



CDR WEEKLY

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Variant Creutzfeldt-Jakob disease and plasma products: implementation of public health precautions in the UK 

The CJD Incidents Panel (CJDIP), an expert committee set up to advise on the management of “incidents” of potential transmission of CJD between patients, has issued recommendations on the management of variant Creutzfeldt-Jakob disease (vCJD) risk from implicated plasma products.

To date, nine UK plasma donors are known to have developed vCJD. Collectively, they made 23 plasma donations. The donated plasma was used to manufacture factor VIII, factor IX, antithrombin, intravenous immunoglobulin G, albumin, intramuscular human normal immunoglobulin, and anti-D.

The potential risk of vCJD infection following treatment with any implicated plasma products, on top of the risk from dietary exposure to the BSE agent, is very uncertain. So far, there are no recorded instances of vCJD being spread through surgery, nor have there been any cases among recipients of plasma products sourced from individuals who later developed vCJD. In December 2003, the death of a person from vCJD some years after receiving a blood transfusion from a donor who themselves died of vCJD, was announced. In July 2004 a second probable case of transfusion-associated vCJD infection was identified. These two events have increased concern about the potential infectivity of blood and plasma products

Public health precautions against vCJD

The CJDIP now recommends that certain special public health precautions need to be taken for some recipients of UK sourced plasma products that were manufactured using donations from individuals who subsequently developed vCJD. This is in order to reduce any possible risk of iatrogenic transmission of vCJD (*ie*, disease or infection acquired via a healthcare setting).

The CJDIP has used a vCJD blood risk assessment

<http://www.dnv.com/consulting/news_consulting/RiskofInfectionfromvariantCJDinBlood.asp> together with information on how the particular batches of plasma products were manufactured, to assess the potential levels of infection that patients were exposed to.

The CJDIP advises certain special public health precautions need to be taken for recipients of UK sourced plasma products who have been exposed to a 1% or greater potential additional risk of vCJD infection as these patients could pose a risk to others in defined circumstances. These “at risk” patients are asked:

- not to donate blood, organs or tissues, and
- to inform their clinician if they need medical, surgical or dental treatment, so that infection control precautions can be taken <<http://www.advisorybodies.doh.gov.uk/acdp/tseguidance/>> to reduce any possible risk of spreading vCJD, and to consider informing their family, in case the patient needs emergency surgery in the future.

The CJDIP has categorised each batch of implicated plasma products according to the likelihood that special public health precautions need to be taken as follows:

- **High:** the amount of potential infectivity in product batches was high enough to warrant special public health precautions following the administration of a very small dose. These batches should be traced, the recipients advised of their exposure and asked to take special public health precautions.
- **Medium:** substantial quantities of the material in question would need to have been administered to warrant special public health precautions. Efforts should be made to trace these batches and assess the additional risk to individual recipients to determine if special precautions should be taken.
- **Low:** the potential additional risk to recipients is considered negligible. These batches do not need to be traced and the individual recipients do not need to be informed.

This categorisation is based on very cautious assumptions, and the uncertainties underlying the assessment of 'risk' are great. The CJDIP guidance is to limit any possible iatrogenic human-to-human transmission of vCJD. It should **NOT** be interpreted as an estimate of an individual patient's additional risk of developing vCJD, which is uncertain, and likely to be very low.

Informing patients

The patients who may be affected include some patients with bleeding disorders, primary immunodeficiency (PID), and with other conditions, who may include, for example, patients with secondary immunodeficiencies, certain neurological and autoimmune conditions, plasma exchange recipients, patients with severe burns, and those with some other conditions requiring critical care.

Patients who are 'at-risk' of vCJD for public health purposes are being contacted by their doctors and informed of the precautions they will need to take.

The **MAIN MESSAGES** for patients are:

1. **ALL** people treated regularly with plasma products , eg, patients with bleeding disorders or primary immunodeficiency (PID) are being contacted by the specialist doctor responsible for their care.
2. Hospitals will trace other people who received implicated plasma products , eg, for emergency treatment of severe burns) and arrange to have their exposure assessed. Individuals will be contacted **ONLY IF THEIR EXPOSURE IS IDENTIFIED AND WARRANTS FURTHER ACTION**. The process of traceback and assessment may take a number of weeks, and, where treatment took place a number of years ago, it may not be possible to find out who received the implicated plasma products.
3. People who have received intramuscular immunoglobulins (eg anti-D for Rhesus negative pregnant women; human normal immunoglobulin for travel prophylaxis for hepatitis A) are **NOT** considered to be 'at-risk' and no action is needed.

