



# CDR WEEKLY

**Current Issue:** Volume 15 Number 5 **Published on:** 3 February 2005

## NEWS STORIES:

- ▾ [Changes in laboratory testing as the increase in mumps cases in England and Wales continues](#)
- ▾ [Nationally co-ordinated hepatitis C look-back: England and Scotland](#)

## INFECTION REPORTS:

### Respiratory:

- ▾ [Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales: weeks 01-04/05](#)

### Travel Health:

- ▾ [Imported Infections, England and Wales: October to December 2004](#)
- 

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## News

[Changes in laboratory testing as the increase in mumps cases in England and Wales continues](#)

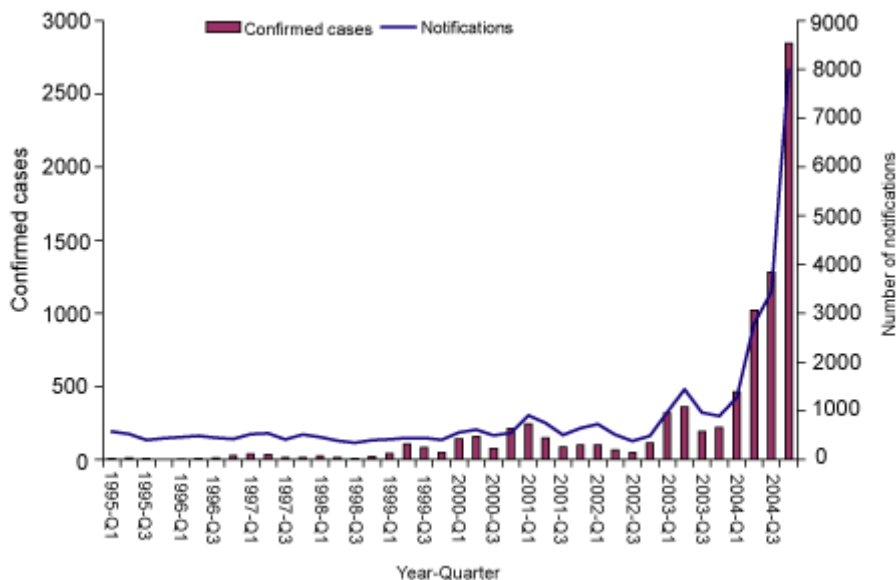
[Nationally co-ordinated hepatitis C look-back: England and Scotland](#)

### Changes in laboratory testing as the increase in mumps cases in England and Wales continues

The number of national notifications of mumps cases has continued to increase (following a slight reduction over the Christmas period) to between 900 and 1300 cases per week. So far in 2004, 7866 cases of mumps have been confirmed in England and Wales, compared with a total of 3907 cases between 1999 and 2003. Confirmed cases are predominantly in older teenagers and young adults with 79% (6046 cases) reported in people aged between 15 and 24 years.

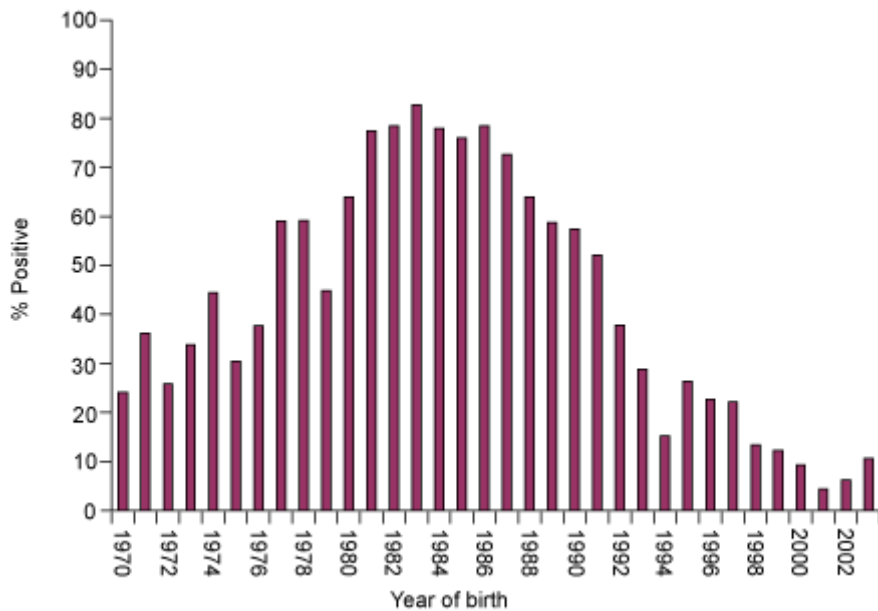
Since 1995, the Health Protection Agency (HPA) has been offering laboratory confirmation of all notified mumps cases using oral fluid (saliva) samples. The number of notifications and the number of confirmed cases for each quarter since 1995 is shown in figure 1.

