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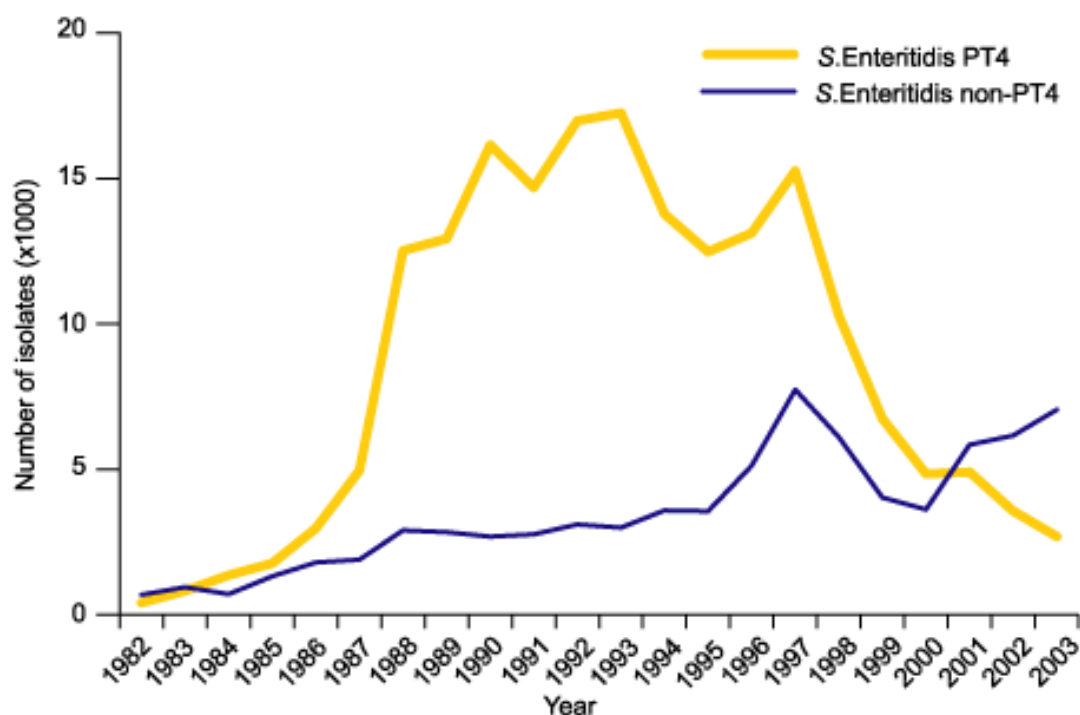
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- [!\[\]\(815df092dd722ee9268ef8e6d0193e3a_img.jpg\) Salmonella Enteritidis non-Phage Type 4 infections in England and Wales: 2000 to 2004 – report from a multi-Agency national outbreak control team](#)
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- [!\[\]\(0c564128c6342bd2f601e97f4518828a_img.jpg\) National surveillance for glycopeptide-resistant enterococci \(GRE\) bacteraemias: report of the Working Group](#)
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Salmonella Enteritidis non-Phage Type 4 infections in England and Wales: 2000 to 2004 – report from a multi-Agency national outbreak control team

