







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News

Last updated: 29 July 2004
Next update due: 5 August 2004

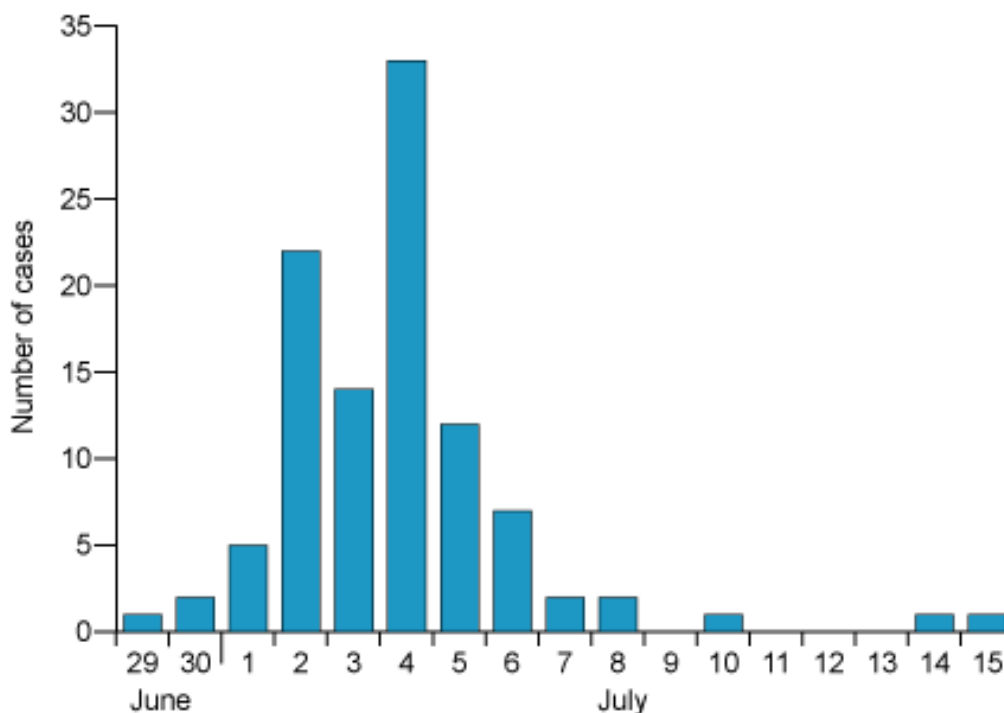
- [!\[\]\(cf5be311f7b2821912d8009884508fa2_img.jpg\) Outbreak of *Salmonella* Typhimurium DT104 in Downpatrick, Northern Ireland](#)
- [!\[\]\(9804e70d96ff9fe9899b264c06a33cd7_img.jpg\) Outbreak of *Salmonella* Typhimurium DT104 in Derwentside, Co Durham](#)
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- [!\[\]\(d8f7165d5a8d1eba426ea452457190e5_img.jpg\) European Surveillance of Sexually Transmitted Infections \(ESSTI\) Network launches new website](#)
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Outbreak of *Salmonella* Typhimurium DT104 in Downpatrick, Northern Ireland

Over the period 6 July to 30 July 2004, the Eastern Health and Social Services Board investigated an outbreak of diarrhoea and vomiting (D&V) in Downpatrick, a small town in Northern Ireland. Over this time, 167 cases of D&V were reported, of which 113 cultured positive for salmonella. The Health Protection Agency's Laboratory of Enteric Pathogens confirmed the outbreak strain as *Salmonella* Typhimurium definitive phage type (DT) 104 resistant to streptomycin, sulphonamides and spectinomycin. Preliminary results suggest that 40 people visited local hospital accident and emergency departments, with ten being admitted.

Figure Number of cases of vomiting and diarrhoea by date of onset



A small hot food establishment was identified as the source of the infection, with the same strain of *S. Typhimurium* DT104 being cultured from the food (both chicken pakora and mayonnaise) as well as the infected people. Initial investigations suggested that contaminated products were on sale for a number of days. The hot food establishment closed voluntarily from Thursday 8 July and has not reopened.



Outbreak of *Salmonella* Typhimurium DT104 in Derwentside, Co Durham

County Durham and Tees Valley Health Protection Unit are currently investigating an outbreak of *Salmonella* Typhimurium infection in patients in Derwentside and surrounding areas. The first case was detected on 27 July 2004.

To date, there have been 41 confirmed and eight suspected cases, aged between 13 and 82 years. Symptoms have included diarrhoea, vomiting, nausea, fever and abdominal pain.

Investigations into the possible source of the outbreak are ongoing but findings so far continue to support a possible link to a food outlet selling cooked poultry, pies, quiche, and sandwiches. The shop has been closed as a result of the council serving an emergency prohibition notice since the afternoon of Thursday 29 July.

