



CDR WEEKLY

Current Issue: Volume 15 Number 1 Published on: 7 January 2005

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Advice for travellers to tsunami affected regions in south Asia and east Africa 

On 26 December 2004, a tsunami struck several Asian and east African countries, resulting in a devastating loss of life and serious damage to basic infrastructures such as housing, water, and sewage treatment services, electricity, and health facilities. Indonesia, Sri Lanka and the Maldives, Thailand, Malaysia, and India were the most affected, but Myanmar, Bangladesh, Somalia, Kenya, Tanzania, and the Seychelles were also affected in varying degrees. The latest information on the developing situation is available from the World Health Organization at http://www.who.int/hac/crises/international/asia_tsunami/sitrep/en/.

The immediate health needs among people returning to the United Kingdom (UK) from tsunami-affected countries are likely to be physical and psychological, resulting from the trauma, shock, and loss that individuals have experienced. Flooding, stagnant water, disruption of sewer lines, and the consequent overcrowded living and poor quality sanitation conditions of displaced people, however, are conducive for development of infectious diseases.

Those who live in and are travelling to affected areas are all likely to be at increased risk of infection from the following illnesses: intestinal illness such as salmonellosis, typhoid, campylobacteriosis, shigellosis, and cholera; mosquito transmitted diseases including malaria and dengue; and other diseases such as leptospirosis, diphtheria, and skin, eye, and ear infections.

More detailed information on the types of infection that flood victims in general may encounter is also available from the World Health Organization <http://www.who.int/hac/techguidance/ems/en/FloodingandCommunicableDiseasesfactsheet.pdf>.

The Health Protection Agency and the National Travel Health Network and Centre (NaTHNaC) have provided advice about the possible infectious risks involved for travellers going to and returning from affected areas, with a summary information sheet and a question and answer document for health professionals. In particular, those who were intending to travel to tsunami-affected countries and have changed their itinerary at the last minute should double check that their travel health needs are still appropriate for the new destination before they depart. All of this information, including links to the Department of Health and Foreign and Commonwealth Office, can be accessed via the travel page on the HPA website at http://www.hpa.org.uk/infections/topics_az/travel/current_items/tsunami_adv.htm.

Further information for travellers going to areas affected by the tsunamis is available at http://www.hpa.org.uk/hpa/news/articles/issues/2004/050106_pre_trav.htm.

Additional advice for healthcare professionals is in the form of questions and answers, available at: http://www.hpa.org.uk/infections/topics_az/travel/current_items/tsunami_QAs.htm.



The Health Protection Agency sets out its commitment to patient confidentiality with new leaflet

The Health Protection Agency (HPA) has prepared a leaflet to inform and reassure patients about the correct use of patient data in monitoring certain diseases. The leaflet is being circulated to all general practitioner (GP) surgeries, hospital outpatients, and to other NHS clinics in England. Although the leaflet is directed at members of the public, it will also help healthcare professionals to answer specific enquiries. The leaflet is available on the HPA website at <http://www.hpa.org.uk/confidentiality/>.

The leaflet, *Safeguarding the confidentiality of information about patients while also protecting public health*, informs patients about reporting arrangements for infectious diseases and other health threats. It is important for patients to know that the 'person identifying' information may be made available to health protection doctors in order to protect the health of others in the wider community.

The background to the production of the leaflet goes back to the Caldicott Report (1) in 1997. At that time the NHS and the Public Health Laboratory Service* (PHLS) was required to examine the use of patient identifying information outside the clinical care context. The use of this information for purposes such as audit, public health, cross charging etc. was examined in this report and the NHS was asked to improve the safeguards in the use of such data. In 2001, as part of the Health and Social Care Act, section 60, a committee was set up to advise the Secretary of State for Health when data transfers could be permitted in the absence of explicit patient consent. Applications had to be made to the Patient Information Advisory Group (PIAG) for data transfers where it had not been anonymised, or where it was not practical or possible to obtain patient consent. Many such data transfers for public health surveillance come into this category and PIAG requested that the HPA produce a leaflet for patients informing them. It is likely that local health protection units, microbiologists, or other public health professionals including hospital clinicians and general practitioners may receive queries on the leaflet. In view of this likelihood, healthcare professionals will be in a better position to answer such patient queries if they can take the time to read the leaflet for themselves.

