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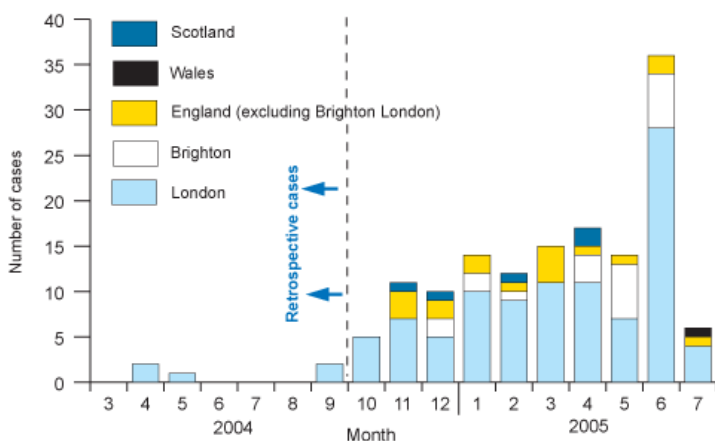
- ▣ **Cases of lymphogranuloma venereum in men who have sex with men exceed 100 in the United Kingdom**
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Cases of lymphogranuloma venereum in men who have sex with men exceed 100 in the United Kingdom

In June 2005, the Health Protection Agency's Sexually Transmitted Bacteria Reference Laboratory (STBRL) confirmed the hundredth case of lymphogranuloma venereum (LGV) in the United Kingdom. Initial results were first reported in the CDR Weekly on 27 January 2005 (1). STBRL has been providing specialist genotypic testing of samples since October 2004 as part of an initiative to raise awareness and improve case ascertainment of LGV in the UK, including diagnostic procedures, case definitions, and enhanced surveillance (2). Further Information on LGV is available on the Health Protection Agency website (3).

One hundred and forty cases of LGV have been confirmed between October 2004 and 26 July 2005 (figure). The total for June is already more than twice that seen in previous months and the numbers for more recent months will increase as samples are processed. The majority of cases have been seen in clinics in London (69%), followed by Brighton (14%), other cities across England (12%), and Scotland (4%). The first genotypically confirmed case in Wales was seen in July 2005.

Figure Laboratory confirmed cases of LGV seen in the UK by 26 July 2005



Surveillance forms have been reported for 86 (61%) of the laboratory confirmed cases to date. All have been men who have sex with men (MSM) (behavioural bisexuality was reported for only one man) with an average age of 38 years (range 21 to 65 years) and 94% white ethnicity. Eighty per cent (67/84) were already known to be HIV positive, ten of whom had also tested positive for hepatitis C antibody. Likely acquisition of LGV in the UK was reported for 81% of cases with unprotected anal intercourse in the three months prior to the onset of LGV symptoms reported for 76%.

The majority of cases presented with anorectal symptoms (typically rectal discharge, pain and bloody stools), although genital/inguinal symptoms have been seen for some men (typically swollen painful lymph nodes, pain on urinating, and penile discharge). On average there has been a delay of 52 days between symptoms appearing and presentation at the clinic. Prior misdiagnosis as non-infectious gastrointestinal illness (typically Crohn's disease) has been frequently reported. A three-week course of oral doxycycline has been the commonest treatment regime as recommended by guidelines
<<http://www.bashh.org/guidelines/ceguidelines.htm>>.

Monitoring of health promotion awareness among cases began in December 2004 following the launch of the Terrence Higgins Trust's LGV health promotion leaflet targeted at men at risk of LGV and the subsequent exposure in the gay press. Clinics were asked to report if cases had seen any of the Terrence Higgins Trust LGV information before their first presentation. Although it appears that the majority of patients have not been asked this question, 21 of the 23 who had were reported to have not seen this information. This suggests there is still considerable scope for raising awareness of LGV among men at risk. The launch of the Terrence Higgins Trust's internet based information campaign to compliment their existing leaflet is therefore timely.
<<http://tht.org.uk/gaymen/lgv/>>.

The control of LGV presents a number of challenges, but ensuring that MSM are aware of LGV and able to recognise the symptoms and get treatment should be a priority. Sexual health clinics, particularly those that care for HIV positive MSM, should obtain supplies of the Terrence Higgins Trust's LGV information leaflet so that their patients can make informed decisions about their sexual health.

Lymphogranuloma venereum is a sexually transmitted disease caused by a specific type of *Chlamydia trachomatis* (serovars L1, L2, and L3). Unlike other forms of *C. trachomatis*, LGV is invasive and affects the lymphatic system. The symptoms of LGV vary according to the site of infection and may include inflamed and swollen lymph nodes in the groin (inguinal syndrome) and acute hemorrhagic proctitis (anorectal syndrome). If left untreated, the symptoms can become more severe and cause lasting damage to health.

