



CDR WEEKLY

Current Issue: Volume 14 Number 40 Published on: 30 September 2004




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-  [Updated *HIV and Infant Feeding* guidance published](#)

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Outbreak of Hepatitis A in men who have sex with men in south east London. 

An outbreak of hepatitis A has been identified in men who have sex with men (MSM) in south east London. Nine cases have been reported with onset dates between mid-August and mid-September 2004. Five of the men affected attended a gay public house in Southwark, in the two months before they became unwell. A sixth is a secondary case with a history of household contact with one of the other cases.

The public house is, in effect, a public sex venue (PSV) where sexual activities occur which carry a high risk of transmission of hepatitis A. The local health protection unit is working with a number of agencies to advise gay men locally of the risk, and how this might be minimised, including advice on immunisation. Increased outreach work at this and other similar PSVs will also be considered, as well as how hygiene at the PSV implicated might be improved.

Of the eight cases where vaccination status was known, none had been vaccinated for hepatitis A. Following a series of outbreaks of Hepatitis A among MSM, including a large outbreak in London in 1997 (1), recommendations of Hepatitis vaccination were extended to include MSM whose sexual behaviour is likely to put them at risk (2,3). The provision of hepatitis A vaccination for MSM at Genitourinary Medicine clinics and outreach services appears to have been successful in curtailing the 1997 outbreak. The recent south east London outbreak may indicate the need to increase hepatitis A vaccination offered to MSM through these services in order to prevent a more wide scale problem.

For further information please contact Donal O'Sullivan, Consultant in Communicable Disease Control, SE London Health Protection Unit 1, Lower Marsh, London SE1 7NT (tel: 020 7716 7030 Fax: 020 7633 9734).

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Bat infected with a rabies-like virus identified in the south-east of England



A Daubenton's bat (*Myotis daubentonii*) infected with European Bat Lyssavirus type-2 (EBLV-2) has been reported in the United Kingdom (UK). The bat was initially noticed by a member of the public on a road in Staines, Surrey, on 17 September 2004. The bat was on the ground and moved off the road to a path where it might be safer. It was observed to remain grounded near the path until 21 September when help was sought from bat conservation group volunteers who took care of the bat until it died on 23 September. The bat was sent to the Veterinary Laboratories Agency (VLA), Weybridge, as part of the routine passive surveillance system of UK bats. The VLA reported on 25 September that it was infected on the basis of confirmatory fluorescent antibody tests and subsequent PCR. The individuals who were in contact with the bats are receiving appropriate medical treatment with rabies immunisation <http://www.hpa.org.uk/infections/topics_az/rabies/menu.htm>. A press statement was issued jointly by the Health Protection Agency (HPA) and the Department for Environment Food and Rural Affairs (Defra) on 28 September to raise awareness of the incident in case any unidentified people or animals might have been in contact with the bat. <http://www.hpa.org.uk/hpa/news/articles/press_releases/2004/040928_bat_rabies.htm>.

Previous incidents

This is the third bat from which EBLV-2 has been isolated in the UK. The previous cases of infected bats were in 1996 in Newhaven (1, 2) and 2002 in Lancashire (3,4). All three of the infected bats have been Daubenton's bats. Further information about the species of bats in the UK is available from the Bat Conservation Trust <<http://www.bats.org.uk/>>.

In addition 2002, a Scottish naturalist and licensed bat handler died from EBLV-2 infection thought to have been acquired from one of the many bats he had handled (5, 6). This case was the second human infection with EBLV-2 to have been identified in the world (5). Two deaths from a related strain, EBLV-1, have also been recorded (5).

Surveys carried out of captured wild bats in Scotland and the North and South of England have found antibodies in Daubenton's bats, but no virus has been isolated (7, 8). This suggests that some species of bat may be adapted to the virus and recover from infection and become non-infectious.

Public health implications

This recent finding re-enforces the advice that has been issued since 2002. People are not at risk unless they have very direct exposure to bats. The virus has only been isolated from a species that does not tend to live near or in human habitations. Pipistrelle bats, one of the more common species, often roost in houses, but the virus has never been isolated from this species in the UK. Anyone who finds a grounded bat should not handle the bat but should seek help from a local bat conservation group. Anyone who is bitten, scratched, or has other direct contact such as exposure of breaks in the skin or mucosa to bat neural tissue, is advised to wash the affected area with soap and water immediately and seek urgent medical advice. Post-exposure vaccination is recommended. Further information is available on the HPA website at: <http://www.hpa.org.uk/infections/topics_az/rabies/menu.htm>.

The challenge for professionals involved in prevention is to raise awareness in the general public of the small risk to human health from UK bats without creating fear of bats, which are an important part of our natural heritage and protected by law. Awareness also needs to be raised among health professionals.