Sources for Additional information

The Health Protection Agency's (HPA) CJD section at the Communicable Disease Surveillance Centre (Colindale) is co-ordinating the patient notification in England, Wales, and Northern Ireland. The Scottish Centre for Infection and Environmental Health (SCIEH) is co-ordinating this notification in Scotland. Background information about vCJD with useful links is available from their websites:

HPA: <http://www.hpa.org.uk/infections/topics_az/cjd/menu.htm>.

SCIEH: <<http://www.show.scot.nhs.uk/scieh>>.

Probable Lassa fever in traveller returning from west Africa



Preliminary tests performed on 14 September 2004 at the Health Protection Agency (HPA), Colindale, indicated Lassa fever virus infection in a patient who has returned to the United Kingdom (UK) from west Africa. Confirmatory tests are in progress, together with virus isolation.

The patient had travelled in west Africa (Ivory Coast and Chad) for a month, before returning to the UK on 9 September 2004. He became unwell the next day with fever, and attended his local Accident and Emergency Department two days later. He was admitted in the early morning of 13 September and when the diagnosis was suspected to be Lassa, he was transferred to medium secure facilities. After initial tests suggested Lassa fever, he was started on ribavirin and transferred to high security infectious disease facilities. He remained well with a low-grade fever, and remained haemodynamically stable. He was discharged from hospital after tests were persistently negative and he had been afebrile (*ie*, non feverish) for three days.

Contacts are being followed up for 21 days, although all are considered to be low risk.

Staff who cared for the patient, handled his specimens or otherwise had contact, visitors of the patient, and other community contacts are being monitored through recording daily temperatures, following the guidance in the 1996 memorandum (1). Possible non-hospital contacts have been assessed as low risk, and are self-monitoring their temperature.

As he was well and asymptomatic at the time of his travel, and Lassa patients are thought not to be infectious until symptomatic, no travel contacts are being followed up.

Only six cases of Lassa fever have been imported into the UK since 1976.

Lassa background

Lassa fever is a zoonosis, an infection acquired from *Mastomys natalensis*, the multimammate rat. It is endemic in west Africa. The risk of further transmission to humans of Lassa fever in the UK from imported cases is extremely low and the natural reservoir is not found in the UK. Risk is confined to those who have had direct physical contact with body fluids from the patient during the infectious period. There have been no recorded transmissions by such a route in the UK, including 74 health care worker contacts followed up by serology after the case in 2000 (2). There is no risk to the general public including travelling companions. A review of casual contacts that took place in the 1960/70s found no transmission among airline passengers travelling with confirmed Lassa cases (3).

References

1. Advisory Committee on Dangerous Pathogens. Management and control of viral haemorrhagic fevers. London: The Stationery Office 1996.
2. CDSC. Lassa fever imported to England. *Commun Dis Rep CDR Wkly* 2000; **10**(11): 99..
3. Galbraith NS, Berrie JRH, Forbes P, Young S. Public Health aspects of viral haemorrhagic fevers in Britain. *J R Soc Health* 1978; **98**: 152-160.

Update on hepatitis A outbreak linked to hotel in Egypt



Six cases of hepatitis A infection with a history of travel to Egypt have been reported in England and Wales between end of August to end of September (1). Five cases are now confirmed to have stayed at the particular hotel of interest, while the sixth case stayed at a separate hotel. Further details on the outbreak are available at: <http://www.eurosurveillance.org/ew/2004/040909.asp>.

Please report any further cases with history of travel to Egypt that might be linked to this outbreak to Julia Granerød, at the Health Protection Agency's Immunisation Department, tel: 020 8327 7060, email: Julia.granerod@hpa.org.uk.

References

1. HPA. Hepatitis A outbreak linked to hotel in Egypt. *Commun Dis Rep CDR Wkly* [serial online] 2004 [cited 21 September 2004]; **14**(36): News. Available at: <http://www.hpa.org.uk/cdr/PDFfiles/2004/cdr3604.pdf>..

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Laboratory reports of invasive meningococcal infections, England and Wales: weeks 17-20/2004

	Method of diagnosis			Total reports		Cumulative*
	CSF and blood Culture	Non-culture	Other sites	17-20/04	Total to week 20/2004	
Group A	–	–	–	–	1	
B	29	29	2	60	527	
C	1	–	–	1	31	
W135	3	–	–	3	21	
X	–	–	–	–	–	
Y	2	–	–	2	14	
Z	–	–	–	–	–	
29E	–	–	–	–	–	
Ungroupable	1	–	–	1	1	
Ungrouped	–	3	–	3	24	
Total	36	32	2	70	619	

