



CDR WEEKLY

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Published on: 27 May 2004

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News

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 [West Nile virus UK surveillance plans for 2004, and an update on the 2003 season](#)

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West Nile virus UK surveillance plans for 2004, and an update on the 2003 season

UK West Nile virus Surveillance 2004

Enhanced surveillance for human West Nile virus (WNV) infection presenting in the United Kingdom (UK) will start on 1 June 2004. There is a small risk of this infection in this country as there is for the rest of Europe. The enhanced surveillance scheme is similar to that used in previous years, and will operate until the end of October 2004. Details, including the surveillance protocol and report forms, and the current recommendations concerning protection during travel to North America, can be found at http://www.hpa.org.uk/infections/topics_az/west_nile/menu.htm.

Regional epidemiologists have been asked to contact clinicians in their regions to raise awareness of the possibility of WNV infection. Clinicians should inform Health Protection Agency's Communicable Disease Surveillance Centre (CDSC), Colindale, of any possible cases of WNV infection (table 1), especially those occurring in individuals with no history of travel, with onset dates from 1 June until the end of October 2004. Appropriate samples (serum and/or cerebrospinal fluid) should be sent to HPA Porton, as outlined in the surveillance protocol.

Table 1 Prospective surveillance: definition for suspected cases on West Nile virus infection in humans

A case of encephalitis or meningitis, defined by the specific criteria below, presenting from 1 June to 31 October 2004	
1. Encephalitis	
Any person with suspected viral encephalitis with all the following criteria:	1. Fever over 38° and ;
	2. Altered mental state (altered level of consciousness, agitation, lethargy) and/or other evidence of cortical involvement (eg, focal neurological findings, seizures) and ;
	3. Cerebrospinal fluid (CSF) pleocytosis with predominant lymphocytes and/or elevated protein with a negative Gram stain and culture and ;
	4. No alternative microbiological cause identified.
2. Meningitis	
Any person with suspected viral (aseptic) meningitis with all the following criteria:	1. Fever over 38° and ;
	2. Headache, stiff neck and/or other meningeal signs and ;
	3. CSF pleocytosis with predominant lymphocytes and/or elevated protein and a negative Gram stain and culture and ;
	4. No alternative microbiological cause identified.

North America WNV season: 2003

During 2003, there was widespread WNV activity over most of the continental United States (US); a total of 9858 human cases

of WNV infection were reported (1). Cases occurred in all states except Maine, Oregon, Washington, Alaska, and Hawaii. Virus was detected in mosquitoes, birds, or animals in all states except Oregon, Washington, Alaska, and Hawaii. Dates of illness onset, in humans, were from 28 March to 14 December 2003, with a peak occurring between 12 July and 4 October (2). The median age was 47 years, and 53% were male. The distribution of disease types among reported cases showed a substantial change from 2002; 69% had mild non-neurological disease (West Nile fever) while 29% had neuroinvasive disease (including meningitis, encephalitis and meningoencephalitis). This is compared with the 2002 proportions of 69% neurological disease, 21% fever, and 10% unclassified. Moreover, it is considered likely that the apparent increase in cases and the change in distribution of disease types is due to increased awareness and testing of less severe disease. United States case count information for 2004 can be found on the Centers for Disease control and Prevention (CDC) website (3); as of 26 May 2004, a single human case has been reported by US authorities.

Transfusion-associated transmission of WNV occurred in at least six recipients of blood or blood products in the US. This was despite screening of 6 million donated units; presumably due to the viral load being below the detection level (4).

Intrauterine transmission of WNV in the US was first described in 2002. The proportion of infected women who transmit WNV to their infant is unknown, and the effects of any such infection on the foetus or infant remains unclear. To evaluate the possible effects of intrapartum WNV infection, CDC are gathering clinical and laboratory data on pregnancy outcomes for women known or suspected to have had WNV infection during their pregnancy (5).

During 2003, WNV infection was also reported in farmed alligators in the US (6). Associated human cases occurred in which the route of transmission could have been percutaneous exposure. There was also evidence of occupational exposure and transmission from infected turkeys to farm workers (7). There was widespread transmission within turkey flocks that could have occurred via non-vector routes (which has been demonstrated experimentally), such as faecal-oral, respiratory, or percutaneous routes.