Microbiological samples from cases have been sent to both regional and national laboratories. The Health Protection Agency's Laboratory of Enteric Pathogens has confirmed 40 isolates as *S. Typhimurium* definitive phage type (DT) 104 with resistance to streptomycin, sulphonamides and spectinomycin. The same properties were detected in the isolates from a recent outbreak in Northern Ireland.



Hepatitis B infected healthcare workers and oral antiviral therapy

The Department of Health has published a consultation document seeking views on the practicability of implementing the advice from the Advisory Group on Hepatitis that, under specified conditions, healthcare workers (HCW) infected with hepatitis B should be allowed to return to perform exposure prone procedures (EPPs) while taking oral antiviral drug therapy (1). The Advisory Group on Hepatitis provides the Department of Health with expert advice on the prevention and control of hepatitis B.

Guidelines on the management of infected HCWs have evolved over time. In 1993 (2) the Department of Health issued guidelines restricting all HCWs who were hepatitis B e-antigen positive from performing EPPs. In June 2000 further guidelines were issued, that the restriction to performing EPPs should encompass all those HCWs with high viral loads (HBV DNA levels), above 10^3 genome equivalents/ml, on the Roche Amplicor assay (3). This update in guidelines was prompted by the findings of further HCW-to-patient transmissions of hepatitis B involving HCWs, hepatitis B e-antigen (HBeAg) negative, but with high HBV DNA levels. Under the June 2000 guidelines, HCWs are not permitted to undertake EPPs while on therapy, but those whose viral load returns 10^3 genome equivalents/ml or below, one year after cessation of therapy, subject to annual testing are permitted to return to EPPs.

In the light of emerging evidence on therapeutic advancements in the management of hepatitis B (1), the Advisory Group on Hepatitis recently reconsidered the guidance on HBeAg negative HCWs on therapy. They have advised that under certain circumstances, HBeAg negative infected HCWs should be allowed to return to EPPs while taking antiviral treatment, provided that their HBV DNA levels are suppressed to 10^3 genome equivalents/ml or below.

Comments are sought on the general principle of the proposal and its implementation, and upon a number of specific questions set out in paragraph 14 of the document. Any comments should be sent to Helen Hamlet, either in writing to Room 631B, Department of Health, Skipton House, 80 London Road, London SE1 6EH, or by email to Hepatitis_B_Info@doh.gsi.gov.uk. The closing date for comments is 22 October 2004.

References

1. Department of Health. *Hepatitis B infected health care workers and oral antiviral therapy : consultation paper on implementing expert advice about a limited relaxation of restrictions on hepatitis B infected health care workers*. London: Department of Health, July 2004. Available at http://www.dh.gov.uk/Consultations/LiveConsultations/LiveConsultationsArticle/fs/en?CONTENT_ID=4086560&chk=KXw3/z
2. Department of Health. *Protecting health care workers and patients from hepatitis B (Health Service Guidelines HSC(93)40)*. Department of Health: London, 1993. Available at <http://www.dh.gov.uk/assetRoot/04/07/93/06/04079306.pdf> and <http://www.dh.gov.uk/assetRoot/04/07/93/07/04079307.pdf>.
3. Department of Health. *Hepatitis B infected health care workers (Health Service Circular HSC2000/020)*. London: Department of Health, 2000. Available at <http://www.dh.gov.uk/assetRoot/04/01/22/57/04012257.pdf> and <http://www.dh.gov.uk/assetRoot/04/05/75/38/04057538.pdf>



The Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) 2003 report has been published and is available on the HPA Website at http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/sti-gonorrhoea/epidemiology/grasp.htm. This report summarises findings from the fourth year of data collection in which 2117 isolates were analysed.

GRASP was launched in June 2000, as a collaborative surveillance programme. In 2003 the participating centres were the Health Protection Agency Communicable Disease Surveillance Centre (CDSC), Imperial College London and the Health Protection Agency Antibiotic Resistance Monitoring and Reference laboratory (ARMRL). Key objectives for the programme are to determine the prevalence and geographic distribution of *Neisseria gonorrhoeae* antimicrobial resistance; and to inform rational and cost-effective antimicrobial prescribing policies for *N. gonorrhoeae*.

The methodology for GRASP has been described in detail previously (1,2), during the months of June, July, and August, 24 laboratories in England and Wales submitted all isolates of gonococci to two reference laboratories for antibiotic susceptibility testing. Their associated genitourinary medicine clinics (GUM) collect detailed demographic and behavioural data on all patients diagnosed with gonorrhoea. At the reference laboratories, minimum inhibitory concentrations (MICs) were determined for the following antimicrobials: penicillin, ciprofloxacin, spectinomycin, tetracycline, ceftriaxone, and azithromycin. The behavioural and susceptibility data were then linked.

