



CDR WEEKLY

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News

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Outbreak of Influenza A (H1N1) in a Leeds primary school

An outbreak of influenza A (H1N1) has been reported from a primary school in Leeds. The outbreak was reported to Leeds Health Protection Unit on 18 June 2004. Since Monday, 14 June, a total of 80 children and two members of staff had been absent or sent home with symptoms including fever, nausea, cough, sore throat, and general malaise. The CCDC sent out an alert message detailing the situation to all general practices in east Leeds and informed the Director of Public Health for the Primary Care Trust in which the school is situated. The local health protection team has supported the school in providing information to both parents and staff and have sent out questionnaires to the families affected as part of their continuing investigation into the outbreak.

During the first week of the emergent outbreak, the school, which is an open plan building, held an event which meant that children from all year groups had been gathered together for a prolonged period of time. Sixty per cent of the children absent due to influenza-like symptoms at the peak of the outbreak were from years one and two (ages from 5 to 6 years). By Friday, 25 June, a total of 100 children had been absent from school.

Nose and throat swabs from five children were tested for influenza by PCR in the Virology Department, HPA Laboratory, Leeds. Specimens from two of the children were reported positive for influenza A and referred to the Enteric, Respiratory, and Neurological Virus Laboratory (ERNVL), Colindale, where they were confirmed as influenza A (H1N1).

It is unusual to receive reports of influenza A outbreaks during the summer months, and this is the second outbreak of influenza A (H1N1) reported in a primary school since the beginning of May (1). Between weeks 30/2003 and 20/2004 only one isolate of influenza (H1N1) and two isolates of (H1N untyped) from hospital derived specimens have been detected by ERNVL, compared with 1404 detections of influenza A (H3), and five detections of influenza B. It is, therefore, not unreasonable to speculate that these late outbreaks of the H1N1 subtype may be an indicator of the dominant circulating strain in the influenza season to come.

References

1. HPA. Outbreak of influenza A (H1N1) in a school in West Sussex. *Commun Dis Rep CDR Wkly* [serial online] 2004 [cited 7 July 2004]; 14(23). Available at <<http://www.hpa.org.uk/cdr/PDFfiles/2004/cdr2304.pdf>>.

***Escherichia coli* outbreak in Durham and Chester-le-Street**



County Durham and Tees Valley Health Protection Unit are currently investigating an outbreak of *Escherichia coli* O157 in patients in the Durham and Chester-le-Street areas. The first case was detected on 28 June 2004.

To date, there have been nine confirmed cases and eight suspected cases, aged between 1 and 75 years. Symptoms have ranged from non-bloody diarrhoea to bloody diarrhoea and dehydration.

Investigations are continuing into the possible source of the outbreak but findings, so far, continue to support a possible link with a butcher's shop in Chester-le-Street. The link is solely in relation cold cooked meat products and this was made public on 3 July 2004. The shop has been co-operating with environmental health officers from Chester-le-Street District Council and closed voluntarily while preliminary investigations were completed. Following full agreement by the outbreak control team, the shop re-opened for the sale of raw meat only on 8 July.

Microbiological samples have been sent to both regional and national laboratories. A case-control study is also being conducted and final results are awaited on all aspects of the investigation.

UNAIDS report for 2004



AIDS has claimed 20 million lives since the first case was diagnosed in 1981, according to the *2004 Report on the global AIDS epidemic*, published this week by the Joint United Nations Programme on HIV/AIDS (1).

The report includes new estimates for global HIV figures. 37.8 million people throughout the world are now estimated to be living with HIV. Although this is lower than the 40 million estimated in 2001, the HIV epidemic is not slowing, rather, improved methods have been used to produce the estimates. This year the UNAIDS Reference Group on estimates, modelling, and projections, have used improved modelling methods, more accurate data from country surveillance systems and supplementary information from household surveys to produce the estimates (2). For the first time, plausible ranges for estimates have been produced rather than a single best estimate. To allow comparison and trend analysis over time, the improved methodologies have also been used to calculate estimates for 2001. These improved estimates show that the number of people living with HIV is still increasing, from 35 million in 2001 to 38 million (range 34.6 to 42.03 million) at the end of 2003.

In 2003 alone there were an estimated 4.8 million (4.2 to 6.3 million) new infections of HIV, the greatest number in a single year since the epidemic began. The virus also claimed 2.9 million (2.6 to 3.3 million) lives in 2003. 5.6 million people in developing countries are expected to die in the next two years (from 2004 to 2005) if they do not receive antiretroviral therapy.