In addition to the poliomyelitis-like syndrome reported in 2002, several novel, but extremely rare, clinical syndromes and presentations of WNV infection were reported during 2003 including:

- o encephalitis with myositis and orchitis (8);
- o transient parkinsonism (9);
- o areflexic paraplegia and brainstem function loss (10);
- o eye symptoms including optic neuritis, uveitis, chorioretinitis, visual loss, optic atrophy, diplopia (11-13);
- o childhood encephalitis with left-sided weakness and long-term neurological sequelae (14).

Canada reported 1388 human cases (14 fatal) in Quebec, Ontario, Manitoba, Saskatchewan, and Alberta.

European WNV season: 2003

In Europe, there was one imported human case in The Netherlands and two cases in France (15) (acquired either locally or in Spain). No cases, as yet, have been reported in the United Kingdom.

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Ebola haemorrhagic fever in Sudan

An outbreak of Ebola haemorrhagic fever (EHF) has been reported in Yambio county, western Equatoria, in south Sudan (around 30 km north of the border with the Democratic Republic of Congo [DRC]). As of 26 May 2004, there have been 20 cases reported including five deaths (1). Laboratory testing performed by the Kenya Medical Research Institute (KEMRI) and the Centers for Disease Control and Prevention (CDC) United States, have confirmed Ebola virus (sub-type Sudan). Epidemiological investigations, social mobilisation, contact tracing, and case management are being undertaken by a crisis committee in order to control the outbreak, which includes the Sudanese health authorities, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), Médecins sans Frontières-France, and other nongovernmental organizations including churches working in public health.

The outbreak so far appears to be confined to Yambio; the WHO therefore has not made any recommendations for restrictions on travel or trade, although neighbouring countries have been notified and enhanced surveillance activities have been stepped up in bordering areas in the DRC and Uganda.

The Ebola virus was first identified in 1976 after two major outbreaks of acute haemorrhagic fever occurred in Sudan (284 cases, including 151 deaths) and the DRC [previously known as Zaire] (318 cases, including 280 deaths) (2,3). There were two further incidents, one small outbreak in Sudan in 1979 involving 14 cases and one case reported in the DRC in 1977 (4). After this, Ebola was not reported in Africa again until 1994, where it was identified in humans in Gabon (51 cases, including 31 deaths) and Côte D'Ivoire (one case). Outbreaks have since been periodically reported in Uganda, Gabon, Congo, and DRC since the 1990s (5).

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Immunisation

Last updated: 27 May 2004

Next update due: 24 June 2004

 [Laboratory reports of invasive meningococcal infections, England and Wales laboratory reports: weeks 01-04/03](#)

 [Enhanced surveillance of meningococcal disease: January to March 2004](#)

Laboratory reports of invasive meningococcal infections, England and Wales laboratory reports: weeks 01-04/2004

Table 1 Invasive meningococcal infections laboratory reports, England and Wales weeks: 01-04/2004

	Method of diagnosis			Total reports	Cumulative*
	CSF and blood Culture	Non-culture	Other sites	01-04/04	Total to week 04/2004
Group A	1	–	–	1	1
B	74	71	12	157	157
C	10	4	–	14	14
W135	3	1	–	4	4
X	–	–	–	–	–
Y	1	–	1	2	2
Z	–	–	–	–	–
29E	–	–	–	–	–
Ungroupable	–	–	–	–	–
Ungrouped	–	8	–	8	8
Total	89	84	13	186	186

*Combined CDSC data and Meningococcal Reference Unit data latex antigen, microscopy, polymerase chain reaction.

Enhanced surveillance of meningococcal disease: January to March 2004

In the first quarter of 2004, enhanced surveillance of meningococcal disease (ESMD)* identified 745 cases of invasive meningococcal disease in the nine English regions, Wales, and Northern Ireland. This is an increase of 2% on the total of 732 in the previous quarter and a decrease of 1% on the total of 755 in the equivalent quarter of 2003. North West region reported the highest number of cases this quarter (103), however, the highest rate was reported in East Midlands (table 1).