Table 1 illustrates the total percentage of GUM isolates resistant to selected antimicrobials in the four GRASP collections between 2000 and 2003. Nine per cent of GRASP isolates were resistant to ciprofloxacin in 2003 compared to 9.8% in 2002. Ciprofloxacin resistance was found to have increased significantly from 2.1% in 2000 to 9.0% in 2003, but no significant change was observed between 2002 and 2003. Prevalences remained at $\geq 5\%$ in all regions of England and Wales in 2003. Overall, 9.7% of isolates demonstrated penicillin resistance in 2003, almost the same as the 9.8% observed in 2002. High-level plasmid-mediated penicillin resistance was observed in 5.6% of isolates, while a further 3.8% of isolates demonstrated chromosomally-mediated penicillin resistance. No significant differences were observed over time for the penicillin resistance types. Tetracycline resistance was identified in 38.2% of isolates in 2003 a significant decrease from the 44.7% observed in 2002. In 2003, 0.9% of GRASP isolates were azithromycin resistant, a significant increase compared to the 0.4% observed in 2002. All isolates were susceptible to spectinomycin and ceftriaxone.

Due to the significant increase in the prevalence of ciprofloxacin resistance to 9.8% observed in England and Wales in 2002, alternative first-line therapies were recommended by the GRASP steering group (3). Subsequently the Clinical Effectiveness Group (British Association of Sexual Health and HIV) gonococcal treatment guidelines are being reviewed and updated in response to these recommendations (4). These guidelines will recommend the use of third generation cephalosporin such as ceftriaxone in place of fluoroquinolones or penicillin as first line therapies (5). These recommendations were reflected in the prescribing practices of participating GUM clinics in 2003, with 42% of GRASP individuals being prescribed a cephalosporin compared to 15% in 2002.

As observed in previous years, the 2003 collection found that gonorrhoea remains concentrated within demographic and behavioural risk groups in England and Wales, with young people, men who have sex with men (MSM) and ethnic minorities, bearing a disproportionate burden of disease. In women, the majority of gonococcal infections were diagnosed among those aged from 16 to 19 years (37%), and in heterosexual males, among those aged from 25 to 34 years (33%). Twenty-six per cent of all gonococcal infection was diagnosed in MSM. Black and ethnic minority groups were also disproportionately affected, in particular black Caribbeans who accounted for 32% and 44% of the total diagnoses in heterosexual males and females respectively in 2003.

The clinical characteristics of patients in 2003 also remained similar to those observed in previous years. Approximately a third (31%) of patients reporting having a previous infection of gonorrhoea suggesting continued contact with transmission networks. Forty-one per cent of women and 13% of men had an asymptomatic infection. Furthermore, 34% of individuals presented with a concurrent sexually transmitted infection (STI). Females in particular presented with high levels of co-infection 41% being diagnosed with concurrent Chlamydia trachomatis infection. The substantial geographical clustering of gonococcal disease, the high proportion of asymptomatic and concurrent STI infections, all highlight the importance of sexual health screening among those at risk to prevent onward transmission and the development of serious complications.

The 2003 GRASP annual report findings illustrate the public health importance of this enhanced antimicrobial resistance surveillance programme. Continued surveillance of the patterns and distribution of gonococcal antimicrobial resistance is required to ensure that prevention and treatment strategies remain responsive to the changing epidemiology of this sexually transmitted infection.

Antimicrobial	Total resistance			
	2000	2001	2002	2003
Penicillin	9.3	8.1	9.8	9.7
(MIC\geq1mg/L or β lactamase positive)	(218/2351)	(192/2372)	(216/2204)	(192/1975)
Tetracycline	37.6	32.5	44.7	38.2
(MIC\geq2mg/L)	(885/2351)	(771/2370)	(985/2204)	(755/1975)
Ciprofloxacin decreased susceptibility	2.5	2.6	4.3	3
(MIC\geq0.125 to 0.5mg/L)	(59/2351)	(62/2369)	(94/2204)	(59/1975)
Ciprofloxacin	2.1	3.1	9.8	9
(MIC\geq1mg/L)	(49/2351)	(74/2369)	(217/2204)	(177/1975)
Ciprofloxacin decreased susceptibility or resistant	4.6	5.7	14.1	12
(MIC\geq0.125mg/L)	(108/2351)	(136/2369)	(311/2204)	(236/1975)
Azithromycin	N/A	0.3	0.4	0.9
(MIC\geq1mg/L)		(6/2350)	(9/2203)	(17/1973)
Ceftriaxone	0	0	0	0
(MIC\geq0.125mg/L)	(0/2351)	(0/2371)	(0/2204)	(0/1975)
Spectinomycin	0.1	0	0	0
(MIC\geq128mg/L)	(2/2351)	(0/2372)	(1/2204)	(0/1975)

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1. Paine T, Fenton KA, Herring A, Tuner A, Ison C, Martin I *et al*. Gonococcal Antibiotic Resistance Surveillance in England and Wales. *Sex Trans Inf* 2001; **77**: 398-410.
2. The Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP). *Protocol of operational aspects and data management of GRASP*. London: HIV & STI Division PHLS Communicable Disease Surveillance Centre. 2000
3. Fenton KA, Ison C, Johnson AP, Rudd E, Soltani M, Martin I, *et al*. Ciprofloxacin resistance in *Neisseria gonorrhoeae* in England and Wales in 2002. *Lancet* 2003; **361**: 1867-69.
4. Bignell C. National guidelines for the management of gonorrhoea in adults. *Sex trans Infect* 1999; **75** (Suppl 1): S13-S5.
5. Clinical Effectiveness Group (BASHH, British Association of Sexual Health & HIV). *National guidelines on the management of gonorrhoea in adults*. London: BASHH, 2001. Available at <<http://www.bashh.org/guidelines/ceguidelines.htm>> (cited 4 August 2004).