Further information, including the LGV enhanced surveillance protocol, can be found on the HPA website at:
<http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/LGV/lgv.htm>.

The HPA is chairing a UK LGV Incident Team to coordinate a public health response to this challenge. Current priorities include working with the Terrence Higgins Trust and other health promotion experts to maximise awareness, expanding case finding, developing diagnostic methods, and working closely with colleagues in other European countries. The LGV Incident team can be contacted via Arlene Fernandez, PA to Dr Helen Ward, Health Protection Agency, Centre for Infections (tel:+ 44 (0) 20 8327 7696; email:arlene.fernandez@hpa.org.uk).

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Case of imported rabies in the UK

There has been a fatal case of imported human rabies in England. Diagnosis followed clinical and epidemiological investigations by the NHS, Health Protection Agency (HPA), Department of Health, and Department for Environment Food and Rural Affairs (DEFRA). The diagnosis of rabies was confirmed by tests on samples sent to the United Kingdom National Reference Laboratory for Rabies at the Veterinary Laboratory Agency, Weybridge, Surrey . The case had been bitten by a dog while on holiday in Goa, India . India is a high-risk rabies destination.

In the last ten years there have been three other imported cases of human rabies in England and Wales , all fatal. The first case occurred in 1996 following a bite from a stray dog in Nigeria where post exposure prophylaxis had not been given (1). The second case occurred in 2001 and followed a bite from a dog in the Philippines (2,3). Medical treatment was not sought following the biting incident. The third case also occurred in 2001 and again followed a dog bite in Nigeria (4,5). Although medical attention was sought in the third case and a course of injections was given it was unclear whether this was rabies vaccine.

There has never been a virologically confirmed case of natural person-to-person transmission of rabies despite there being tens of thousands of cases of human rabies every year worldwide. The risk to healthcare staff and family contacts, while a theoretical possibility, is therefore extremely low. There should be a very limited need for post-exposure prophylaxis if universal infection control measures have been effectively applied. Rabies virus is a hazard group 3 pathogen and as such all clinical specimens should be labelled, handled, and processed in the appropriate manner.

There are risk factors associated with travel to rabies endemic countries (6). Travellers should be advised to avoid all unnecessary contact with animals. If bitten or scratched by a warm blooded animal they should wash the wound with plenty of soap and water and seek medical attention immediately, even if previously vaccinated. If they do not seek medical treatment while abroad, they should still seek it when they come home, even if it is some time after the event. Promptly administered post-exposure prophylaxis is extremely effective in preventing rabies. For people who have not received any rabies vaccine prior to a potential exposure, post-exposure prophylaxis consists of a dose of vaccine as soon as possible after the bite followed by **four further doses 3, 7, 14, and 30 days later** . If the person has been previously vaccinated then fewer doses of vaccine are required. Human rabies immunoglobulin may also be given if the exposure is considered high risk.

Travellers should always be advised to seek travel health advice well in advance of their holiday or trip overseas to ensure that the risks of all travel associated illness, not just rabies, have been explained. Although rabies vaccine is not routinely advised for all travellers, pre-exposure immunisation is recommended for those:

- (1) living in or travelling for more than one month to rabies enzootic areas, unless there is reliable access to prompt and safe medical care;
- (2) travelling for less than one month in rabies enzootic areas, but who may be exposed to rabies because of their travel activities and;
- (3) who have limited access to post-exposure medical care.

Detailed information is available in the Department of Health *Immunisation against Infectious Diseases* ('The Green Book') chapter on rabies
<<http://www.dh.gov.uk/assetRoot/04/11/09/70/04110970.pdf>>.

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First human case of avian influenza (H5N1) reported from Indonesia, and WHO statement on A/H5N1 vaccine prototype strains

A man aged 38 years who died on the 12 July 2005 has been identified as Indonesia 's first human case of avian influenza H5N1 infection. Avian influenza has been present in Indonesian poultry stocks since January 2004, but previous reports of human infection during the current outbreak of avian influenza in Asia have been restricted to Thailand, Cambodia, and Vietnam .

The case developed respiratory symptoms compatible with H5N1 infection on 2 July, eight days after his eldest daughter (aged 8 years) and three days after his younger daughter (aged 1 year) developed similar symptoms. The samples taken from the man tested positive for avian influenza H5N1 virus. A limited number of samples were collected from the two children, who also died, which are still being tested by the WHO H5 reference laboratories in Hong Kong, and the Centers for Disease Control and Prevention in the United States .

