







MAIN STORIES THIS WEEK:







-  [New guidance on post exposure prophylaxis for HIV](#)
-  [Avian influenza \(H5N1\) among poultry in south east and east Asia, and humans in Viet Nam and Thailand](#)
-  [The European Parliament has passed legislation creating a European Centre for Disease Prevention and Control](#)
-  [Call for abstracts at the Health Protection Agency Annual Conference 2004](#)

REPORTS BY INFECTION:



Enteric:

-  [General outbreaks of foodborne illness, England and Wales laboratory reports: weeks 01-05/04](#)
-  [Salmonella infections, England and Wales, reports to the HPA \(salmonella data set\): December 2003](#)
-  [Common gastrointestinal infections, England and Wales laboratory reports: weeks 01-05/04](#)
-  [Typhoid and paratyphoid, England and Wales laboratory reports: October to December 2003](#)
-  [Laboratory reports of cases of typhoid and paratyphoid, England and Wales: 1990-2003](#)


HIV/STIs:



-  [HIV and AIDS in the United Kingdom quarterly update: data to end December 2003](#)

CDR SUBSCRIPTION:



-  To subscribe to CDR Weekly, please visit: <<http://www.hpa.org.uk/cdr/contact.htm>>

News

Last updated: **12 February 2004**
Next update due: **19 February 2004**

-  [New guidance on post exposure prophylaxis for HIV](#)
-  [Avian influenza \(H5N1\) among poultry in south east and east Asia, and humans in Viet Nam and Thailand](#)
-  [The European Parliament has passed legislation creating a European Centre for Disease Prevention and Control](#)
-  [Call for abstracts at the Health Protection Agency Annual Conference 2004](#)

New guidance on post exposure prophylaxis for HIV

The Expert Advisory Group on AIDS (EAGA) has recently published revised guidelines (1) on the use of post-exposure prophylaxis (PEP) for HIV following occupational exposure. This document replaces the one issued in July 2000 (2) and can be viewed on the Department of Health's website at <<http://www.advisorybodies.doh.gov.uk/eaga/publications.htm>>.

The most substantial addition to the guidance is a new annex, Annex G, on PEP for patients following possible exposure to an infected health care worker. Such exposures are expected to occur rarely, but the guidance aims to facilitate a consistent approach to management of such incidents. It also serves as a reminder of the responsibilities of health care workers to seek and follow confidential advice on whether they should be tested if they may have been exposed to a blood-borne virus (HIV, hepatitis B, or hepatitis C). The key points raised in the guidance are detailed below.

Key Points:

- Clarification on how and when a source patient should be approached for HIV testing where their status is not known, including obtaining informed consent for testing the sample.
- A change in the antiretroviral drugs recommended for use in PEP starter packs from indinavir to nelfinavir, 1250 mg twice daily (or 750 mg three times a day) along with zidovudine, 250 or 300 mg twice daily and lamivudine, 150 mg twice daily.
- **Prime importance** must always be the prevention of avoidable exposure ([3]).
- Every NHS employer should have a policy on the management of exposures, which ensures **24-hour cover** is available.
- Accurate risk assessment of the incident to identify **significant exposure**, prior to obtaining consent from the source patient for testing.
- The use of PEP is unlikely to be justified in the majority of exposures where the source patient is **unknown**. This decision should be underpinned by a case-by-case risk assessment.
- PEP **should not** be offered if the source is HIV negative, or, following a risk assessment that suggests that the risk of HIV infection is highly unlikely.
- Baseline blood sample from the health care worker should be stored for **two years** and the health care worker should be informed of the retention policy at the time the sample is taken.
- Enhanced surveillance for occupational exposure to blood borne viruses is in operation (4). Occupational health physicians and clinicians involved in the care of exposed health care workers are encouraged to report to the Health Protection Agency's Communicable Disease Surveillance Centre, Colindale, or the Scottish Centre for Infection and Environmental Health (SCIEH).

It is anticipated that this document will also provide a framework for professions outside the health care setting (eg, police, fire service, voluntary aid agencies, armed forces) when they are developing guidance relevant to their own occupational setting.