Table 1 Meningococcal disease by region: January to March 2004

Region	B	C	Other	Infection not confirmed	Rate per 100,000	Total
North East	17	4	3	16	1.59	40
Yorkshire & Humberside	48	1	3	43	1.91	95
East Midlands	26	5	1	49	1.92	81
East of England	31	3	2	12	0.89	48
London	27	4	4	44	1.07	79
South East	29	3	5	56	1.16	93
South West	38	–	5	25	1.37	68
West Midlands	31	1	2	37	1.34	71
North West	54	6	4	39	1.53	103
Wales	1	–	1	45	1.61	47
Northern Ireland	9	1	3	7	1.18	20
Total	311	28	33	373	–	745

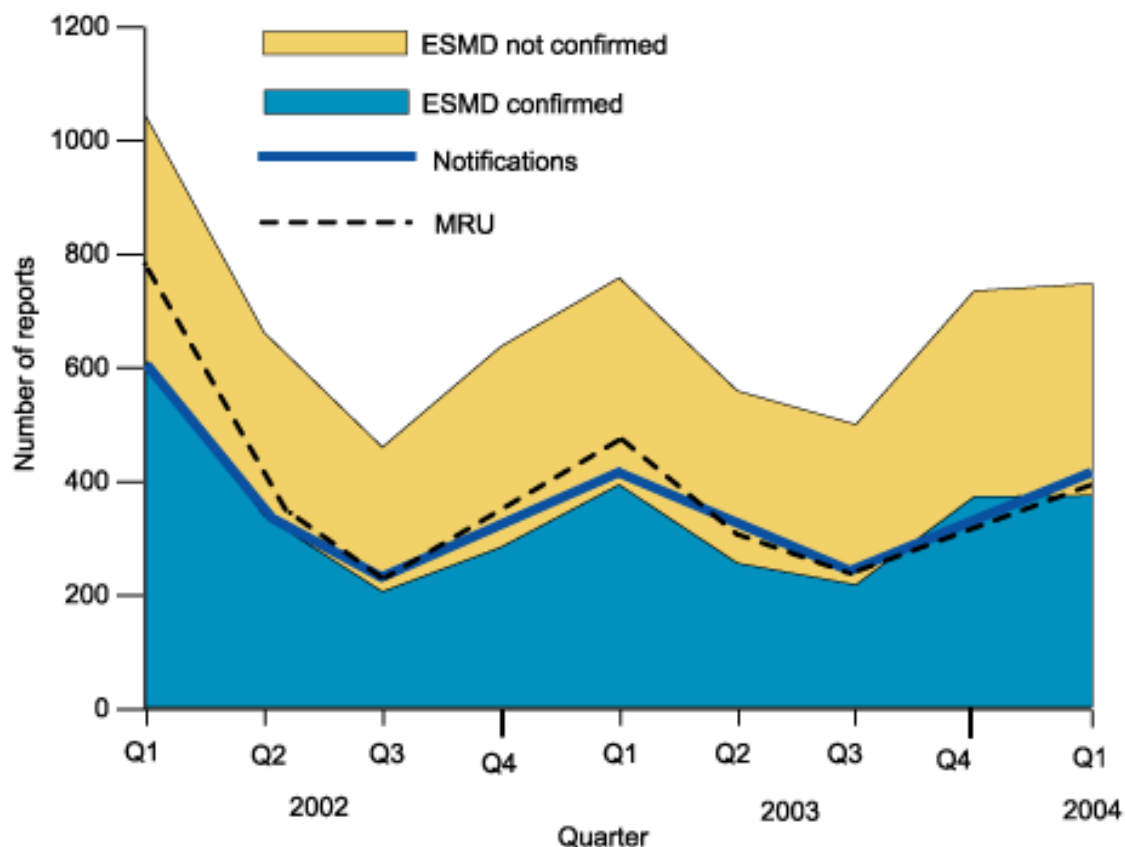
In England and Wales, a clinical diagnosis of invasive meningococcal disease was reported for 703 cases compared to 460 cases of meningitis and septicaemia officially notified to the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC) during the same period. This implies that approximately 65% of clinically diagnosed meningococcal disease is formally notified, although crosschecking to compare the identity of those notified to those reported in ESMD has not been carried out. The overall case fatality ratio in cases identified in ESMD with a clinical diagnosis (in England, Wales, and Northern Ireland) was 5 per 100 cases, whereas the case fatality ratio for cases with septicaemia alone was 6/100 cases (table 2).