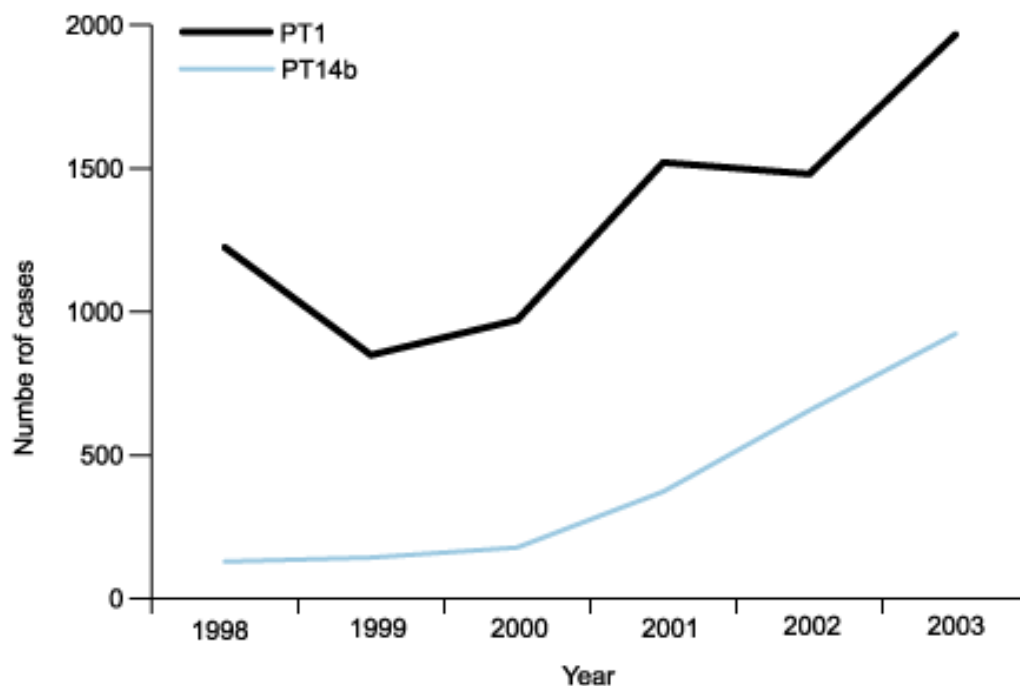
An increase in laboratory reports of confirmed infections caused by *Salmonella* Enteritidis phage types (PT) other than PT4 (*S. Enteritidis* non-PT4) has been observed in England and Wales since 2000 (figure 1). The incidence of *S. Enteritidis* PT4 infection (the single most common phage type, responsible for the salmonella and eggs epidemics of the late 1980s) in England and Wales has declined rapidly in recent years from 10,056 cases in 1998 to 2693 cases in 2003. This decline is due, in part, to the vaccination of broiler breeder flocks (from 1994) and commercial laying flocks (from 1996) in the United Kingdom (UK) against *S. Enteritidis*.

Figure 1 Laboratory reports of *Salmonella* Enteritidis infections, England and Wales: 1982-2003



Between 2000 and 2003, the incidence of *S. Enteritidis* non-PT4 infection has almost doubled from 3548 to 7065 cases (figure 1), with PT1 and PT14b accounting for most of the increase (917 to 1966 cases [102% increase] and 178 to 923 cases [419% increase] respectively) (figure 2). Provisional data for the first six months of 2004 show further increases in infection with these phage types (14% and 86% increases respectively) compared with the same period in 2003.

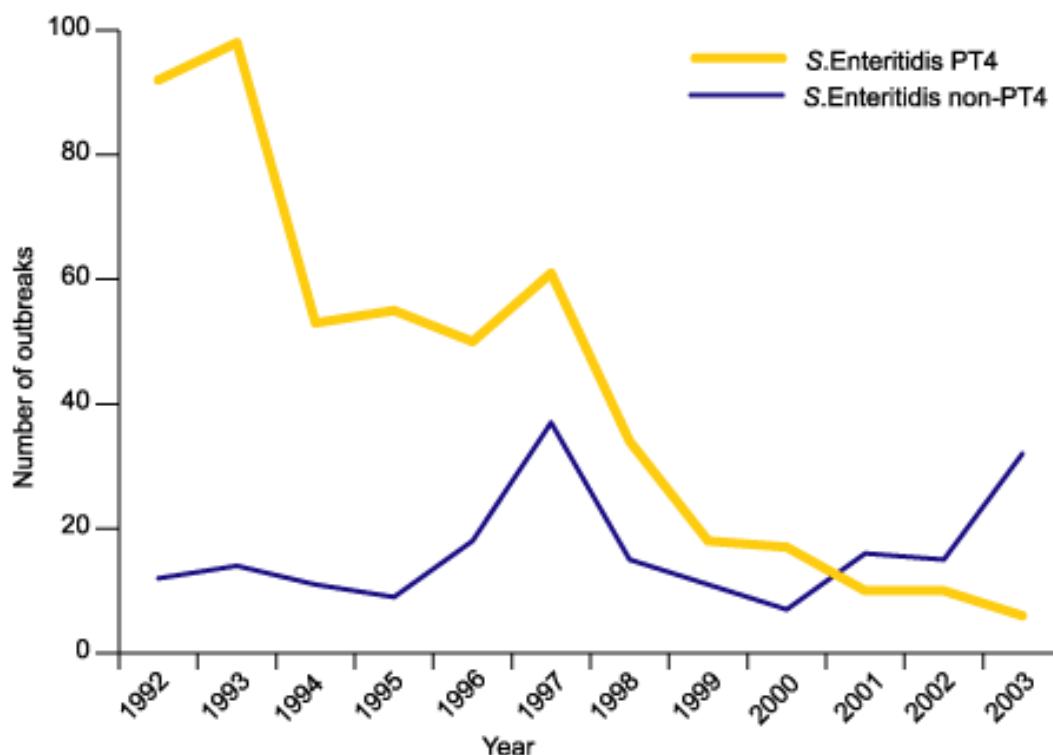
Figure 2 Laboratory reports of *Salmonella* Enteritidis infection, England and Wales - major phage type trends: 1998-2003