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



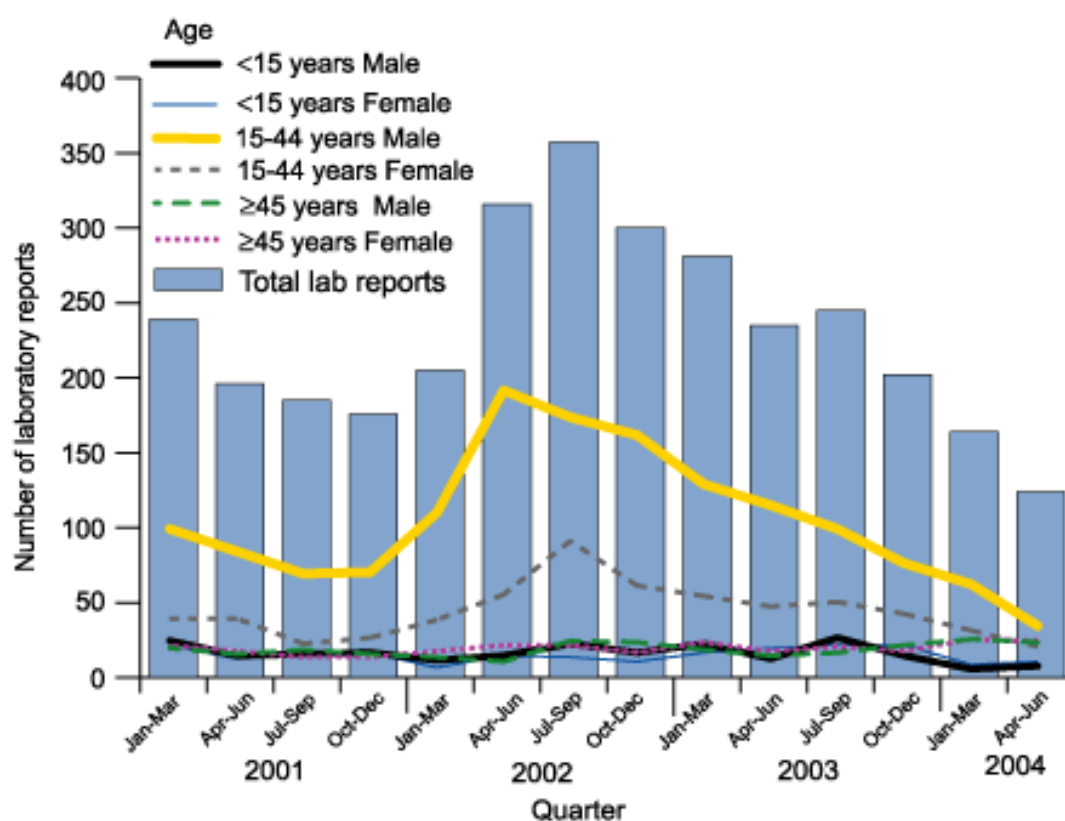
Laboratory reports of hepatitis A infection in England and Wales: April to June 2004

During the second quarter of 2004, 125 laboratory reports of hepatitis A were made to the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC), 47% (110) less than in the equivalent quarter of 2003. The last five quarters have seen a decrease in the number of cases compared to the equivalent quarters in the previous year. Twenty-eight per cent (35) were men aged between 15 and 44 years (table) and the majority of cases occurred in the Yorkshire and Humberside region. Seven people acquired their infection abroad (Pakistan 5; India 1; and South Africa 1) and three infections were reported to be in injecting drug users (IDUs). The overall number of cases of hepatitis A in the second quarter of 2004 decreased by 24% (39), compared to that of the first quarter of 2004. This is similar to last quarter and is compatible with the general declining trend seen following the 2002 outbreak year (figure). Unlike last quarter, however, the decrease seen this quarter occurred in males and females aged over 45 years, whereas a slight increase was seen in children aged under 15 years. Similar to last quarter, the largest decrease was seen in males and females aged between 15 and 44 years, the age group where most increase has been seen previously.

Table Laboratory reports of hepatitis A infection in England and Wales: April to June 2004

Age Group (years)	Male	Female	Not known	Total
1-4	3	5	–	8
5-9	4	6	–	10
10-14	1	–	–	1
15-24	11	8	–	19
25-34	19	9	–	28
35-44	5	4	1	10
45-54	9	7	–	16
55-64	6	7	–	13
≥65	9	11	–	20
Total	67	57	1	125

Figure Number of laboratory reports of hepatitis A by age group and sex: January 2001 to June 2004



Under-reporting and variations in regional reporting continue to present a challenge. One hundred and sixty-six cases of hepatitis A were formally notified in the second quarter of 2004, 25% more than laboratory confirmed. The number of notifications exceeded the number of laboratory reports for four regions, while the number of laboratory reports exceeded the number of notifications for four other regions. In addition, in Wales and the North East, the same number of cases was notified and laboratory reported. Discrepancy between notifications and laboratory reports was highest in the South East and London regions. In these regions twenty-two and thirty-six cases were formally notified and only six and twelve laboratory reports were made, respectively.