Table 2 Clinically diagnosed cases (deaths) of meningococcal disease: England, Wales, and Northern Ireland: January to March 2004

Region	Meningitis	Septicaemia	Meningitis and Septicaemia	Not meningitis or septicaemia	Total
North East	11	17	11 (1)	–	39 (1)
Yorkshire & Humberside	18	49 (4)	28	–	95 (4)
East Midlands	34 (1)	29	13 (1)	5	81 (2)
East of England	21 (1)	17 (2)	8	–	46 (3)
London	47 (2)	19 (4)	11 (2)	1 (1)	78 (9)
South East	38 (1)	43 (3)	11 (1)	–	92 (5)
South West	18	37 (4)	11	–	66 (4)
West Midlands	20	44	7	–	71
North West	30 (1)	39 (2)	25 (1)	5 (1)	99 (5)
Wales	–	35 (3)	1	–	36 (3)
Northern Ireland	1	12	5 (1)	–	18 (1)
Total	238 (6)	341 (22)	131 (7)	11 (2)	721 (37)

Three hundred and seventy-two of the 745 cases (50%) identified in ESMD were confirmed as *Neisseria meningitidis* infection, compared to 429 reports of laboratory confirmed meningococcal disease made to the Health Protection Agency's Meningococcal Reference Unit (MRU) in the same period (figure 1).

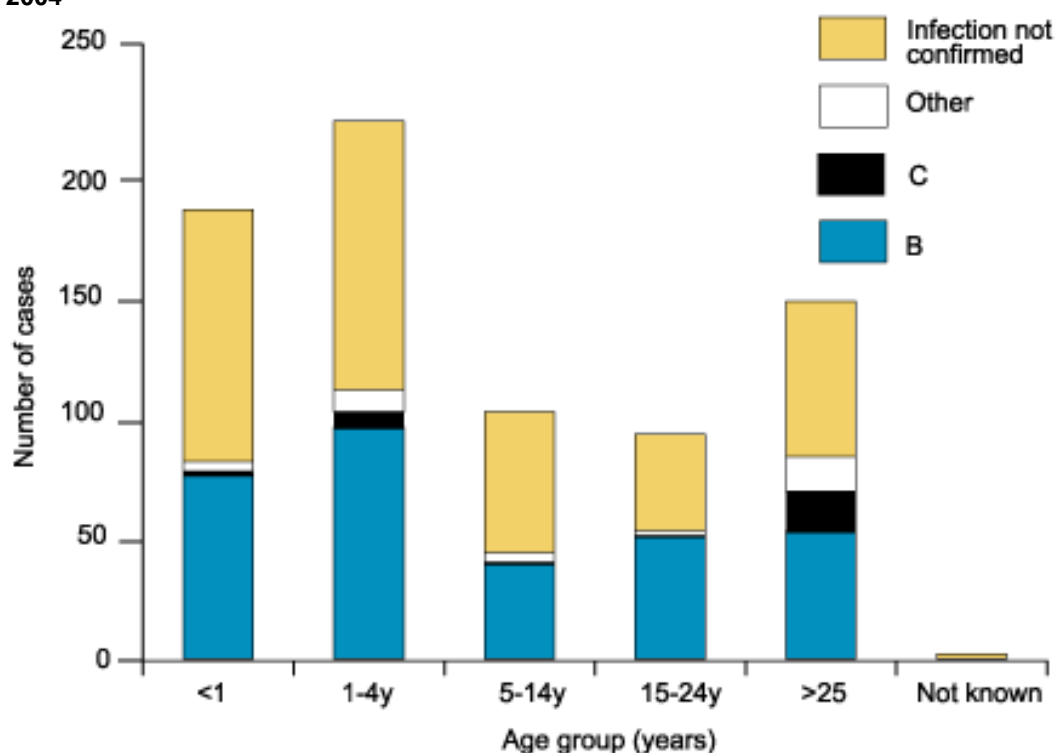
Figure 1 Number of confirmed and unconfirmed reports made to ESMD compared to notifications and reports to MRU: January 2002 to March 2004



Serogroup B *N.meningitidis* was detected in 84% (311/372) of confirmed cases identified in ESMD, serogroup C in 7% (28/372), and the remaining 9% included other serogroups (33/372). The latter consisted predominantly of serogroup W135 (11/33) followed by ungrouped (9/33) and serogroup Y (6/33).