Guidelines for the provision of PEP following sexual (*ie, non-occupational*) exposure are being prepared by the HIV Special Interest Group of the British Association for Sexual Health and HIV (BASHH).

References

1. Department of Health. *HIV Post-Exposure Prophylaxis: guidance from the UK Chief Medical Officers' Expert Advisory Group of AIDS*. London: Department of Health, 2004. Available at <<http://www.advisorybodies.doh.gov.uk/eaga/publications.htm>>.
2. Department of Health. UK Health Departments. *HIV post-exposure prophylaxis: guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS*. London: Department of Health, 2000.
3. Department of Health. UK Health Departments. *Guidance for clinical health care workers: protection against infection with blood-borne viruses; recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis [HSC 1998/063]*. London: Department of Health, 1998.
4. Health Protection Agency. *Surveillance of Occupational Exposure to Bloodborne Viruses in Health Care Workers*. London: HPA, 2004. Available at: <http://www.hpa.org.uk/infections/topics_az/bbv/bbmenu.htm>.



Avian influenza (H5N1) among poultry in south east and east Asia, and humans in Viet Nam and Thailand

Outbreaks of avian influenza in poultry

Confirmed or suspected outbreaks of avian influenza (H5N1) remain widespread among poultry in China (14/31 provinces, autonomous regions, and municipalities), Thailand (40/76 provinces), and Viet Nam (28/64 provinces). In addition by 11 February 2004, the World Health Organization (WHO) has confirmed outbreaks of avian influenza (H5N1) among poultry in Cambodia, Indonesia, Japan, Laos, and South Korea.

Unconfirmed data from the World Organisation for Animal Health (OIE) indicate that antibodies to influenza A (H5N1) have been found in pigs in Viet Nam. The potential susceptibility of pigs to avian influenza viruses is well known, and OIE is advising countries infected with avian influenza viruses to closely monitor pigs that are in contact with infected birds, and cull those in which the presence of the virus is confirmed. <http://www.oie.int/eng/press/en_last.htm>.

Influenza A (H7) has been reported in a poultry flock in Delaware State in the United States

<http://www.oie.int/eng/info/en_urgences.htm>. This virus appears to be a low pathogenic strain of avian influenza (LPAI), which very rarely transmits to humans and causes severe illness. A flock of 12,000 birds has been culled to prevent further spread of the virus. Avian influenza (H7) has also been reported in Pakistan, and influenza A (H5N2) has been reported in Taiwan. Further information is available at:<http://www.oie.int/download/AVIAN%20INFLUENZA/A_AI-Asia.htm>.

Human cases of avian influenza

Viet Nam and Thailand are the only countries that have reported human cases of infection. As of 10 February 2004, Viet Nam has reported 18 cases, 13 of whom have died, and Thailand has reported five cases, all of whom have died. It is anticipated that human cases will also be detected in other countries where outbreaks in poultry are occurring.

Evidence, to date, suggests that the H5N1 strain is not easily transmitted from poultry to humans. Data also suggest that the virus has not become adapted to be transmitted easily from one human to another. Sequence data from one of the sisters in a family cluster in Viet Nam indicates that the virus was of entirely avian origin, with no human genes. The virus from the second sister is being sequenced this week.

<http://www.who.int/csr/don/2004_02_06/en/>

<http://www.who.int/csr/don/2004_02_09/en/>

The threat of avian influenza A (H5N1) to the United Kingdom remains low at this time. Interim guidelines for the surveillance of suspected human cases of avian influenza are available on the HPA website:

<http://www.hpa.org.uk/infections/topics_az/avianinfluenza/guidelines.htm>.

Updated information is available on the avian influenza topic page of the HPA website:

<http://www.hpa.org.uk/infections/topics_az/avianinfluenza/menu.htm>.