Laboratory surveillance of salmonellosis underestimates disease in the community by a third (1), suggesting that approximately 20,000 cases of *S. Enteritidis* PT1 and PT14b infection have occurred in England and Wales since 2000. An estimated 3.6% of cases of salmonella infection are admitted to hospital and 0.28% of cases die due to their illness (2). Deaths from salmonellosis often occur in the elderly and the infirm, and this proportion of the population is less likely to be exposed to food from catering premises.

The trends in general foodborne outbreaks of *S. Enteritidis* infection reported to the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC) mirrors laboratory reports (figure 3). Between 1998 and 2001, 49 outbreaks of *S. Enteritidis* non-PT4 infection were reported (annual mean 16 outbreaks). Restaurants accounted for a third (33%) of outbreaks in this time with Chinese restaurants (38%) and cafés (25%) the most commonly reported restaurant type.

Figure 3 Foodborne general outbreaks of *Salmonella* Enteritidis infection reported to CDSC, England and Wales: 1992 to 2003



Between 2002 and 2003, 48 foodborne outbreaks of *S. Enteritidis* non-PT4 were reported (annual mean 24 outbreaks). Restaurants (52%) accounted for over half of these outbreaks, and Chinese restaurants (72%) were the most commonly

reported restaurant type. To date, 26 outbreaks of *S. Enteritidis* non-PT4 infection have been reported (preliminary) to CDSC in 2004. Most outbreaks (74%) were linked to restaurants, with Chinese restaurants being most commonly (74%) reported. Much descriptive, statistical, and microbiological evidence supplied by investigators pointed to the use of eggs imported from Spain as a cause of the outbreaks.

Following a national outbreak of *Salmonella* Enteritidis PT14b infection in 2002, the Health Protection Agency (HPA) initiated a public health investigation of raw shell eggs used in premises linked to outbreaks of *Salmonella* infection thought to be associated with the use of eggs in England and Wales. Raw shell eggs from the premises or their sources of supply were examined for the presence of *Salmonella* spp. Between October 2002 and September 2004, 11,718 shell eggs were sampled from 79 premises. *Salmonella* spp were isolated from 5.6% of Spanish eggs used in catering premises, which compares unfavourably with salmonella levels (1.1%) found in non-Lion Quality UK eggs sampled. Moreover, no UK Lion Quality eggs sampled were found to contain salmonella. Molecular typing (plasmid profile and pulsed field gel electrophoresis analysis) has shown that isolates from some Spanish eggs were indistinguishable from some human isolates.

Most (67% in 2003) sampling of chicken flocks in the UK is undertaken for statutory monitoring or for surveillance purposes. As a result, most incidents and isolations reported to the Veterinary Laboratories Agency/Scottish Executive Environment and Rural Affairs Department are not associated with clinical disease, but with identification of subclinical carriage of salmonella. Of the 36 *S. Enteritidis* incident reports in 2003, most were caused by PT4 (20; 56%), PT6 (7; 19%), and PT6a (5; 14%). There was one incident report of PT1 and none for PT14b (3) .

Imported shell eggs form a relatively small proportion of the UK egg market. This proportion, however, has increased over the past twenty years, especially in the last four years (figures 4a and 4b). Since 2000, the importation of eggs from Spain has increased to such an extent that Spain is now the largest exporter of eggs to the UK. It is the UK catering sector and not the shop sold market that receives a large proportion of the non-UK eggs and UK eggs not produced under the UK Assurance schemes.