European Surveillance of Sexually Transmitted Infections (ESSTI) Network launches new website

On 1 August 2004, the European Surveillance of Sexually Transmitted Infections (ESSTI) network launched its new website at <<http://www.essti.org/>>. This completes the range of activities planned during the first phase of the DG SANCO funded ESSTI Network.

The ESSTI website provides a focus for all network participants and those interested in STI laboratory and epidemiological surveillance in Europe. Current content includes: information about the ESSTI network; ESSTI member details; country-specific links; current issues in STI research; ESSTI resources; ESSTI publications; calendar of events; and information on ESSTI ALERT, the European STI outbreak early warning system. The website hosts a password protected site for network members, which will allow the dissemination of confidential surveillance data and other restricted materials.

Since its inception in December 2001, ESSTI has completed a range of activities geared towards greater harmonisation and strengthening of European STI surveillance. Network members have carried out a comprehensive review of European Union (EU) STI surveillance systems and a retrospective analysis of EU STI surveillance trends from 1990 to 2000. The network has also completed a survey of laboratory methods for diagnosis of gonorrhoea, chlamydia and syphilis infections in different countries of the EU. A panel exchange for *Neisseria gonorrhoeae* isolates among 14 laboratories across Europe for quality assurance of antimicrobial susceptibility testing has also been completed. Results of these activities are being prepared, or have been submitted, for publication. They should be available on the website in coming months.

The ESSTI network's co-financing application to the European Commission for 2005 to 2008 was recently approved. Plans for the future include extending the quality assurance programme for *Neisseria gonorrhoeae* isolates to the new states in the EU, instituting an annual quality assurance programme, and completing a survey of surveillance programmes in the new EU states.

Heatwave plan for England



The Department of Health has recently published the Heatwave plan for England (1). During a heatwave, when temperatures remain abnormally high over more than a couple of days, it can prove fatal. Climate change means heatwaves are likely to become more common in England and Wales. In one hot spell in London in August 2003, deaths among people aged over 75 rose by 60%.

The purpose of the Heatwave plan is to enhance resilience in the event of a heatwave. The Plan sets out the arrangements which will apply, and the actions required, in advance of, and during, a heatwave. The plan details what needs to be done by health and social care services and other bodies to raise awareness of risks relating to severe hot weather and what preparations both individuals and organisations should make to reduce those risks. The plan also makes clear the responsibilities at national and local level for alerting people once a heatwave has been forecast, and advising them what to do during a heatwave.

The core elements of the plan are:

- A 'Heat-Health' watch system operating from 1 July to 15 September, based on Meteorological Office forecasts, which will trigger levels of response from the Department of Health and other bodies.
- Advice and information issued by the Department of Health direct to the public and to health and social care professionals, particularly those working with at-risk groups, both before a heatwave is forecast and when one is imminent.
- Identification of individuals most at risk by primary care teams and social services. These people will be the first to receive advice on preventive measures. They may be assessed to see if they need extra care and support during a heatwave.
- Extra help, where available, from the voluntary sector, families, and others, to care for those most at risk, mainly older people and people with a disability.
- Using the media to get advice to people quickly both before and during a heatwave.

The Health Protection Agency will be contributing to the 'Heat-Health watch' system through the collaborative NHS Direct surveillance and RCGP surveillance systems that provide information of heat-related illness reflected in calls to NHS Direct and GP consultations.

Reference

1. Department of Health. *Heatwave plan for England*. London: Department of Health, 2004. Available at: <<http://www.dh.gov.uk/assetRoot/04/08/68/76/04086876.pdf>>.

Respiratory

Last updated: 5 August 2004
 Next update due: 2 September 2004

 [Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales: weeks 27-31/2004](#)



Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales: weeks 27-31/2004

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 27-31/2004

Week	27/04	28/04	29/04	30/04	31/04	
Week ending	04/07/04	11/07/04	18/07/04	25/07/04	01/08/04	Total
Influenza A	15	1	7	–	2	25
Isolation	–	–	–	–	–	–
DIF	–	1	–	–	–	1
Four-fold rise in paired sera	1	–	–	–	–	1
PCR	2	–	–	–	–	2
Other	12	–	7	–	2	21
Influenza B	1	–	–	–	–	1
Isolation	–	–	–	–	–	–
DIF	–	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–	–
PCR	–	–	–	–	–	–
Other	1	–	–	–	–	1
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 27-31/2004