The total number of laboratory reports, as well as the number of notifications, has decreased this quarter compared to last, which may reflect a real decrease in the number of cases of hepatitis A. This suggests that the outbreaks occurring in the IDU community are being controlled.

Priorities for improving control of hepatitis A include enhancing risk factor reporting by clinicians to laboratories and from laboratories to CDSC, increasing the speed and rates of notification of cases by clinicians to Health Protection Units, obtaining greater participation in laboratory reporting of cases especially in London, and providing better detection and definition of outbreaks through means such as the application of hepatitis A virus genotyping.

Laboratory reports of acute hepatitis B infection by age group and sex, England and Wales: April to June 2004

One hundred and ten cases of acute hepatitis B infection were reported to the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC) during the second quarter of 2004, compared to 167 reports in the equivalent quarter in 2003. The majority of cases (70%) occurred in those aged between 15 and 44 years (77/110). The ratio of males to females was 3.2:1 (table 1).

Table 1 Laboratory reports of acute hepatitis B infection by age group and sex, England and Wales: April to June 2004*

Age Group (years)	Male	Female	Not known	Total
<1	–	–	–	–
1-4	–	–	–	–
5-9	–	–	–	–
10-14	–	–	–	–
15-24	10	6	1	17
25-34	28	11	1	40
35-44	15	5	–	20
45-54	16	2	–	18
55-64	6	1	–	7
≥65	5	1	–	6
Not known	2	–	–	2
Total	82	26	2	110

* All data are provisional.

Forty-nine per cent (54/110) of reports had information on risk factor. Of these 42.5% (23/54) were acquired through injecting drug use, 31.5% (17/54) heterosexual exposure, and 13% (7/54) sex between men (table 2).

Table 2 Laboratory reports of acute hepatitis B infection by exposure category in England and Wales: April to June 2004*

Summary	Total
IVDU†	23
Sex between men and women	17
Sex between men	7
other identified risk	7
NRI	56
Total	110

* All data are provisional.

† Intravenous drug user.

Laboratory reports of hepatitis C infection in England and Wales: April to June 2004



One thousand seven hundred and eleven reports of hepatitis C infection were reported to CDSC during the second quarter of 2004. Sixty-four per cent of cases (1091/1711) occurred in those aged between 25 and 44 years. Cases in males exceeded those in females.

Table Laboratory reports of hepatitis C infection in England and Wales: April to June 2004*

Age Group (years)	Male	Female	Not known	Total
<1	–	–	–	–
1-4	7	8	1	16
5-9	1	1	1	3
10-14	3	1	1	5
15-24	70	81	4	155
25-34	345	184	10	539
35-44	400	148	4	552
45-54	206	67	4	277
55-64	51	19	1	71
≥65	41	36	2	79
Not known	8	2	4	14
Total	1132	547	32	1711

* All data are provisional.



COVER programme: April to June 2004

Quarterly vaccination coverage statistics for children aged up to five years in the United Kingdom

This report of the COVER programme presents quarterly coverage data for children in the United Kingdom (UK) who reached their first, second, or fifth birthday during the evaluation quarter, April to June 2004, and coincides with publication by the Department of Health of 2003-04 annual coverage data by Primary Care Trust (PCT) for children aged 12 months, 24 months, and five years, for England (1).

Children who reached their first birthdays in the quarter would have been scheduled to receive their third-dose primary vaccinations (third-dose diphtheria, tetanus, pertussis (DTP vaccine), *Haemophilus influenzae* type b (Hib vaccine), polio vaccine, and MenC vaccine) during the period between August and October 2003. Children who reached their second birthdays would have been scheduled to receive their third-dose primary vaccinations between August and October 2002 and first measles, mumps, and rubella (MMR) vaccination between April and October 2003. Children who reached their fifth birthdays would have been scheduled to receive their third-dose primary vaccinations between August and October 1999, their first MMR during the period between April 2000 and October 2001, their pre-school diphtheria, tetanus, acellular pertussis (DTaP) booster, polio, and second-dose MMR from August 2002 onwards. Two catch-up doses of MenC would have been scheduled for these children from mid-January 2000 onwards.

