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-  [HPA develops faster test to detect tetanus in heroin](#)
-  [Dengue fever in Indonesia](#)



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## News

Last updated: **11 March 2004**  
Next update due: **18 March 2004**

-  [Tuberculosis surveillance: notifications and enhanced surveillance](#)
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### Tuberculosis surveillance: notifications and enhanced surveillance

Surveillance for new cases of tuberculosis in England and Wales employs two different reporting systems: statutory Notification of Infectious Disease (NOIDS) and Enhanced Tuberculosis Surveillance (ETS). Since 1912, it has been a statutory legal requirement in England and Wales to notify all cases of clinically diagnosed tuberculosis through NOIDS to ensure that all cases and their contacts are managed appropriately, and to contribute to local and national surveillance. ETS was established in 1999 with the specific aim of providing more detailed and comparable information on the occurrence of tuberculosis in England and Wales.

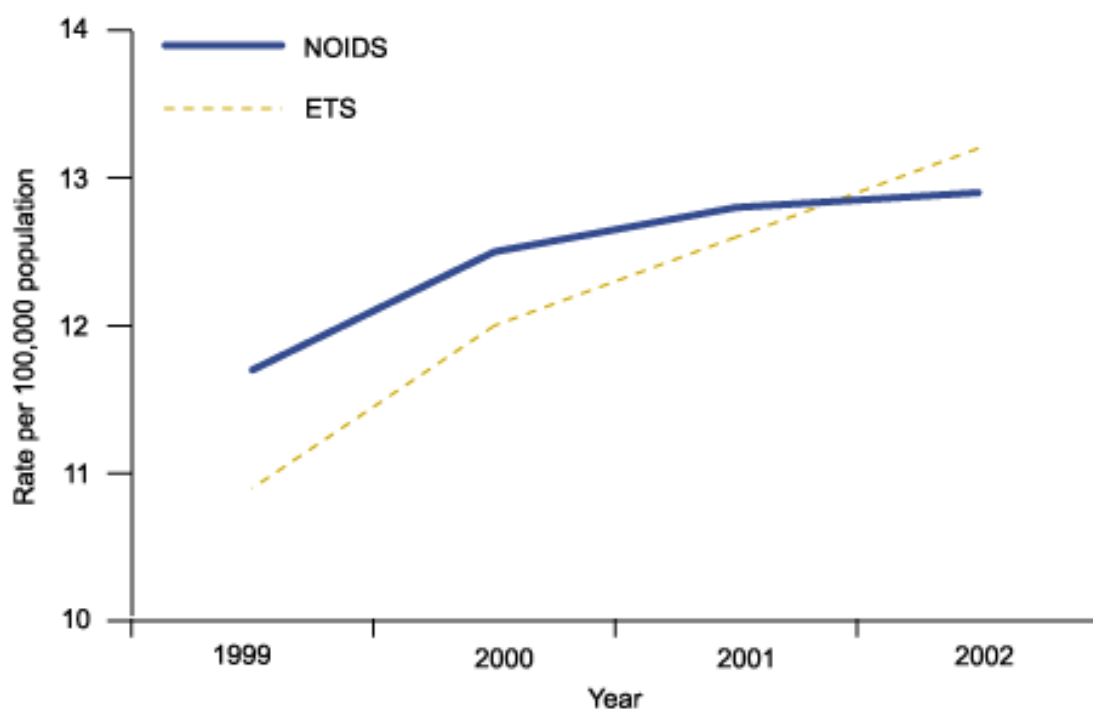
Following the introduction of ETS, the number of formally notified cases has generally exceeded the number of cases reported through ETS. Notifications include some cases subsequently found not have tuberculosis (some of which are de-notified) and some duplicate reports. The ETS system is able to exclude such reports and provide a more precise estimate of the true incidence of tuberculosis in England and Wales. At present, data from the ETS system are only available 12 months or more after the year of report. The more rapidly available notification data provides a useful preliminary estimate of case numbers. Work is currently underway to revise the ETS system to ensure more timely availability of data at local and national levels.

Case numbers reported in ETS system in 2002 exceeded notifications (table 1) for the first time. The apparent decline in cases reported through NOIDS is not uniform across the country and is most likely to be attributable to changes in surveillance practice at local level. In some areas, electronic reporting systems linked to the ETS system have been associated with reduced reporting of cases through NOIDS. In the light of these observations, recent trends in tuberculosis based on NOIDS data should be interpreted with caution. Provisional ETS data for 2002 demonstrate that overall tuberculosis case numbers continue to increase in England and Wales. Further work is being carried out to investigate recent trends in more detail.