The World Health Organization (WHO) has issued a statement to confirm that currently no further cases have been identified by the Indonesian Ministry of Health which is monitoring the remaining members of the affected household, and 300 contacts for signs of infection (1).

WHO has released a statement confirming that the current microbiological evidence supports the continued use of the influenza A (H5N1) vaccine prototype strain recommended by the WHO in April 2004. This

evidence was collected by the WHO H5 Reference laboratory network and the WHO collaborating Centres and Reference laboratories that have studied human and animal H5N1 viruses collected in 2004 and 2005 for antigenic or genetic change (2). The Department of Health in England has announced that it will stockpile influenza H5N1 vaccine as part of the work to prepare for and reduce the impact of a possible influenza pandemic (3).

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National Minimum Standards for Immunisation Training

Two documents on immunisation training have been published: National Minimum Standards for Immunisation Training and an accompanying Core Curriculum for Immunisation Training. These have been written by a group of immunisation specialists led by the Immunisation Department within the Health Protection Agency's Centre for Infections. These have been circulated for comment and endorsement by the different professional organisations which represent professionals involved in immunisation and approved for use in England, Northern Ireland, and Wales. Further consultation is underway on their use in Scotland.

In the current climate, where changes to the vaccine schedule and vaccine controversies are frequent and public confidence in vaccines may waver, it is vital that immunisers are confident, knowledgeable and up-to-date. They need to be able to meet the increasing demand for information from parents as well as the increasing requirements of clinical governance and professional accountability. Well-implemented training has the potential to equip healthcare professionals with the knowledge they need to meet these demands, to provide a high standard of safe and effective care and also to prevent serious adverse events. Specific training in immunisation should therefore be seen as a priority by the NHS and related organisations, and National Standards should help both to raise awareness of the need to make immunisation training a priority and to assist in the planning and provision of training at all levels.

In addition, the Standards have also been written with the aims of providing consistency in the training provided across the country and aiding those areas where training is not currently established. Recent changes to the organisation of the NHS have interrupted the provision of immunisation training programmes in some areas (1). It is thus intended that the Standards should help to enable those now in charge of designing and running local immunisation courses to ensure that all core areas of knowledge and competency are covered by providing a curriculum around which to structure the training they offer.

Although the Standards have been written mainly for those working in primary care, where the majority of vaccinations are given, everyone who administers or advises on vaccination as part of their clinical

practice should have access to training and it is hoped that the Standards and Core Curriculum will be used in both undergraduate and postgraduate education for nurses, midwives, doctors, and pharmacists.

The National Standards documents are being sent to universities and professionals responsible for immunisation training across the UK. Further copies can be downloaded from http://www.hpa.org.uk/infections/topics_az/vaccination/training_menu.htm or ordered by email from imunisationtraining@hpa.org.uk.

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Immunisation

Laboratory reports of invasive meningococcal infections, England and Wales: weeks 11-15/05

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Laboratory Reports of *Haemophilus influenzae* by age group and serotype, England and Wales: January to March 2005* (2004)

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Laboratory reports of hepatitis A infection in England and Wales: January to March 2005

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Laboratory reports of acute hepatitis B infection by age group and sex, England and Wales: January to March 2005

Published 28 July 2005, Volume 15 Number 30

Laboratory reports of hepatitis C infection in England and Wales: January to March 2005

Published 28 July 2005, Volume 15 Number 30

Transfusion transmitted infections reported to National Blood Service/HPA infection surveillance: 2004

Published 28 July 2005, Volume 15 Number 30

Laboratory reports of invasive meningococcal infections, England and Wales: weeks 11-15/05

	Method of diagnosis			Total reports	Cumulative*
	CSF and blood Culture	Non-culture	Other sites	11-15/05	Total to week 15/2005
Group A	–	–	–	–	1
B	47	68	11	126	557
C	3	1	–	4	12
W135	2	–	–	2	12
X	–	–	–	–	–
Y	1	–	–	1	13
Z	–	–	–	–	–
29E	–	–	–	–	–
Ungroupable	–	–	–	–	–
Ungrouped	–	21	–	21	46
Total	53	90	11	154	641

*Combined CDSC data and Meningococcal Reference Unit data latex antigen, microscopy, polymerase chain reaction.