The questions that health professionals are likely to be asked fall into three broad areas:

1) Confidentiality

The leaflet is intended to inform, not alarm. Patients have a right to know what is happening to information about them. Patients can be reassured that the reporting arrangements and data sharing between professionals have been going on for years and the arrangements are not a departure from established practice. The only changes are in the way in which the NHS (and HPA) inform patients about what happens to such information. The fact that this has been going on safely without loss of confidentiality should provide reassurance to patients.

2) How the reporting arrangements work

Some patients may want more detail on how reporting occurs and on what constitutes compulsory (statutory notification) and voluntary reporting. Patients can be directed to the HPA's website for more information, available at <http://www.hpa.org.uk/caldicott/> and <http://www.hpa.org.uk/confidentiality/>.

3) Can patients opt out?

Although patients cannot opt out of the statutory notification of certain infections, they can opt out of the voluntary reporting arrangements including both laboratory reporting or directly from reports made by clinicians. Patients who request such opt-out may be concerned about confidentiality – in which case they could be invited to consult the HPA website. It should be explained to patients that effective public health monitoring in the UK is contingent on the appropriate organisations being permitted to use a sufficient amount of information on infections and other health risks – thus if significant numbers of people opt-out, health protection of the population will be compromised. If a patient continues to insist on opt-out and the disease is not statutorily notifiable, then the laboratory investigation requests should be appropriately marked in such a way that makes clear that they should not be reported for public health purposes with the patients' identifiers present.

*The Health Protection Agency was set up as a Special Health Authority on 1 April 2003. Part of the former PHLS was one such organisation absorbed by the formation on this date.

1. Department of Health. The Caldicott Committee Report on the Review of Patient-Identifiable Information. London: Department of Health, 1997. Available at: <http://www.publications.doh.gov.uk/ipu/confiden/report/caldrep.pdf>.



Further human cases of avian influenza (H5N1) in Viet Nam

On 30 December 2004, the World Health Organization (WHO) issued a statement confirming a further case of human infection with influenza A (H5N1) in Viet Nam. The case, a female aged 16 years from the southern province of Tay Ninh has been hospitalised since 26 December and remains in a critical condition. The source of the infection is being investigated by Vietnamese authorities.

On 6 January 2005, WHO reported two further cases of avian influenza in humans in Viet Nam, both of whom have died. The first, a male aged 6 years from the southern province of Dong Thap died on 30 December 2004. The second, a male aged 9 years from the southern province of Tra Vinh was hospitalised on 2 January and died on 4 January 2005.

All three cases have occurred in the southern region of Viet Nam, where poultry outbreaks have been recurring since December 2004.


These cases bring the total in Viet Nam to 30, of which 22 have been fatal. Since January 2004, 47 human cases of avian influenza have been reported in Asia, of which 34 have been fatal.

Further information is available from the WHO:

<http://www.who.int/csr/disease/avian_influenza/en/>.

Respiratory

Last updated: 7 January 2005
Next update due: 3 February 2005

 [Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales: weeks 49-53/04](#)

Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales: weeks 49/04 to 01/05

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 49-53/04

Week	49/04	50/04	51/04	52/04	53/04*	Total
Week ending	05/12/04	12/02/04	19/12/04	26/12/04	02/01/05	
Influenza A	1	8	7	2	6	24
Isolation	–	–	1	1	1	3
DIF	–	1	2	1	2	6
Four-fold rise in paired sera	–	–	–	–	1	1
PCR	–	–	–	–	–	–
Other	1	7	4	–	2	14
Influenza B	–	1	1	–	1	3
Isolation	–	–	–	–	1	1
DIF†	–	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–	–
PCR	–	–	–	–	–	–
Other	–	1	1	–	–	2
Influenza (untyped)	–	–	–	–	–	–
Isolation	–	–	–	–	–	–
DIF	–	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–	–
PCR	–	–	–	–	–	–
Other‡	–	–	–	–	–	–

*Week 53 from 27 December 2004 and 2 January 2005, but is still denoted as 53/04.

†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 49-53/04

Week	49/04	50/04	51/04	52/04	53/04*	Total
Week ending	05/12/04	12/02/04	19/12/04	26/12/04	02/01/05	
Adenovirus†	21	22	26	25	9	13
Coronavirus	–	–	–	–	–	–
Parainfluenza‡	8	11	5	8	6	38
Rhinovirus	5	3	15	3	2	28
Respiratory syncytial virus (RSV)	440	542	580	616	157	2335

*Week 53 from 27 December 2004 and 2 January 2005, but is still denoted as 53/04.

†Respiratory samples only. Excludes diagnoses made by electron microscopy (EM).

‡ Includes parainfluenza types 1, 2, 3, 4, and untyped.