**Figure 1 Mumps notifications and confirmed cases in England and Wales, by quarter: 1995 to 2004**



In the past year the number and proportion of confirmed mumps cases has increased dramatically with an overall confirmation rate of around 60%. As shown in figure 2, the proportion of cases confirmed as IgM positive varies by age with the highest confirmation rates (over 75%) in those born between 1981 and 1986 (ie, aged between 18 and 23 years). False negative results can also occur in a small percentage of cases particularly if the sample is taken early and, therefore, it is likely that virtually all cases in this age range are genuine mumps.

**Figure 2 Proportion of positive saliva samples in 2004 by year of birth**



On the basis of this, the HPA is recommending that during this period of increased mumps incidence, oral fluid samples should not be taken from individuals with clinical mumps who were born between 1981 and 1986, and that they should be managed as if they were a confirmed case. Samples should continue to be taken from cases in all other age groups or where it is clinically important to confirm the diagnosis (for example, where a complication has been observed).

For further information on mumps is available on the HPA website at:  
[http://www.hpa.org.uk/infections/topics\\_az/mumps/menu.htm](http://www.hpa.org.uk/infections/topics_az/mumps/menu.htm).

## Nationally co-ordinated hepatitis C look-back: England and Scotland

The second phase of a hepatitis C look-back exercise across eight NHS Trusts in England and one Health Board in Scotland has just been completed. It was coordinated by the Health Protection Agency's Centre for Infections.

In the original exercise in 2003, Kent Health Protection Unit acting on the advice of the UK Advisory Panel for healthcare workers infected with blood-borne viruses (UKAP) conducted a look-back to notify the most recent 500 women who had undergone high-risk exposure-prone procedures (EPP) involving a hepatitis C-infected healthcare worker (HCW). Four hundred and thirty-two women were identified and offered a test for hepatitis C. No positive cases of hepatitis C linked to the HCW were ascertained during this notification exercise. A patient who had undergone an EPP involving the HCW, and who was outside the period restricted to the first phase of the exercise, reported that they were hepatitis C positive. Following further consultation with UKAP, the Panel advised that there was a strong likelihood that the patient acquired their hepatitis C infection from the HCW and recommended that the look-back should be extended to involve all patients who had undergone an EPP involving the HCW.

On 31 January 2005, 2350 patients who underwent high-risk EPPs involving the HCW, and for whom addresses were known, were sent letters explaining the situation and offering them a blood test for hepatitis C. Their general practitioners (GPs) have also been written to. Dedicated help lines offering support to the patients have been set up at each Trust. NHS Direct has also set up a dedicated helpline number to provide advice to people who may be concerned, but have not been informed by the Trust that they should be tested because they were assessed as having no risk of infection even though they received medical care from the HCW. Some patients may have moved from the addresses they were in at the time they received their care and the Trusts do not have current contact details. NHS Direct will provide information for such patients, and details on how they can access the help and support they need.

Information about hepatitis C is also available from the HPA website at:  
[http://www.hpa.org.uk/infections/topics\\_az/hepatitis\\_c/menu.htm](http://www.hpa.org.uk/infections/topics_az/hepatitis_c/menu.htm).

