Health Protection Agency

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NEWS STORIES:

INFECTION REPORTS

Respiratory:

Travel Health:

DIARY

CDR SUBSCRIPTION:

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Current Issue: Volume **15** Number **22** **Published on**: 3 June 2005

News

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Interim guidance on the control of multi-resistant acinetobacter outbreaks

Interim guidance on the control of multi-resistant acinetobacter outbreaks has been published on the Health Protection Agency (HPA) website at <http://www.hpa.org.uk/infections/topics_az/acinetobacter_b/guidance.htm>. Multiple-antibiotic resistant *Acinetobacter* species (MRAB) have emerged as important pathogens and caused outbreaks in hospitals in England in recent years (1-3). A working party was convened by the HPA with representation from the Association of Medical Microbiology (AMM), British Society for Antimicrobial Chemotherapy (BSAC), Hospital Infection Society (HIS), Infection Control Nurses Association (ICNA) and Department of Health (DH) to address this problem, and it is this group which has issued the interim control guidance. The working prarty has defined MRAB as *Acinetobacter* spp. isolates that are resistant to any aminoglycoside (*eg* gentamicin) AND to any third generation cephalosporin (*eg* ceftazidime, cefotaxime). An even more multi-resistant *Acinetobacter* spp, designated MRAB-C, is defined as an MRAB that is also resistant to carbapenems (imipenem or meropenem).

Microbiologists have been asked to report outbreaks of MRA under the serious untoward reporting scheme to their regional epidemiologists and to send isolates to the HPA Laboratory of Healthcare-Associated Infection at Colindale for typing and further investigation.

Comments on the interim guidance should be sent to the Group's chairman, Barry Cookson: email <barry.cookson@hpa.org.uk>, before the end of August 2005.

References

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3. HPA. Multi-resistant Acinetobacter baumannii: update. *Commun Dis Rep CDR Wkly* [serial online] 2004 [cited 23 May 2005]; **14**(1): news. Available at <http://www.hpa.org.uk/cdr/archives/2004/cdr0104.pdf>

First serotine bat from southern England found to be positive for EBLV1 antibodies

A three-year prevalence study of European Bat Lyssaviruses (EBLV), or bat rabies, in the United Kingdom (UK) bat population undertaken by the Veterinary Laboratories Agency has identified one (of 51 examined) serotine bat (Eptesicus serotinus) from southern England to be antibody positive for EBLV1 (1). This EBLV-1 strain is the predominant type in bats throughout continental Europe, especially in serotine bats. Previously in the UK, only Daubenton's bats (Myotis daubentonii) have been found to be positive for EBLV, and only for the rarer type EBLV-2 (2-4). The presence of EBLV-2 antibodies, but not the virus, in Daubenton bats has previously been estimated at between 6 and 15% in the UK bat population. Just over 4% of the Daubenton's bats were antibody positive in this recent study. The presence of EBLV2 virus have been detected previously in four (of 113 examined) Daubenton's bats in the UK. The Pipistrelle bat (Pipistrellus pipistrellus), the most common bat in the UK, has not been found to carry EBLV in the UK.

The risk to the general public from EBLV remains low. Only volunteer or licensed bat handlers will routinely come into contact with bats. This new finding increases the very limited understanding of EBLVs in bats and surveillance in bats should be continued. The presence of antibodies and not virus may indicate that the bats were not infectious. The natural history of EBLV infection in bats may include full recovery with sterilising immunity.

These findings do not change the previous public health advice. Clinicians do, however, need to be aware of the risk of rabies after significant exposure to bats. If a person is bitten, scratched, or there is direct contact with a bat to mucosa or broken skin, the area should be cleaned thoroughly with water and soap and medical advice should be sought urgently and expert assessment performed. Post-exposure prophylaxis (vaccination and possibly administration of immunoglobulins) is recommended. Any member of the public finding a bat behaving abnormally, found in an unusual place, or under unusual circumstances, should not attempt to handle or move the animal, but contact their local bat conservation group or the Bat Conservation Trust (details can be found on the Trust's website at http://www.bats.org.uk/). All bat handlers and other people likely to be at risk of exposure through the close handling of bats should be vaccinated against rabies and this is provided free of charge by the Health Protection Agency through the NHS. The awareness in the general public and health care professionals of this small risk needs to be addressed without creating unnecessary fear of these endangered and protected animals.