The risk of infection with EBLV to the general public and to domestic animals, including cats, is thought to be minimal. All bats are protected species by law and should not be disturbed. Anyone who finds a bat should avoid handling it and seek help from the Bat Conservation Trust (helpline number: 0845 130 0228).

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Health Protection Agency (HPA) weekly influenza report – winter 2004/05

Reporting of influenza surveillance information for the United Kingdom (UK) will begin in week 40 for the 2004/05 season through the weekly influenza report. The report will be published on the HPA website at http://www.hpa.org.uk/infections/topics_az/influenza/flu.htm.

Initially the report will be produced every two weeks starting Wednesday 29 September, and will become weekly when activity levels begin to increase. The report provides a timely summary, along with comments and interpretation, of clinical and virological indicators of influenza activity in the United Kingdom. Reports of influenza activity in Europe and other parts of the world will also be included. Graphs and maps on the influenza web page will also be updated on a weekly basis to provide more comprehensive information on influenza activity. Graphs for the 2004/05 season are available at http://www.hpa.org.uk/infections/topics_az/influenza/graphmenu0405.htm.

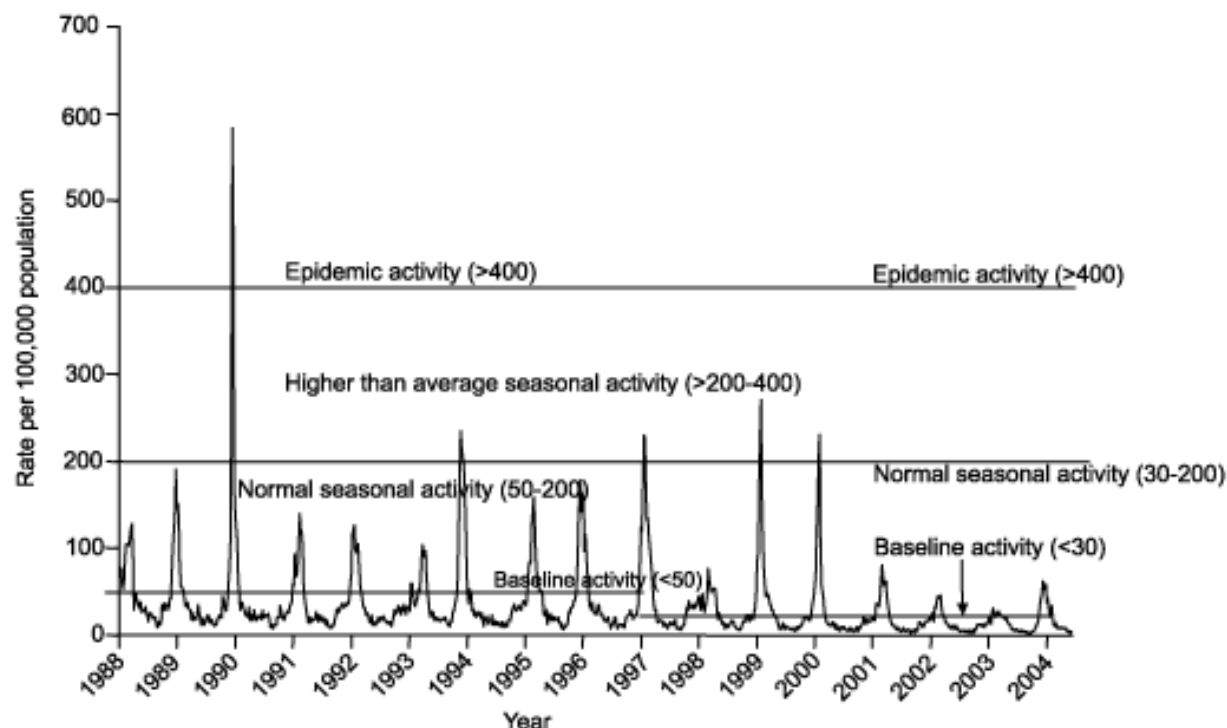
Change in thresholds used to describe levels of influenza activity

Thresholds, and a standard set of definitions, are used to provide a clear and consistent message to the general public and media about the level of influenza virus circulation, and provide an indication to general practitioners (GPs) when sufficient virus is circulating in the community to warrant the use of antiviral drugs.

In light of data analysis undertaken by the HPA (1), the numerical thresholds and their descriptions have been revised for the forthcoming 2004/05 influenza season. The previous thresholds were no longer considered appropriate for the levels of influenza activity recently observed in England, given a secular decline in GP consultation rates for influenza like illness (ILI) over recent years.

The new threshold values are shown for recent influenza seasons (figure). Using the new criteria, levels of activity in three years (1996/97, 1998/99 and 1999/2000) would have been classified as 'epidemic'. Data analysis for these years demonstrated that there was a similar impact with respect to mortality and laboratory reports of influenza virus infection as the 'epidemic' season of 1989/90. The table below shows the new and old threshold values for comparison.

