	2
S. Kedougou	7
S. Manhattan	3
S. Mississippi	6
S. Muenchen	8
S. Mikawasima	9
S. Nagoya	2
S. Napoli	4
S. New-Haw	3
S. Newington	2
S. Nima	2
S. Ohio	7
S. Oslo	3
S. Panama	7
S. Pomona	2
S. Poona	4
S. Potsdam	2

S. Richmond	2
S. Rissen	8
S. San-Diego	2
S. Schwarzengrund	9
S. Senftenberg	8
S. Sofia	2
S. Stanleyville	2
S. Tennessee	2
S. Uganda	4
S. Wien	2
S. Weltevreden	7
S. Zanzibar	2

One each of the following were received:

S. Agbeni	1
S. Albany	1
S. Amsterdam	1
S. Ardwick	1
S. Arkansas	1
S. Binza	1
S. Bolton	1
S. Brancaster	1
S. Bristol	1
S. Burgas	1
S. Caracas	1
S. Carmel	1
S. Concord	1
S. Diguel	1
S. Durban	1
S. Elomrane	1
S. Eppendorf	1
S. Falkensee	1
S. Fresno	1
S. Hartford	1
S. Havana	1
S. Hindmarsh	1
S. Holcomb	1
S. Javiana	1
S. Johannesburg	1
S. Kintambo	1
S. Kirkee	1
S. Kisangani	1
S. Kua	1
S. Lagos	1
S. Lindern	1
S. Llandoff	1

S. Lome	1
S. Menston	1
S. Miami	1
S. Minnesota	1
S. Natal	1
S. Oakland	1
S. Obogu	1
S. Perth	1
S. Reading	1
S. Ried	1
S. Tel-El-Kebir	1
S. Tokoin	1
S. Wa	1
S. Weybridge	1
S. Wippra	1
S. Zaiman	1
S. Zega	1