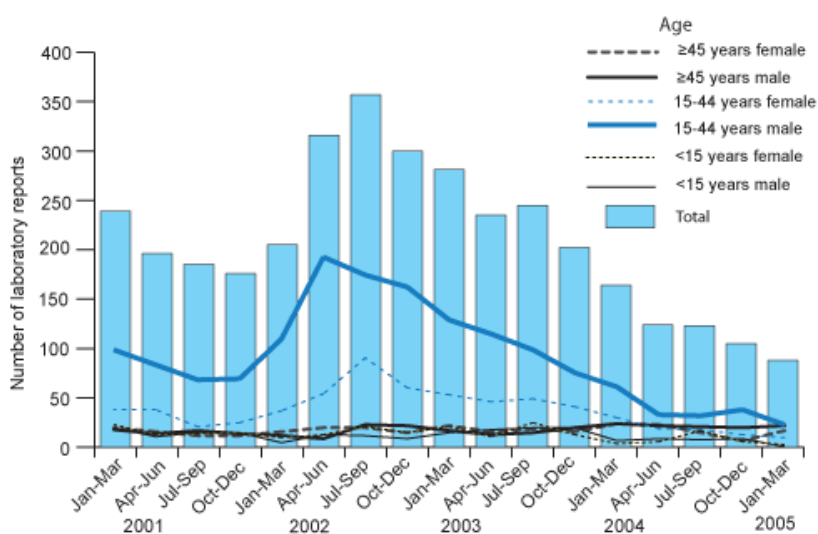
Laboratory Reports of *Haemophilus influenzae* by age group and serotype, England and Wales: January to March 2005* (2004)

Serotype	Age					Total
	<1 year	1-5 years	5-14 years	≥15 years	Not known	
b	5(9)	3(4)	3(7)	23(21)	–(–)	34(41)
nc	11(9)	10(10)	3(3)	71(57)	1(7)	96(86)
a,e,f	–(–)	1(1)	1(1)	11(7)	–(2)	13(11)
not typed	8(1)	2(2)	1(–)	54(32)	1(2)	66(37)
Total	24(19)	16(17)	8(11)	159(117)	2(11)	209(175)

*Data provisional.

Laboratory reports of hepatitis A infection in England and Wales: January to March 2005

During the first quarter of 2005 (January to March 2005), 89 laboratory reports of hepatitis A were made to the Health Protection Agency Centre for Infections (Cfi), 46% (75) fewer than in the equivalent quarter of 2004. This follows the trend of a decrease in the number of cases compared to the equivalent quarters in the previous year. Twenty-eight per cent (25) were men aged from 15 to 44 years (table) and the majority of cases occurred in the North West region. One person acquired their infection abroad (South Africa) and no infections were reported in injecting drug users (IDUs). The overall number of cases of hepatitis A in the first quarter of 2005 decreased by 18% (20), compared to that of the fourth quarter of 2004. A decrease in the number of cases was seen across all age groups for both males and females, with the exception of males and females aged over 45 years. The total number of males aged between 15 and 44 years reported this quarter decreased by 38% (15) on last quarter, reversing the increasing trend reported in this age group last quarter (1) (figure).

Figure Number of laboratory reports of hepatitis A by age group and sex: January 2001 to March 2005**Table Laboratory reports of hepatitis A in England and Wales: January to March 2005***

Group	Male	Female	Total
1-4	1	1	2
5-9	3	2	5
10-14	1	–	1
15-24	8	3	11
25-34	14	5	19
35-44	3	4	7
45-54	12	3	15
55-64	6	4	10
≥65	6	12	18
Not Known	1	–	1
Total	55	34	89

Under-reporting and variations in regional reporting continue to present a challenge. A total of 131 cases of hepatitis A were formally notified in the first quarter of 2005, 32% more than were laboratory confirmed. The number of notifications exceeded the number of laboratory reports for five English regions and Wales, while the number of laboratory reports exceeded the number of notifications for three English regions. Yorkshire and the Humber region had the same amount of laboratory reports and notifications. Discrepancy between notifications and laboratory reports was highest in London where 25 cases were formally notified and only four laboratory reports were made. The South East also had a high discrepancy with 24 cases notified and only five laboratory reports. Conversely, in the North West there were 25 laboratory reports and only 15 notifications.

The increase in notifications noted last quarter is not evident in this quarter. Total notifications decreased by 46% (111) this quarter. As numbers of laboratory reports and notifications have decreased this quarter, this probably reflects a real decrease in the number of hepatitis A cases.

Priorities for improving control of hepatitis A include enhancing risk factor reporting by clinicians to laboratories and from laboratories to Cfl, increasing the speed and rates of notification of cases by clinicians to Health Protection Units, obtaining greater participation in laboratory reporting of cases, and providing better detection and definition of outbreaks through means such as the application of hepatitis A virus genotyping.