Figure 4a The United Kingdom egg market: 1980 to 2003

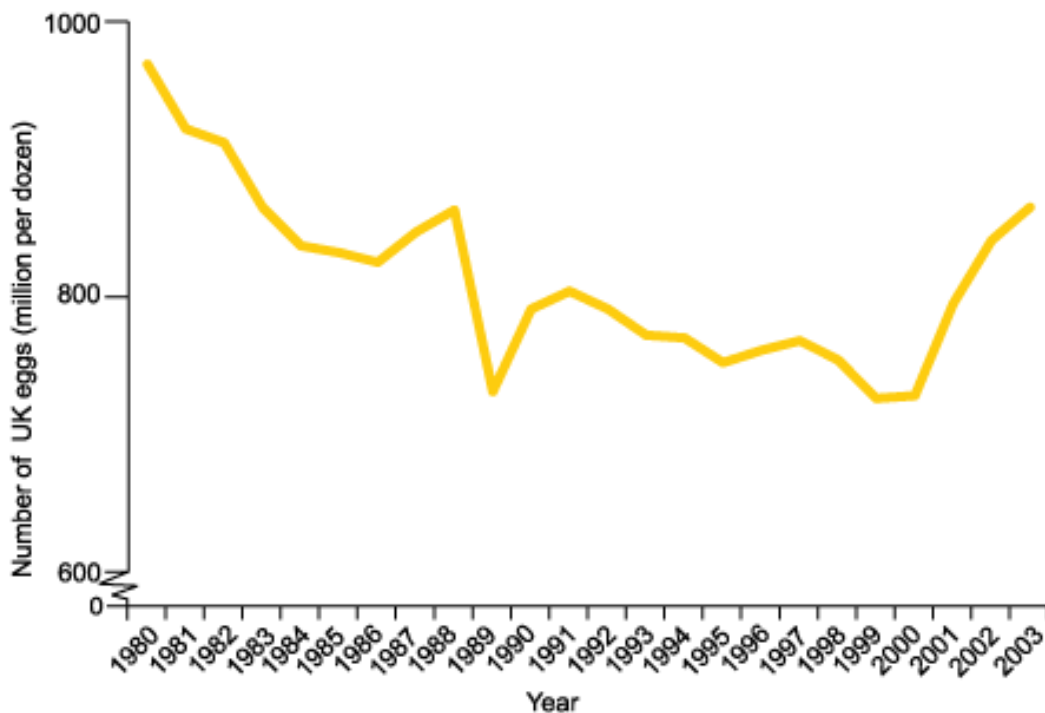
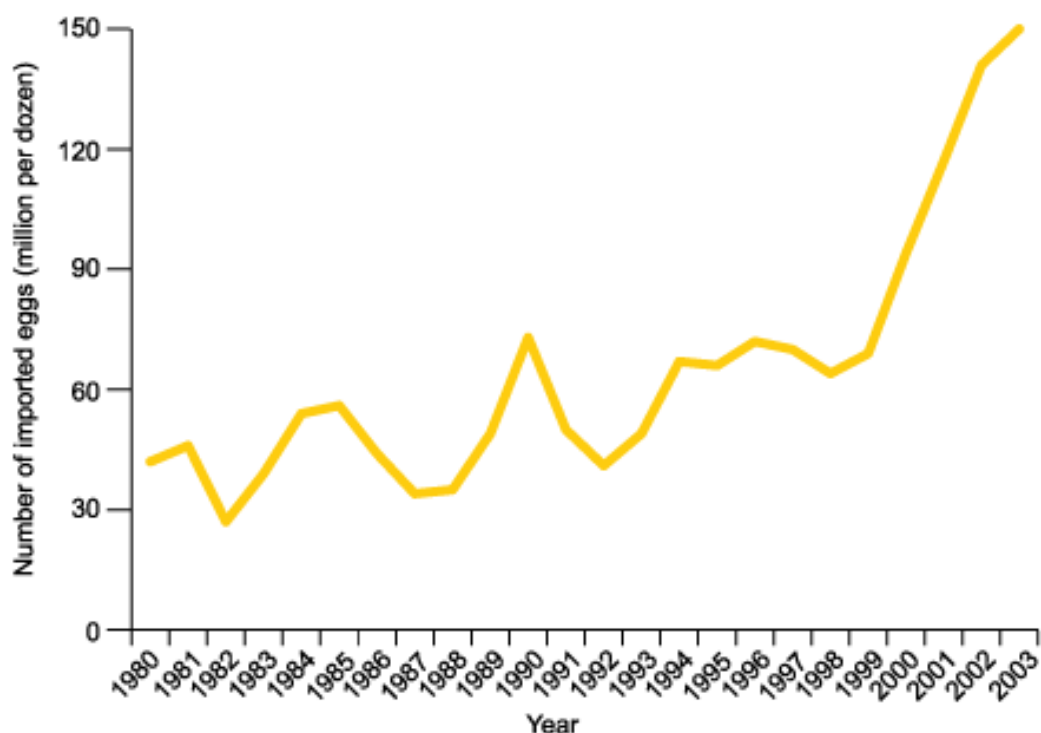


Figure 4b The United Kingdom imported egg market: 1980 to 2003

In August 2004, the HPA convened a multi-agency UK outbreak control team (OCT) to examine the evidence, identify appropriate interventions, and make recommendations (which have now have been agreed):

- The case will be presented to the European Commission for further action;
- Formal discussions will be held with the appropriate authorities in Spain;
- Advice will be issued to the relevant sectors of the catering industry, including Chinese restaurants;
- This problem will be brought to the attention of the major importers of eggs;
- The results of microbiological and epidemiological investigations will be posted on the HPA website<<http://www.hpa.org.uk>>.