The Department of Health has produced a helpful booklet on hepatitis C: Hepatitis C – Essential information for professionals and guidance on testing. It is available in pdf format at: [http://www.hepc.nhs.uk/resources/documents/HepatitisC\\_information08.12.04.pdf](http://www.hepc.nhs.uk/resources/documents/HepatitisC_information08.12.04.pdf).

## Respiratory

 [Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales: weeks 01-04/05](#)

 [Influenza and other respiratory viruses surveillance in the United Kingdom: October 2003 to May 2004](#)

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

Week	01/05	02/05	03/05	04/05	Total
Week ending	09/01/05	16/01/05	23/01/05	30/01/05	
<b>Influenza A</b>	11	38	98	42	189
Isolation	4	10	17	6	37
DIF	4	16	24	16	60
Four-fold rise in paired sera	–	–	1	–	1
PCR	2	5	10	5	22
Other	1	7	46	15	69
<b>Influenza B</b>	1	8	6	2	17
Isolation	–	3	4	–	7
DIF*	–	2	2	–	4
Four-fold rise in paired sera	–	–	–	–	–
PCR	–	2	–	1	3
Other	1	1	–	1	3
<b>Influenza (untyped)</b>	–	–	–	–	–
Isolation	–	–	–	–	–
DIF	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–
PCR	–	–	–	–	–
Other†	–	–	–	–	–

\*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 01-04/05**

Week	01/05	02/05	03/05	04/05	Total
Week ending	09/01/05	16/01/05	23/01/05	30/01/05	
Adenovirus*	21	19	52	25	117
Coronavirus	–	–	–	–	–
Parainfluenza†	5	14	12	5	36
Rhinovirus	–	9	4	7	20
Respiratory syncytial virus (RSV)	380	502	342	191	1415

\*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 01-04/05**

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥65 years	Unknown	Total
Adenovirus*	25	23	4	42	15	8	–	117
Coronavirus	–	–	–	–	–	–	–	–
Influenza A	34	25	19	34	31	44	2	189
Influenza B	3	2	2	6	3	1	–	17
Parainfluenza†	22	6	–	6	1	1	–	36
Rhinovirus	11	3	–	3	3	–	–	20
Respiratory syncytial virus (RSV)	1176	150	14	23	23	19	10	1415

\*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 01-04/05**

Week	01/05	02/05	03/05	04/05	Total
Week ending	09/01/05	16/01/05	23/01/05	30/01/05	
<i>Coxiella burnetii</i>	–	1	–	–	1
Respiratory <i>Chlamydia</i> sp*	–	2	2	–	4
<i>Mycoplasma pneumoniae</i>	2	3	12	12	29
<i>Legionella</i> sp	5	4	6	4	19

\*Includes *Chlamydia psittaci*, *Chlamydia pneumoniae*, and *Chlamydia* sp detected from blood, serum, and respiratory specimens.

**Table 5a Reports of legionnaires' disease (pneumonic and non-pneumonic) cases in England and Wales, by week of report: weeks 01-04/05**

Week	01/05	02/05	03/05	04/05	Total
Week ending	09/01/05	16/01/05	23/01/05	30/01/05	
Nosocomial	–	–	1	–	1
Community	3	1	1	4	9
Travel abroad	2	2	3	–	7
Travel UK	–	1	1	–	2
<b>Total</b>	<b>5</b>	<b>4</b>	<b>6</b>	<b>4</b>	<b>19</b>
Male	–	2	2	2	6
Female	5	2	4	2	13

Nineteen cases were reported with pneumonia: six males aged between 40 and 67 years and thirteen females aged between 35 and 72 years. Nine cases had community-acquired infection. F 72y died. Nine cases were travel-associated: Spain, Turkey, and United Kingdom (two each), and Italy, Malta, and Switzerland (one each).