Table 3 Respiratory viral detections by age group: weeks 49-53/04

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥65 years	Unknown	Total
Adenovirus*	17	11	10	50	23	2	–	113
Coronavirus	–	–	–	–	–	–	–	–
Influenza A	1	1	2	9	5	6	–	24
Influenza B	–	–	1	2	–	–	–	3
Parainfluenza†	19	6	4	5	2	1	1	38
Rhinovirus	16	4	2	2	3	1	–	28
Respiratory syncytial virus (RSV)	1987	263	21	15	14	13	22	2335

*Respiratory samples only, and excludes diagnoses made by electron microscopy (EM).

†includes parainfluenza types 1, 2, 3, 4, and untyped.

Table 4 Laboratory reports of infections associated with atypical pneumonia, by week of report: weeks 49-53/04

Week	49/04	50/04	51/04	52/04	53/04*	Total
Week ending	05/12/04	12/02/04	19/12/04	26/12/04	02/01/05	
<i>Coxiella burnetii</i>	–	–	–	–	–	–
Respiratory <i>Chlamydia</i> sp†	3	–	–	–	1	4
<i>Mycoplasma pneumoniae</i>	13	7	2	2	2	26
<i>Legionella</i> sp	6	3	3	2	–	14

*Week 53 from 27 December 2004 and 2 January 2005, but is still denoted as 53/04.

†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 49-53/04

Week	49/04	50/04	51/04	52/04	53/04*	Total
Week ending	05/12/04	12/02/04	19/12/04	26/12/04	02/01/05	
Nosocomial	1	–	–	–	–	1
Community	2	2	1	1	–	6
Travel abroad	3	1	2	1	–	7
Travel UK	–	–	–	–	–	–
Total	6	3	3	2	–	14
Male	2	3	2	2	–	9
Female	4	–	1	–	–	5

*Week 53 from 27 December 2004 and 2 January 2005, but is still denoted as 53/04.

Fourteen cases were reported with pneumonia - nine males aged between 45 and 78 years and five females aged between 41 and 65 years. Six cases had community-acquired infection. Four deaths were reported, (M 47y and M 78y, and F 41y and F58y).

Seven cases were travel associated: United States (3), Spain (2), Malta (1), and Turkey (1).

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Zoonoses

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Common animal associated infections, England and Wales laboratory reports: weeks 49-52/04**Common animal associated infections, England and Wales laboratory reports: weeks 49-52/04**

	Total reports for weeks 49-52		Cumulative totals for weeks 49-52	
	2004*	2003	2004*	2003
<i>Borrelia burgdorferi</i> *‡	–	3	245	284
<i>Leptospira hardjo</i> †§	–	–	3	–
<i>Leptospira icterohaemorrhagiae</i> †§	1	3	10	11
<i>Leptospira other</i> †§	4	1	24	9
<i>Pasteurella haemolytica</i>	–	–	9	3
<i>Pasteurella multocida</i>	25	5	289	268
<i>Pasteurella pneumotropica</i>	–	–	6	8
<i>Pasteurella</i> spp	5	8	78	86
<i>Toxocara</i> spp	–	–	3	4
<i>Toxoplasma gondii</i>	2	–	25	30
<i>Toxoplasma</i> spp	4	5	55	57
<i>Capnocytophaga</i> spp	–	–	5	11
<i>Echinococcus granulosus</i>	–	–	4	10
<i>Coxiella burnetii</i>	–	1	31	36
<i>Chlamydia psittaci</i>	2	9	67	96
<i>Brucella</i> spp	–	2	16	5
Orf-paravaccinia virus	–	2	1	5

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

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

Comment

Leptospirosis

Leptospira icterohaemorrhagiae: M 57y, no clinical or epidemiological information

***Leptospira* spp**: M 32y, Territorial Army, swimming and capsizing in freshwater pools; M 36y canoeing. M 52y; F 53y, no clinical information.

Pasteurellosis

Pasteurella multocida: Ten females aged between 15 and 85 years with no clinical or epidemiological history

Four females aged between 10 and 75 years with dog bites; one female aged 84y with infected cat scratch.

***Pasteurella* spp**: Eight males aged between 28 and 84 years with no clinical history; two males aged between 25 and 58 years with dog bites.

Toxoplasmosis

Toxoplasma gondii: M 47y, cat died two weeks before onset of symptoms; M 42y.

***Toxoplasma* spp**: F 18y, F 26y, F 31y, M 47y

Psittacosis

Chlamydia psittaci: F 63y, M 71y, no clinical information.