



CDR WEEKLY

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News

Last updated: **1 April 2004**
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-  [Mandatory surveillance of surgical site infections in orthopaedic surgery](#)
-  [Tonsillectomy, the use of diathermy, and variant CJD – interim guidance from NICE](#)

Mandatory surveillance of surgical site infections in orthopaedic surgery

The mandatory surveillance of surgical site infection (SSI) in orthopaedic surgery announced by the Chief Medical Officer in June 2003 (1) commences in 1 April and represents the next phase of Department of Health initiatives for monitoring healthcare-associated infections (HCAI) (2). Surveillance of HCAI was highlighted as a priority for action in *Getting Ahead of the Curve* (3). This surveillance is being co-ordinated by the Health Protection Agency's Healthcare-associated Infection and Antimicrobial Resistance Department within the Communicable Diseases Surveillance Centre (CDSC), Colindale. The surveillance system builds on previous experience of SSI surveillance in England, with modifications taking account of recommendations from a sub-group of the Department of Health's Healthcare Associated Infection Surveillance Steering Group. The initiative has been discussed with representatives of the British Orthopaedic Association (BOA), and an announcement about the mandatory SSI surveillance has been made in the spring issue of the BOA newsletter.

All hospitals where orthopaedic surgery is performed are expected to carry out a minimum of three months surveillance in at least one of the four orthopaedic categories – total hip replacements, knee replacements, hip hemiarthroplasties, or open reductions of long bone fractures. Individual reports for each participating hospital will be provided at the end of each surveillance period and data shared with the relevant regional epidemiology unit. A key objective of the surveillance is to enable hospitals to use data on their rates of SSI to inform local practice, and guide the review or change of practice where results indicate these may be necessary to improve the quality of care. This flexible approach should enable hospitals to balance the requirements of the surveillance with local resources and priorities. Hospitals can choose to collect data continuously if they prefer and are advised to collect for longer periods if their throughput of procedures is too small to obtain meaningful results in a single quarter. It is important that there is clinical ownership of this surveillance, and infection control teams are encouraged to liaise with orthopaedic colleagues about progressing it.

An innovative development of the surveillance service is the option to submit data via a web link. This enables errors in the data to be detected and corrected automatically at the time of submission and should greatly enhance the efficiency of data transfer. Unlike many other forms of surveillance for infections, data for SSI surveillance is not routinely available. Standard case definitions and surveillance methodology are essential to enable comparable rates to be produced and these are described in a comprehensive surveillance protocol, which will be published in April 2004. Training on the surveillance system is provided by the SSI surveillance system team. Hospitals wishing to register with the SSI Surveillance Service, find out more about the scheme, or to pre-register for a copy of the surveillance protocol should contact the SSI team at: email <ssi@hpa.org.uk> or tel: 020 8200 6868 ext 4240.

References

1. Department of Health. *CMO to step up fight against hospital infections. (press release) 2003/0222*. London: Department of Health, Monday 9 June 2003. Available at <http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleases/Notices/fs/en?CONTENT_ID=4047130&chk=6M5jVP>.
2. Public Health Laboratory Service (PHLS). Activation of next phase of the healthcare associated infection. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 30 Mar 2004]; **13**(24): News. Available at <<http://www.hpa.org.uk/cdr/PDFfiles/2003/cdr2403.pdf>>.
3. Department of Health. *Getting Ahead of the Curve: a strategy for combating infectious diseases (including aspects of health protection)*. London: Department of Health, 2002. Available at: <<http://www.doh.gov.uk/cmo/idstrategy/idstrategy2002.pdf>>.



Tonsillectomy, the use of diathermy, and variant CJD – interim guidance from NICE

The National Institute for Clinical Excellence (NICE) has issued interim guidance stating that surgeons who use diathermy in tonsillectomies should consider changing the way they operate so that they minimise their use of diathermy during tonsillectomies. The risk of complications may also be higher with currently available disposable diathermy equipment for tonsillectomy and, again, surgeons should consider discontinuing their use. Diathermy involves using a high-frequency electrical current that passes through an area of the body to produce heat to remove tonsils and/or to seal up the area where tonsils are removed. The interim guidelines are available at <http://www.nice.org.uk/pdf/diathermytonsillectomyinterimguidance.pdf>.