Further information on EBLV

http://www.hpa.org.uk/infections/topics_az/rabies/menu.htm

http://www.defra.gov.uk/animalh/diseases/notifiable/q&a/rabiesq&a.htm

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Poliomyelitis in Yemen: update

An outbreak of polio in Yemen which started in February, and was first reported to the World Health Organization (WHO) in April (1), has grown to include 179 cases. Most have occurred in the same area – the Hudaida governate on the Red Sea coast, although eleven governates are affected (2).

A nationwide house-to-house vaccination campaign for children under five years of age was conducted from 29 May to 2 June. The Yemeni Ministry of Health has also strengthened surveillance of acute flaccid paralysis since the outbreak began. The second round National Immunization Day will be on 11 July.

The Yemeni Ministry of Health is working with UN organisations led by WHO and UNICEF to make these polio vaccination campaigns a UN priority in Yemen.

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Current Issue: Volume **15** Number **22** **Published on**: 3 June 2005

Respiratory

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Laboratory reports of respiratory infections made to CDSC from Health Protection Agency and NHS laboratories in England and Wales: weeks 18-21/05

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 18-21/2005

Week	**18/05**	**19/05**	**20/05**	**21/05**	**Total**
Week ending	**08/05/05**	**15/05/05**	**22/05/05**	**29/05/05**	
Influenza A	20	9	20	1	**50**
Isolation	2	2	3	–	**7**
DIF*	–	–	1	–	**1**
Four-fold rise in paired sera	–	–	–	–	**–**
PCR	–	–	–	–	**–**
Other†	18	7	16	1	**42**
Influenza B	4	14	11	4	**33**
Isolation	–	3	4	–	**7**
DIF*	–	1	1	–	**2**
Four-fold rise in paired sera	–	–	–	–	**–**
PCR	–	**–**	**–**	–	**–**
Other†	4	10	6	4	**24**
Influenza (untyped)	–	–	–	–	**–**
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 18-21/2005

Week	18/05	19/05	20/05	21/05	Total
Week ending	**08/05/05**	**15/05/05**	**22/05/05**	**29/05/05**	
Adenovirus*	18	39	41	19	**117**
Coronavirus	1	1	–	–	**2**
Parainfluenza†	14	32	33	14	**93**
Rhinovirus	1	9	9	9	**28**
Respiratory syncytial virus (RSV)‡	17	18	5	7	**47**

*Respiratory samples only. Excludes diagnoses made by electron microscopy (EM).
†Includes parainfluenza types 1, 2, 3, 4, and untyped.
‡ Excludes diagnosis made by electron microscopy (EM).

Table 3 Respiratory viral detections by age group: weeks 18-21/2005

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥65 years	Unknown	Total
Adenovirus*	21	21	4	49	15	3	4	**117**
Coronavirus	–	1	–	–	1	–	–	**2**
Influenza A	1	3	2	13	15	14	2	**50**
Influenza B	2	1	2	11	13	4	–	**33**
Parainfluenza†	57	14	4	11	6	–	1	**93**
Rhinovirus	15	8	1	1	1	1	1	**28**
Respiratory syncytial virus (RSV)	32	3	2	3	5	2	–	**47**

*Respiratory samples only.
†includes parainfluenza types 1, 2, 3, 4, and untyped.
‡ Excludes diagnoses made by electron microscopy (EM).

Table 4 Laboratory reports of infections associated with atypical pneumonia, by week of report: weeks 18-21/2005

Week	18/05	19/05	20/05	21/05	Total
Week ending	**08/05/05**	**15/05/05**	**22/05/05**	**29/05/05**	
Coxiella burnettii	–	1	–	–	**1**
Respiratory *Chlamydia* sp*	1	4	1	3	**9**
Mycoplasma pneumoniae	15	27	13	6	**61**
Legionella sp	1	–	4	5	**10**

*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 18-21/2005

Week	18/05	19/05	20/05	21/05	
Week ending	**08/05/05**	**15/05/05**	**22/05/05**	**29/05/05**	**Total**
Nosocomial	–	–	–	–	**–**
Community	–	–	1	–	**1**
Travel abroad	1	–	2	4	**7**
Travel UK	–	–	1	1	**2**
Total	**1**	–	**4**	**5**	**10**
Male	1	–	3	2	**6**
Female	–	–	1	3	**4**

*Represents non-pneumonic cases where present..