Methods

Data from computerised child-health information systems were submitted in August and September 2004 for children resident in Administrative Regions in Wales, Health Boards in Scotland and Northern Ireland, and British Forces Germany (BFG), and for children in the Primary Care Trust (PCT) responsible population (as defined below) in England, on 30 June 2004. Data were collected for those reaching their first, second, or fifth birthdays during the evaluation quarter (April to June 2004) and completing a primary course of each antigen: three doses of diphtheria (D3), tetanus (T3), pertussis (P3), polio (Pol3), *Haemophilus influenzae* type b (Hib3), Meningococcal conjugate Group C (MenC3) vaccines; and one dose of measles, mumps, and rubella (MMR1) vaccine given at any time up to their first or second birthdays. Numbers were also requested for children who had received a primary course of each antigen (DTPol3, P3, and Hib3), a pre-school booster dose (DTPol4), at least one MMR (MMR1), and two doses of MMR (MMR2) given at any time up to their fifth birthdays.

For this quarter, COVER data in England were collected by PCT and summarised by Government Office Regions (GORs) (2). The PCTs and GORs have different boundaries and populations to health authorities and regional health authorities used in previous reports. The PCT responsible population for COVER data includes all children registered with a general practitioner whose practice forms part of the PCT, regardless of where the child is resident. In addition, the PCT responsible population will also include any children not registered with a general practitioner (GP), who are resident within the PCTs statutory geographical boundary. Children resident within the PCT geographical area, but registered with a GP belonging to another PCT, are the responsibility of that other PCT

<http://www.hpa.org.uk/infections/topics_az/vaccination/eval_quarterly-.pdf>.

These data are evaluated against the World Health Organization (WHO) targets of 95% coverage annually for each antigen (except MenC) by two years of age at the national level and of at least 90% coverage annually in each strategic health authority (2).

Results

Coverage at 12 and 24 months

Data were received from 322 PCTs (England), Health Boards (Scotland and Northern Ireland), and Administrative Regions (Wales) (PCT/HB/AR) (tables 1 and 2). Eighty of the participating (PCT/HB/AR) (25%) achieved at least the 95% coverage at 12 months for three doses of diphtheria, tetanus, and polio vaccine (DTPol3). Seventy-five (23%) achieved at least 95% coverage at 12 months for three doses of Hib vaccine (Hib3), and 69 (21%) for three doses of pertussis vaccine (P3). One hundred and ninety-five PCT/HB/AR (60%) achieved at least 95% coverage at 24 months for DTPol3, 178 (55%) for P3, and 187 (58%) for Hib3. All countries and all English regions, except for London and Yorkshire and the Humberside, achieved at

least 90% coverage for these antigens. No PCT/HB/TR reached 95% coverage for MMR at 24 months. Compared to the previous quarter, UK coverage for all antigens at 12 months decreased by 0.4%, except for MenC, which stayed the same. UK coverage for all antigens at 24 months increased by 0.1%, except for DTPol3, which stayed the same, and MMR1, which decreased 0.4% to 81.5% (tables 1 and 2) (3).

Table 1 Completed primary immunisations (all antigens) by 12 months: April to June 2004

Region/Country	Reports * (total)	DTPol3 %	P3 %	Hib3 %	MenC %
Regions of England					
North East	14 (16)	92.7	92.2	92.6	92.5
North West	42 (42)	90.9	90.5	90.8	90.7
Yorkshire and Humberside	34 (34)	89.6	89.3	89.5	89.1
East Midlands	28 (28)	92.6	92.3	92.2	91.6
West Midlands	30 (30)	91.9	91.5	91.9	91.9
East of England	41 (41)	93	92.7	92.9	92.7
London	32 (32)	80.3	80.1	80.6	79.9
South East	47 (49)	91.6	91.3	91.5	91.4
South West	32 (32)	93	92.7	92.8	92.6
England (Total)	300 (304)	89.7	89.4	89.6	89.3
Wales	3 (3)	93.6	92.9	93.4	93.3
Northern Ireland	4 (4)	94.6	94.1	94.9	95
Scotland 6 years	15 (15)	95.5	95.2	95.3	94.7
United Kingdom	322 (326)	90.5	90.1	90.4	90.1

*PCTs/health boards/administrative regions

Table 2 Completed primary immunisations (all antigens) by 24 months: April to June 2004