Figure RCGP weekly consultation rate for influenza-like illness (ILI), England, showing revised thresholds for describing levels of influenza activity*



*Revised thresholds for forthcoming influenza season (2004/05) shown for previous seasons for illustrative purposes. There has been a secular decline in GP consultation rates for influenza-like illness over recent years (1).

Table New and old threshold values for comparison

Threshold description	GP consultation rate (per 100, 000)	
	New thresholds	Old thresholds
Baseline activity	0-30	0-50
Normal seasonal activity	30-200	50-200
Higher than average seasonal activity	–	200-400
Epidemic activity	>200	>400

Influenza vaccination uptake monitoring

As in previous years, the HPA will be monitoring uptake of influenza vaccination on behalf of the Department of Health (DH). For the first time, reporting will be through the web-based vaccine tracking programme sponsored by the DH. Further information on the influenza immunisation campaign for 2004/05 was published in CDR Weekly, volume 14 number 34, available at: <http://www.hpa.org.uk/cdr/PDFfiles/2004/cdr3404.pdf>.

Influenza activity in the southern hemisphere

There has been an increase in levels of influenza activity reported in the southern hemisphere during August and September. Australia reported high levels of influenza like illness (ILI) with localised outbreaks in New South Wales during August, which have subsequently declined. New Zealand continues to report higher than expected levels of activity in the northern and southern islands. Virological testing of samples in New Zealand indicate that influenza A/Fujian/411/02 (H3N2)-like virus is circulating throughout the country; this was the predominant circulating strain in the United Kingdom last winter (2003/04). Fiji has also reported an increased incidence of ILI since August; preliminary analysis suggests influenza A as the causative agent.

Samples received by the World Health Organization (WHO) Melbourne Influenza Reference Laboratory from south east Asia and Oceania indicate that influenza A (H3), influenza A (H1), and influenza B are all currently circulating in this region.

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Possible human-to-human transmission of avian influenza (H5N1) in Thailand

On 28 September 2004, the World Health Organization (WHO) issued a statement confirming two new human cases of H5N1 infection in Thailand. The two cases, a woman aged 26 years who has died, and her sister, aged 32 years who is hospitalised, are part of a family cluster that is being investigated to determine whether human-to-human transmission has occurred. The current assessment from the WHO is that non-sustained, inefficient, dead-end human-to-human transmission might have occurred, but that this is not unexpected from an avian influenza virus.

Further information is available from WHO website at: http://www.who.int/csr/disease/avian_influenza/en/.

Viruses isolated from the cases will undergo further genetic and antigenic testing to determine whether the virus has acquired genes to allow improved transmissibility among humans. There is no evidence so far of wider transmission within the community, but surveillance for additional cases has been intensified in the northern Province of Kamphaeng Phet, and within hospitals nationwide.

Outbreaks of avian influenza (H5N1) in poultry continue to be reported in Cambodia, China, Malaysia, Thailand, and Viet Nam. On the 27 September, the United Nations Food and Agriculture Organisation (FAO) and the World Organisation for Animal Health (OIE) issued a statement describing the avian influenza epidemic as a 'crisis of global importance'. The two organisations warned that it is unlikely that the virus will be eradicated in the near future, and that major investment is required to strengthen veterinary services, in particular surveillance, early warning, detection, reporting, and response. Further information is available the FAO website at: http://www.fao.org/ag/againfo/subjects/en/health/diseases-cards/special_avian.html.



Updated *HIV and Infant Feeding* guidance published

The Department of Health (DH) has recently published an updated version of *HIV and infant feeding*, guidance from the UK Chief Medical Officers'

Expert Advisory Group on AIDS (EAGA). This updated guidance reaffirms existing advice, following a review of the research evidence. Directed to health professionals who advise HIV-infected pregnant women and new mothers, it recommends avoidance of breastfeeding as part of a programme of interventions to reduce the risk of mother to child HIV transmission.

The guidance aims to help health care professionals provide the necessary information, advice, and support to women who are infected with human immunodeficiency virus (HIV) to help them make personal, well-informed decisions about infant feeding. It is not intended to apply to the situation in less developed countries, where the risks associated with infant formula milk feeding are much higher.

The updated guidance document is available on the DH website at:
<<http://www.dh.gov.uk/assetRoot/04/08/98/93/04089893.pdf>>.