**Table 1 NOIDS vs ETS national comparison of cases reported from 1999 to 2002**

Year	NOIDS	ETS
1999	6143	5704
2000	6572	6271
2001	6714	6597
2002	6752	6907*

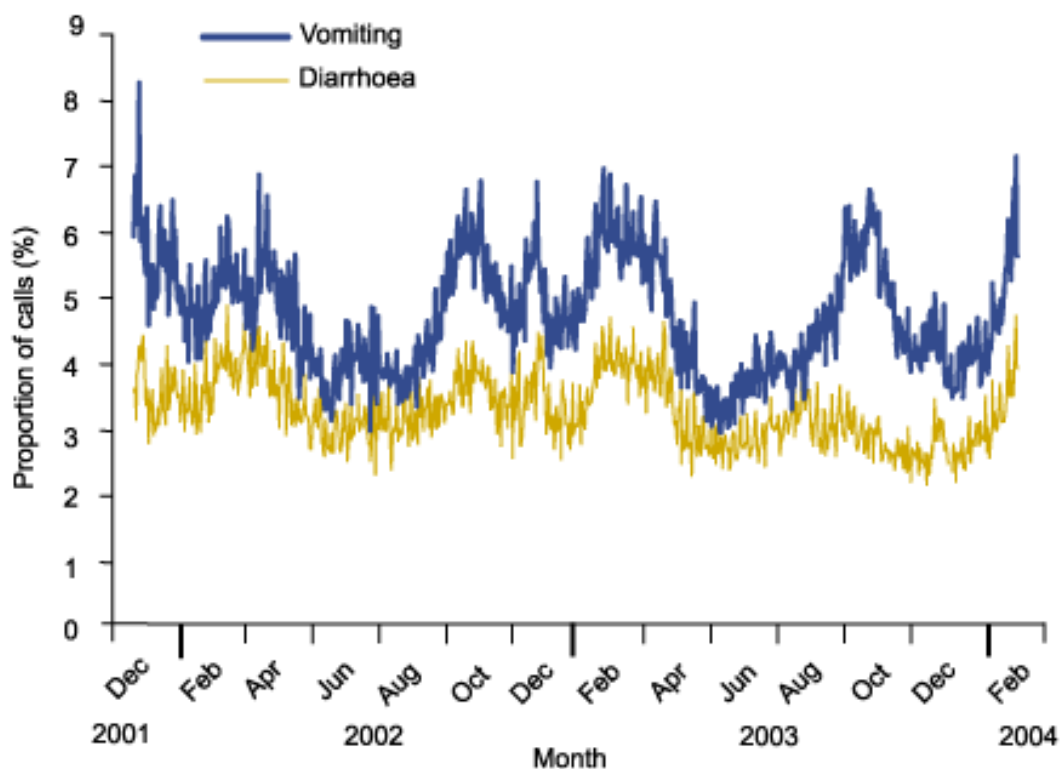
\* preliminary data

**Figure 1 NOIDS vs ETS national comparison of cases reported by rate per 100,000 population from 1999 to 2002**

## An increase in calls to NHS Direct about vomiting and diarrhoea during February/March 2004

During February 2004 there was a gradual increase in the proportions of NHS Direct calls made about vomiting and diarrhoea. This increase accelerated during the first week of March (week 10/04: vomiting increased to 6% of total calls, diarrhoea to 3.8%). Similar rises have occurred at the same time over the last two years. During week 10, the proportions of vomiting calls were 5.1% (2002) and 6% (2003), and diarrhoea 3.9% (2002 and 2003) (figure1).