Ten cases were reported with pneumonia – six males aged from 27 to 65 years and four females aged from 55 to 84 years. One case had community-acquired infection. No deaths were reported.

Nine cases were travel associated: two from United Kingdom, and one from each of China and UK, Czech Republic, India, Italy, Majorca, Malaysia, Malta, and UK.

Table 5b Reports of Legionnaires' disease (pneumonic and non-pneumonic*) cases by region of report in England and Wales: weeks 18-21/2005

Region	Nosocomial	Community	Travel (Abroad)	Travel	Total
North East	–	–	–	–	**–**
Yorkshire & the Humber	–	–	3	1	**4**
East Midlands	–	–	–	–	–
East of England	–	–	–	– (1)†	**1**
London	–	–	1	–	**1**
South East	–	–	1	–	**1**
South West	–	1	–	–	**1**
West Midlands	–	–	–	–	–
North West	–	–	2	–	**2**
Wales	–	–	–	–	–
Total	**–**	**1**	**7**	**2**	**10**

*Represents non-pneumonic cases where present.
†Case with date of onset of symptoms in 2004.

Current Issue: Volume **15** Number **22** **Published on**: 3 June 2005

Travel Health

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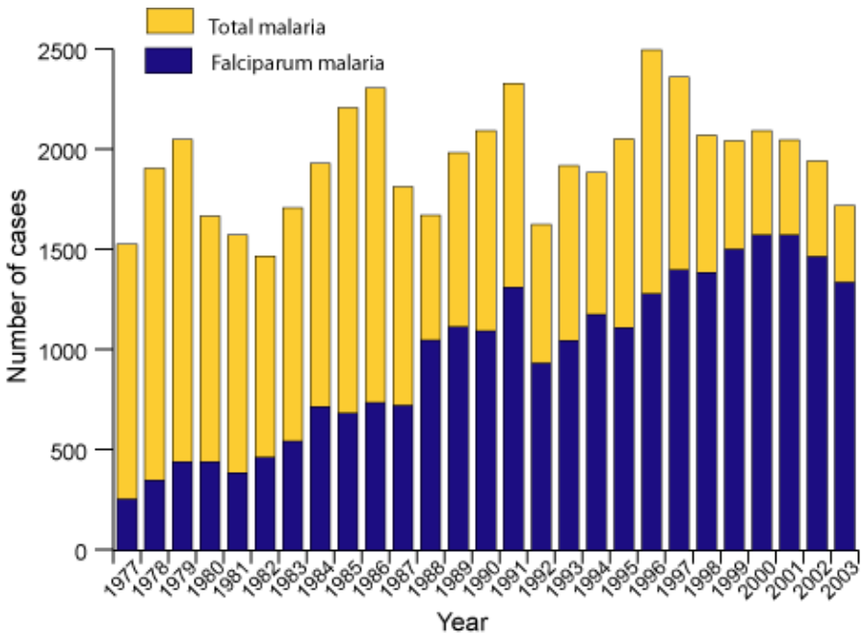
Next update due: **9 June 2005**

Malaria imported into the United Kingdom: implications for those advising travellers

This article presents the provisional data on malaria imported into the UK in 2004, based on figures reported to the Health Protection Agency (HPA) Malaria Reference Laboratory.. Details on methods of data collection for malaria were presented in *Illness in England, Wales, and Northern Ireland associated with foreign travel – baseline report to 2002* (1).

One thousand six hundred and sixteen cases of malaria were reported in 2004, a fall of 7% compared with 2003, although it is possible that a few cases have still to be reported. Over 70% of these cases were the potentially fatal falciparum malaria, which has accounted for an increasing proportion of the malaria seen in the UK over the last ten years (figure 1). Over twice as many cases of falciparum malaria, are now seen in the UK compared to 20 years ago. The breakdown by area of travel and species is shown in table 1.