Region/Country	Reports* (total)	DTPol3 %	P3 %	Hib3 %	MenC %	MMR1%
Regions of England						
North East	14 (16)	95.9	95.6	96	95.4	86.1
North West	42 (42)	94.5	94.1	94.2	94.4	83.3
Yorkshire and Humberside	34 (34)	93.9	93.6	94	93.1	83.6
East Midlands	28 (28)	96.4	96.1	96.3	95.5	86.1
West Midlands	30 (30)	94.9	94.5	94.6	94.8	83.1
East of England	41 (41)	95	94.7	95	94.4	81.5
London	32 (32)	86.6	86.4	87	85	69.5
South East	47 (49)	94.3	94	94.3	93.7	80.8
South West	32 (32)	96.1	95.7	95.8	95	81.4
England (Total)	300 (304)	93.5	93.2	93.5	92.8	80.5
Wales	3 (3)	96	95.1	96	95.5	82.1
Northern Ireland	4 (4)	97.2	96.7	97	96.3	88.5
Scotland 6 years	15 (15)	97.4	97.1	96.7	96.6	88
United Kingdom	322 (326)	94.1	93.7	94	93.3	81.5

* PCTs/health boards/administrative regions

The country specific 12-month coverage for MenC vaccine was 89.3% in England, 93.3% in Wales, 95.0% in Northern Ireland, and 94.7% in Scotland. Coverage for the 24-month cohort was 92.8% in England, 95.5% in Wales, 96.3% in Northern Ireland, and 96.6% in Scotland. This is the tenth 24-month cohort to be entirely routinely scheduled for three doses of MenC vaccine.

Coverage at 5 years

Data were received from 307 PCT/HB/AR in England, Northern Ireland, and Wales. Compared to last quarter, coverage at five years increased by 0.2% for Hib3 and P3, stayed the same for DTPol3, and decreased by 2.2% for MenC. Coverage for DTPol4 increased by 0.5% to 81.1%. Coverage for MMR1 decreased by 0.5% to 89.6% and by 0.6% to 74.9% for MMR2 (table 3) (3). Country-specific data for MenC catch-up coverage at five years was 84.3% in England, 90.8% in Wales, and 91.0% in Northern Ireland (table 3). Data for children reaching their sixth birthday in Scottish health boards were also received for DTPol4 and MMR2; coverage was 95.0% and 91.3% respectively.

Table 3 Completed primary immunisations (all antigens) by 5 years: April to June 2004

Region/Country	Reports* (total)	DTPol3 %	P3 %	Hib3 %	MenC %	MMR1 %	MMR2 %	DTPol4 %
Regions of England								
North East	14(16)	96.4	95.5	96.1	91.7	92.7	81.5	86
North West	42 (42)	95.5	94.3	94.8	89.4	91.5	76.8	82.3
Yorkshire and Humberside	34 (34)	94.5	93.6	94	83.7	90.9	77.7	80.9
East Midlands	28 (28)	97.2	96.6	96.7	90.8	93.9	79.9	85.2
West Midlands	30 (30)	95.7	94.8	94.7	86.6	92.5	79.2	84.3
East of England	41(41)	94.3	93.4	94	88.1	89	76.5	83.4
London	32 (32)	86.1	85.6	86.6	70.1	79.8	58.1	64.3
South East	47 (49)	93.1	92.3	92.6	83.8	88.5	72.3	81.2
South West	32 (32)	96.6	95.6	96	86.3	92.1	78.4	85.2
England (Total)	300(304)	93.7	92.9	93.2	84.3	89.2	74.4	80.6
Wales	3 (3)	95.5	93.7	95.1	90.8	90.3	75.9	84.1
Northern Ireland	4 (4)	97.6	96.9	97.1	91	96.1	86.1	88.8
Scotland 6 years†	15 (15)	–	–	–	–	–	91.3	95
England, Wales, and Northern Ireland	322(326)	93.9	93.1	93.4	84.9	89.6	74.9	81.1

*PCTs/health boards/administrative regions

† No data available at 5 year

British Forces Germany Health Service

Comparable COVER data have been received from the regions across British Forces Germany (BFG). The BFG child population is approximately 1500 and is spread over five separate geographical regions throughout Germany. The average coverage at 12 months (n=186) was 98.9% for all antigens; at 24 months (n=179) coverage was 98.9% for all antigens except for MMR1, which was 93.9%, and at five years (n=174) coverage was 99.4% for DTPol3, P3 and Hib3, 98.3% for MenC and MMR1, and 96.0% for MMR2 and DTPol4.