Week	27/04	28/04	29/04	30/04	31/04	Total
Week ending	04/07/04	11/07/04	18/07/04	25/07/04	01/08/04	
Adenovirus*	32	42	18	28	27	147
Coronavirus	–	–	–	–	–	–
Parainfluenza†	11	5	13	5	5	39
Rhinovirus	2	1	2	7	6	18
Respiratory syncytial virus (RSV)‡	3	3	7	4	8	25

*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 27-31/2004

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥65 years	Unknown	Total
Adenovirus*	20	10	8	79	17	10	1	147
Coronavirus	–	–	–	–	–	–	–	–
Influenza A	–	–	7	4	5	8	1	25
Influenza B	–	1	–	–	–	–	–	1
Parainfluenza†	22	4	2	3	7	1	–	39
Rhinovirus	11	2	1	1	2	1	–	18
Respiratory syncytial virus (RSV)‡	16	2	–	2	3	2	–	25

*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 27-31/2004

Week	27/04	28/04	29/04	30/04	31/04	Total
Week ending	04/07/04	11/07/04	18/07/04	25/07/04	01/08/04	
<i>Coxiella burnetii</i>	2	–	2	1	–	5
Respiratory <i>Chlamydia</i> sp†	–	1	4	4	3	12
<i>Mycoplasma pneumoniae</i>	3	2	13	10	8	36
<i>Legionella</i> sp	11	6	7	9	10	43

†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 27-31/2004

Week	27/04	28/04	29/04	30/04	31/04	Total
Week ending	04/07/04	11/07/04	18/07/04	25/07/04	01/08/04	
Nosocomial	–	–	–	–	–	–
Community	5	1	3	5	4	18
Travel abroad	6	5	2	4	6	23
Travel UK	–	–	2	–	–	2
Total	11	6	7	9	10	43
Male	9	4	7	6	7	33
Female	2	2	–	3	3	10

* Non-pneumonic cases in brackets.

Forty-three cases were reported with pneumonia, 33 males aged between 31 and 83 years and ten females aged between 48 and 84 years. Eighteen cases were community acquired infections. Six deaths were reported, (F 49y and F 84y, and four males aged between 54 and 63 years).

Twenty-five cases were travel associated: Italy 6, Malta, Spain, two each, and Antigua, Belgium, France & Netherlands, England, England and Jersey, England and Netherlands, England and Turkey, France, Greece, Greece and Italy, Mexico, Netherlands, Sri Lanka, Switzerland, Thailand, and Turkey one each.

Travel health

Last updated: 5 August 2004
Next update due: 3 September 2004

Imported Infections, England and Wales: April to June 2004

Imported Infections, England and Wales: April to June 2004

This second quarterly report on imported infections in England and Wales covers the period from April to June 2004. The data presented below must be interpreted with caution and it is recommended that the section 'Sources of data on travel-associated illness and their limitations for analysis' in *Illness in England, Wales, and Northern Ireland associated with foreign travel – a baseline report to 2002* (1) be used for guidance on interpretation of data on travel-associated illness. Please note that all data are provisional and subject to change; the confirmed final data will be presented annually.

In general, there were fewer infections reported in England and Wales via LabBase in the second quarter of 2004 (13,855) compared to the same period in 2003 (17,204)*. Travel history reporting however, has improved slightly from 11.6% of reports stating any information at all on travel in 2003 to 14.5% in 2004, although the proportion is still very low and limits the interpretation of the data.

Gastrointestinal infections

Gastrointestinal infections are generally the most commonly reported illnesses associated with foreign travel. In the second quarter of 2004, *Salmonella* spp (non-typhoidal) were the most frequently reported bacterial infections that stated 'recent travel abroad' (467/2292), although *Campylobacter* infections were the most frequently reported in England and Wales (9928 reports, of which 293 stated recent travel abroad). Travel history continues to be more complete for *Salmonella* infections (57.2% of reports stated a travel history) than for *Campylobacter* infections (4.6%) and they are both slightly higher proportions than for the first quarter of 2004. In the second quarter of 2003, only 45% of laboratory reports of *Salmonella* and 4% of *Campylobacter* infections had a travel history stated. (NB. Data collected by the *Campylobacter* Sentinel Surveillance Scheme suggest that the proportion of *Campylobacter* spp reports that are associated with foreign travel is more likely to be 20% (2). Travel history reporting in LabBase for *Campylobacter* spp is underestimated.)

Of *Salmonella* infections that stated recent travel abroad in the second quarter of 2004, 36% (167/467) travelled to Europe, of which 62% (103/167) travelled to Spain, 11% to Greece (19/167), and 10% (17/167) to Portugal. Thirty-five per cent (95/467) of those stating recent travel abroad, travelled to the Indian sub-continent (Pakistan and India the most frequently reported), 13% (59/467) reported recent travel to north Africa and the middle east, 11% (50/467) to south east Asia and the far east, and 9% (42/467) had no country of travel stated. A similar trend was seen for *Campylobacter* infections; 41% (120/293) of those that stated recent travel abroad travelled to Europe (60% (72/120) to Spain and Spanish islands), and 24% (69/293) to the Indian sub-continent (39/69 to India).