Intensive national and local work is now being undertaken by the Health Protection Agency with the Food Standards Agency to pursue these actions, working with local authorities, Primary Care Trusts, and the catering trade.

This issue has been extensively reported in the *Communicable Disease Report Weekly* (5-10) and led to repeated issuing of guidance to caterers by the Food Standards Agency (11). A similar outbreak was experienced by the Netherlands in 2003 following increased imports of eggs from Spain. Increased importation occurred because of the large scale culling of poultry flocks in the Netherlands, as a result of the avian influenza outbreaks (12). In 2002, a European Commission mission to Spain criticised the quality of eggs/eggs products (13), although an action plan to improve the situation has been drawn up by the Spanish authorities (14).

Further information on the national data is available from the HPA's Environmental and Enteric Disease Department, email: <eedd@hpa.org.uk>. Information on local activity is available from the local HealthProtection Unit concerned.

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Shooting Up: infections among injecting drug users in the United Kingdom 2003



Infections among injecting drug users (IDUs) in the United Kingdom (UK) are a growing public health problem. In addition to the well recognised problems with hepatitis B and C, there have been outbreaks in recent years of hepatitis A, wound *botulism*, and *tetanus*. Injecting site infections caused by *methicillin-resistant Staphylococcus aureus* (MRSA) and group A *Streptococcus* bacteria have also become a cause for concern. Data on a range of infections that can affect IDUs have been brought together in the second edition of *Shooting Up; infections among injecting drug users* (1). This report brings together surveillance data from across the UK, including the national results for 2003 from the Unlinked Anonymous Prevalence Monitoring Programmes Survey (UAPMP) of injecting drug users in contact with services.

A key finding is that more than two in five IDUs have been infected with hepatitis C, with the incidence among recent initiates in Glasgow and London being estimated to be high. In England and Wales there is some evidence that transmission may have increased recently, with the prevalence among those participants in the UAPMP survey who first injected in the previous three years, having doubled from one in twelve in 2000 (66 of 767) to one in six in 2003 (67 of 365). Prevalence among this group is a marker of recent transmission and is one of the Department of Health's outcome measures as outlined in the *Hepatitis C Action Plan for England* (2).

Another aim of the *Hepatitis C Action Plan for England* is to increase the proportion of sufferers who are aware of their infection through improved uptake of voluntary confidential screening. It sets a national standard of good practice that all those attending specialist drug treatment services should be offered hepatitis C testing routinely. In 2003, 37% of IDUs (897 of 2449) who took part in the UAPMP survey reported not having had a voluntary confidential test for hepatitis C, this compares with 51% (1532 of 2998) in 2000. Of those who were infected with hepatitis C, 53% (511 of 972) were unaware of their infection, compared to 60% (569 of 956) in 2000.

By the end of 2003 there had been around 60,000 laboratory reported cases of hepatitis C in the United Kingdom (UK), the majority of these were associated with injecting drug use. The UAPMP survey of IDUs indicates that in 2003 around 50% of IDUs with antibodies to hepatitis C were unaware of their exposure and possible ongoing infection.

Transmission of hepatitis B continues among injectors even though there is an effective vaccine that can protect injectors, with policy that all injectors receive this. In 2003, 22% of IDUs who took part in the UAPMP survey in England, Wales, and Northern Ireland had evidence of past or current infection. Uptake of hepatitis B vaccine among IDUs has increased in recent years. In 2003, 50% of IDUs who took part in the UAPMP survey in England, Wales, and Northern Ireland reported receiving at least one dose of hepatitis B vaccine, with 42% of those who first injected in the previous three years receiving at least one dose of hepatitis B vaccine.

The prevalence HIV infection has been low and unchanging and remains stable among injectors in the UK in recent years. In 2003 there is evidence of a possible increase in transmission. The prevalence among those participants in the UAPMP survey in England, Wales, and Northern Ireland who had first injected during the last three years was in 2003 the highest seen in this group since the survey's first year in 1990. The prevalence of HIV among IDUs participating in the UAPMP survey in London was 2.9% compared to 0.5% elsewhere in England. In Northern Ireland 1% of IDUs participating in the UAPMP survey were HIV positive, and in Wales there were no HIV infections among participants.