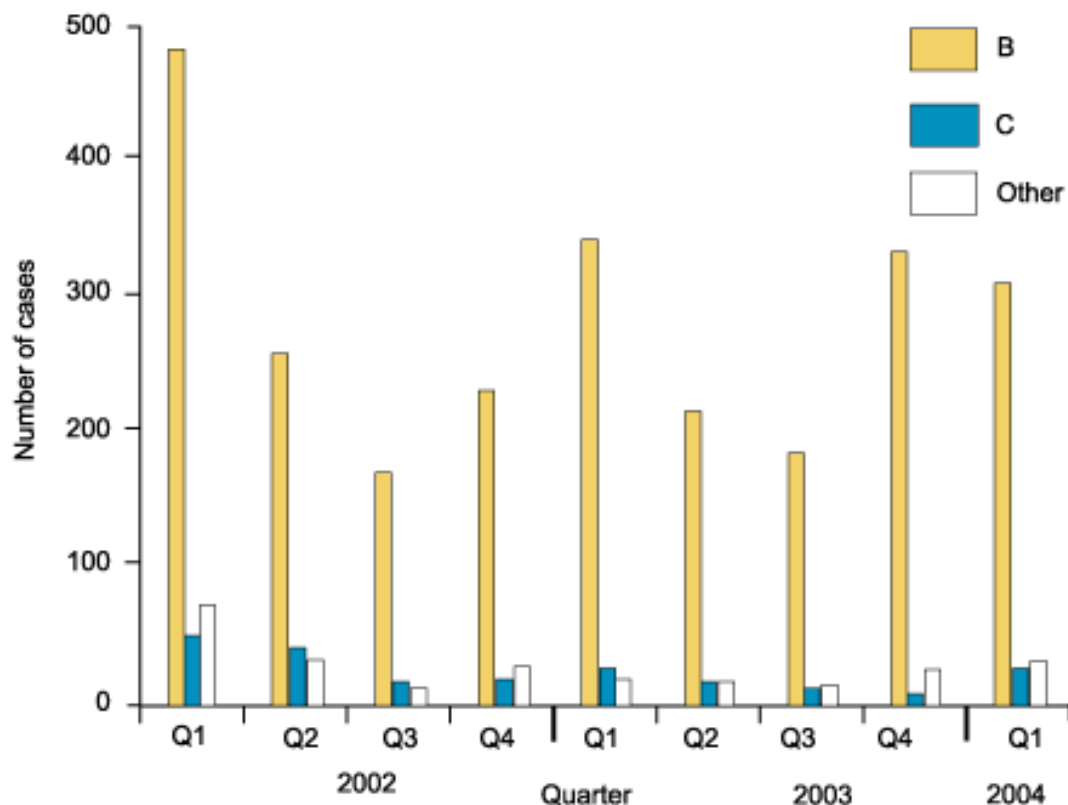
Over half (51%) of all confirmed cases were in children aged under 5 years. Serogroup B accounted for 88% of these infections, serogroup C accounted for 5%, and other serogroups for 7%. Nine serogroup C infections occurred in this age group of children (figure 2). Five children had received the MenC vaccination and were documented vaccine failures, while two children did not receive the vaccine. It is not yet known whether the remaining two had received the full course of MenC vaccination.

Figure 2 Serogroups of *N. meningitidis* identified in cases in England, Wales, Northern Ireland by age: weeks 01-13, 2004



Unlike last quarter, meningococcal disease attributed to serogroup B has decreased this quarter compared to the equivalent period in the previous year (figure 3). Serogroup B disease decreased by 9% (311 cases compared to 343 in 2003), reversing the previous suggestion of a possible new trend of increasing serogroup B disease (1). Unconfirmed cases of meningococcal disease and other serogroups increased by 2% (373 cases compared to 364 in 2003) and 39% (33 cases compared to 20 in 2003), respectively. The observed number of cases of meningococcal disease due to serogroup C remained the same this quarter when compared to the equivalent quarter in the previous year (28 cases).

Figure 3 Number of cases of meningococcal disease due to serogroups B, C, and other serogroups: January 2002 to March 2004



Routine surveillance data have shown an increase of 11% in clinical notifications (460 compared to 411 in 2003) this quarter compared to the corresponding quarter last year, while laboratory reports have decreased by 16% (429 compared to 511 in 2003).