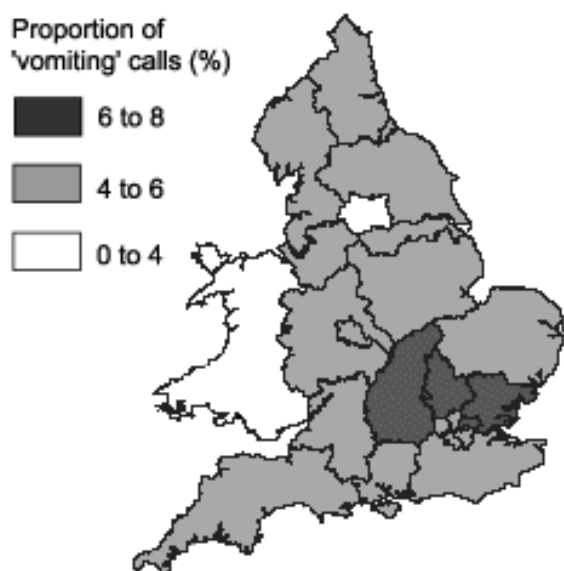
**Figure 1 Proportion of daily vomiting and diarrhoea calls in England and Wales (all ages)**



The largest increases in vomiting and diarrhoea calls have been noted for calls made about children aged under five years. For week 10/2004, the proportions of calls about those aged under one year were 17% for vomiting and 12.6% for diarrhoea: for those between aged between one and four years the proportions were 14.9% for vomiting and 7.1% for diarrhoea. These proportions are similar to the equivalent week during 2003, the only year for which there are comparable data.

During the first week of March 2004, statistically significant daily excesses ('exceedances') of vomiting calls occurred predominantly at NHS Direct sites in the South and South East of England (figure 2). These increases in the proportions of vomiting and diarrhoea calls coincide with an increase in the reports of norovirus outbreaks from across the country.

**Figure 2 Proportion of vomiting calls by NHS Direct site (all ages): week 09/2004**





## HPA develops faster test to detect tetanus in heroin

The Health Protection Agency has developed a laboratory test that could speed up the process of examining samples of heroin for *Clostridium tetani*. In trials so far, the new test has enabled detection of *C. tetani* in heroin samples within hours. This is substantially quicker than conventional laboratory methods, which can take three days.

Faster detection would enable rapid identification of the source of tetanus outbreaks in injecting drug users, so that action could be taken earlier to stop current outbreaks and prevent more people from becoming ill.

The test was developed during the investigation of the ongoing outbreak of tetanus among injecting drug users (1).

### References

1. HPA. Ongoing national outbreak of tetanus in injecting drug users. *Commun Dis Rep CDR Wkly* [serial online] 2004 [cited 11 March 2004]; 14(9): news. Available at <<http://www.hpa.org.uk/cdr/PDFfiles/2004/cdr0904.pdf>>.



## Dengue fever in Indonesia

The Ministry of Health in Indonesia reported 23,857 cases of dengue fever (including 367 deaths) between 1 January and 3 March 2004 (1). The majority of dengue cases have been reported from the islands of Java (all provinces), south Kalimantan region of Borneo, south Sulawesi, Bali, east and west Nusa Tenggara, and Aceh (northern Sumatra). Den-3 is the predominant serotype circulating, but all four serotypes (Den-1, Den-2, Den-3, and Den-4) are present.

Indonesia has traditionally been a popular destination for British travellers, although at the present time the Foreign and Commonwealth Office in the United Kingdom advises against all non-essential travel to Indonesia, and all travel to Aceh and Poso district in central Sulawesi, due to a high general threat from terrorism in the country. Further information and advice regarding the security situation Indonesia can be found on the FCO website (2).

Travellers who do visit Indonesia, in addition to exercising extreme caution in terms of security, should practise insect bite avoidance during the day, particularly around dawn and dusk, when the *Aedes* mosquito vector is most active. Information sheets about dengue fever and insect bite avoidance for travellers and health professionals are available from the National Travel Health Network and Centre (NaTHNaC) website (3).

Dengue fever has been endemic in Indonesia since the 17th century, but the more severe form dengue haemorrhagic fever (DHF) was first reported in Surabaya and Jakarta in 1968 (4). Dengue fever tends to occur in cycles and since 1980 large outbreaks have occurred every three or four years according to DengueNet figures (5). In response to this outbreak, the Indonesian Ministry of Health is conducting mosquito control measures with intensive insecticide spraying, and the World Health Organization is assisting with the laboratory diagnosis of disease.

### References

1. World Health Organization. Dengue fever in Indonesia – update [online] 5 March 2004. Geneva: WHO, 2004 [cited 9 March 2004]. Available at <[http://www.who.int/csr/don/2004\\_03\\_05/en/](http://www.who.int/csr/don/2004_03_05/en/)>.
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3. The National Travel Health Network and Centre (NaTHNaC) website. London: NaTHNaC, 2003. Available at <<http://www.nathnac.org>>.
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5. World Health Organization. DengueNet. Geneva: WHO, 2002. Available at <<http://rhone.b3e.jussieu.fr/DengueNet/>>.