NICE has been asked by the Chief Medical Officers of England, Scotland, and Northern Ireland to urgently review the use of diathermy in tonsillectomy. This follows an interim analysis of the results of the National Prospective Tonsillectomy Audit in England and Northern Ireland carried out since July 2003 by the British Association of Otorhinolaryngologists Head and Neck Surgeons (ENT UK) and the Clinical Effectiveness Unit of The Royal College of Surgeons of England (CEU-RCS). The audit was established to investigate the occurrence of haemorrhages and other complications after tonsillectomy, as well as the risk factors that may be involved including the type of instruments used, surgical techniques, surgical experience, and patient factors.

The results of the audit suggest that there are higher risks of secondary haemorrhage requiring readmission and return to theatre after tonsillectomy using diathermy techniques or coblation, compared with techniques that use no diathermy either for dissection or for sealing the blood vessels (the 'cold steel' technique). It is this that has led to the issuing of interim guidelines.

NICE has also been asked by the Chief Medical Officers to develop guidance on the best technique for reducing any possible risks of variant Creutzfeldt-Jakob Disease (vCJD) transmission, while minimising the surgical complications of tonsillectomy. Data from national audits will inform this guidance, and ear, nose, and throat surgeons should continue to collect information about patients who have tonsillectomies (provided that the patient agrees) and this data should be included in such audits.

In January 2001, the Department of Health (DH) had recommended that single-use instruments should be used for adenotonsillectomy to minimise the risk of transmission of vCJD. This followed DH advice describing the present state of knowledge of vCJD transmission risk from one patient to another (1,2). During the course of 2001, however, various difficulties were highlighted with single use instruments and reports of both primary and secondary haemorrhage following surgery increased. As a consequence, the DH reintroduced standard reusable instruments for tonsil and adenoid surgery (3).

Definitive guidance on the use of diathermy in tonsillectomy will be issued by NICE after a review has been undertaken, which will take into account data from the Scottish National Tonsillectomy Audit, and once an evaluation of disposable instruments, that is being carried out in Wales, has been completed. Full details of the timescales for developing guidance on the use of diathermy in tonsillectomy and the best technique for reducing any possible risks of vCJD transmission will be published on the NICE website at <http://www.nice.org.uk/ip> once they become available.

A letter from Professor Richard Ramsden, President Elect, ENT UK and the Chairman of the National Steering Group of the National Prospective Tonsillectomy Audit that presents a summary of the results for five popular tonsillectomy techniques is

available at <<http://www.nice.org.uk/pdf/diathermytonsillectomyletterichardramsdn.pdf>>.

More information about the National Prospective Tonsillectomy Audit is available at: <<https://www.tonsil-audit.org/>>.

References

1. Department of Health. *Single-use instruments for tonsil and adenoid surgery*. Press Release. London: Department of Health, 1 January 2001.
2. Department of Health. *Single-use instruments for tonsil and adenoid surgery*. Letter issued 6 June 2001. London: Department of Health. Available at: <<http://www.dh.gov.uk/assetRoot/04/01/41/67/04014167.pdf>>.
3. Department of Health. *Re-introduction of re-usable instruments for tonsil surgery*. Press Release 2001/0623. London: Department of Health, 14 December 2001. Available at: <http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4011629&chk=7VV%2BPw>.

Respiratory

Last updated: 1 April 2004

Next update due: 7 May 2004

 [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 10-13/2004

Week	10/04	11/04	12/04	13/04	Total
Week ending	07/03/04	14/03/04	21/03/04	28/03/04	
Influenza A	7	12	6	2	27
Isolation	–	–	1	–	1
DIF	–	–	–	–	–
Four-fold rise in paired sera	1	10	1	1	13
PCR	–	–	–	–	–
Other	6	2	4	1	13
Influenza B	1	3	2	–	6
Isolation	1	–	1	–	2
DIF	–	–	–	–	–
Four-fold rise in paired sera	–	2	–	–	2
PCR	–	–	–	–	–
Other	–	1	1	–	2
Influenza (untyped)	–	–	–	–	–
Isolation	–	–	–	–	–
DIF	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–
PCR	–	–	–	–	–
Other	–	–	–	–	–