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Laboratory reports of acute hepatitis B infection by age group and sex, England and Wales: January to March 2005

Forty cases of acute hepatitis B infection were reported in the first quarter of 2005 (January to March 2005). Twenty-eight out of 40 cases occurred in those in the 15 to 44 years age group (table 1).

Table 1 Laboratory reports of acute hepatitis B infection by age group and sex, England and Wales: January to March 2005*

Age Group (years)	Male	Female	Not known	Total
<1	–	–	–	–
1-4	–	–	–	–
5-9	–	–	–	–
10-14	–	–	–	–
15-24	4	1	–	5
25-34	8	7	1	16
35-44	3	2	2	7
45-54	7	–	–	7
55-64	1	1	–	2
≥65	2	1	–	3
Total	25	12	3	40

*All data are provisional.

During the first quarter of 2005, sex between men and women was the most commonly reported risk-factor accounting for four out of seven individuals with known risk factors (table 2).

Table 2 Laboratory reports of acute hepatitis B infection by exposure category in England and Wales: January to March 2005*

Summary	Total
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IVDU†	2
Sex between men and women	4
Sex between men	1
other identified risk	–
NRI	33
Total	40

*All data are provisional.

† Intravenous drug user.

A relatively low number of cases were reported compared to previous quarters and the majority 33 out of 40 had no risk factor information reported.

Laboratory reports of hepatitis C infection in England and Wales: January to March 2005

A total of 1676 reports of hepatitis C infection were reported in the first quarter of 2005 (January to March 2005) (table). Seventy-six per cent (1254/1655) of the cases occurred in those aged in the 25 to 44 years age group. Cases in males exceeded those in females.

Table Laboratory reports of hepatitis C infection in England and Wales: January to March 2005

Group	Male	Female	Not known	Total
<1	–	–	–	–
01-04	5	7	–	12
05-09	–	–	–	–
10-14	–	1	–	1
15-24	88	74	4	166
25-34	349	182	12	543
35-44	376	156	13	545
45-54	192	77	2	271
55-64	51	15	2	68
>65	25	22	2	49
Not known	13	7	1	21
Total	1099	541	36	1676

*All data are provisional.

Transfusion transmitted infections reported to National Blood Service/HPA infection surveillance: 2004

The surveillance of suspected transfusion transmitted infections (TTIs) began in October 1995 and is coordinated by the National Blood Service (NBS)/ Health Protection Agency (HPA) Centre for Infections (CfI). The collected data forms part of the Serious Hazards of Transfusion (SHOT) haemovigilance scheme. Data presented here are for the NBS/HPA CfI surveillance scheme only. The 2004 SHOT Annual Report is due to be published shortly and will be available through the website <<http://www.shotuk.org>>.

Methods

Blood centres in England, Wales, and Northern Ireland report suspected transfusion transmitted infections (TTIs) to the TTI surveillance scheme. All twelve blood centres reported possible incidents during 2004. Blood centres in Scotland report all incidents to the Microbiology Reference Unit of the Scottish National Blood Transfusion Service, for investigation. Details and findings on each incident are passed to the NBS/HPA CfI surveillance system.

Reports of suspected transfusion transmitted infections

Between January 1 2004 and December 31 2004, 34 reports of suspected TTIs were made by blood centres throughout the United Kingdom to NBS/HPA CfI surveillance (33 in England and Wales, 1 in Scotland). After complete investigations, only one report (hepatitis E) was determined to be a transfusion transmitted infection according to the definition (Box 1). Of the 33 remaining reports, 31 (14 bacteraemia, 1 hepatitis A virus (HAV), 10 hepatitis B virus (HBV), 5 hepatitis C virus (HCV), 1 HIV) did not implicate transfusion as the source of infection. One report (HCV) involved a recipient transfused with 143 units during 1993 that could neither be confirmed nor refuted as a TTI, and one with human herpesvirus 8 (HHV-8) for whom a complete investigation is pending. A report of possible prion transmission was made for an elderly British citizen who died from vCJD in 2001 (1).

Box 1: Definition

A suspected report is classified as a transfusion transmitted infection (TTI) if, following investigation:

The recipient had evidence of infection post-transfusion, and there was no evidence of infection prior to transfusion, and no evidence of an alternative source of infection.

