Health Protection Agency

# CDR WEEKLY

*the Communicable Disease Report Weekly*

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# News



News Ar chive

## WHO team find no evidence that human influenza (H5N1) infections are spreading readily among humans in Vietnam. State of pandemic alert remains unchanged

The World Health Organisation (WHO) has confirmed that the current level of pandemic alert, in effect since January 2004, will remain unchanged at Pandemic Alert Phase 3, “Human infections with a new sub-type but no human-to-human spread or at most rare instances of spread to a close contact” (1,2). This follows from an earlier WHO consultation of international experts on the status of human avian influenza in South East Asia carried out in Manila on 5 and 6 May 2005 (3) and recent reports claiming that the WHO has downgraded its assessment of the pandemic threat (1).

This decision to keep the current level of pandemic alert unchanged was based on the preliminary findings of a team of international experts which met in Viet Nam at the request of the Vietnamese Ministry of Health in response to recent concerns that human infections of influenza (A/H5N1) were occurring more frequently. The team, which includes members from six different countries, reported that as yet they have found no laboratory evidence to support these concerns (1).

Evidence of the increased transmissibility of influenza (A/H5N1) would have been grounds for changing the level of pandemic alert. Recent testing of clinical specimens in Viet Nam had raised the possibility of wider spread of infection in the community. The current investigative team have not confirmed these findings. WHO states that although these initial results are reassuring, the retesting of clinical specimens will continue in order to provide a firmer foundation for pandemic risk assessment.

The risk of pandemic influenza from A/H5N1 remains significant. The WHO, the Food and Agriculture Organization (FAO) and the World Organization for Animal Health (OIE) held a meeting this week in Kuala Lumpur, Malaysia, building on an earlier joint FAO/OIE scientific conference (4, 5). The WHO/FAO/OIE meeting has drawn up a multipoint plan to reduce the risk of the virus in birds and animals spreading from poultry to humans. It also appealed to the international community to come forward with funds to support this plan, and a number of donor countries are known already to be committing funds (4).

On the basis of current evidence, a pandemic due to influenza A/H5N1 is neither inevitable nor necessarily imminent. Equally it does not follow that an H5N1 pandemic would necessarily be as severe as previous pandemics in the 20th Century, but this possibility cannot be excluded. Though the mortality experienced by the limited number of human cases to date has been substantial, if the virus adapts to a human host and becomes readily transmissible between humans, it is likely that virulence will decline substantially. Even a mildly pathogenic pandemic virus would result in major mortality, morbidity, and perhaps social and economic disruption.

For that reason countries like the United Kingdom are rapidly preparing for the eventuality with interlocking plans developed by the Departments of Health and the Health Protection Agency and ensuring that national preparations follow World Health Organization recommendations (2,6,7,8,)

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## Changes to the BCG vaccination programme and tuberculin testing

The Chief Medical Officer has announced changes to the BCG (Bacillus Calmette-Guerin) vaccination programme. The new policy is based on targeted immunisation of neonates and others at high risk and will replace the schools' programme for older children (1).

Those now recommended to receive BCG are:

- All infants in areas within the United Kingdom where the incidence of tuberculosis is greater than 40 per 100,000 population per year.
- Infants, wherever they live, with one or more parent or grandparent born in a country with a tuberculosis incidence of greater than 40 per 100,000.
- previously unvaccinated new immigrants from high incidence countries.

The recommendations for immunisation of those at high risk as a result of contact with an infectious case, through occupational exposure or as a result of prolonged travel in high incidence areas of the world, remain unchanged.

Stopping the schools' programme nationally will mean that local arrangements will have to be made to test and vaccinate children at increased risk of tuberculosis, who have not already been immunised and who will no longer be offered BCG vaccination through the schools programme.