**Table 5b Reports of Legionnaire's disease (pneumonic and non-pneumonic) cases by Region of Report in England and Wales: weeks 01-04/05**

Region	Nosocomial	Community	Travel (Abroad)	Travel	Total
North East	–	–	1	–	1
Yorkshire & Humber	–	2	1	–	3
East Midlands	–	–	–	–	–
East of England	–	2	–	1	3
London	–	1	1	–	2
South East	1	–	–	1	2
South West	–	3	–	–	3
West Midlands	–	–	2	–	2
North West	–	–	2	–	2
Wales	–	1	–	–	1
<b>Total</b>	<b>1</b>	<b>9</b>	<b>7</b>	<b>2</b>	<b>19</b>

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[Infection Reports](#) | Travel Health

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## Travel health

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### Imported infections, England and Wales: October to December 2004

This fourth quarter report on imported infections in England and Wales covers the period from October to December 2004 inclusive. The data should be interpreted in conjunction with the report *Illness in England, Wales, and Northern Ireland associated with foreign travel – a baseline report to 2002* (1), especially the content under the section 'Sources of data on travel-associated illness and their limitations for analysis'. All data presented are provisional and subject to change; the confirmed final data will be presented annually.

In general, there were fewer infections reported in England and Wales via LabBase\* in the final quarter of 2004 (11,867)† compared with the same period in 2003 (15,229) (Table). This may be as a result of current data loading problems within Co-Surv‡, and is currently being addressed. Travel history reporting, however, has improved significantly in the fourth quarter of 2004, from 12.6% reports stating any information about recent travel abroad in the third quarter of 2004 to 19.4% in the same period ( $\chi^2 = 234.79$ , 1df,  $p < 0.01$ ). This is consistent with the second and third quarters (2,3) and may represent an overall improvement of travel history reporting in 2004 compared with 2003. The overall proportion of travel history reporting, however, is still low and limits the interpretation of the following data (Table).

**Table Imported infections in England and Wales: October to December 2004**

Organism	Total reports for Oct to Dec				Cumulative totals for Oct to Dec			
	2004*		2003		2004*		2003	
	Travel-related	All reports	Travel-related	All reports	Travel-related	All reports	Travel-related	All reports
<b>Gastrointestinal Infections</b>								
<b>Bacterial</b>								
<i>Salmonella</i> spp	458	2521	509	3205	1967	11404	2759	15057
<i>Campylobacter</i> spp	228	7447	320	9214	1050	35939	1404	44688
<i>Shigella flexneri</i>	10	67	6	52	35	204	32	258
<i>Shigella dysenteriae</i> †	12	15	9	19	49	223	31	50

<i>Shigella sonnei</i>	36	185	15	97	100	609	83	578
<i>Shigella boydii</i> †	14	31	21	30	64	113	52	94
<i>Shigella</i> unknown spp	1	17	1	17	6	101	3	68
<b>Bacterial</b>								
<i>Salmonella</i> Typhi	31	43	26	37	116	193	118	201
<i>Salmonella</i> Paratyphi (A,B,C)	37	58	15	27	136	213	107	199
<i>Vibrio cholerae</i> (Type O1)†	2	2	4	4	8	10	10	11
<b>Protozoal</b>								
<i>Entamoeba histolytica</i>	4	29	15	72	20	149	58	264
<i>Entamoeba coli</i>	1	15	1	17	8	68	6	66
<i>Giardia lamblia</i>	64	616	67	890	229	2453	283	3332
<i>Cryptosporidium</i> spp	18	797	58	1430	96	3046	405	5778
<i>Cyclospora</i> spp	5	9	2	7	16	43	13	40
<i>Endolimax nana</i>	–	5	–	7	5	23	5	50
<b>Helminths</b>								
<i>Strongyloides stercoralis</i>	1	3	4	6	1	18	7	25
<i>Strongyloides</i> spp	–	1	–	1	–	5	–	7
<i>Ancylostoma duodenale</i>	–	–	–	–	–	1	1	1
<i>Necator americanus</i>	–	–	–	–	–	–	–	–
Hookworm unspecified	–	3	5	15	3	18	10	73
<i>Ascaris lumbricoides</i> (round worm)	1	8	9	29	8	64	18	105
<i>Trichuris trichiura</i> (whip worm)	2	5	1	11	9	39	5	77
<i>Hymenolepis diminuta</i>	–	–	–	–	–	–	–	–
<i>Hymenolepis nana</i>	–	–	–	3	1	5	1	16
<i>Hymenolepis</i> spp	–	–	–	–	–	–	–	–
<i>Taenia saginata</i>	2	8	5	28	5	38	6	49
<i>Taenia</i> spp	–	7	1	13	2	27	2	45
<i>Gnathostoma</i> spp	–	–	–	1	–	2	–	2
<i>Diphyllobothrium latum</i> (fish tape worm)	–	2	–	2	–	2	–	2
<b>Arthropod borne infections</b>								
<b>Arboviruses</b>								
Dengue virus	–	3	3	9	2	15	6	21
Chikungunya virus	–	–	–	–	–	–	–	–
Ross river virus	–	–	–	–	–	1	–	1
Sandfly fever virus	–	–	–	–	–	–	1	1
Unspecified	–	2	–	–	1	6	–	1
<b>Leishmaniases</b>								
Cutaneous	–	–	7	7	8	9	23	28
Visceral	–	–	–	–	–	1	1	1