Figure 1 Malaria imported into the UK: 1977-2004 *



*2004 provisional data

Table 1 Distribution of malaria parasites by region, travellers to the United kingdoml: 2004*

Region of the world	Malaria parasite species					
	Pf	Pv	Pm	Po	Mixed	Total
North Africa	–	1	–	–	–	1
Central Africa	55	–	–	5	–	60
East Africa	81	11	9	17	–	118
Southern Africa	55	7	–	8	–	70
West Africa	723	8	16	50	5	802
Africa- unspecified	23	–	–	7	1	31
Middle East	–	3	–	–	–	3
Indian sub-continent	9	157	1	2	1	170

Far East/South East Asia	4	6	–	–	–	10
Central/South America	3	14	–	–	–	17
Oceania	1	15	–	–	1	17
Cryptic	–	–	–	–	–	–
Not stated	231	54	2	26	4	317
Total	**1185**	**276**	**28**	**115**	**12**	**1616**

Pf – *Plasmodium falciparum*
Pv – *P. vivax*
Pm – *P. malariae*
Po – *P. ovale*

* provisional data

Five deaths were reported, all from falciparum malaria. One of these cases acquired their malaria in India, highlighting the point that good advice on prophylaxis is essential for those travelling to Asia as well as to Africa. Malaria should be considered in all those who are unwell following a trip to Asia, even though the risk of acquiring falciparum malaria remains substantially higher in sub-Saharan Africa than in all but a few parts of Asia. In Africa, the great majority of malaria is falciparum malaria. The risk of vivax malaria is substantially greater in the Indian sub-continent.

Among patients with malaria where the history of prophylaxis was obtained, 678 out of 880 (77%) had not taken prophylaxis. It is clear that some groups in particular are not being reached by health messages about the importance of antimalarial prophylaxis. The burden of malaria falls heavily on those of African and South Asian ethnicity (table 2).

Table 2 Ethnicity of travellers with malaria: 2004

Ethnicity, where stated	**No of cases**
White British	124
Other white	27
Black African	547
Black Caribbean	16
Other black	8
Indian sub continent	111
Southeast Asian	3
Other Asian	9
Other ethnicity	4
Categories – not on standard surveillance form*	
African descent *	365
Asian descent *	71
Ethnicity not stated	331
Total	**1616**

* These are not self-reported categories

The reason for travel among cases is shown in table 3. Overall 57% of all imported infections where a reason for travel was known occurred in people who were visiting friends and relatives. This represents 66% of the total imported malaria infections acquired by travellers from the UK.

Table 3 Reason given for travel

Reason for travel	No of cases
New entrant to UK	101
Visiting friends and relatives	522
UK citizen living abroad	25
Civilian sea/air	0
British forces	10
Business	59
Foreign student in UK	26
Holiday	93
Foreign visitor	76
Children visiting parents abroad	–
Other	–
Not stated	704
Total	**1616**

These figures should be interpreted with caution, but they imply that those travelling to visit friends and relatives are either not seeking medical advice on malaria prevention before they travel, or not being given good advice, or not adhering to advice given; probably all three contribute. Many people born in Africa but now resident in the UK wrongly assume that they are immune to the disease.

This provisional data for 2004 demonstrates that the failure to take prophylaxis remains one of the main reasons for travellers acquiring malaria, and there is clear, if indirect, evidence that those of African or Asian ethnicity going to visit friends and relatives are at particular risk. Targeting these groups, and their healthcare providers, should be considered for pre-travel health promotion and education.

Reference

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/publications.htm>.

Current Issue: Volume **15** Number **22** **Published on**: 3 June 2005

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Diary

The 16th National Immunisation Conference for Health Care Workers

The 16th National Immunisation Conference for Health Care Workers will be held on Friday, 2 December 2005 from 09:00 to 17:00 at the Manchester Conference Centre.

The Conference is for any health worker involved with immunisation and should be of interest to Clinical Medical Officers, General Practitioners, Health Visitors, Practice Nurses, Occupational Health Practitioners, Paediatricians, Microbiologists, School Nurses and District Immunisation Co-ordinators.

The Conference fee is £75 for nursing staff and £100 for doctors, managers and other staff. This includes refreshments on arrival, all refreshments during the day including a hot/cold 2 course buffet lunch, delegate pack and certificate. CPD approval will be applied for. Further information can be obtained from Stockport Postgraduate Medical Education Centre, Stepping Hill Hospital, Stockport, Cheshire, SK2 7JE; tel 0161 419 4684; fax 0161 419 4686.