**Tuberculin skin testing**
Tuberculin skin testing is also to change. The manufacturer that has supplied tuberculin ppd for both Heaf and Mantoux testing in the UK (Chiron Vaccines Evans) is ceasing production of these products. There is no other supplier of tuberculin ppd for Heaf testing. The Department of Health (DH) has obtained alternative supplies of ppd for Mantoux testing from the Statens Serum Institute (SSI) in Denmark (summary of product characteristics at <http://www.immunisation.nhs.uk/files/SSI_SPC.pdf>. This is currently only available as an unlicenced product in the UK . As current stocks of Heaf strength tuberculin ppd run out, services will need to change to Mantoux testing using the SSI product. Tuberculin PPD (SSI) for routine use in the Mantoux test is the 2TU per 0.1ml dose. A summary of the differences between the tuberculin ppd products from Chiron Vaccines Evans and SSI can be found at <http://www.immunisation.nhs.uk/files/PPD_difference.pdf>.

**Further information**

Guidance and training materials is being produced by the DH and will be circulated widely. This will include information on high incidence areas within the UK , high incidence countries elsewhere, and guidance (with examples) of effective models of service delivery. The Department will also be sending out an operational note shortly on Mantoux testing and the phasing out of Heaf testing.

**References**

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## Evidence for increased HIV transmission among IDUs in recent years

A recent paper in the journal AIDS describes trends in HIV prevalence among injecting drug users (IDUs) in England and Wales between 1990 and 2003 (1). It presents evidence suggesting a possible increase in HIV transmission among IDUs particularly in London.

This paper for the first time bring together data on HIV among IDUs from the Unlinked Anonymous Prevalence Monitoring Programmes annual surveys of IDUs in contact with services for drug users and the series of community recruited surveys undertaken by the Centre for Research on Drugs and Health Behaviour. These voluntary unlinked anonymous cross-sectional surveys collect oral-fluid samples and behavioural information, and almost 28,000 samples were collected from current IDUs (those who had injecting in the four weeks prior to taking part in the surveys) by the two survey programmes between 1990 and 2003.

Analyses of the dataset obtained by combining the results of the two survey programmes indicates that HIV prevalence among IDUs in England and Wales declined from 5.9% in 1990 to 0.6% in 1996 and then remained stable until 1999, after which it increased to 1.4% in 2003. A;though very few HIV infections were detected among short-term injectors (those injecting for less than three years) between 1994 and 1999, the prevalence increased among this group in more recent years. Modelling was used to explore changes in incidence over time, and the force of infection was found to have increased in recent years in London.

The data presented in the paper suggest that incidence and prevalence of HIV may have increased among IDUs in England and Wales. An increase in HIV incidence is supported by the results from a recent London based cohort study (2), while other indicators have suggested an increase in injecting risk behaviour in the late 1990s (3). There may also have been changes in the patterns of drug use during this time, with evidence to suggest an increase in injecting overall (4) and also in the injection of crack-cocaine (5), while other data indicate that the coverage of syringe distribution may have fallen or remained unchanged (6). The authors conclude that there is a need to develop and reinvigorate harm reduction measures and policies to response to the evolving patterns of drug use and risk behaviour.

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## Consultation document on control of healthcare-associated infections to be published]

The Department of Health is expected to publish a consultation document on new legislative proposals pertaining to the control of healthcare associated infections on its website <www.doh.gov.uk> on Friday 8 July 2005 in preparation for the drafting of the *Health Improvement and Protection Bill* by the end of October. This is an opportunity for all infection control practitioners to contribute and have their views heard.

# Respiratory

**Laboratory reports of respiratory infections made to the Health Protection Agency Centre for Infections from HPA and NHS laboratories in England and Wales: weeks 22-26/05**
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## Laboratory reports of respiratory infections made to the Health Protection Agency Centre for Infections from HPA and NHS laboratories in England and Wales: weeks 22-26/05