Unspecified	–	–	1	3	5	6	1	6
<b>Filariases</b>								
Loa loa	–	–	–	–	–	2	–	1
<i>Wuchereria bancrofti</i>	–	–	–	1	–	–	–	2
<i>Mansonella perstans</i>	–	–	1	2	–	–	1	4
<i>Onchocerca volvulus</i>	–	–	–	–	–	–	–	–
Unspecified	–	–	–	–	–	–	2	3
<i>Lyme borreliosis</i> †	22	100	5	31	54	323	24	315
<b>Miscellaneous</b>								
<b>Schistosome infections</b>								
<i>Schistosoma mansoni</i>	–	–	3	5	5	12	5	13
<i>Schistosoma haematobium</i>	–	5	2	8	3	21	16	43
<i>Schistosoma intercalatum</i>	–	–	–	–	–	–	–	–
Schistosoma unknown spp	1	5	–	6	4	21	–	10
<b>Other infections</b>								
Leptospirosis‡	3	11	2	8	6	30	7	30
Legionnaires' disease§	42	68	33	92	137	273	143	310
<i>Coxiella burnetii</i> (Q fever)	–	5	1	7	1	28	3	46
Rickettsia spp	–	–	–	–	–	1	1	1

\*All data for 2004 is provisional and subject to change.

† Data on cholera, *S.boydii* and *S.dysenteriae* supplied by the SMRD Laboratory of Enteric Pathogens

‡ The Zoonoses Surveillance Reference Unit, CDSC Wales, supplied data for Lyme borreliosis and leptospirosis on behalf of the Leptospira Reference Unit, Hereford and the Lyme Disease Reference Unit, Southampton.

§ Data on legionnaires' disease were supplied by the Legionella Section of the Respiratory Diseases Department of CDSC and represent cases of legionnaires' disease reported to the National Surveillance Scheme in residents of England and Wales. Travel-related cases are those who have spent all or part of the incubation period of between two and ten days abroad prior to onset of symptoms.

Gastro data extracted from Labbase 10 January 2005, enteric fever and other infections 19 January 2005 Table compiled by the Health Protection Agency's Travel Health Surveillance Section at the Centre for Infections, Communicable Disease Surveillance Centre (CDSC), London.