And, either

At least one component received by the infected recipient was donated by a donor who had evidence of the same transmissible infection,

Or

At least one component received by the infected recipient was shown to contain the agent of infection

Case report: transfusion transmitted hepatitis E

A repeat donor reported onset of jaundice 23 days after donating blood in 2004. The platelets and red cells of this donation had been transfused and the recipients were traced and tested; the plasma had been discarded. The archive sample from the donation was tested and found positive for hepatitis E virus (HEV) RNA. The recipient of the platelets (F 55y) was tested 84 days after transfusion, and had not developed any markers for HEV infection. A second recipient (M 65y) had received the red cells unit for treatment of anaemia due to lymphoma and tested positive for HEV RNA and HEV IgM two months post-transfusion. The recipient remained asymptomatic for HEV, apart from a mild jaundice and elevated liver function tests, which may not have been noted if the patient had not been under surveillance. The recipient became HEV RNA-negative three months following the transfusion. No source of the donor's infection was identified. Sequence and phylogenetic analysis showed identity between donor and recipient viruses.

Bacterial incident

In 2004, and for the first time since surveillance of TTIs began in 1995, there were no reports of bacterial infection by transfused components. However, one report was made of an incident involving the transfusion of a unit of platelets contaminated with *Staphylococcus epidermidis* from a donor's arm, but transmission to the recipient could not be confirmed. A female patient aged 75 years with chronic lymphatic leukaemia developed rigors, vomiting and pyrexia following transfusion of a five day old pooled platelet unit. The transfusion was terminated and the patient recovered. An identical strain of *Staphylococcus epidermidis* was isolated from the transfused platelet pack and from the venepuncture site of one of the four contributing donors. The organism was not, however, isolated from the recipient following the reaction. This is evidence of bacterial contamination of a platelet pool from a donor's arm and suggests arm cleansing was inadequate, although transmission to the recipient was not confirmed.

Cumulative total (1995 to 2004)

There have been 52 confirmed TTIs reported to the scheme since surveillance began in 1995, with eight deaths. Table 1 shows the cumulative number of reports of TTIs by year of transfusion.

Table 1 Cumulative total of reports of TTIs made to NBS/HPA Centre for Infections surveillance between 1 October 1995 and 31 December 2004 by year of transfusion and infection

Year of transfusion	Pre 1997	1997	1998	1999	2000	2001	2002	2003	2004	Total	Deaths
Infection											
HAV	1(1)	–	–	–	1 (1)	–	–	–	–	2	–
HBV	3(3)	1(1)	1(1)	2(3)	1(1)	–	1(1)	1(1)	–	10	–
HCV	1(1)	1(1)	–	–	–	–	–	–	–	2	–
HIV	1(3)	–	–	–	–	–	1(1)	–	–	2	–
HEV	–	–	–	–	–	–	–	–	1(1)	1	–
HTLV I	2(2)	–	–	–	–	–	–	–	–	2	–
Bacteria	2(2)	3(3)	4(4)	4(4)	7(7)	5(5)	1(1)	3(3)	–	29	7
Malaria	–	1(1)	–	–	–	–	–	1(1)	–	2	1
vCJD	1(1)	–	–	–	–	–	–	–	–	1	–
Possible prion transmission	–	–	–	1(1)	–	–	–	–	–	1	–
Total	11(13)	6(6)	5(5)	7(7)	9(9)	5(5)	3(3)	5(5)	1(1)	52	8

*The number of incidents is shown with the total number of identified infected recipients in brackets.

Comment

Despite reports of suspected transfusion transmitted HBV, HCV, and HIV during 2004, all investigations concluded transfusion was not the source of the recipient's infection. The risk of HIV, HCV or HBV infectious donation entering the blood supply still remains low (2). This is in the presence of donor selection criteria and routine screening of blood donations using highly sensitive techniques, including HCV RNA testing, and combined HIV antibody and antigen assays. The absence of proven bacterial transmissions has followed the implementation in 2002 of procedures to divert the first 20 to 30 mL of each blood donation. The NBS encourage donors to report any illness post-donation, and during 2004 the report of onset of jaundice in a regular donor led to the identification of the confirmed hepatitis E transmission. Donor selection criteria have since been amended to include specific exclusion for individuals who have been in contact with an individual with hepatitis E. (General hepatitis exclusions would have applied prior to amendment ,

<<http://www.transfusionguidelines.org.uk>>. Each year the number of TTIs is small and fluctuations are

to be expected. The reporting system is likely to be biased toward ascertainment of infections that cause rapid onset of acute disease. Transfusion transmitted infections continue to be rare in the United Kingdom .

References

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HIV/Sexually Transmitted Infections (STIs)

HIV and AIDS in the United Kingdom quarterly update: data to the end of June 2005

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HIV and AIDS in the United Kingdom quarterly update: data to the end of June 2005

HIV and AIDS in the United Kingdom quarterly update: data to the end of June 2005 United Kingdom (UK) data from the Health Protection Agency Centre for Infections, Health Protection Scotland, and the Institute of Child Health (London).