In this same period, there were 69 reports of gastrointestinal illness events†, 28 due to *Salmonella* and 25 due to *Campylobacter*, although these are not confirmed or typed further. Seventeen out of 53 of outbreaks caused by these two organisms were associated with travel to Spain.

There were 50 laboratory reports of *Salmonella* Typhi, of which 25 had reported recent travel abroad, 16/25 to the Indian sub-continent (Pakistan 7, India 6, Bangladesh 2, Nepal 1), sub-Saharan and southern Africa five, south east Asia and the far east two, and country not stated two. There were 52 reports of *Salmonella* Paratyphi (S. Paratyphi A 25 and S. Paratyphi B 2), of which 35 reported recent travel abroad, 32/35 to the Indian sub-continent (India 25, Pakistan 5, Bangladesh 1, Sri Lanka 1), country not stated two, and Bulgaria one.

There was one report of cholera in the second quarter of 2004, but travel history was unknown.

Twenty-four per cent (48/197) of all reports of *Shigella* infection reported recent travel abroad, 63% (30/48) of which specified travel to the Indian sub-continent, 19 of those were due to *Shigella sonnei*. Data for *S. boydii* and *S. dysenteriae* were unavailable.

There was a 25% reduction in the total number of *Giardia lamblia* infections reported in the second quarter of 2004 compared to the same period in 2003, but the number of infections specifying recent travel abroad were much the same (56 in 2004, 57 in 2003). The proportion of infections where any travel history had been stated improved slightly from 8.5% in 2003 to 11% in 2004. *Entamoeba* spp were reported in much smaller numbers in this quarter compared with 2003. There were three individuals with dual infections, F 35y with *Entamoeba coli* and *Giardia lamblia* who had travelled to India, F 43y with *Endolimax nana* and *Giardia lamblia* who had also travelled to India, and F 27y with *Entamoeba histolytica* and *Endolimax nana* who was from Ethiopia (not known whether immigrant or traveller).

Table 1 Imported Infections: gastrointestinal infections data

Organism	Total reports for Apr to Jun				Cumulative totals for Jan to Jun			
	2004*		2003		2004*		2003	
	Travel-related	All reports	Travel-related	All reports	Travel-related	All reports	Travel-related	All reports
Gastrointestinal Infections								
Bacterial								
<i>Salmonella</i> spp	467	2292	587	3074	729	3768	931	4852
<i>Campylobacter</i> spp	293	9928	370	12034	527	17,404	620	20,217
<i>Shigella flexneri</i>	16	47	7	57	23	96	15	142
<i>Shigella dysenteriae</i> †								
<i>Shigella sonnei</i>	29	127	25	162	44	243	45	302
<i>Shigella boydii</i> †								
<i>Shigella</i> unknown spp	3	23	–	16	3	57	1	28
<i>Salmonella Typhi</i>	25	50	40	75	50	91	66	117
<i>Salmonella</i> Paratyphi (A,B,C)	35	52	42	64	56	83	57	103
<i>Vibrio cholerae</i> (Type O1)‡	–	1	1	1	1	2	1	1
<i>Vibrio parahaemolyticus</i>	3	4	1	2	5	7	3	8
<i>Vibrio enterocolitica</i>	–	–	–	–	–	–	–	–
Protozoal								
<i>Entamoeba histolytica</i>	6	36	18	79	11	67	28	129
<i>Entamoeba coli</i>	2	16	1	13	5	38	3	32
<i>Giardia lamblia</i>	56	534	57	715	120	1153	129	1429
<i>Cryptosporidium</i> spp	14	644	21	626	30	1162	41	1170
<i>Cyclospora</i> spp	5	19	7	19	5	21	7	20
<i>Endolimax nana</i>	2	4	–	9	4	11	3	34
Helminths								
<i>Strongyloides stercoralis</i>	–	3	–	8	–	9	–	9
<i>Strongyloides</i> spp	–	–	–	2	–	–	–	3
<i>Ancylostoma duodenale</i>	–	1	1	1	–	1	1	1
<i>Necator americanus</i>	–	–	–	–	–	–	–	–
Hookworm unspecified	2	4	1	37	2	7	3	49
<i>Ascaris lumbricoides</i> (round worm)	4	21	4	34	6	37	4	53
<i>Trichuris trichiura</i> (whip worm)	1	8	2	44	2	18	2	56
<i>Hymenolepis diminuta</i>	–	–	–	–	–	–	–	–
<i>Hymenolepis nana</i>	1	2	–	5	1	4	1	10
<i>Hymenolepis</i> spp	–	–	–	–	–	–	–	–
<i>Taenia saginata</i>	–	3	–	–	1	15	1	10
<i>Taenia</i> spp.	–	3	1	16	1	14	1	26
<i>Gnathostoma</i> spp	–	–	–	–	–	1	–	1

*All data for 2004 is provisional and subject to change.