## Gastrointestinal infections

### Bacterial infections

Gastrointestinal infections are the most frequently reported type of infection in England and Wales and, although under reported, are the most common infection in travellers. In the fourth quarter of 2004, *Salmonella* spp (non-typhoidal) were the most frequently reported infection associated with recent travel abroad (458/2521) even though more campylobacter infections are reported in England and Wales in general (7447 in total of which 228 reported recent travel abroad). Travel history reporting was slightly better for the fourth quarter compared with the third quarter of 2004, and more complete for *Salmonella* spp than for campylobacter, with 68.3% of *Salmonella* spp reports having any information about foreign travel compared with only 4.6% for *Campylobacter* spp. Travel history reporting for campylobacter is historically under- estimated in routine surveillance systems (3).

Of the *Salmonella* spp reports that stated recent travel abroad, 33% (151/458) reported recent travel abroad to Europe and 22% (101/458) travelled to north Africa and the middle east. The travel destinations most frequently reported were Spain, including the resort islands of the Canaries and Balearics, (17.9%, 82/458), Egypt (8.1%, 37/458), Greece and India (both 7% (32/458), Thailand (4.8%, 22/458), Turkey (4.4%, 20/458), and Tunisia (4.1%, 19/458). Fifty-eight (12.7%) reports had no country of travel stated.

Thirty-two per cent (73/228) of the *Campylobacter* spp reports showing a recent history of foreign travel reported recent travel to mainland Europe, 25.9% (59/228) to the Indian sub continent, and 15.6% (35/228) to north Africa and the middle east. The most frequently reported countries of travel were Spain (21.5%, 49/228) and India (20.2%, 46/228). Twenty-two reports (9.6%) had no country of travel stated.

In the fourth quarter of 2004, there were 315 reports of shigella infection, 31 due to *Shigella. boydii* and 15 due to *Shigella. dysenteriae*, the organisms that cause dysentery-like (bloody diarrhoea) illness. There was information about recent travel abroad for 24.4% (77/315) of reports, of which 73 (95%) specified recent travel abroad. The countries of travel most frequently reported were Egypt (20/73) and India (13/73).

There were two reports of *Vibrio cholerae*, both serotype O1, biotype El Tor Ogawa; one was imported from Cameroon and the other from India.

The geographical distribution of gastrointestinal infections, in particular salmonella and campylobacter, tends to reflect the travelling patterns of British travellers, as they are common worldwide. As the winter months approach, travellers tend to travel further afield for winter sun holidays, eg, northern Africa, the middle east, and to tropical countries; this is also reflected by the countries of travel that have been reported in the above data.

### Protozoal infections

During the fourth quarter, there were 797 reports of cryptosporidiosis in England and Wales, of which 18 reported recent travel abroad. Of those, the Indian sub-continent (ISC), Europe and the Caribbean were stated regions of travel. There were 616 reports of *Giardia lamblia*, of which 64 reports stated recent travel abroad. The most frequently reported regions of travel were the ISC (20), sub-Saharan and southern Africa (nine), north Africa, the middle east, and Europe (eight each). Only 3.4% of Cryptosporidium reports had any information about travel history stated, but travel history reporting for *Giardia lamblia* was significantly better at 11.2% ( $\chi^2 = 33.5$ , 1df,  $p < 0.01$ ). Other infections reported in this category included *Entamoeba histolytica* and *Entamoeba coli*, *Cyclospora* spp, and *Endolimax nana*; those that reported recent travel abroad were mainly associated with travel to the Tropics, particularly to the ISC, south east Asia, and the far east. There were two cases with dual infections, one with *Giardia lamblia* and *Ent. coli*, who had travelled to Angola, and one with *Giardia lamblia* and cryptosporidium, who had travelled to Pakistan.

### Enteric fever

In the fourth quarter of 2004, there were 43 reports of *Salmonella* Typhi, of which 31 reported recent travel abroad. Twenty-six reports stated recent travel to the ISC (India 13, Pakistan 9, Bangladesh 3, and Nepal 1), two with no country stated, and one each stated travel to Nigeria, Niger, and Cameroon. There were 58 reports of *S. Paratyphi* (53 *S. Paratyphi* A, 4 *S. Paratyphi* B, and one *S. Paratyphi* C), of which 37 stated recent travel abroad (35 *Paratyphi* A and two *Paratyphi* B). Thirty-three reports stated travel to the ISC (India 18, Pakistan 7, Bangladesh 7, Nepal 1), two to South America, one to Indonesia, and one with no country stated. On average, for each quarter in 2004, 74% of all enteric fever reports have some information about their history, which is 13% higher than in 2003 ( $\chi^2 = 13.8$ , 1df,  $p < 0.01$ ). Travel history reporting, therefore, has improved for enteric fever over 2004.