*Regional enhanced surveillance of meningococcal disease (ESMD) began on 1 January 1998 in five regions of England and was extended to include all English regions, Wales, and Northern Ireland from 1 January 1999. The national enhanced surveillance system relies upon consultants in communicable disease control (CCDC) reporting confirmed and probable cases of meningococcal disease occurring in their district each week. Data are collated at regional level and sent on to the Health Protection Agency's Immunisation Department at the Communicable Disease Surveillance Centre (CDSC), Colindale, each month. These data are subsequently published quarterly in *CDR Weekly*. Additionally, CCDCs are asked to report details of any clusters of meningococcal disease occurring in educational establishments.

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Current Issue: Volume 14 Number 22

Published on: 27 May 2004

HIV / STIs

Last updated: 27 May 2004

Next update due: 5 August 2004

 [HIV and AIDS in the United Kingdom quarterly update: data to the end of March 2004](#)
 HIV and AIDS in the United Kingdom quarterly update: data to the end of March 2004

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

In the first three months of 2004, 1389 new diagnoses of HIV infection were reported. This brought the cumulative total to 62,709 since surveillance began in 1982. To date, 20,307 individuals have been diagnosed with AIDS, of which 12,898 (64%) have died with a further 2818 individuals having died without being reported with AIDS.

Table 1 New diagnoses of HIV in the UK by infection route, sex and year of diagnosis: data to the end of March 2004

How infection was probably acquired	Sex	<1994	1994	1995	1996	1997	1998	1999	2000	2001	2002*	2003*	Jan-Mar 2004	Total
Sex between men	M	15,944	1485	1475	1552	1408	1369	1363	1514	1758	1795	1641	178	31,482
Sex between men and women	M	1783	353	388	358	451	519	600	757	1067	1289	1172	83	8820
	F	2024	442	465	479	557	644	832	1245	1809	2200	2199	152	13,048
Injecting drug use	M	1842	121	123	118	121	96	77	72	97	81	65	8	2821
	F	858	46	59	54	48	35	34	39	36	26	32	2	1269
Receiving blood or blood products	M	1419	9	12	10	16	4	10	9	14	14	11	–	1528
	F	116	8	8	11	13	6	11	15	11	16	12	1	228
Mother to infant	M	116	34	32	29	51	47	37	54	52	48	61	6	567
	F	126	32	28	33	33	50	42	49	40	49	55	5	542
Other	M	9	2	2	2	1	2	6	3	7	2	1	–	37
	F	13	–	2	1	–	2	2	3	–	4	2	–	29
Undetermined	M	430	27	34	27	24	22	21	20	18	18	9	–	650
	F	50	3	3	6	6	9	4	3	2	3	2	–	91
Follow-up ongoing	M	89	10	16	16	12	20	28	36	82	189	301	72	871
	F	21	4	4	3	7	8	12	27	45	208	301	45	685
Total†		24,840	2576	2651	2699	2748	2833	3079	3846	5038	5942	5864	552	62,668

*Numbers will rise as further reports are received.

†Forty-one people whose sex was not reported were excluded: seven infected through sex between men and women, three blood recipients, two infected through mother to infant transmission, and 29 for whom the likely route of infection is not known.

Of the 5864 diagnoses reported so far in 2003, 28% (1641) were acquired through sex between men, and 57% (3371) through sex between men and women, with almost two thirds (2199) of those being female (table 1). Diagnoses among injecting drug users remained relatively low in 2003, making up 2% of the total, reported to date. Follow-up to ascertain the probable route of infection was still ongoing for 10% (602) of reports.

Since 1999, the number of infections diagnosed in heterosexual men and women have exceeded those in men who have sex with men (MSM). Diagnoses in both groups has subsequently risen each year. The increase in diagnoses has been substantial in those infected through heterosexual sex, with the majority of these infections acquired abroad. For diagnoses in heterosexual men and women made in 2003, 70% were infected in African countries, and 7.5% in other parts of the world (table 2). Although these figures include individuals infected while travelling or living abroad, for the most part they represent those who were born in and who lived for most of their lives in the country where they were infected.

