








CDR WEEKLY

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News

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Three fatal human cases of avian influenza in Viet Nam

On 12 August 2004, the World Health Organization (WHO) issued a statement confirming that three previously reported deaths in Viet Nam, which occurred between 2 and 6 August, were due to infection with avian influenza. So far, samples from two of the three cases have tested positive for H5N1. The three fatalities consist of a woman aged 25 years from the southern Hau Giang province, and a girl aged 11 months and a boy aged 4 years from the northern Ha Tay province; additional laboratory testing is being conducted. The most recent case died on 6 August and no new human cases have been identified since then.

Samples have also been taken from poultry and other domestic animals as part of an epidemiological investigation into sources of infection and modes of transmission in the current outbreak. Further information is available from WHO website at http://www.who.int/csr/disease/avian_influenza/en/.

Vietnamese health authorities have also reported that a hospitalised woman in Ho Chi Minh City has also tested positive for H5N1, but this has not yet been confirmed by WHO.

A 'second wave' of avian influenza has been occurring in poultry in several Asian countries since 5 July 2004. One outbreak occurred in China, which was controlled, and additional outbreaks have been occurring in Thailand and Viet Nam, where control efforts are underway.

A small WHO team has been assembled and will be travelling to Viet Nam around the weekend of 20 August. On the basis of the WHO information, the current guidance on the Health Protection Agency website remains unchanged, and can be found at http://www.hpa.org.uk/infections/topics_az/avianinfluenza/menu.htm.

Second possible case of transfusion-transmitted variant CJD

A recent issue of the *Lancet* reported a second possible case of transfusion transmitted variant Creutzfeldt-Jakob disease (vCJD) (1,2). In 1999 an elderly patient received a unit of non leuco-depleted red blood cells (*ie*, containing white blood cells). The donor developed symptoms of vCJD 18 months after donation and died in 2001. The diagnosis of vCJD in the donor was confirmed at post mortem. The recipient died of causes unrelated to vCJD five years after the transfusion. Autopsy performed on the recipient detected protease-resistant prion protein (PrP^[res]) – the agent of vCJD – in the spleen and within a cervical lymph node. The patient was a United Kingdom (UK) resident, so dietary exposure to bovine spongiform encephalopathy (BSE) is possible. It is uncertain whether the individual would have subsequently developed clinically evident vCJD or posed a risk for iatrogenic transmission (*ie*, infection via a healthcare related source). The patient has a different genetic type to that found so far in people with vCJD, which has implications for future estimates of vCJD in the UK.

All cases who develop vCJD are reported by the National CJD Surveillance Unit to the UK Blood Services, and blood donation records are checked. If blood has been donated, any in-date stocks are immediately destroyed and recipients of transfused blood components are traced. Precautions established by the Blood Services to reduce the risk of transmission of vCJD by blood transfusion include the removal of white blood cells (since 1999, a process known as leuco-depletion), the use of virally inactivated fresh frozen plasma (FFP) obtained outside the UK for vulnerable groups (children born after 1 January 1996), importation of plasma for fractionation (since 1998) and the exclusion of donors who have received a blood transfusion in the UK since 1980 (implemented in April 2004) (3).

This is the first recorded case in the UK of autopsy detection of preclinical vCJD. The authors of the report see a clear role for autopsy in investigation and diagnosis of clinical and preclinical forms of human prion disease. This case highlights the need for ongoing surveillance for CJD in the UK.

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2. Llewelyn CA, Hewitt PE, Knight RS, Amar K, Cousens S, Mackenzie J, *et al*. Possible transmission of variant Creutzfeldt-Jakob disease by blood transfusion. *Lancet* 2004; **363**:417-21.
3. Department of Health. *Update on precautions to protect blood supply (press release 2004/0270)*. London: Department of Health, 22 July 2004. Available at <http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotic/PressReleasesNotices/fs/en?CONTENT_ID=4086160&chk=9/Ni4w>.

Department of Health CMO letter on influenza and pneumococcal immunisation programmes

The annual Chief Medical Officer (CMO) letter on the influenza and pneumococcal immunisation programmes was published on 9 August 2004 (1).

Influenza immunisation 2004/05

Influenza policy remains unchanged, with immunisation recommended for all people aged 65 years and over, those aged over 6 months in a clinical risk group, and those staying in long term residential care homes. As in previous years, NHS employers should offer immunisation to employees directly involved in patient care.

The target uptake among people aged 65 years and over will remain at 70% nationally. As in previous years, the Health Protection Agency will take the lead in monitoring uptake on behalf of the Department of Health (DH). Reporting will be through the web-based vaccine tracking programme, sponsored by the DH, and is part of the mandate for all transfers of data in the NHS to be sent electronically via web-based reporting systems by 2005.

Pneumococcal immunisation

From 1 April 2004, all people aged 75 years and over who have not previously been immunised against pneumococcal infection should be offered pneumococcal polysaccharide vaccine. From April 2005, in the second phase of the immunisation programme, all those aged 65 years and over should be offered immunisation.

The Joint Committee on Vaccination and Immunisation (JCVI) has recommended that pneumococcal conjugate vaccine should now be recommended for at-risk children aged under five years. In addition, the risk groups recommended to receive pneumococcal vaccine have been revised by JCVI to include new risk groups, and to clarify existing risk groups.

The full CMO letter is available from the DH website at:
<<http://www.dh.gov.uk/assetRoot/04/08/73/40/04087340.pdf>>.

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1. Chief Medical Officer. *Update on the influenza and pneumococcal immunisation programmes. PL CMO (2004)4*. London: Department of Health, 2004. Available at <<http://www.dh.gov.uk/assetRoot/04/08/73/40/04087340.pdf>>.



Audit tools for monitoring infection control standards 2004

Audit tools for monitoring infection control standards 2004 written by a working group of the Infection Control Nurses Association (ICNA), funded by the Department of Health and with a foreword from the Chief Medical Officer and Chief Nursing Officer England, was published in July 2004. Originally developed by the West Midlands ICNA, this audit tool has been developed and updated in consultation with infection control teams and other key stakeholders. They provide a standardised method for monitoring both clinical practice, and the clinical environment. Developed initially for acute and intermediate care areas, they are relevant to other health care settings. Guidelines for using the audit tools include instructions on using scores to allocate a level of compliance, and how to give feedback. The package includes a database that can be installed onto desktop and/or pocket PCs.

Copies of the complete audit tool are available from Fitwise, email: <info@fitwise.co.uk> or as a downloadable file from the ICNA website <www.icna.co.uk>.