The ongoing occurrence of MRSA infections (3), and the recent marked increase in severe group A streptococcal (GAS) infection (4) indicate a growing problem with infectious diseases amongst IDUs. The reasons for the occurrence of these infections are unclear and needs further investigation, though they may possibly reflect an increased vulnerability in IDUs to skin sepsis

through a change in risk behaviour, possibly linked to increased use of stimulants, known to be associated with increased risk behaviour compared to opioid use. They are, however, an increasing cause of morbidity among this group and, if the number of these infections continues to grow unchecked, they will lead to a rising burden on health services.

The recent outbreak of tetanus (5) and the ongoing occurrence of wound botulism cases indicate continuing problems with environment contamination of heroin with bacterial spores. Healthcare workers should remain alert to the possibility of these infections among IDUs, particularly those who inject subcutaneously or intramuscularly.

Needle and syringe sharing remains a problem among injecting drug users. In 2003, the proportion of current IDUs participating in the UAPMP survey, sharing needles, and syringes remain high at 29%. Those that inject and share their equipment remain at increased risk of infection with hepatitis C, hepatitis B, and HIV.

The report makes a number of recommendations on priorities for those commissioning services for drug users:

1. Developing high quality needle exchange services for those unable to stop injecting, with sufficient coverage to prevent the sharing of needles and syringes. All needle exchange should also provide:
 - a. Information and advice on safer injecting practices, the prevention of blood-borne virus transmission, and on the safe disposal of used equipment
 - b. Injecting related equipment other than needles and syringes;
 - c. Easy access to other on-site services such as vaccinations, health checks, and diagnostic tests.
2. Ensuring hepatitis B vaccination services are easily accessible to IDUs, and the development of follow-up strategies for those who have started vaccination courses.
3. Examining the incorporation of hepatitis A vaccination into community and prison vaccination programmes for IDUs, and developing procedures for the provision of tetanus vaccine and boosters to those IDUs who may need them.
4. Further improving access to diagnostic testing for hepatitis C in line with strategies such as the '*Hepatitis C Action Plan for England*'.
5. Ensuring easy access to treatment and support services for all those who wish to cease injecting, or to reduce, or stop their drug use

For further information please contact Vivian Hope (tel 020 8327 7930; email: <vivian.hope@hpa.org.uk> or Fortune Ncube (tel: 020 8327 6423; email: <fortune.ncube@hpa.org.uk>).

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National surveillance for glycopeptide-resistant enterococci (GRE) bacteraemias: report of the Working Group

The report of the Working Group on glycopeptide-resistant enterococci (GRE) bacteraemias: has been published at http://www.hpa.org.uk/infections/topics_az/bacteraemia/pubs.htm.

The Working Group was established in April 2003 by the members of the GRE Working Party (comprised of various healthcare professionals including HPA staff) to review the methods used to identify enterococci, test susceptibility to glycopeptide antibiotics and to make recommendations on the reporting of GRE bacteraemias. The group included experts on enterococci, surveillance and laboratory testing, as well as representatives from relevant national organisations.

The Working Group reviewed testing methods and risk factors for GRE bacteraemias and made a number of recommendations:

1. A phased approach to some of the developments recommended, as mandatory surveillance had already begun.
2. Trust rates of GRE bacteraemias should not be used as performance indicators due to the small number of reports.
3. The proportion of clinically significant bacteraemias that are GRE bacteraemias should be measured as an indicator of changing trends.
4. Reports of GRE bacteraemias should include specialty data.
5. Data on clinical activity in Trusts where patients acquired GRE bacteraemias should be collected where the Trust reports more than five GRE bacteraemias in one year.
6. Both mono- and poly-microbial, clinically significant, bacteraemias due to GREs should be reported.
7. Enterococci should be identified to species level to provide data on resistance rates in different species.
8. Biochemical identification should be augmented by antimicrobial susceptibility patterns, which can indicate the likely species. The identification of enterococcal isolates with unusual resistances should be checked, and if confirmed, these should be sent to a reference laboratory for further investigation.
9. Enterococci isolated from blood cultures should be tested for susceptibility to vancomycin. Teicoplanin is not an acceptable alternative to vancomycin for this purpose.
10. Standardised methods should be used for glycopeptide susceptibility testing of enterococci.
11. A review of the surveillance scheme should be carried out after one year and the methodology amended as appropriate.