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 22-26/2005**

| Week | 22/05 | 23/05 | 24/05 | 25/05 | 26/05 | Total |
|---|---|---|---|---|---|---|
| Week ending | 05/06/05 | 12/06/06 | 19/06/05 | 26/06/05 | 03/07/05 | |
| **Influenza A** | **3** | **5** | **11** | **4** | **4** | **27** |
| Isolation | – | – | – | – | – | **–** |
| DIF* | – | 2 | – | – | 1 | **3** |
| Four-fold rise in paired sera | – | – | – | – | – | **–** |
| PCR | – | – | – | – | 1 | **1** |
| Other† | 3 | 3 | 11 | 4 | 2 | **23** |
| **Influenza B** | **2** | **8** | **6** | **2** | **3** | **21** |
| Isolation | – | – | – | – | – | **–** |
| DIF* | – | 2 | – | 1 | – | **3** |
| Four-fold rise in paired sera | – | – | – | – | – | **–** |
| PCR | – | – | – | – | – | **–** |
| Other† | 2 | 6 | 6 | 1 | 3 | **18** |
| **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 22-26/2005**

| Week | 22/05 | 23/05 | 24/05 | 25/05 | 26/05 | Total |
|---|---|---|---|---|---|---|
| Week ending | 05/06/05 | 12/06/06 | 19/06/05 | 26/06/05 | 03/07/05 | |
| Adenovirus* | 20 | 19 | 24 | 34 | 35 | **132** |
| Coronavirus | – | – | – | – | – | **–** |
| Parainfluenza† | 9 | 16 | 19 | 15 | 33 | **92** |
| Rhinovirus | 3 | 3 | 13 | 13 | 12 | **44** |
| Respiratory syncytial virus (RSV)‡ | 1 | 3 | 7 | 1 | 4 | **16** |

*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 22-26/2005**

| Age group (years) | <1 year | 1-4 years | 5-14 years | 15-44 years | 45-64 years | ≥65 years | Unknown | Total |
|---|---|---|---|---|---|---|---|---|
| Adenovirus* | 19 | 30 | 9 | 50 | 15 | 7 | 2 | **132** |
| Coronavirus | – | – | – | – | – | – | – | **–** |
| Influenza A | 1 | 1 | 2 | 7 | 11 | 4 | 1 | **27** |
| Influenza B | 1 | – | 2 | 7 | 8 | 1 | 1 | **21** |
| Parainfluenza† | 42 | 16 | 3 | 14 | 13 | 3 | 1 | **92** |
| Rhinovirus | 16 | 20 | 1 | 6 | 0 | 1 | – | **44** |
| Respiratory syncytial virus (RSV) | 9 | – | – | 4 | 2 | 1 | – | **16** |

*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 22-26/2005**

| Week | 22/05 | 23/05 | 24/05 | 25/05 | 26/05 | Total |
|---|---|---|---|---|---|---|
| *Week ending* | 05/06/05 | 12/06/06 | 19/06/05 | 26/06/05 | 03/07/05 | |
| *Coxiella burnettii* | – | – | – | – | 2 | **2** |
| Respiratory *Chlamydia* sp* | 2 | – | 3 | 1 | 2 | **8** |
| *Mycoplasma pneumoniae* | 8 | 3 | 20 | 11 | 16 | **58** |
| *Legionella* sp | 6 | 1 | 4 | 7 | 5 | **23** |

*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 22-26/2005**

| Week | 22/05 | 23/05 | 24/05 | 25/05 | 26/05 | |
|---|---|---|---|---|---|---|
| Week ending | 05/06/05 | 12/06/06 | 19/06/05 | 26/06/05 | 03/07/05 | Total |
| Nosocomial | – | – | – | 1 | – | **1** |
| Community | 6 | – | – | 3 | 2 | **11** |
| Travel abroad | – | 1 | 3 | 2 | 2 | **8** |
| Travel UK | – | – | 1 | 1 | 1 | **3** |
| **Total** | **6** | **1** | **4** | **7** | **5** | **23** |
| Male | 5 | – | 2 | 5 | 4 | **16** |
| Female | 1 | 1 | 2 | 2 | 1 | **7** |

*Represents non-pneumonic cases where present..

Twenty-three cases were reported with pneumonia – 16 males aged from 31 to 90 years and seven females aged fro 49 to 77 years. Eleven cases had community-acquired infection and one was a possible nosocomial case. Two deaths in males aged 64 and 65 years were reported, along with one death in F 77y.

Eleven cases were travel associated: England (3), Spain (3), andone each of Bermuda, Bulgaria, France/Italy, Greece, and Italy.