By the end of June 2005, 72,938 diagnoses of HIV had been made and reported in the United Kingdom (UK) since surveillance began in 1982. To date, 21,552 individuals have been diagnosed with AIDS, of whom 13,225 (61%) have died, with a further 3233 individuals having died without being reported with AIDS.

Table 1 New diagnoses of HIV in the UK by infection route, sex, and year of diagnosis: data to end of June 2005

How infection was probably acquired	Sex	1995 and earlier *	1996	1997	1998	1999	2000	2001	2002	2003†	2004†	Jan-June 2005	Total
Sex between men	M	18,926	1558	1414	1370	1376	1518	1771	1868	1926	1956	614	34,297
Sex between men and women	M	2525	358	451	525	601	759	1069	1358	1547	1486	347	11,026
	F	2937	479	562	645	840	1252	1821	2367	2816	2548	602	16,869
Injecting drug use	M	2089	119	123	96	79	73	98	88	86	90	26	2967
	F	963	54	48	36	34	41	36	27	42	28	8	1317
Blood transfusion or blood factor products	M	1440	10	16	4	11	10	14	15	17	10	1	1548
	F	134	11	13	6	11	15	11	20	19	10	3	253
Mother to infant	M	182	29	50	47	35	57	54	56	77	53	18	658
	F	185	33	33	52	42	47	46	63	67	66	5	639
Other	M	13	2	1	2	6	3	7	2	3	–	1	40
	F	15	1	–	2	2	3	1	4	2	2	–	32
Undetermined	M	489	27	23	22	22	22	23	21	18	9	1	677
	F	56	6	6	9	4	4	3	6	2	–	–	96
Follow-up ongoing	M	116	16	15	21	26	42	74	175	340	403	226	1454
	F	30	3	7	8	12	28	41	156	232	311	196	1024
Total‡		30,135	2706	2763	2846	3103	3874	5070	6226	7194	6973	2048	72,938

*Figures include all reports received since surveillance of AIDS (and subsequently of HIV infection) began in the early 1980s.

†Numbers will rise as further reports are received.

‡Forty-one people whose sex was not reported are included in this total: seven infected through sex between men and women, one blood/ blood product recipients, four infected through mother-to-infant transmission and 29 for whom likely route of infection is not known.

Surveillance of HIV diagnoses is subject to reporting delay, but by the end of June in any year it is estimated that over 90% of reports of diagnoses for the previous year will have been received, and so in this HIV/AIDS update the near-complete figures for 2004 are presented. Table 1 shows new diagnoses of HIV over time by probable route of infection. Of the 6973 diagnoses so far reported for 2004, 58% (4034/6973) were acquired through sex between men and women, with almost two-thirds (2548/4034) of those being female. Diagnoses among men who have sex with men (MSM) remained high, making up 28% (1956/6973) of the total, a further 1.7% (118/6973) of infections were acquired through injecting drug use, 2% (141/6973) through other routes, and 714 reports (10%) are awaiting further follow-up to determine probable route of infection (403 males and 311 females).

Since 1999, the number of HIV infections diagnosed in heterosexual men and women has exceeded those in MSM and this trend continues. At the same time there has also been a yearly increase in MSM being diagnosed. Further reports of diagnoses expected for 2004 and the addition of reports, already received, where the route of infection has yet to be clarified will bring total figure for the year to 2000 or higher, the largest number of new diagnoses in MSM since the mid-1980s when the laboratory test for HIV was first available. Increased testing and better reporting will account for some of this rise, but ongoing transmission of HIV is also a factor with around 80% of HIV infections in MSM acquired in the UK.

The converse is seen for diagnoses in heterosexual men and women, with the majority of these infections acquired abroad in high prevalence countries of origin, particularly in sub-Saharan Africa. For 3526 diagnoses in 2004 of individuals heterosexually infected without evidence of a 'high risk' partner, but with information about country of infection 12% (431) were infected in the UK, 78% (2766) in Africa and 7% (249) in mainly higher prevalence countries of Asia and the Caribbean, particularly Thailand and Jamaica. Less than 1% (32/4034) heterosexual men and women diagnosed in 2004 had a 'high risk' partner such as an injecting drug user (table 2) and most of these infections were acquired in the UK.

Infections transmitted through blood transfusion or from mother-to-child are mostly acquired outside of the UK. Of the 120 reported HIV diagnoses acquired through mother-to-child transmission in 2004, 49% (59/120) of individuals were probably infected in Africa, and 38% (45/120) were probably infected in the UK. Infections acquired through this route are usually diagnosed early, but can be reported in later years.