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 10-13/04

Week	10/04	11/04	12/04	13/04	Total
Week ending	07/03/04	14/03/04	21/03/04	28/03/04	
Adenovirus*	23	34	25	23	105
Coronavirus	–	–	–	–	–
Parainfluenza†	3	2	11	8	24
Rhinovirus	2	12	5	2	21
Respiratory syncytial virus (RSV)‡	146	99	58	98	401

*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 10-13/04

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥65 years	Unknown	Total
Adenovirus*	18	9	3	54	17	4	–	105
Coronavirus	–	–	–	–	–	–	–	–
Influenza A	1	1	2	8	5	10	–	27
Influenza B	1	1	–	2	1	1	–	6
Parainfluenza†	15	3	–	3	3	–	–	24
Rhinovirus	9	7	2	1	–	1	1	21
Respiratory syncytial virus (RSV)‡	343	22	4	13	8	10	1	401

*Respiratory samples only, and excludes diagnoses made by electron microscopy (EM).

†includes parainfluenza types 1, 2, 3, 4, and untyped.

‡Excludes diagnoses made by electron microscopy (EM).

Table 4 Laboratory reports of infections associated with atypical pneumonia by week of report (non-pneumonic cases*): weeks 10-13/04

Week	10/04	11/04	12/04	13/04	Total
Week ending	07/03/04	14/03/04	21/03/04	28/03/04	
<i>Coxiella burnetii</i>	–	–	1	2	3
Respiratory <i>Chlamydia</i> sp†	–	3	2	1	6
<i>Mycoplasma pneumoniae</i>	22	6	4	2	34
<i>Legionella</i> sp	4	7	5	1	17

* Non-pneumonic cases in brackets.

†Includes *Chlamydia psittaci*, *Chlamydia pneumoniae*, and *Chlamydia* sp detected from blood, serum, and respiratory specimens.

Table 5 Reports of legionnaires' disease (pneumonic and non-pneumonic*) cases in England and Wales, by week of report: weeks 10-13/04

Week	10/04	11/04	12/04	13/04	Total
Week ending	07/03/04	14/03/04	21/03/04	28/03/04	
Nosocomial	–	1	–	–	1
Community	–	2	2	1	9
Travel abroad	–	3	3	–	6
Travel UK	–	1	–	–	1
Total	4	7	5	1	17
Male	4	7	3	–	14
Female	–	–	2	1	3

* Non-pneumonic cases in brackets.

Seventeen cases were reported with pneumonia. Fourteen males aged between 36 and 78 years and three females aged between 37 and 84 years. One case was hospital acquired and nine cases were due to community acquired infection. Two deaths (M 70y and M 78y) were travel associated.

Seven cases were travel associated: Dubai and India (1), England (1), France (1), Hungary and Romania (1), Switzerland (1), Tunisia (1), and United States(1).

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Zoonoses

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 [Common animal associated infections, England and Wales laboratory reports: weeks 10-13/04](#)
 [Common imported infections, England and Wales laboratory reports: weeks 10-13/04](#)

Common animal associated infections, England and Wales laboratory reports: weeks 10-13/04


	Total reports for weeks 10-13		Cumulative totals for weeks 10-13	
	2004*	2003	2004*	2003
<i>Borrelia burgdorferi</i> *‡	–	3	22	5
<i>Leptospira hardjo</i> †§	–	–	–	–
<i>Leptospira icterohaemorrhagiae</i> †§	–	1	3	4
<i>Leptospira other</i> †§	–	2	1	8
<i>Pasteurella haemolytica</i>	1	–	4	1
<i>Pasteurella multocida</i>	24	22	67	72
<i>Pasteurella pneumotropica</i>	–	1	1	2
<i>Pasteurella</i> spp	7	8	19	17
<i>Toxocara canis</i>	–	1	–	1
<i>Toxocara cati</i>	–	–	–	–
<i>Toxocara</i> spp	–	–	–	–
<i>Toxoplasma gondii</i>	5	1	8	7
<i>Toxoplasma</i> spp	7	1	17	14

* provisional data; † by specimen date; ‡ Lyme Disease Reference Laboratory and CDSC.

§ *Leptospira* Reference Laboratory and CDSC.

NA = Not available.