MMR sentinel surveillance scheme coverage

In order to give a more timely indication of trends in MMR coverage, a sentinel surveillance scheme has monitored MMR coverage in a sample of children becoming 16 and 24 months of age in a particular month in England from April 1999. Initially, this information was requested every four months for all children in the participating trusts/health authorities who were turning 16 months or 24 months old in the defined one-month period. From March 2001, the request was made quarterly so that the information coincided with routine COVER reports. Since March 2002, this information has been routinely collected every month and was extended in June 2002 to include coverage at 20 and 36 months of age to help determine whether there is further improvement in coverage as children get older, because some parents delay MMR vaccination. This sentinel scheme is based on a sample of trusts/PCTs in England and represents approximately 20% of the population, although monthly reporting is not always complete for the whole sample. This means that these data are not geographically representative or sufficiently detailed to allow us to compare different regions, and will be subject to greater variability than the national data due to varying monthly sample size. Data collected from June to August 2004 for children in the four age cohorts is summarised in table 4 (range for the three months was from 66.9% to 68.2% at 16 months, 76.1% to 76.3% at 20 months, 80.9% to 81.4% at 24 months, and 82.1% to 83.2% at 36 months).

Table 4: Monthly sentinel estimates of measles, mumps rubella (MMR) coverage at 16, 20, 24 and 36 months: June to August 2004

Evaluation month	Number of PCTs/trust	Age at vaccination			
		16 months	20 months	24 months	36 months
Jun 04	40	67.10%	76.30%	80.90%	83.20%
Jul 04	38	68.20%	76.10%	80.90%	82.10%
Aug 04	38	66.90%	76.30%	81.40%	82.90%

Comments

Coverage of MMR1 in the UK at 24 months shows a small decrease of 0.4% from 81.9% to 81.5% since the last quarter (3). This decrease was observed across the UK in all regions/countries except for Scotland. The children evaluated in this cohort would have been scheduled for their MMR1 between April and October 2003, a period when there was media interest in a flawed report published in the US which suggested a correlation between autism and thiomersal in vaccines (4). The American Academy of Pediatrics stated that the study failed to show any connection and that it contained numerous conceptual and scientific flaws (5). Despite thiomersal being absent from MMR vaccines, speculation over MMR was again raised by media coverage in the UK. This decrease was predicted in England by the sentinel surveillance of MMR coverage at 16 months (5). Current data from this surveillance scheme suggests that there has been some recovery in coverage recently (table 4).

MenC coverage at 5 years reflects vaccine coverage achieved for the catch-up programme for all children aged up to 17 years implemented following the introduction of the vaccine in 1999. Children aged over 12 months only require one dose of MenC vaccine. The cohort evaluated this quarter (born April to June 1999) was scheduled for two catch-up doses of MenC from mid-January 2000, but depending on the age the first dose was given, may only have needed one dose to complete the course. Therefore the drop in MenC coverage of 2.2% from the last quarter may be due to some children being erroneously recorded as incompletely vaccinated (6).

The Department of Health are publishing 2003-04 annual coverage data by PCT for children aged 12 months, 24 months, and five years for England in the *Statistical Bulletin NHS Immunisation Statistics, England : 2003-04* (1).

Relevant links for country specific coverage data

- Wales: <<http://www.wales.nhs.uk/sites/page.cfm?OrgID=368&PID=2278>>;
- Scotland: <<http://www.show.scot.nhs.uk/scie/h/>>;
- Northern Ireland: <<http://www.cdscni.org.uk/surveillance/Coveragestats/default.asp>>;
- England: <<http://www.publications.doh.gov.uk/public/sb0416.htm>>.

Other relevant links

- <http://www.hpa.org.uk/infections/topics_az/vaccination/vac_coverage.htm>
- <<http://www.mmrthefacts.nhs.uk/>>

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Laboratory confirmed cases of measles, mumps and rubella, England and Wales: April to June 2004

The four weekly reporting of laboratory confirmed cases of measles, mumps, and rubella previously published in the *CDR Weekly* have been replaced by quarterly reporting. Cases include those confirmed by oral fluid IgM antibody tests and routine laboratory reports (table 1). Analyses are by date of onset. Regional breakdown figures relate to Government Office Regions rather than regional health authorities (pre-April 2002 definitions) as used previously in this section. Quarterly figures for cases confirmed by oral fluid antibody detection only from 1995 are available from:

<http://www.hpa.org.uk/infections/topics_az/measles/data_not_confirmed.htm>

<http://www.hpa.org.uk/infections/topics_az/mumps/data_quarter.htm>

<http://www.hpa.org.uk/infections/topics_az/rubella/data_rub_not.htm>

and annual total numbers of confirmed cases by health region and age from:

<http://www.hpa.org.uk/infections/topics_az/measles/data_reg_age.htm>

<http://www.hpa.org.uk/infections/topics_az/mumps/data_reg_age.htm>

<http://www.hpa.org.uk/infections/topics_az/rubella/data_reg_age.htm>

Table 1 Total confirmed cases of measles, mumps and rubella, and oral fluid IgM antibody tests in cases notified to ONS*, weeks 14-26/04 ONS*

	Cases			Oral fluid IgM antibody results				
	Notified	Tested	%	Total positive	Recently vaccinated	Confirmed	Other lab confirmed	Total confirmed cases
Measles	741	831	112.1†	56	12	44	60	104
Mumps	2784	1745	62.7	868	4	864	488	1352
Rubella	399	335	84.0	1	–	1	4	5

*ONS = the Office for National Statistics

† = Some oral fluid specimens were submitted early from suspected cases and may not have been subsequently notified, thus the proportion tested is artificially high for this quarter.