**Table 5b Reports of Legionnaires' disease (pneumonic and non-pneumonic*) cases by region of report in England and Wales: weeks 22-26/2005**

| Region | Nosocomial | Community | Travel (Abroad) | Travel | Total |
|---|---|---|---|---|---|
| North East | – | – | – | – | **–** |
| Yorkshire & the Humber | – | 4 | 1 | – | **5** |
| East Midlands | – | 2 | 1 | – | **3** |
| East of England | – | – | – | – | **–** |
| London | – | – | 1 | 1 | **2** |
| South East | – | 1 | 3 | 1 | **5** |
| South West | 1 | –(1†) | – | 1 | **3** |
| West Midlands | – | 3 | – | – | **3** |
| North West | – | – | – | – | **–** |
| Wales | – | – | 2 | – | **2** |
| **Total** | **1** | **11** | **8** | **3** | **23** |

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

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# Travel health

**Imported infections, England and Wales: January to March 2005**
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## Imported infections, England and Wales: January to March 2005

This first quarter report on imported infections in England and Wales covers the period from January to March 2005 inclusive. The data presented in this report 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'. Please note that all data presented are provisional and subject to change; the confirmed final data will be presented annually.

Of the infections in table 1 that were reported via LabBase*, there were fewer reported in England and Wales in the first quarter of 2005 (9538) compared with the same period in 2004 (12,198). This difference seems to be primarily an effect of a fall in reports of campylobacter and cryptosporidium infections in the first quarter of 2005 compared to 2004. Travel history reporting, however, has improved significantly in the first quarter of 2005 compared to 2004, from 12.3% reports stating any information about recent travel abroad in the first quarter of 2004 to 14.9% in the first quarter of 2005 (chi square = 31.54, 1df, p<0.01). This is consistent with previous quarters in 2004 (2-4) and may represent a continuous (albeit small) improvement of travel history reporting since the beginning of 2004. This will be analysed further in forthcoming annual reports. The overall proportion of travel history reporting, however, is still low and limits the interpretation of the following data.