Table 2 New diagnoses of HIV in those infected through sex between men and women by year of diagnosis: data to the end of March 2004

How HIV infection was probably acquired		<1994	1994	1995	1996	1997	1998	1999	2000	2001	2002*	2003*	Jan-Mar 2004	Total
Exposure to "high risk" partner(s), ie, to partner(s) presumed infected through:	Sex between men	133	21	12	11	11	12	12	13	25	20	12	2	284
	Injecting drug use	236	32	41	33	49	49	25	23	37	22	20	–	567
	Blood factor treatment	67	2	3	6	1	1	1	1		1	2	–	85
	Blood/tissue transfer	13	–	1	3	5	3	4	1	4	2	–	–	36
Exposure to presumed heterosexually infected partner(s):	In Africa	2450	532	560	552	642	750	1000	1497	2205	2600	2370	123	15,281
	In Latin America/Caribbean	86	26	13	24	30	32	64	68	83	125	92	7	650
	In Asia	95	18	39	44	53	79	76	109	100	101	102	6	822
	In North America	72	9	8	8	10	15	7	6	9	6	6	–	156
	In Europe (not UK)	165	36	43	42	50	42	50	46	46	53	51	2	626
	In Australasia	8	–	2	1	2	4	6	2	5	2	4		36
	In country(ies) not known (abroad)	23	–	2	7	3	15	–	2	–	–	–	–	52
	In UK - partner infected outside Europe	108	39	49	42	72	84	91	135	170	185	177	10	1162
	In UK - partner infected in Europe (including UK)	144	43	38	29	40	39	46	47	53	31	51	5	566
	In UK - partner's country of infection not known	185	30	33	28	30	26	30	25	48	85	85	10	615
Partner(s) exposure category undetermined:	Investigation continuing	4	3	2	3	2	9	16	23	89	253	399	70	873
	Investigation closed	23	4	7	4	8	4	5	4	2	3	–	–	64
Total		3812	795	853	837	1008	1164	1433	2002	2876	3489	3371	235	21,875

*Numbers will rise as further reports are received

Infections transmitted through blood transfusion or from mother to child are for the most part acquired outside the United Kingdom (UK). Men who have sex with men are the group most at risk of acquiring HIV in the UK. For new diagnoses in 2003 in MSM, where country of infection was reported (891 of 1641), 84% (749) were infected in the UK. This compares with 11% (328/2966) of heterosexual cases – this figure includes those who had a "high risk" partner and who were infected in the UK, and excludes from the denominator 405 individuals where country of infection was not yet ascertained. Numbers of individuals infected through heterosexual contact in the UK have been increasing gradually and continue to make up around 10% to 11% of new diagnoses in heterosexual men and women annually.

Table 3 describes new diagnoses of HIV infection over time by the region where the earliest diagnosis was made. London remains the focus of HIV in the UK, with 2566 (44%) of new diagnoses in 2003 being made there. A further 21% of diagnoses were in the regions adjacent to London. All regions have seen increases in new diagnoses each year since 1999 including areas that previously saw relatively few HIV cases, such as the North East, Yorkshire and Humberside, Eastern England, and Wales. In each of these regions (and Wales) new diagnoses more than doubled between 1999 and 2002. Figures for 2003 are incomplete due to reporting delay and on the basis of previous patterns of reporting delay they will exceed those for 2002, and are expected to do so by a considerable margin.

Since 1997 there has been a steadying in the number of AIDS cases and deaths (table 3, figure 1). There has also been a reduction in AIDS reporting since the advent of HAART (highly active antiretroviral therapy), and AIDS defining illnesses are more likely to be reported if the HIV and AIDS diagnoses are simultaneous. In 2003, 77% (545) of the 705 AIDS cases diagnosed were diagnosed at the same time as the HIV infection. Reporting of deaths is also subject to reporting delay so the figure of 462 already known about in 2003 is elevated compared to previous years. Reports of deaths occurring in HIV infected individuals in 2002 rose from 349 at the end of March 2003 to 405 a year later.