The European Parliament has passed legislation creating a European Centre for Disease Prevention and Control

The European Parliament passed an opinion on 10 February 2004, bringing the new European Centre for Disease Prevention and Control (ECDC) into being (1). This legislation has been fast-tracked since July 2003, when both the European Parliament and Council recognised the importance of having such a centre when the European Commission presented the draft proposal. The opinion still has to be passed by national governments at a European Council meeting to become law.

The European Commissioner for Health and Consumer Protection welcomed the vote, citing the events of the past year with regard to avian influenza and SARS as being strong proof that increased cross-border collaboration and coordination was necessary to enable European countries to be prepared for threats posed by global diseases.

To date, the European cooperation in investigating and controlling disease has been *ad hoc*, although the European Union does have a system for pan-European epidemiological surveillance of infectious disease. The new ECDC will provide the opportunity for substantial reinforcement of the current system, and has the backing of the state epidemiologists from member states <http://europa.eu.int/comm/health/ph_overview/strategy/ecdc/ecdc_en.htm>.

It will enable Europe to coordinate and mobilise its considerable disease control expertise efficiently and systematically, and improve effective communication to national governments and public health authorities.

There are already many Europe-wide disease surveillance systems and networks in existence, and the ECDC will make use of the expertise and working relationships already established. The initial focus of the Centre will be communicable disease and outbreaks of diseases of unknown origin as well as monitoring and preparedness planning against bioterrorist attacks. After three years of operation, the focus may widen to include other public health activities, such as health monitoring.

The ECDC is on track to begin functioning in 2005, and work is underway to select a management board. The Centre will be based in Sweden (2), although a precise location is yet to be announced.

References

1. EUROPA (portal site of the European Union). 'EU will be better prepared for future epidemics' says Byrne as Parliament backs new health agency. (press release) IP/04/190. EUROPA, 10 February 2004. Available at <[http://europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=IP/04/190\[0\]RAPID&lg=EN&display=>](http://europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=IP/04/190[0]RAPID&lg=EN&display=>)>.
2. Von Holstein I. Ministers decide the ECDC shall be in Sweden and the EFSA in Italy. *Eurosurveillance Weekly* [serial online] 2003 [cited 12 February 2004]; 7(11). Available at <<http://www.eurosurveillance.org/ew/2003/031218.asp>>.

Call for abstracts at the Health Protection Agency Annual Conference 2004

Abstract submissions for oral and poster presentations at the Health Protection Agency Annual Conference 2004 are invited from 12 February. These presentations will form an important element of the conference, and provide researchers with a prestigious opportunity to bring their projects to the attention of a wide audience within health protection and public health.






Abstracts are invited that fit topics within the main themes of the Conference (Children's Health, International Health, and Risk Communication) and other selected categories, which reflect the scope of the HPA including Environmental, Epidemiology, Medical Treatment and Control Strategies, Methodologies, and Surveillance.

For full details about abstract submission (**before 22 April**), please visit <<http://www.hpaconference.org.uk>>.

Enteric

Last updated: 12 February 2004

Next update due: 11 March 2004

-  [General outbreaks of foodborne illness, England and Wales laboratory reports: weeks 01-05/04](#)
-  [Salmonella infections, England and Wales, reports to the HPA \(salmonella data set\): December 2003](#)
-  [Common gastrointestinal infections, England and Wales laboratory reports: weeks 01-05/04](#)
-  [Typhoid and paratyphoid, England and Wales laboratory reports: October to December 2003](#)
-  [Laboratory reports of cases of typhoid and paratyphoid, England and Wales: 1990-2003](#)

General outbreaks of foodborne illness, England and Wales laboratory reports: weeks 01-05/04

Health Protection Unit	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
Wales	S. Enteritidis PT 1C	Restaurant	December	4	4	None	-
Kensington & Chelsea	S. Enteritidis PT6A PT6D	Restaurant	December	>5	5	Eggs	M

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

Details of serotypes, of 625 salmonella infections recorded in December 2003, are given in the adjacent table. In January 2004, 200 salmonella infections were recorded and preliminary information was received about two outbreaks (see above table).