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**Enteric**

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-  [Salmonella serotypes recorded in the Health Protection Agency salmonella data set: October to December 2003](#)

### General outbreaks of foodborne illness, England and Wales laboratory reports: weeks 06-09/04

Health Protection Unit	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
East Midlands	S. Enteritidis	Restaurant	February	23	23	Chicken	M*
East Midlands	S. Enteritidis PT14b	Restaurant	February	>7	>7	Egg	M
Tees	Campylobacter	Hospital	January	7	7	None	–

\* 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

### Salmonella infections (faecal specimens), England and Wales reports to the HPA (salmonella data set\*): January 2004

Details of serotypes, of 314 salmonella infections recorded in January 2004 are given in the table below .

Total <i>Salmonella</i> (provisional data)	Jan 04
	<b>314</b>
S.Enteritidis (PT4)	76
S.Enteritidis (other PTs)	126
S.Typhimurium	45
S.Virchow	7
Others (typed)	60

\* Data provisional

**Common gastrointestinal infections, England and Wales laboratory reports: weeks 06-09/04**

Laboratory reports	Number of reports received				Total reports 06-09/04	Cumulative total to	
	06/04	07/04	08/04	09/04		09/04	09/03
<b><i>Campylobacter</i></b>	623	544	463	260	<b>1890</b>	<b>4565</b>	<b>5654</b>
<b><i>Escherichia coli</i> O157*</b>	4	1	6	2	<b>13</b>	<b>20</b>	<b>16</b>
<b><i>Shigella sonnei</i></b>	12	12	3	–	<b>27</b>	<b>67</b>	<b>98</b>
<b>Rotavirus</b>	195	281	319	299	<b>1094</b>	<b>1706</b>	<b>4402</b>
<b>Norovirus</b>	18	20	15	11	<b>64</b>	<b>162</b>	<b>862</b>
<b><i>Cryptosporidium</i></b>	42	40	21	18	<b>121</b>	<b>316</b>	<b>333</b>
<b><i>Giardia</i></b>	59	40	41	19	<b>159</b>	<b>398</b>	<b>476</b>

\* 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



## General outbreaks of foodborne illness in humans, England and Wales quarterly report: July to September 2003

Health Protection Unit	Organism	Location of food prepared or served	Number ill	Cases positive	Suspect vehicle	Evidence*
National	S. Bareilly	National	128	128	Pre-packed sandwiches	S
Berkshire	S. Enteritidis PT1	School	24	24	None	–
Bedfordshire	S. Enteritidis PT1	Restaurant	2	2	Egg fried rice	M
Wales	S. Enteritidis PT1	Restaurant	4	4	None	–
County Durham	S. Enteritidis PT1	Restaurant	3	3	Eggs	D
South and West Devon	S. Enteritidis PT4	College	12	12	Rice salad, coleslaw	M
Leeds	S. Enteritidis PT4	Residential Institution	6	6	Eggs	D
Norfolk	S. Enteritidis PT4	Public House	4	4	Eggs	D
Humber	S. Enteritidis PT6	Retailer	11	11	Vanilla slices	M
Gloucestershire	S. Enteritidis PT6	Retailer	15	15	Eggs	M
Humber	S. Enteritidis PT6	Residential Institution	4	4	Eggs	–
Berkshire	S. Enteritidis PT6A	Restaurant	2	2	None	–
Suffolk	S. Enteritidis PT8	Hospital	12	12	Made up milk drinks	–
Cornwall and Isles of Scily	S. Enteritidis PT14B	Restaurant	13	13	Eggs, chicken	M
South and West Devon	S. Enteritidis PT14B	Restaurant	23	11	None	–
South and West Devon	S. Enteritidis PT14B	Restaurant	8	8	None	–
Cornwall and Isles of Scily	S. Enteritidis PT14B	Café	18	18	Eggs	D
Essex	S. Enteritidis PT14B	Restaurant	14	14	Eggs	–
Tees	S. Enteritidis PT 24	Restaurant	10	10	Salad	D
South Yorkshire	S. Enteritidis PT53	Restaurant	3	3	None	–
National	S. Typhimurium U277	National	103	103	None	–

\* 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.