### Gastrointestinal incidents

In the fourth quarter of 2004, there were 50 incidents § of gastrointestinal illness reported to be associated with foreign travel with onset dates between October and December 2004. Of those, 19 were due to salmonella, 19 to campylobacter, and five to *Shigella* spp, although these events/outbreaks were not typed any further. Forty-two per cent of gastrointestinal events reported, specified travel to Europe (16 to Spain), and ten specified travel to north Africa and the middle east.

### Helminths

In the fourth quarter of 2004, there were 38 reports of helminth infection, six of which stated recent travel abroad. There were eight reports each of *Taenia saginata* (of which two stated recent travel abroad to South Africa and Thailand) and *Ascaris lumbricoides* (of which one stated recent foreign travel but country unknown). There were seven reports of *Taenia* spp, five *Trichuris trichiura* (of which two stated recent travel abroad to Bangladesh and Nigeria).

### Arthropod borne infections

#### Dengue

Only three cases of dengue fever were reported through the routine laboratory reporting system, none of which had any information about travel history. This is probably an underestimate.

#### Lyme borreliosis

One hundred reports of Lyme borreliosis were received during the fourth quarter of 2004 of which, 22 were known to have been acquired overseas. Eight infections were acquired in Scandinavian countries (Sweden and Norway); five infections were acquired in the United States (New England and other eastern seaboard states); five were acquired in France, two in Germany (one of whom was in the British Army), and one each in Belgium and Portugal. All, apart from the soldier, are believed to have acquired their infections during recreational activities. The proportion of overseas-acquired infections (22%) is comparable with previous experience.

## Other infections

### Legionnaires' disease

As of 19 January 2005, there were 68 legionnaires' disease cases reported for the fourth quarter of 2004, of which, 42 were travel-related. Nine of the travel-related cases were associated with five different outbreaks in Bulgaria, Malta, Turkey, and the United Arab Emirates.

### Schistosomiasis

Only ten cases of schistosomiasis were reported for the final quarter of 2004, compared to 19 in 2003. Only one report of schistosomiasis (unspciated) had a reported travel history, with travel to Africa (country not stated).

### Leptospirosis

Eleven cases of leptospirosis were reported during the fourth quarter of 2004 compared with eight in the same quarter of 2003. Three cases, all males, were reported to have been acquired overseas. One had been canoeing in France, one had been fishing in Thailand, and the epidemiological history remains unavailable for one.

## Footnotes

\*Labbase is the database that collects laboratory reports of all microorganisms isolated at nearly 400 NHS and other laboratories throughout England and Wales . The database is managed and accessed at CDSC.

†Note that these figures refer to data extracted from Labbase only, and do not include cholera, malaria, Legionnaires' disease, Lyme borreliosis or leptospirosis where data has been obtained from other sources.

‡Co-Surv is an electronic reporting system, and is managed at the HPA's Centre for Infections.

§Gastrointestinal illness incidents are reported to the Environmental and Enteric Diseases Department of CDSC by CCDCs and Environmental Health officers and each event may be one or more cases. It is a passive database and can only give a broad idea as to what sort of infections travellers are returning to England and Wales with. It cannot be matched to the laboratory reporting system.

## References

1. Health Protection Agency. Illness in England , Wales , and Northern Ireland associated with foreign travel – a baseline report to 2002. London: HPA, 2004. Available at <[http://www.hpa.org.uk/infections/topics\\_az/travel/pdf/full\\_version.pdf](http://www.hpa.org.uk/infections/topics_az/travel/pdf/full_version.pdf)>.
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