The working group made further recommendations for research, including the formation of a group to explore methods of data collection for risk factors for GRE bacteraemia, further research on the performance of commercial enterococcal identification kits, and the reliability of susceptibility testing methods.

Compulsory reporting of hospital-acquired infections was announced in October 2000 and began in April 2001 with the mandatory reporting of bacteraemias due to *Staphylococcus aureus*. In June 2003, surveillance for bacteraemias due to glycopeptide-resistant enterococci (GRE) was announced and the mandatory reporting of GREs began in October 2003.

Further information is available from the Health Protection Agency's Healthcare Associated Infections Department, email: hcai.amrdivision@hpa.org.uk.



Steering group on healthcare-associated infection

The Department of Health has charged the Health Protection Agency with the establishment and maintenance of an expert group to provide recommendations on developments required in the field of healthcare-associated infection. The Steering Group's remit is to advise the Health Protection Agency on all matters relating to healthcare-associated infection, so as to enable it to respond to requests for advice from the Department of Health. This Steering Group subsumes many of the functions of the earlier Department of Health's Healthcare-Associated Infection Surveillance Steering Group (HAISSG) and PHLS Advisory Committee on Hospital-Acquired Infection and Antimicrobial Resistance, both disbanded in 2002.

Healthcare-associated infection is a high priority area for the UK government, featuring in the Chief Medical Officer's Report '*Getting ahead of the curve*', (1) as one of the four action areas and being the subject of a more recent report in December 2003 from the Chief Medical Officer, '*Winning Ways*' (2), and '*Towards cleaner hospitals and lower rates of infection: A summary of action*' (3) in July 2004. As a result, Ministers of State have already required that systems are put in place to undertake surveillance and monitoring of healthcare-associated infection across the NHS, for example, mandatory surveillance of *Staphylococcus aureus* and glycopeptide resistant enterococcal bacteraemia, *Clostridium difficile* associated disease, orthopaedic surgical site infection, and serious untoward incident monitoring.

The National Audit Office also published a second report on hospital acquired infection '*Improving patient care by reducing the risk of hospital acquired infection*' (4) in July 2004.

The Group will address issues raised in these reports. Priority considerations for the Group will be the improvement and development of current surveillance that monitors healthcare-associated infection across the NHS.

The membership of the Group, chaired by Professor Don Jeffries, has been drawn from experts in the fields of healthcare-associated infection and antimicrobial resistance and key stakeholders, including the Inspector of Microbiology and Infection Control, the Hospital Infection Society, the Infection Control Nurses' Association, the Association of Medical Microbiologists, and representatives from National Health Service. The first meeting will take place on Thursday, 21 October 2004.

If you require any additional information please contact the Secretariat to the Group, in the HPA Expert Advice Support Office, tel: 020 8327 7946 or email: <[easo@hpa.org.uk](mailto: easo@hpa.org.uk)>.

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The HPA's Haemophilus Reference Unit relocates to Colindale

From 1 November 2004, the laboratory services of the Health Protection Agency's Haemophilus Reference Unit (HRU) will be provided from the Health Protection Agency's Centre for Infections (Central Public Health Laboratory), Colindale, north west London. This will not affect the service provided by the HRU. The HRU will continue to work closely with the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC) also at the Centre for Infections, and the Oxford Vaccine Group (OVG) in conducting collaborative activities on *Haemophilus influenzae* and assessing the impact of Hib vaccine. It is of vital importance that this high quality surveillance continues in order to fully assess the effect of the recent Hib booster campaign.

From 1 November 2004 all invasive isolates of *Haemophilus species* (excluding *Haemophilus ducreyi*) from normally sterile sites (blood cultures, cerebro-spinal fluid [CSF] etc) from patients of all ages should be submitted to:

Mary Slack, HPA's Centre for Infections Haemophilus Reference Unit, Respiratory and Systemic Infection Laboratory (RSIL), CPHL, 61 Colindale Avenue, London NW9 5HT (or via Hays DX – Dr Mary Slack, HPA Colindale, SRMD (RSIL), DX 6530011, Colindale, London) tel: 020 8327 6091, fax: 020 8205 6528, email: <mary.slack@hpa.org.uk>.

From 1 November 2004, isolates should not be submitted to the previous HRU location in Oxford as the unavoidable delay involved in forwarding them to London may compromise viability. HRU request forms can be downloaded from HPA website at: <http://www.hpa.org.uk/srmd/div_rsil/greensurveyform_hru060902.pdf>.