The epidemic continues to affect sub-Saharan Africa disproportionately. Three million (2.6 to 3.7 million) people were newly infected in sub-Saharan Africa last year, representing over 60% of new infections globally. There are, however, continuing worrying signs from other parts of the world as well. Asia, home to 60% of the world's population, is seeing a fast-growing epidemic. Although at present the majority of new infections are among high-risk groups, there is also an increase in risky activities in the general population. For example, in Thailand, a country that has been among the most successful in fighting HIV, behavioural surveillance has shown that an increasing proportion of secondary school students are sexually active and there is a consistently low level of condom use.

It is not only low and middle-income countries that are affected by HIV. The report shows that there are now an estimated 1.6 million people living with HIV/AIDS in high-income countries. These figures are rising in the United States and Western Europe. There has been an increase of 7% in Western Europe with the current estimate at 580,000 (460,000 to 730,000), compared to 540,000 in 2001. UNAIDS estimates that there are 51,000 people living with HIV in the United Kingdom compared to 43,000 in 2001.

Women are increasingly at risk of infection and now account for nearly 50% of those infected globally, and in sub-Saharan Africa, 57% of those infected. In 2003, the Global Coalition on Women and AIDS was launched. The coalition will not only facilitate increased prevention activities for women, but it recognises that there are wider issues that affect women that must be addressed to help them protect themselves against HIV.

The report also highlights the vulnerability of young people in this epidemic. In 2003, those aged between 15 and 24 years accounted for half of all new HIV infections worldwide. Although two thirds of young people living with HIV are in sub-Saharan Africa there are emerging threats among this age group in other regions of the world. In Central Asia and Eastern Europe, the average age of initiation of injecting drug use is decreasing. This group are at risk of infection, as they do not have the knowledge and skills to protect themselves. In addition, 12 million children in sub-Saharan Africa alone have lost one or both parent to HIV and this is expected to rise to over 18 million by 2010. The full ramifications of this situation are yet to be seen.

With no cure or HIV vaccines available, prevention remains the mainstay of the responses to HIV. Fewer than one in five people worldwide have access to HIV prevention services. Effective prevention could avert 29 million of the 45 million infections expected to occur this decade. Without a fall in the number of new infections occurring every year, expanded access to treatment services is unsustainable.

This report highlights that the HIV epidemic is by no means under control and in many areas of the world the infection is spreading at ever increasing rates. Even though financial commitment is high for HIV, with spending increasing 15 times since 1996 (to US\$5 billion), this falls far short of what is needed to combat the disease. It is estimated that US\$20 billion will be needed by 2007 to provide the support, therapy, and prevention activities required. This would include antiretroviral therapy to over 6 million people and voluntary counselling and testing for over 100 million adults.

The report shows just how much remains to be accomplished globally in the fight against HIV/AIDS. *Report on the global AIDS epidemic* can be found at the UNAIDS website <www.unaids.org>.

References

1. UNAIDS website homepage [online] 2004 - Joint United Nations Programme on HIV/AIDS. *2004 Report on the global AIDS epidemic: 4th global report*. Geneva: UNAIDS, 6 July 2004. Available at <www.unaids.org>.
2. Walker N, Grassly NC, Garnett GP, Stanecki KA, Ghys PD. Estimating the global burden of HIV/AIDS: what do we really know about the HIV pandemic? *Lancet* 2004; **363**(9427): 2180-5..

Hepatitis C Action Plan for England



On the 1 July 2004 the Department of Health launched the *Hepatitis C Action Plan for England*(1). The *Hepatitis C Action Plan* implements the *Hepatitis C Strategy for England* (2), which was published for consultation in 2002. The strategy highlighted the importance of hepatitis C as a public health issue and suggested how prevention, diagnosis, and treatment of hepatitis C could be improved. The action plan describes ongoing work that needs to be maintained and intensified, and identifies new areas for further action. Four main areas are listed that are considered essential in tackling hepatitis C in England:

- improvement of surveillance and research that enables trends in hepatitis C infection and the effectiveness of prevention measures to be monitored;
- increasing the awareness of hepatitis C and reducing the number of diagnosed infections. This includes continuing to develop and raise the professional awareness of hepatitis C and to increase testing for hepatitis C especially among injecting drug users;
- ensuring that high-quality health and social care services are provided for the assessment and treatment of all patients with hepatitis C. These clinical care pathways should be co-ordinated locally and be accessible across the country;
- the need to intensify prevention efforts so that the risk of hepatitis C infection is reduced in those at high risk of infection.






Copies of the document *Hepatitis C Action Plan for England* are available to download from the Department of Health website at <www.dh.gov.uk/publications>. Printed copies can be obtained from: Department of Health Publications, PO Box 777 London SE1 6XU, tel: 08701 555 455, fax: 01623 724 524.