† Data for *S. boydii* and *S. dysenteriae* not available.

‡ Data on cholera supplied by the SMRD Laboratory of Enteric Pathogens.

Helminths

In the second quarter of 2004, there were 20 laboratory reports of *Ascaris lumbricoides*; only four specified recent travel abroad. Of those, M 24y was a recent immigrant (country not stated) and was co-infected with hookworm (genus and species unknown), *Entamoeba histolytica* and *Entamoeba coli*, and one F 22y was co-infected with *Trichiuris trichuria* (country of travel not stated).

There were two reports of *Hymenolepis nana* infection, M 35y specified recent travel to India and was co-infected with *Giardia lamblia*.

Arthropod borne infections

There were five laboratory reports of dengue virus in the second quarter of 2004, none of which specified any travel history and one of which was serotype 3, the others were untyped.

There was one report of Ross River virus in the second quarter of 2004; travel history was unknown, although this virus is usually associated with travel to Australia.

Eighty-two reports of Lyme borreliosis were received during the quarter of which, 16 (20%) reported overseas travel. One patient diagnosed with neurological symptoms had received a tick bite in Poland in 2002. Four patients reported initial exposure in 2003, but with recurrent or continuing symptoms (Austria 1, Czech Republic 1, France 1 and 'Europe' 1). One patient was an immigrant worker from Poland. Four patients reported exposure in Scandinavia. Exposures were also reported in France (2), Greece (1), Italy (1), Black Forest region in Germany (1), and Old Lyme, United States (1). Most of these patients reported a tick bite followed by erythema migrans; other symptoms reported include neurological signs, arthritis, and lethargy. This level of travel-associated infection is consistent with the experience of recent years.

Other infections

There were eleven laboratory reports of schistosomiasis, five caused by *Schistosoma mansoni*, of which one reported recent travel to Zambia and four were caused by *Schistosoma haematobium*, of which one reported recent travel to Zimbabwe. Two reports were unspciated.

One overseas-acquired case of leptospirosis was identified out of a total of four reported during the quarter.

There were 48 cases of Legionnaires' disease reported in the second quarter of 2004, 29 were related to travel abroad, of which two died. Three cases were involved in three separate outbreaks that occurred in Mexico and Antigua.

If there are any queries or comments on the above data, please contact the Travel Health Surveillance Section the Communicable Disease Surveillance Centre, Health Protection Agency, email: <thss@hpa.org.uk>.

Table 2 Imported Infections: arthropod borne infections data

Organism	Total reports for Apr to Jun				Cumulative totals for Jan to Jun			
	2004*		2003		2004*		2003	
	Travel-related	All reports	Travel-related	All reports	Travel-related	All reports	Travel-related	All reports
Arthropod borne infections								
Arboviruses								
Dengue virus	–	5	–	1	–	8	1	5
Chikungunya virus	–	–	–	–	–	–	–	–
Ross river virus	–	1	–	1	–	1	–	1
Sandfly fever virus	–	–	1	1	–	–	1	1
Unspecified					–	–	–	1
Leishmaniases								
Cutaneous	–	1	4	4	3	4	9	12
Visceral	–	–	1	1	–	–	1	1
Unspecified	–	1	–	–	–	1	–	1
Filariases								
Loa loa	–	1	–	–	–	1	–	–
<i>Wuchereria bancrofti</i>	–	–	–	1	–	–	–	1
<i>Mansonella perstans</i>	–	–	–	–	–	–	–	1
<i>Onchocerca volvulus</i>	–	–	–	–	–	–	–	–
Unspecified	–	–	–	1	–	–	1	2
<i>Lyme borreliosis</i> †	16	82	6	39	20	104	11	53
Miscellaneous								
Schistosome infections								
<i>Schistosoma mansoni</i>	1	5	2	2	1	7	2	6
<i>Schistosoma haematobium</i>	1	4	6	12	3	11	11	28
<i>Schistosoma intercalatum</i>	–	–	–	–	–	–	–	–
Schistosoma unknown spp	–	2	–	2	2	9	–	3
Other infections								
Leptospirosis†	1	4	–	7	1	8	–	19
Legionnaires' disease‡	29	48	33	67	40	84	53	121
<i>Coxiella burnetii</i> (Q fever)	1	12	–	15	1	19	1	28
Rickettsia spp	–	–	1	1	–	–	1	1

*All data for 2004 is provisional and subject to change.

†The Zoonoses Surveillance Reference Unit, CDSC Wales, supplied data for Lyme borreliosis and leptospirosis on behalf of the Leptospira Reference Unit, Hereford and the Lyme Disease Reference Unit, Southampton.