**Table Imported infections in England and Wales: January to March 2005**

| Organism | Total reports for Jan to Mar | | | | Cumulative totals for Jan to Mar | | | |
|---|---|---|---|---|---|---|---|---|
| | 2005* | | 2004 | | 2005* | | 2004 | |
| | Travel-related | All reports | Travel-related | All reports | Travel-related | All reports | Travel-related | All reports |
| **Gastrointestinal Infections** | | | | | | | | |
| **Bacterial** | | | | | | | | |
| *Salmonella* spp | 324 | 1629 | 287 | 1565 | 324 | 1629 | 287 | 1565 |
| *Campylobacter* spp | 207 | 6525 | 275 | 8636 | 207 | 6525 | 275 | 8636 |
| | | | | | | | | |
| *Shigella flexneri* | 5 | 64 | 9 | 65 | 5 | 64 | 9 | 65 |
| *Shigella dysenteriae*† | 5 | 8 | 6 | 12 | 5 | 8 | 6 | 12 |
| *Shigella sonnei* | 29 | 170 | 19 | 163 | 29 | 170 | 19 | 163 |
| *Shigella boydii*† | 17 | 24 | 18 | 24 | 17 | 24 | 18 | 24 |
| Other (species unknown) | 1 | 25 | – | 39 | 1 | 25 | – | 39 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| *Salmonella* Typhi | 29 | 40 | 24 | 41 | 29 | 40 | 24 | 41 |
| *Salmonella* Paratyphi (A,B,C) | 16 | 28 | 21 | 32 | 16 | 28 | 21 | 32 |
| *Vibrio cholerae* O1† | NA | NA | NA | NA | NA | NA | NA | NA |
| *Vibrio parahaemolyticus* | 2 | 6 | 3 | 5 | 2 | 6 | 3 | 5 |
| | | | | | | | | |
| **Protozoal** | | | | | | | | |
| *Entamoeba histolytica* | 12 | 66 | 10 | 78 | 12 | 66 | 10 | 78 |
| *Entamoeba coli* | – | 13 | 5 | 25 | – | 13 | 5 | 25 |
| *Giardia lamblia* | 54 | 570 | 94 | 800 | 54 | 570 | 94 | 800 |
| Cryptosporidium | 18 | 304 | 24 | 598 | 18 | 304 | 24 | 598 |
| *Cyclospora* spp | 3 | 7 | – | 5 | 3 | 7 | – | 5 |
| *Endolimax nana* | – | 10 | 2 | 9 | – | 10 | 2 | 9 |
| | | | | | | | | |
| **Helminths** | | | | | | | | |
| *Strongyloides stercoralis* | – | 5 | 1 | 11 | – | 5 | 1 | 11 |
| *Strongyloides* spp | – | 1 | 1 | 1 | – | 1 | 1 | 1 |
| *Ancylostoma duodenale* | – | – | – | – | – | – | – | – |
| *Necator americanus* | – | – | – | – | – | – | – | – |
| Hookworm unspec | 1 | 1 | 1 | 5 | 1 | 1 | 1 | 5 |
| *Ascaris lumbricoides* (round worm) | 2 | 13 | 4 | 25 | 2 | 13 | 4 | 25 |
| *Trichuris trichiura* (whip worm) | 1 | 9 | 2 | 16 | 1 | 9 | 2 | 16 |
| *Hymenolepis diminuta* | – | – | – | – | – | – | – | – |
| *Hymenolepis nana* | – | 2 | 1 | 3 | – | 2 | 1 | 3 |
| *Hymenolepis* spp | – | – | – | – | – | – | – | – |
| *Taenia saginata* | 3 | 12 | 3 | 19 | 3 | 12 | 3 | 19 |
| *Taenia* spp | – | 8 | 1 | 10 | – | 8 | 1 | 10 |
| *Gnathostoma* spp | – | 1 | – | – | – | 1 | – | – |
| *Diphyllobothrium latum* (fish tape worm) | 1 | 1 | – | – | 1 | 1 | – | – |
| | | | | | | | | |
| **Arthropod borne infections** | | | | | | | | |
| | | | | | | | | |
| Malaria‡ | 339§ | 339 | 356 | 356 | 339§ | 339 | 356 | 356 |
| *Plasmodium falciparum* | 269 | 269 | 271 | 271 | 269 | 269 | 271 | 271 |
| *Plasmodium*. vivax | 33 | 33 | 42 | 42 | 33 | 33 | 42 | 42 |
| *Plasmodium* malariae | 7 | 7 | 9 | 9 | 7 | 7 | 9 | 9 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| *Plasmodium* ovale | 28 | 28 | 33 | 33 | 28 | 28 | 33 | 33 |
| | | | | | | | | |
| **Arboviruses** | | | | | | | | |
| Dengue virus | – | 1 | – | 3 | – | 1 | – | 3 |
| Chikungunya virus | – | – | – | – | – | – | – | – |
| Ross river virus | – | – | – | – | – | – | – | – |
| Sandfly fever virus | – | – | – | – | – | – | – | – |
| Unspecified | – | – | – | 2 | – | – | – | 2 |
| | | | | | | | | |
| **Leishmaniases** | | | | | | | | |
| Cutaneous | 4 | 5 | 4 | 5 | 4 | 5 | 4 | 5 |
| Visceral | 1 | 1 | 2 | 2 | 1 | 1 | 2 | 2 |
| Unspecified | – | – | 1 | 2 | – | – | 1 | 2 |
| | | | | | | | | |
| **Filariases** | | | | | | | | |
| *Loa loa* | – | – | – | – | – | – | – | – |
| *Wucheria bancrofti* | – | – | – | – | – | – | – | – |
| *Mansonella perstans* | – | – | – | – | – | – | – | – |
| *Onchocerca vulvulus* | – | – | – | – | – | – | – | – |
| Unspecified | – | 1 | – | 1 | – | 1 | – | 1 |
| | | | | | | | | |
| Lyme borreliosis# | – | 10 | 7 | 38 | – | 10 | 7 | 38 |
| | | | | | | | | |
| **Miscellaneous** | | | | | | | | |
| **Schistosome infections** | | | | | | | | |
| *Schistosoma mansoni* | – | 2 | 3 | 5 | – | 2 | 3 | 5 |
| *Schistosoma haematobium* | 3 | 8 | 2 | 9 | 3 | 8 | 2 | 9 |
| *Schistosoma intercalatum* | – | – | – | – | – | – | – | – |
| *Schistosoma* spp. | 1 | 3 | 2 | 8 | 1 | 3 | 2 | 8 |
| | | | | | | | | |
| Other infections | | | | | | | | |
| Leptospirosis# | 3 | 7 | – | – | 3 | 7 | – | – |
| Legionnaires' disease¶ (4) | NA | NA | NA | NA | NA | NA | NA | NA |
| *Coxiella burnetii* (Q fever) | – | 3 | – | 10 | – | 3 | – | 10 |
| *Rickettsia* spp | – | 4 | – | – | – | 4 | – | – |