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## Salmonella serotypes recorded in the Health Protection Agency salmonella data set: October to December 2003



All serotypes recorded in the Health Protection Agency salmonella data set in the fourth quarter of 2003 are listed below. There were more than ten reports of 19 serotypes, two to ten reports of 54 serotypes, and one report of 46 serotypes

	October to December 2003 (provisional)
S. Agona	24
S. Anatum	11
S. Blockley	14
S. Braenderup	30
S. Corvallis	13
S. Enteritidis	2230
S. Hadar	37
S. Infantis	32
S. Java	18
S. Kentucky	18
S. Mbandaka	14
S. Newport	28
S. Saint-Paul	15
S. Stanley	28
S. Thompson	14
S. Typhimurium	442
S. Virchow	51
S. Unnamed	40
S. Weltevreden	12

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

S. Aberdeen	2
S. Abony	8
S. Agama	5
S. Ajiobo	3
S. Alachua	2
S. Albany	2
S. Arizonae	3
S. Altona	4

S. Bareilly	10
S. Bovis-Morbificans	6
S. Brandenburg	7
S. Bredeney	10
S. Chailey	2
S. Chester	2
S. Coeln	2
S. Colindale	5
S. Cubana	2
S. Derby	7
S. Dublin	5
S. Durban	3
S. Emek	4
S. Gold-Coast	4
S. Haifa	5
S. Havana	2
S. Heidelberg	10
S. Hessarek	3
S. Hull	2
S. Ibadan	2
S. Indiana	3
S. Javiana	2
S. Kedougou	7
S. Kottbus	6
S. Litchfield	2
S. Livingstone	8
S. London	3
S. Manhattan	8
S. Mikawasima	4
S. Mississippi	5
S. Montevideo	10
S. Muenchen	4
S. Ohio	7
S. Oranienburg	9
S. Oslo	4
S. Meleagridis	2
S. Panama	4
S. Poona	4
S. Reading	3
S. Schwarzengrund	7
S. Senftenberg	6
S. Stanleyville	5
S. Tel-El-Kebir	2
S. Tennessee	2
S. Uganda	7
S. Wien	3

One report of each of the following serotypes were received:

S. Adelaide	1
S. Augustenborg	1
S. Banana	1
S. Bargny	1
S. Bechuana	1
S. Bousso	1
S. Brazzaville	1
S. Budapest	1
S. Butantan	1
S. Cannstatt	1
S. Cerro	1
S. Chandans	1
S. Chittagong	1
S. Cholerae-Suis	1
S. Curacao	1
S. Degania	1
S. Duesseldorf	1
S. Durham	1
S. Eastglam	1
S. Eimsbuettel	1
S. Hvittingfoss	1
S. Istanbul	1
S. Kiambu	1
S. Kisarawe	1
S. Lerum	1
S. Lindern	1
S. Miami	1
S. Muenster	1
S. Nairobi	1
S. Napoli	1
S. New-Haw	1
S. Newington	1
S. Ngozi	1
S. Nima	1
S. Oxford	1
S. Pakistan	1
S. Richmond	1
S. Rissen	1
S. Rubislaw	1
S. Sofia	1
S. Tyresoe	1
S. Umbilo	1
S. Vitkin	1
S. Westphalia	1
S. Worthington	1
S. Zanzibar	1

## Diary

Last updated: 11 March 2004

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[Medical guide to bioterrorist and related threats – Bristol, 30 April 2004](#)



### Medical guide to bioterrorist and related threats – Bristol, 30 April 2004

An introductory course designed for Medical Microbiologists, Biomedical Scientists, and Infection Control Specialists focusing on potential biological weapon agents, their clinical presentation, and treatment is taking place at the Ramada Plaza, Bristol, 30 April 2004.

An overview of chemical and radiological threats will also be presented along with incident management guidelines. The programme includes interactive sessions involving a panel of national experts. The audience is invited to participate in real time, to influence discussions surrounding various scenarios.

This course is sponsored by the Emergency Response Division of the Health Protection Agency (HPA) and is provided **FREE** of charge to HPA and NHS employees. Places are limited and will be allocated on a first come first served basis.

This course is organised by Strategic Response Capability (SRC) Training Group, HPA, Porton Down. Please register by contacting SRC Training with Full Contact Details: title, name, occupation, work address, phone, fax, and email address to: <[src.training@hpa.org.uk](mailto:src.training@hpa.org.uk)>.

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