Total <i>Salmonella</i> (provisional data)	Dec 03
	625
S.Enteritidis (PT4)	381
S.Enteritidis (other PTs)	85
S.Typhimurium	83
S.Virchow	13
Others (typed)	148

* Data provisional

Common gastrointestinal infections, England and Wales laboratory reports: weeks 01-05/04



Laboratory reports	Number of reports received					Total reports 01-05/04	Cumulative total to	
	01/04	02/04	03/04	04/04	05/04		05/04	05/03
<i>Campylobacter</i>	485	523	459	324	274	2065	2065	3185
<i>Escherichia coli</i> O157*	–	2	2	1	2	7	7	10
<i>Salmonella</i>†	88	108	50	17	10	273	273	735
<i>Shigella sonnei</i>	5	20	4	1	0	30	30	47
Rotavirus	61	78	99	118	93	449	449	1278
Norovirus	10	27	20	8	6	71	71	448
<i>Cryptosporidium</i>	32	48	22	29	11	142	142	166
<i>Giardia</i>	36	46	49	27	11	169	169	284

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

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



Typhoid and paratyphoid, England and Wales: laboratory reports, October to December 2003

Organism and phage type	Number of cases	Infection acquired abroad			Excretors and carriers
		Yes	No	Not reported	
S. Typhi					
A	2	2	–	–	–
B1	4	2	–	2	–
B2	4	–	–	4	–
D1	3	3	–	–	–
E1	19	12	–	7	–
E3	2	2	–	–	–
M1	1	1	–	–	–
O	1	1	–	–	–
56	1	–	–	1	–
Degraded	1	1	–	–	–
Untypable Vi	1	1	–	–	–
Untypable Vi-1	1	–	–	1	–
S. Paratyphi A					
1	9	4	–	5	–
1A	6	5	–	1	–
2	1	–	–	1	–
3	1	–	–	1	–
4	4	2	–	2	–
13	10	8	–	2	–
Untypable	1	–	–	1	–
S. Paratyphi B					
Taunton	3	1	–	2	–
1 var 1	2	–	–	2	–
3a1 var 1	2	1	–	1	–

Forty cases of *Salmonella* Typhi infection were reported in the fourth quarter of 2003. Twenty-five cases were infected abroad (Indian subcontinent 21, Ghana 2, Nigeria 1, Abroad country unspecified 1). In 15 cases the country of infection was not stated.

Thirty-two cases of *S. Paratyphi A* infection were reported. Nineteen were infected abroad (all Indian subcontinent). In 13 cases the country of infection was not stated.

Seven cases of *S. Paratyphi B* were reported. Two cases acquired their infection abroad (Indian subcontinent 1, Turkey 1). In five cases the country of infection was not stated.

**Laboratory reports of cases of typhoid and paratyphoid, England and Wales: 1990-2003**

Year	S. Typhi	S. Paratyphi A	S. Paratyphi B
1990	184 (166)	75 (73)	32 (14)
1991	132 (118)	79 (77)	12 (8)
1992	198 (177)	104 (100)	21 (15)
1993*	173 (144)	118 (108)	15 (11)
1994	227 (201)	180 (168)	37 (27)
1995	265 (196)	153 (113)	17 (12)
1996	179 (116)	116 (88)	35 (19)
1997	134 (96)	130 (91)	37 (14)
1998	134 (85)	156 (109)	28 (6)
1999	153 (94)	149 (106)	44(30)
2000	165 (105)	137 (92)	17 (9)
2001	170 (96)	219(148)	17(10)
2002	138 (94)	137 (92)	11 (6)
2003†	201 (111)	219 (148)	21 (9)

*Active ascertainment of travel details ceased in 1993.

†Provisional.

Infections acquired abroad are shown in brackets and are included in the total.

HIV / STIs

Last updated: 12 February 2004

Next update due: 27 May 2004

 HIV and AIDS in the United Kingdom quarterly update: data to end December 2003

 HIV and AIDS in the United Kingdom quarterly update: data to end December 2003

United Kingdom (UK) data from the Health Protection Agency Communicable Disease Surveillance Centre (CDSC), Scottish Centre for Infection and Environmental Health, Institute of Child Health, London.