*All data for 2004 is provisional and subject to change. All data extracted from Labbase 27 May 2005, except for gastro infections for 2005 unless otherwise specified, which were extracted from Labbase 25/05/05.

† 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 supplied by the Legionella Section of the Respiratory Diseases Department of CfI ...

# Data for malaria supplied by the HPA Malaria Reference Laboratory and are provsional. Trends are best interpreted on an annual basis.
¶ Includes one case with a mixed infection and one with organism unidentified.

NA = Data not available at time of publication.

Table compiled by the Health Protection Agency's Travel Health Surveillance Section at the Centre for Infections, 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 first quarter of 2005, *Salmonella* spp (non-typhoidal) were the most frequently reported infection associated with recent travel abroad (324/1629) even though more campylobacter infections are reported in England and Wales in general (6525 in total of which 207 reported recent travel abroad). Travel history reporting was more complete for *Salmonella* spp than for campylobacter, with 55.9% of Salmonella spp reports having any information about foreign travel compared with only 4.8% 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, 23% (76/324) reported recent travel abroad to the Indian sub-continent, 15.1% (49/324) to north Africa and the middle east, 14.5% (47/324) to sub-Saharan and southern Africa, and 12.7% (41/324) travelled to Europe. The countries of travel most frequently reported were India , (16.7%, 54/324), Spain including resort islands of the Canaries and Balearics (31/324, 9.6%), Egypt (7.7%, 25/324), Kenya (6.8%, 22/324), and Thailand (6.2%, 20/324), 38 (11.7%) reports had no country of travel stated.

A similar pattern was seen for *campylobacter* spp. Of reports that stated recent travel abroad, 31.9% (66/207) reported recent travel to the Indian sub-continent, 24.6% (51/207) to Europe , and 15.5% (32/207) to north Africa and the middle east. The most frequently reported countries of travel were India (22.7%, 47/207) and Spain (13%, 27/207); only nine reports (4.3%) had no country of travel stated.

In the first quarter of 2005, there were 291 reports of *Shigella* infection, 24 due to *S. boydii* and eight due to *S . dysenteriae* , the organisms that cause dysentery-like (bloody diarrhoea) illness. There was information about recent travel abroad for 20.3% (59/291) of all *Shigella* reports, of which 53 (18.2%) specified recent travel abroad. The countries of travel most frequently reported were Egypt (14/53) and India (13/53).

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. During the winter months, travellers tend to travel further afield for winter-sun holidays, (eg, northern Africa and the middle east and the Tropics).

**Protozoal infections**
During the first quarter, there were 304 reports of cryptosporidiosis in total in England and Wales , of which 21 (6.9%) had any information stated about travel history. Eighteen reports stated recent travel abroad; the Indian sub-continent (ISC)(eight reports) and sub Saharan and southern Africa (four reports) were the most frequently visited regions. There were 570 reports of *Giardia lamblia* , of which 57 (10%) had any information stated about travel history. Of those, 54 reports stated recent travel abroad; the most frequently reported regions of travel were the ISC (31 reports) and Sub Saharan and southern Africa (eight reports). 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 the ISC. There were two cases with dual infections, one with *Giardia lamblia* and cryptosporidium, who had travelled to Pakistan , and one with *Giardia lamblia* and *Entamoeba histolytica*, who had travelled to Indonesia .