**Common imported infections, England and Wales laboratory reports: weeks 10-13/04**

Organism	Total reports for weeks 10-13		Cumulative totals for weeks 10-13	
	2004*	2003	2004*	2003
Arbovirus	–	–	–	–
Dengue virus	–	–	6	7
<i>Ascaris</i> spp	13	9	33	22
Hookworms (unspecified)	3	3	12	7
<i>Leptospira</i> spp†	–	–	–	–
<i>Ancylostoma duodenale</i>	–	–	–	–
<i>Necator americanus</i>	–	–	–	–
<i>Hymenolepis diminuta</i>	–	–	–	–
<i>Hymenolepis nana</i>	1	1	3	3
<i>Hymenolepis</i> spp	–	–	–	–
<i>Schistosoma haematobium</i>	–	–	–	–
<i>Schistosoma intercalatum</i>	–	–	–	–
<i>Schistosoma mansoni</i>	3	4	8	5
<i>Schistosoma</i> spp	1	–	7	2
<i>Strongyloides stercoralis</i>	2	4	11	10
<i>Strongyloides</i> spp	1	–	1	1

* Provisional data.

† *Leptospira* Reference Laboratory and CDSC.

NA = Not available.

Comments: weeks 10-13/04

Pasteurellosis: nineteen females, twelve males, one sex not stated.

***P. multocida*:** (15 females, eight males, one sex not stated) F 8y, cat scratch; F 47y, dog bite; M 69y, infected cat bite; 13 females 17y to 91y, seven males 36y to 81y, one sex not stated, 19y, all with no clinical details/exposure history.

***Pasteurella haemolytica*:** (one female) F 47y with no clinical details/exposure history

***P. spp*:** (three females, four males) F 47y, infected cut to hand; F 76y, diabetic with cat scratch to hand, cellulites; F 58y, four males aged <1y to 57y, all with no clinical details/exposure history.

Toxoplasmosis: five females, six males, one sex not stated.

***Toxoplasma gondii*:** (two females, three males) F 33y, F 40y, M 27y, M43y, M 44y, all with no clinical details/exposure history.

***Toxoplasma spp*:** (three females, three males, one sex not stated) F33y, F 38y, F 40y; M 15y, M 18y, M 32y, all with no clinical details/exposure history; one sex not stated <1y with congenital toxoplasmosis.

Ascariasis: nine females, three males, one sex not stated.

***Ascaris lumbricoides*:** M 34y, recently arrived from The Congo, also with concurrent *Trichuris trichiura* infection; F 2y, F 23y, F 25y, F 27y, F 31y, F 32y, F 38y, F 43y, F 64 y; M 7y, M 43y, one sex not stated 4y, all with no clinical details or exposure history.

Hookworm disease (ancylostomiasis)

Hookworm unspecified: one female, two males.

F 17y, M 25y, M 72y, all with no clinical details/exposure history.

Hymenolepis nana: F 28y, no clinical details/exposure history.

Schistosomiasis: two females, two males.

S. mansoni: F 24y, F 37y, M 28y.

***Schistosoma* spp**: M 29y, all with no clinical details/exposure history.

Strongyloidiasis: two females, one male.

S. stercoralis: F 11y, M 31y.

***Strongyloides* spp**: F 52y, all with no clinical details/exposure history.

Diary

Last updated: **18 March 2004**

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 [Blood-borne virus exposure and transmission in health care – one day conference](#)

Blood-borne virus exposure and transmission in health care – one day conference



The Royal Free Hospital, London, are hosting a one day conference – Blood-borne virus exposure and transmission in health care, on 18 June 2004. The expert speakers' presentations are:

- Setting the scene: Occupational transmissions of HIV and HCV to date
- Epidemiology of HCV and update on transmissions from health care workers to patients
- Epidemiology of HIV infection
- Update on Department of Health guidelines FTW & PEP
- Assessment of source patients
- Management of BFEs
- Anti-retroviral therapy as PEP
- What do we still need to know? Planning future BBV educational programmes

For more details or booking enquiries please contact Judith Swallow, Occupational Health and Safety Unit, Royal Free Hospital, Pond Street, London NW3 2QG tel: 0207 830 2513 email: [<judith.swallow@royalfree.nhs.uk>](mailto:judith.swallow@royalfree.nhs.uk).