References

1. Department of Health. *Hepatitis C Action Plan For England*. London: Department of Health, 2004. Available at <www.dh.gov.uk/publications>.
2. Department of Health. *Hepatitis C Strategy for England*. London: Department of Health, 2002. Available at <www.publications.doh.gov.uk/cmo/hcvstrategy/hcvstratsum.htm>.

Enteric

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General outbreaks of foodborne illness, England and Wales, laboratory reports: weeks 23-26/04

Preliminary information has been received about the following outbreaks. Final information will be published in the quarterly report.

Health Protection Unit	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
Bedfordshire	S. Enteritidis PT24	Retailer	May	5	5	–	–
Kensington, Chelsea, and Westminster	S. Enteritidis PT22	Restaurant	May	21	21	–	–
Surrey/Sussex	S. Enteritidis PT4	School	June	10	2	–	–
Surrey/Sussex	S. Typhimurium DT15	School	June	9	9	–	–

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

Details of serotypes of the 673 salmonella infections recorded in May 2004 are given in the table below. In June 2004, 651 salmonella infections were recorded and preliminary information was received about four outbreaks (see table above).

	May 2004
Total Salmonella *	673
S.Enteritidis (PT4)	141
S.Enteritidis (other PTs)	287
S.Typhimurium	73
S.Virchow	23
Others (typed)	149

* Data provisional.

**Common gastrointestinal infections, England and Wales, laboratory reports: weeks 23-26/04**

Laboratory reports	Number of reports received				Total reports 23-26/04	Cumulative total to	
	23/04	24/04	25/04	26/04		26/04	26/03
<i>Campylobacter</i>	828	1046	874	453	3201	17,947	19,863
<i>Escherichia coli</i> O157*	17	12	13	21	63	192	150
<i>Salmonella</i> †	185	219	169	69	642	3567	4759
<i>Shigella sonnei</i>	5	7	3	9	24	263	304
Rotavirus	181	157	85	53	476	11,845	13,890
Norovirus	61	25	7	7	100	1243	1677
<i>Cryptosporidium</i>	26	33	21	24	104	1205	1170
<i>Giardia</i>	33	36	32	25	126	1222	1413

* 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.

**Less common gastrointestinal infections, England and Wales, laboratory reports: weeks 14-26/04**

Laboratory reports	Total reports	Cumulative total to 26/04	Cumulative total to 26/03
Adenovirus	3	10	47
Astrovirus	31	124	74
Calicivirus	6	22	11
<i>Shigella flexneri</i>	47	106	142
<i>Aeromonas</i>	32	65	55
<i>Plesiomonas</i>	3	12	10
<i>Vibrio</i>	5	9	7
<i>Yersinia</i>	2	8	19
<i>Entamoeba histolytica</i>	33	95	124
<i>Blastocystis hominis</i>	44	132	132
<i>Dientamoeba fragilis</i>	33	95	93
<i>Taenia</i> spp	15	66	43
<i>Trichostrongylus</i> spp	–	–	1
<i>Trichuris trichiura</i>	15	31	63

**Surveillance of *Shigella boydii* and *S. dysenteriae* infection in England and Wales: 2003**

The Health Protection Agency's Laboratory of Enteric Pathogens (LEP) provides a reference service for the confirmation and typing of *Shigella boydii* and *S. dysenteriae*. In 2003, LEP confirmed 94 cases of *Shigella boydii* infection and 50 cases of *S. dysenteriae* infection from cultures referred by laboratories in England and Wales.

Fifty-two cases of *Shigella boydii* were reported to have acquired their infections while travelling abroad (table) . Most cases visited Asia (30) or Africa (20).

Twenty-six cases of *S. dysenteriae* infection reported to have acquired their infections while travelling abroad. Most cases visited Asia (13) and Africa (12).

Region/Country	Number of cases	
	<i>S. Boydii</i>	<i>S. Dysenteriae</i>
Africa		
Cameroon	1	–
Egypt	8	5
Gambia	1	–
Ghana	2	1
Morocco	2	4
Mozambique	–	1
Nigeria	4	–
South Africa	1	–
Sudan	1	–
Africa Not Stated	–	1
Asia		
Bangladesh	1	–
Far East	1	–
India	17	7
Iraq	1	–
Malaysia	–	1
Nepal	1	–
Pakistan	7	3
Saudi Arabia	1	–
Thailand	–	1
Turkey	1	–
Yemen	–	1
Americas		
South America	1	–
Peru	1	1
Country Stated	52	26
Country Not Stated	42	24
Total	94	50