**Enteric fever**
In the first quarter of 2005, there were 40 reports of *Salmonella* Typhi, of which 29 reported recent travel abroad.

Twenty-four reports stated recent travel to the ISC ( India 13, Pakistan 8, and Bangladesh 3), two stated travel to Nigeria , one to Indonesia , and two had no country stated. There were 28 reports of *S*. Paratyphi (*S*. Paratyphi A 26 and S. Paratyphi B 2 reports), of which 16 stated recent travel abroad (Paratyphi A 15 and Paratyphi B 1). Fifteen reports stated travel to the ISC ( India 10, Bangladesh 3, Pakistan 2); the case of paratyphoid B had recently travelled to south America. Seventy-eight per cent of all enteric fever reports had some information about travel history compared to 74% in the first quarter of 2004.

**Helminths**
In the final quarter of 2004, there were 53 reports of helminth infection, eight of which stated recent travel abroad. Of thirteen reports of *Ascaris lumbricoides* , one reported recent travel to Bangladesh and one to Africa . Of 12 reports of *Taenia saginata*, three reported recent foreign travel, two to Ethiopia and one country was not stated. There were nine reports of *Trichuris trichiura* , one of which stated recent travel abroad to Bangladesh . One case of diphyllobothriasis reported recent travel to Brazil . Helminth infections can persist in the body for months and it is therefore not possible to say for certain where these infections may have been acquired.

**Arthropod borne infections**

**Malaria**
There were 339 cases of malaria reported in the United Kingdom during the first quarter of 2005 (it must be noted that these figures are provisional and any trends are best interpreted on an annual basis). Nearly 80% (269/339) were due to *Plasmodium falciparum* , the most severe and potentially fatal form of malaria, followed by *P. vivax* (9.7%, 33/339), *P. ovale* (8.3%, 28/339), and *P. malariae* (2.1%, 7/339). There were two deaths reported, one of which was from *P. vivax* infection. Africa , particularly west Africa was the most frequently reported region of travel for malaria cases (148/339) where a country was stated, especially for falciparum malaria (131/269). The majority of vivax malaria, where a country was stated, was acquired in Asia (14/33). All malaria cases are presumed to have been acquired abroad although 26.5% (90/339) had no country stated.

**Dengue**
One case of dengue fever was reported through the routine laboratory reporting system; no travel history was available for this case. This is very likely an under estimate.

**Leishmaniasis**
Five cases of cutaneous‡ leishmaniasis were reported in the first quarter of 2005, four of them stated recent foreign travel (three to Belize and one to Afghanistan ). One case of visceral leishmaniasis was reported with recent travel to Pakistan .

**Lyme borreliosis**

Ten cases of Lyme borreliosis were identified during the first quarter of 2005 none were identified as having been acquired overseas. Consistently for several years, between 20 and 25% of all infections with *Borrelia burgdorferi* identified in England and Wales residents are acquired overseas, usually in northern European countries including France, Germany, Austria, and Scandinavia, or in the United States. The importance of tick awareness, prompt removal of ticks, wearing appropriate clothing and the use of insect repellents, all of which reduce the risk of transmission should be emphasised for travellers to endemic countries.

**Other infections**

**Schistosomiasis**
Thirteen cases of schistosomiasis were reported in the first quarter of 2005, compared to 23 in 2004. Four reports had travel history reported despite the absence of this infection in the United Kingdom . Three cases with *S. haematobium* infection had travelled to Mali , Nigeria and Zimbabwe, with one case of unspecified species with travel to Malawi .

**Leptospirosis**
Three cases of overseas-acquired leptospirosis were reported during the first quarter of 2005, all were in males aged under 50 years. Two had been to the Dominican Republic where one, a serviceman, had been quad biking and the other, who had undertaken water sports, was identified with *Leptospira* serovar *hardjo* . The third, who had been white water rafting in Equador, was identified with *Leptospira* serovar *cynopteri* .

**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.

‡The type of leishmaniasis is determined by the usual expression of the organism identified in the laboratory report as specified in Manson's Tropical Diseases (5).

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