Measles

One hundred and four cases of confirmed measles with onset dates in the second quarter of 2004 were reported compared to 46 cases in the first quarter of 2004 (1). Eighty-nine (86%) were under 15 years (12 aged less than one year, 47 aged between 1 and 4 years; 17 aged between 5 and 9 years; 13 aged between 10 and 14 years); 13 were adults aged between 15 and 61 years. The age was not stated for two cases. Twelve cases had a history of vaccination.

Cases were reported from all regions of England (except the North East) and from Wales, although only seven regions reported five or more cases; East Midlands (34), London (29), Yorkshire and Humberside (11), North West (8), South East (7), West Midlands (5), and East of England (5). Nineteen further cases associated with the cluster in East Midlands reported in the last quarter were identified (1). The index case had been to Pakistan and a genotype D4 strain was identified in nine cases. D4 strains were also identified from cases in South East (ex Pakistan), Yorkshire and Humber, West Midlands, East of England, and London. Three cases, reported from different regions, all returned from France within a few days of each other at the end of March with onset dates within the first two weeks of April; one case was identified as being infected with a genotype D5 strain. D5 strains were also identified with a small cluster in a nursery in the East Midlands, a family cluster of three cases in Yorkshire and Humberside, and cases in East of England and London. Three other genotypes were seen, all associated with cases in London; five C2 strains, two D8 strains, and one D7 imported from Bangladesh.

Mumps

One thousand three hundred and fifty-two cases of mumps were confirmed with onset dates in the second quarter of 2004 compared to 578 in the first quarter of 2004 (1). This is the highest quarterly total since oral fluid surveillance began in 1995. All regions, including Wales, reported an increase in the number of cases in the second quarter compared to the first quarter of 2004. The largest increase was seen in the South West where the number of cases increased from 18 to 211. Large increases were also seen in the East Midlands (from 64 to 182), and the North West (98 to 213). Wales, which had the highest number of cases in the first quarter (119), experienced the smallest increase. One case of viral meningitis was reported in a male aged 21 years.

The cohort at an increased risk of mumps are those currently aged between 14 and 22 years (born 1982-1990), because they have either received no MMR vaccine, or only one dose (2) and more than 75% of cases reported this quarter were born in this period. Outbreaks have moved from being predominantly in secondary schools to being in universities and military establishments. In response to outbreaks in a variety of settings, the Health Protection Agency's Health Protection Units have been working with primary care trusts (PCTs), general practitioners, schools, colleges, military bases, universities, and prison/remand services in their areas to ensure that action is taken. PCTs could consider an age-based or institution-based campaign either in response to a local increase or even prior to such an increase. Many areas have decided to undertake campaigns in local educational establishments. The Department of Health produced a leaflet and poster specifically to support local university MMR vaccination campaigns. Immunisation co-ordinators can order copies of the leaflet and poster from Robert Duff, Department of Health, email: <Robert.duff@doh.gsi.gov.uk>.

Table 2 Laboratory confirmed cases of mumps by age group and region, England and Wales: weeks 14-26/04

Region	Age group						NK	Total
	<1y	1-4y	5-9y	10-14y	15-19y	≥20y		
North East	–	–	2	15	53	48	1	119
North West	–	3	5	32	100	73	–	213
Yorkshire and Humberside	–	1	–	6	33	37	–	77
East Midlands	–	2	2	8	96	74	–	182
West Midlands	–	–	4	16	98	68	5	191
East of England	–	–	1	2	21	27	–	51
London	–	–	2	5	16	14	–	37
South East	–	4	1	5	56	60	–	126
South West	–	4	5	2	95	105	–	211
Wales	–	2	4	8	72	35	2	123
Not known	–	–	–	2	12	6	2	22
Total	–	16	26	101	652	547	10	1352

Rubella

Five cases of rubella with onset dates in the second quarter of 2004 were confirmed. One case was a child aged six months; further investigations to determine whether or not the infection was acquired congenitally are being undertaken. One case was in a male aged 14 years and his infection was possibly acquired in Russia. The other three cases were in female adults aged between 29 and 38 years.

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