HIV / Sexually Transmitted Infections (STIs)

Last updated: **30 September 2004**
Next update due: **25 November 2004**

[The HepB3 study: Hepatitis B vaccine uptake in men who have sex with men \(MSM\) attending a GUM clinic in England as first time attendees](#)

The HepB3 study: hepatitis B vaccine uptake in men who have sex with men (MSM) attending a GUM clinic in England as first time attendees

Chronic hepatitis B infection has serious long-term sequelae such as fulminant liver failure, liver disease, and hepatocellular carcinoma, but has been a vaccine preventable disease since 1982. There are three vaccine schedules: normal (0, 1, 6 months), rapid (0, 1, 2 months), and super-accelerated (0, 7, 21 days). The shorter schedules are useful for those who need to receive a quick vaccination such as travellers to high endemic countries and some high risk, low compliant groups such as injecting drug users.

The Department of Health (DH) recommends that in England where hepatitis B prevalence is low, high-risk groups such as commercial sex workers, intravenous drug users, and men who have sex with men (MSM) should receive hepatitis B vaccination. Laboratory data for 2003 reports that 17% of new infections (with an identified risk) were in MSM (1), and research conducted in genitourinary medicine clinic attendees has found infection prevalence to be much higher for MSM (38.7%) than for heterosexual men and women, 5.9% and 3.5% respectively (2).

As part of the DH's National Strategy for Sexual Health and HIV, hepatitis B vaccine should be offered to all MSM on first attendance at a genitourinary medicine (GUM) clinic in England from 2003 (3). An investment of £1m was made by the DH with which to buy and distribute extra vaccine. The Infectious Disease Strategy (4) specified the following standards:

- Expected uptake of the first dose vaccine in those not previously immunised should reach 80% by the end of 2003;
- Expected uptake of the three doses of vaccine in those not previously immunised, within one of the recommended regimes, to reach 50% by the end of 2004 and 70% by the end of 2006

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Diary

Last updated: **30 September 2004**

For information about other conferences, courses, and events visit
http://www.hpa.org.uk/hpa/about_us/events.htm

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-  [National meeting: laboratory managers \(or deputies\) in microbiology](#)
-  [Seafood is good for you – isn't it?](#)

Health Protection Agency chlamydia diagnosis forum educational meeting

Moving towards a national chlamydia programme

Following the success of the chlamydia diagnosis forum half-day educational meetings earlier in the year we are pleased to confirm that arrangements have been made to hold another event. The meeting on 25 November 2004 at the Health Protection Agency HPA, Colindale, is for those involved in diagnosis, screening, laboratory testing, and management of genital chlamydia infection.

The meeting is funded by a grant from the Department of Health.

There is no cost for this event. To obtain a course outline and receive a nomination form please contact Sabrina Senior, Learning Education and Development, Health Protection Agency, 61 Colindale Avenue, London NW9 5DF, tel: 020 8327 6622. Deadline for the forms is **20 October 2004**.

If you have any further queries please contact Joanna Edwards (tel: 020 8327 7946, email: joanna.edwards@hpa.org.uk) or Sue Skidmore 01952 641 222 / sue.skidmore@rsh.nhs.uk.

**National meeting: laboratory managers (or deputies) in microbiology**

The Health Protection Agency are organising and hosting an event, *National meeting: laboratory managers (or deputies) in microbiology*, Health Protection Agency, Colindale, London 28 and 29 October 2004.

Programme:

- Thursday 28 October
- (afternoon) Keynote speaker: David Bailey - "The Budget Holder's Survival Guide"

- Friday 29 October
- Keynote speaker: Professor Brian Duerden "Inspecting Microbiology – An Opportunity to Develop the Service"

Presentation topics:

- How to Cope with Corporate Governance
- Modernising Pathology (Pathlinks; Teespath; Nottingham)
- Developing the Profession & Extending Roles
- Portfolios, Co-terminus Degrees & Professional Doctorates

Cost £70 per person includes:

- Wine Reception & Evening Meal (Thursday) & Lunch & Refreshments (Friday)
- Optional Tour of CPHL (Thursday morning)
- Trade Show (Thursday & Friday)

For further details of the programme and an application form please contact: Janet Norcup, Evaluations & Standards Lab, SRMD, Health Protection Agency, 61 Colindale Avenue, London NW9 5DF (tel: 020 8200 1295 ext 7920, Email: <Janet.Norcup@HPA.org.uk>.

**Seafood is good for you – isn't it?**

A half-day scientific meeting organised by the Comparative Medicine Section of the Royal Society of Medicine will be held at the Royal Society of Medicine in London on the afternoon of Wednesday 27 October 2004. The meeting will address the public health issues associated with fish consumption, *ie*, nutritional benefits versus potential hazards such as food poisoning and toxic residues. This meeting is relevant to scientists and medical practitioners with an interest in public health, microbiology, or nutrition. Registration fee (Fellows) £15, (Non-Fellows) £20. CME/CPD credits available.

For more details or to register, contact Clare Bergin, Academic Dept, Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE (tel: 020 7290 2986)