One thousand six hundred and sixty-nine reports of new HIV diagnoses were received in the last quarter of 2003, bringing the total for the United Kingdom (UK) HIV dataset to 61,179 diagnoses since reporting began in 1982. Thirty-three per cent (20,096) of the total have been diagnosed with an AIDS defining condition, of which 12,839 (21% of total) have died. A further 2762 (4.5% of the total) individuals have died without being reported with AIDS.

To date, there have been 5047 new diagnoses reported for 2003. If reporting delay is the same as in previous years it is estimated that this will rise to over 7000 new diagnoses for the full year. The 5047 diagnoses represent an increase of 20% on the equivalent diagnoses at the same time last year (4204). Of diagnoses made in 2003 55% (2785/5047) were acquired through sex between men and women, 28% (1414/5047) through sex between men, 1.5% (75/5047) through injecting drug use, and 2.4% (109/5047) through other routes. Six hundred and sixty-four reports (13%) are awaiting further follow-up to determine probable route of infection (334 males and 330 females) (table 1). The difference between the number of males and females reported as being infected through sex between men and women has further increased, and the ratio is now 1:1.9 (males to females; 958:1827). The proportion of females diagnosed continues to rise slowly, accounting for 44% (2237/5047) of all diagnoses in 2003. Eighty-nine individuals (2%) reported were probably infected through mother-to-child transmission.

Table 1 New diagnoses of HIV in the UK by infection route, sex and year of diagnosis: data to the end of December 2003

How infection was probably acquired	Sex	<1993	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002*	2003*	Total
Sex between men	M	14,435	1507	1484	1474	1548	1405	1364	1357	1502	1747	1749	1414	30,986
Sex between men and women	M	1424	357	353	389	358	451	518	597	756	1063	1267	958	8491
	F	1608	416	442	465	479	556	640	831	1244	1803	2152	1827	12,463
Injecting drug use	M	1690	151	122	123	119	121	96	77	70	96	81	52	2798
	F	805	53	46	59	54	47	35	35	39	35	25	23	1256
Blood transfusion or blood factor products	M	1409	9	9	12	10	16	4	10	9	14	12	9	1523
	F	108	8	8	8	11	13	6	11	15	11	16	9	224
Mother to infant	M	91	26	34	32	29	48	45	40	53	48	46	43	535
	F	85	40	31	29	33	32	49	42	49	34	54	46	524
Other	M	7	2	2	2	2	1	2	6	3	7	2	–	36
	F	11	2		2	1	–	2	2	3	–	4	2	29
Undetermined	M	477	43	37	50	43	36	42	49	57	101	224	334	1493
	F	58	13	8	8	9	13	17	16	31	53	222	330	778
Total†		22,208	2627	2576	2653	2696	2739	2820	3073	3831	5012	5854	5047	61,136

*Numbers will rise as further reports are received.

†Excluded 43 people whose sex was not reported: seven infected through sex between men and women, three blood recipients, two infected through mother-to-infant transmission, and 31 for whom the likely route of infection is not known.

Table 2 presents a breakdown of diagnoses where probable route of infection was through sex between men and women. Reports for 2003 show that less than 1% (23/2785) of individuals infected through heterosexual intercourse had a high-risk partner, ie, a partner infected through sex between men, injecting drug use, or infected blood or blood factor. This proportion has declined throughout the epidemic. Eighty-three per cent (2298/2785) of individuals probably infected through heterosexual intercourse were reported as infected by partners who had also been infected

through heterosexual intercourse. Of these individuals, 80% (1846/2298) were probably infected in Africa, with 8.5% (196/2298) infected abroad in other countries. Eleven per cent (254/2298) were probably infected in the UK, of whom 46% (116/254) were infected by partners who had been infected outside Europe, while 20% (50/254) had been infected by partners infected within Europe (including the UK). The remainder (88/254) were infected by partners whose country of infection is as yet, unknown. Follow-up over the coming year will result in the re-categorisation of many of these individuals.