‡ Data on legionnaires' disease were supplied by the Legionella Section of the Respiratory Department of CDSC and represent cases of legionnaires' disease reported to the National Surveillance Scheme in residents of England and Wales. Travel-related cases are those who have spent all or part of the incubation period of between two and ten days abroad prior to onset of symptoms.

Most of the data was extracted from LabBase (non-provisional database) on 7 July 2004 using earliest specimen quarter unless otherwise stated. Information on travel history was extracted using the 'Recent travel abroad' field, the comments field and the feature fields 'Acquired in GB', 'Lived/travelled abroad in past', and 'Travel abroad'.

References

1. Health Protection Agency. *Illness in England, Wales, and Northern Ireland associated with foreign travel – a baseline report to 2002*. London: HPA, 2004. Available at <http://www.hpa.org.uk/infections/topics_az/travel/pdf/full_version.pdf>..
2. The *Campylobacter* Sentinel Surveillance Scheme Collaboration. Foreign and domestic travel and the risk of *Campylobacter* infection: results from a population-based sentinel surveillance scheme. *J Travel Med* 2003; **10**: 136-8.

Zoonoses

Last updated: 5 August 2004
Next update due: 2 September 2004

Common animal associated infections, England and Wales laboratory reports: weeks 27-31/04

Common animal associated infections, England and Wales laboratory reports: weeks 27-31/04

	Total reports for weeks 27-31		Cumulative totals for weeks 01-31	
	2004*	2003	2004*	2003
<i>Borrelia burgdorferi</i> *‡	26	95	110	154
<i>Leptospira hardjo</i> †§	–	–	–	–
<i>Leptospira icterohaemorrhagiae</i> †§	–	–	3	4
<i>Leptospira other</i> †§	–	–	5	7
<i>Pasteurella haemolytica</i>	3	1	8	3
<i>Pasteurella multocida</i>	23	22	167	155
<i>Pasteurella pneumotropica</i>	2	3	5	7
<i>Pasteurella</i> spp	3	12	49	51
<i>Toxocara canis</i>	–	–	–	–
<i>Toxocara cati</i>	–	–	–	–
<i>Toxocara</i> spp	–	2	3	3
<i>Toxoplasma gondii</i>	2	2	17	22
<i>Toxoplasma</i> spp	7	5	32	39
<i>Capnocytophaga</i> spp	–	–	3	5
<i>Capnocytophaga canimorsus</i>	–	–	1	–
<i>Echinococcus granulosus</i>	–	–	2	6
<i>Coxiella burnetii</i>	5	1	24	25
<i>Chlamydia psittaci</i>	10	10	44	51
<i>Brucella</i> spp	1	–	6	4
Orf-paravaccinia virus	1	–	1	5

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

§ *Leptospira* Reference Laboratory and CDSC. NA = Not available.

Comment

Lyme borreliosis

M 34y deer stalker with recent tick bites; F 27y tick bite, rash & fatigue; M 43y tick bite, myalgia, arthralgia; F 53y tick bite in France, rash; F 81y tick bite; F 64yr resident in UK Lyme endemic area; F 53y tick bite in New Forest, rash; F 55y with erythema migrans; M 74y tick bite, rash on leg; M 9y rash, facial palsy, school outing to nature reserve; M 73y rash, neuropathy, possible exposure in Greece; M 34y tick on buttock; F 34yr tick bite, erythema migrans; F 67y tick bite, resident in UK endemic area; F 75y erythema migrans, resident in UK endemic area; F 7y erythema migrans,

flu-like illness, resident in UK endemic area; M 63yr erythema migrans; F 56y tick bite, erythema migrans; F 59y tick bite, fever, rash; F 36y tick bite, erythema migrans; M 63y, M 61y, F 70y, F 33y, F 40y, M 34y with no clinical details

Leptospirosis: No cases were identified this month

Pasteurellosis

Pasteurella multocida: F 65y and F 68y with a cat bite, F 21y with dog bite to face, M 60y with skin infection, M 73y with 'animal contact', 9nine females aged 17 to 84y, nine males aged 46 to 86y with no clinical details.

Pasteurella pneumotropica: F 68y, M 79y.

Pasteurella haemolytica: M 8y, M 46y, F 84y.

Pasteurella spp: F 47y, M 68y, M 84y.

Toxoplasmosis

Toxoplasma gondii: F 27y HIV positive and pregnant with epilepsy and calcified lesions, M 45y with no clinical details

Toxoplasma spp: F 27y, M 52y, M 58y, M 38y, M 36y, M 2m, M age not stated.

Q fever: M 26y, M 31y, M 33y, M 55y all with acute Q fever, F 53y with no clinical details

Psittacosis

Chlamydia psittaci: M 66yr with EAE, M 35yr with persistent cough, M 34y, M 45y, M 46y, M 53y, M 58y, M 59yr, F 18y, F 38y with no clinical details

Brucellosis

Brucella spp: M 37y with no clinical details

Orf-paravaccinia virus: F 13y with no clinical details