Table 3 New diagnoses of HIV infection by country and region where diagnosed and year of diagnosis: data to the end of March 2004

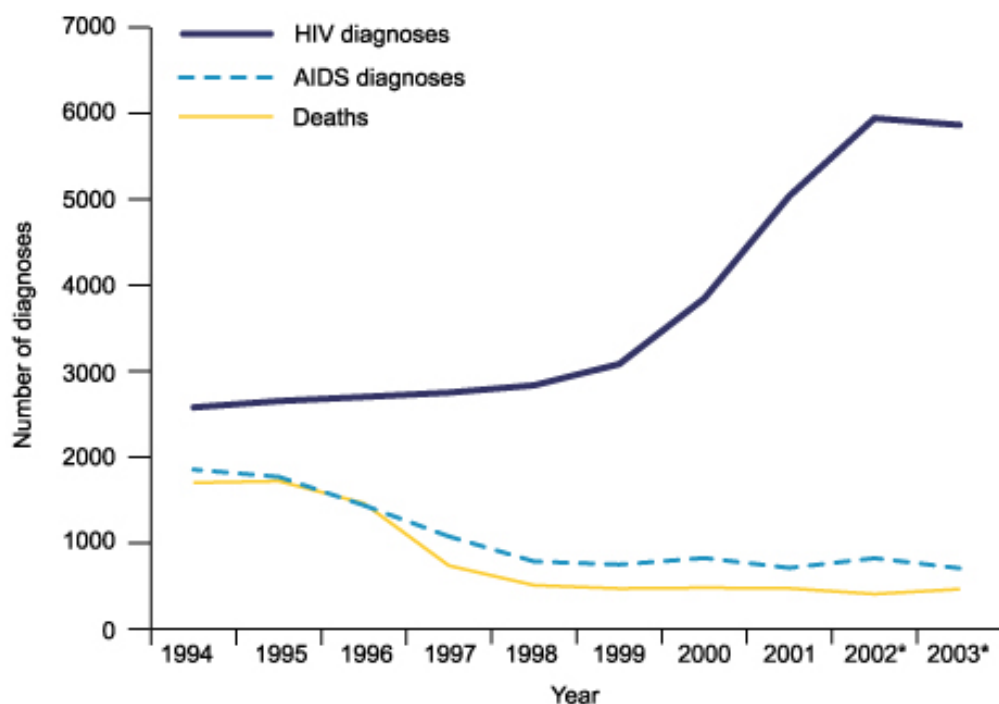
Country and region of diagnosis	<1994	1994	1995	1996	1997	1998	1999	2000	2001	2002*	2003*	Jan-Mar 2004	Total
England													
North East	391	32	21	24	34	22	30	36	53	95	127	14	879
Yorkshire & Humberside	800	65	81	90	82	86	91	99	181	299	369	24	2267
East Midlands	490	57	52	48	44	62	85	100	197	253	299	27	1714
East of England	636	61	77	56	77	85	96	186	311	477	504	42	2608
London	15,041	1584	1680	1707	1730	1768	1952	2341	2786	2831	2566	293	36,279
South East	2027	233	169	227	215	207	217	351	486	677	752	62	5623
South West	793	108	87	77	91	104	103	104	135	177	180	15	1974
West Midlands	775	75	99	64	99	109	103	178	213	403	297	13	2428
North West	1414	147	179	186	149	187	207	234	424	403	392	9	3931
England (total)	22,367	2362	2445	2479	2521	2630	2884	3629	4786	5615	5486	499	57,703
Wales	372	46	46	36	44	31	34	46	65	78	100	1	899
Northern Ireland	122	14	12	16	9	9	14	19	19	25	31	-	290
Scotland	1984	147	147	162	167	158	148	151	161	217	243	52	3737
UK Total	24,845	2569	2650	2693	2741	2828	3080	3845	5031	5935	5860	552	62,629
Channel Islands/Isle of Man	31	8	1	6	8	6	1	1	7	7	4		80
Total diagnoses†	<1994	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Jan-Mar 2004	Total
HIV diagnoses	24,876	2577	2651	2699	2749	2834	3081	3846	5038	5942	5864	552	62,709
AIDS diagnoses	9551	1853	1769	1438	1075	784	748	824	709	822	705	29	20,307
Deaths‡	7004	1700	1719	1462	735	507	469	478	471	405	462	61	15,716

* Numbers will rise as further reports are received

Includes diagnoses in the Channel Islands and the Isle of Man

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

Figure 1 New diagnoses of HIV and AIDS and deaths in HIV infected individuals by year of occurrence: data to the end of March 2004



*Figures for recent years will rise as delayed reports are received