Table 2 New Diagnoses of HIV in those infected through sex between men and women by year of diagnosis: data to the end of December 2003

How HIV was probably acquired		<1993	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002*	2003*	Total	
Exposure to 'high risk' partner(s)	Sexual Intercourse between men	109	24	21	12	11	10	12	12	13	25	19	7	275	
	Injecting drug use	199	37	32	41	33	49	48	25	23	37	19	14	557	
	Blood factor treatment (eg, for haemophilia)	65	2	2	3	6	1	1	1	1	–	1	2	85	
	Blood/tissue transfer (eg, transfusion)	10	3	–	1	3	5	3	4	1	4	2	–	36	
Exposure to presumed heterosexually infected partner(s)	Exposure abroad	Africa	1940	509	532	560	552	642	747	998	1495	2190	2554	1846	14,565
		Latin America/Caribbean	62	24	27	14	24	30	32	64	68	84	121	75	625
		Asia	66	28	18	39	44	53	79	76	109	98	101	84	795
		North America	56	16	9	8	8	10	15	7	6	9	6	2	152
		Europe	127	38	36	43	42	50	42	50	46	45	51	32	602
		Australasia	6	2	–	2	1	2	4	6	2	5	2	3	35
		country(ies) not known	23	–	–	2	7	3	15	–	2	–	–	2	54
Exposure in the UK to partner(s) presumed infected	outside Europe	91	17	38	48	42	72	83	90	135	166	177	116	1075	
	within Europe	103	41	43	38	29	40	40	45	48	52	34	50	563	
	country(ies) not known	156	29	30	33	28	30	25	29	24	51	91	88	614	
Partners exposure category undetermined:	investigation continuing	3	1	3	3	3	2	9	18	23	99	238	464	866	
	investigation closed	21	2	4	7	4	8	4	4	4	1	3	0	62	
Total		3037	773	795	854	837	1007	1159	1429	2000	2866	3419	2785	20,961	

* Numbers will rise as further reports are received.

Table 3 New diagnoses of HIV infection by country and region where diagnosed and year of diagnosis: data to the end of December 2003

Country and region of diagnosis	<1993	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002*	2003*	Total
England													
North East	369	22	32	21	24	34	22	30	36	53	90	107	840
Yorkshire & Humberside	721	79	65	81	90	82	85	92	98	180	293	269	2135
East Midlands	421	67	57	52	48	44	61	84	101	195	249	257	1636
East of England	551	86	61	78	55	76	85	96	186	310	471	421	2476
London	13,408	1632	1584	1684	1707	1722	1762	1950	2329	2766	2787	2261	35,592
South East	1805	222	233	169	226	215	205	216	352	489	661	608	5401
South West	725	67	108	87	77	91	104	102	103	134	175	161	1934
West Midlands	693	82	75	98	63	99	107	101	178	211	400	247	2354
North West	1267	147	147	179	187	149	187	207	235	423	405	385	3918
England (total)	19,960	2404	2362	2449	2477	2512	2618	2878	3618	4761	5531	4716	56,286
Wales	331	41	46	46	36	44	31	34	46	65	76	82	878
Northern Ireland	109	12	14	12	16	9	9	14	19	19	24	22	279
Scotland	1814	169	147	147	161	167	157	148	147	160	216	224	3657
UK Total	22,214	2626	2569	2654	2690	2732	2815	3074	3830	5005	5847	5044	61,100
Channel Islands/ Isle of Man	29	2	8	1	6	8	6	1	1	7	7	3	79
Total diagnoses†	<1993	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
HIV diagnoses	22,243	2628	2577	2655	2696	2740	2821	3075	3831	5012	5854	5047	61,179
AIDS diagnoses	7764	1786	1853	1769	1436	1073	784	747	813	704	807	560	20,096
Deaths‡	5441	1563	1700	1719	1462	735	507	469	477	471	400	414	15,601

* Numbers will rise as further reports are received.

†Includes diagnoses in Channel Islands and Isle of Man.

‡Total includes 243 deaths where year of death is not known (including all deaths in children).