Enteric

Last updated: **14 October 2004**
 Next update due: **4 November 2004**

-  [General outbreaks of foodborne illness, England and Wales: weeks 36-39/04](#)
-  [Salmonella infections, England and Wales, reports to the HPA \(salmonella data set\): August 2004](#)
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General outbreaks of foodborne illness, England and Wales: weeks 36-39/04 

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

Health Protection Unit	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
Hampshire & Isle of Wight	Campylobacter	Restaurant	May	10	8	None	–
North Yorkshire	S. Enteritidis PT1	Hospital	September	3	3	None	–
Cheshire & Merseyside	S. Enteritidis PT4	Restaurant	August	4	4	None	–
Greater Manchester	S. Enteritidis PT4	Residential Home	August	6	6	None	–
North west London	S. Enteritidis PT4	Nursery school	August	3	3	None	–
S Yorkshire	S. Enteritidis PT12	Residential Home	August	4	4	None	–
North west	S. Enteritidis PT14B & 59	Restaurant	August	>20	>20*	Liquid egg, fried rice, chicken	M
County Durham & Tees	S. Enteritidis	Restaurant	September	4	4	None	–
National	S. Newport	National	August	>250	>250	Lettuce	S

* Includes asymptomatic food handlers.

M (microbiological): identification of an organism of the same type from cases and in the suspect vehicle, or vehicle ingredient(s), or detection of toxin in faeces or food; D (descriptive): other evidence, usually descriptive, reported by local investigators as indicating the suspect vehicle.

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

Details of serotypes of the 1764 *Salmonella* infections recorded in August 2004 are given in the table below. In September 2004, 1834 *Salmonella* infections were recorded and preliminary information was received about eight outbreaks (see table above).

	August 2004
Total <i>Salmonella</i> *	1764
S. Enteritidis (PT4)	450
S. Enteritidis (other PTs)	924
S. Typhimurium	152
S. Virchow	13
Others (typed)	225

* Data provisional.

Common gastrointestinal infections, England and Wales, laboratory reports: weeks 36-39/04

Laboratory reports	Number of reports received				Total reports 36-39/04	Cumulative total to	
	36/04	37/04	38/04	39/04		39/04	39/03
<i>Campylobacter</i>	774	880	807	675	3136	30565	35,540
<i>Escherichia coli</i> O157*	42	39	26	45	152	497	388
<i>Salmonella</i> †	418	481	448	337	1684	8891	11,532
<i>Shigella sonnei</i>	10	19	18	9	56	460	480
Rotavirus	26	28	24	19	97	12,688	14,240
Norovirus	15	15	16	12	58	1693	1820
<i>Cryptosporidium</i>	103	137	130	84	454	2288	4284
<i>Giardia</i>	43	67	63	44	217	2026	2425

* Vero cytotoxin producing isolates (data from Health Protection Agency's Laboratory of Enteric Pathogens (LEP)).

† Data from Health Protection Agency's Laboratory of Enteric Pathogens.

Less common gastrointestinal infections, England and Wales laboratory reports: weeks 27-39/04

Laboratory reports	Total reports 27-39	Cumulative total to 39/04	Cumulative total to 39/03
Adenovirus	9	21	36
Astrovirus	9	139	86
Calicivirus	9	32	19
<i>Shigella boydii</i>	23	82	64
<i>Shigella dysenteriae</i>	12	38	31
<i>Shigella flexneri</i>	44	166	208
<i>Aeromonas</i>	52	121	123
<i>Plesiomonas</i>	13	26	21
Vibrio	12	23	14
Yersinia	3	11	30
<i>Entamoeba histolytica</i>	57	168	188
<i>Dientamoeba fragilis</i>	38	144	174
<i>Blastocystis hominis</i>	82	237	240
<i>Taenia</i> spp	14	78	60
<i>Trichostrongylus</i> spp	–	–	1
<i>Trichuris trichiura</i>	8	39	79

Commentary:***Taenia saginata* (7):**

F 16y, F 31y, F 30y, M 24y, M 30y, M 42y, sex not stated 36y; all with no clinical or epidemiological details.

***Taenia* spp (7):**

F 16y, F 23y, M 30y, M 28y, M 43y, M 24y, M 30y; all with no clinical details.

***Trichuris trichiura* (8):**

F 4y, F 20y, F 25y, M 9y, M 19y, M 30y, M 32y, M 37y; all with no clinical or epidemiological details.