Table 2 New diagnoses of HIV in those infected through sex between men and women by year of diagnosis: data to end of June 2005

How HIV infection was probably acquired	1995 and earlier*	1996	1997	1998	1999	2000	2001	2002	2003	2004†	2005†	Total
Exposure to 'high risk' partner(s)												
Sexual intercourse between men	179	11	12	12	12	13	26	26	15	15	3	324
Injecting drug use	428	44	62	58	34	27	43	28	29	16	5	774
Blood factor treatment (eg, for haemophilia)	73	8	1	1	1	1	0	2	7	–	–	94
Blood/tissue transfer (eg, transfusion)	15	3	5	3	3	1	4	2	–	1	–	37
Exposure to presumed heterosexually infected partner(s):												
Exposure abroad:												
Africa	3550	553	644	757	1005	1511	2241	2891	3326	2766	615	19,859
Latin America/Caribbean	125	24	30	32	66	68	91	138	146	109	10	839
Asia	151	44	52	79	76	111	101	118	137	140	25	1,034
North America	89	8	10	15	7	8	9	6	7	2	2	163

Europe	243	41	47	44	50	44	48	62	78	73	16	746
Australasia	10	1	2	4	7	2	5	3	5	–	2	41
Country(ies) not known	31	9	3	15	–	2	1	0	1	5	–	67
Exposure in the UK to partner(s) presumed infected												
Outside Europe	209	45	79	85	96	138	180	217	267	260	52	1,628
Within Europe	281	35	51	48	55	56	66	49	70	68	19	798
Country(ies) not known	46	7	4	6	8	8	20	48	58	103	53	361
Partner(s) exposure category undetermined:												
Investigation continuing	2	–	4	7	16	18	56	148	269	475	61	1056
Investigation closed	32	4	8	4	5	4	–	2	–	1	–	60
Total	5467	837	1014	1168	1439	2011	2887	3702	4303	3627	205	26,660

*Figures include all reports received since surveillance of AIDS (and subsequently of HIV infection) began in the early 1980s.

†Numbers will rise as further reports are received.

Table 3 describes new diagnoses of HIV infection over time by the region where the earliest diagnosis was made. London remains the focus of HIV in the UK, with 2890 (41%) of new diagnoses in 2004. A further 20% of diagnoses were in the regions adjacent to London. All English regions have seen increases in new diagnoses since 1999 including areas that previously saw relatively few HIV cases, such as the North East, Yorkshire and the Humber, and East of England, where diagnoses have more than tripled between 1999 and 2004. Wales, Northern Ireland, and Scotland have also seen large increases in new diagnoses, particularly in more recent years since 2001.

Table 3 HIV infected individuals by country, region and year of HIV diagnosis, UK data to end of June 2005

Country and region of diagnosis	1995 and earlier *	1996	1997	1998	1999	2000	2001	2002	2003	2004†	2005†	Total
England												
North East	441	24	35	22	29	37	56	98	147	132	4	1025
Yorkshire & Humber	948	90	83	85	91	104	181	305	432	346	27	2692
East Midlands	600	48	45	62	91	103	198	258	327	326	27	2085
East of England	769	58	75	88	96	186	315	486	541	526	17	3157
London	18,323	1706	1737	1766	1957	2338	2791	2987	3195	2611	299	39,710
South East	2425	227	213	207	219	362	500	711	865	772	53	6554
South West	988	78	92	104	103	104	136	180	206	209	31	2231
West Midlands	952	63	101	113	104	178	215	423	482	440	28	3099
North West	1759	188	150	191	210	240	422	433	538	551	5	4687
England (total)	27,205	2482	2531	2638	2900	3652	4814	5881	6733	5913	491	65,240
Wales	458	36	46	30	34	46	63	77	108	99	2	999
Northern Ireland	146	16	9	9	15	19	20	27	33	53	–	347
Scotland	2283	164	169	161	149	154	166	219	258	334	58	4115
UK Total	2887	216	224	200	198	219	249	323	399	486	60	5461
Channel Isles / Isle of Man	40	6	8	6	1	1	5	7	4	4	–	82

UK total HIV diagnoses	30,132	2704	2763	2844	3099	3872	5068	6211	7136	6403	551	70,783
UK total AIDS diagnoses	13,177	1444	1080	788	756	831	727	867	886	698	26	21,280
UK total deaths‡	10,423	1462	736	506	467	478	468	510	523	411	39	16,023

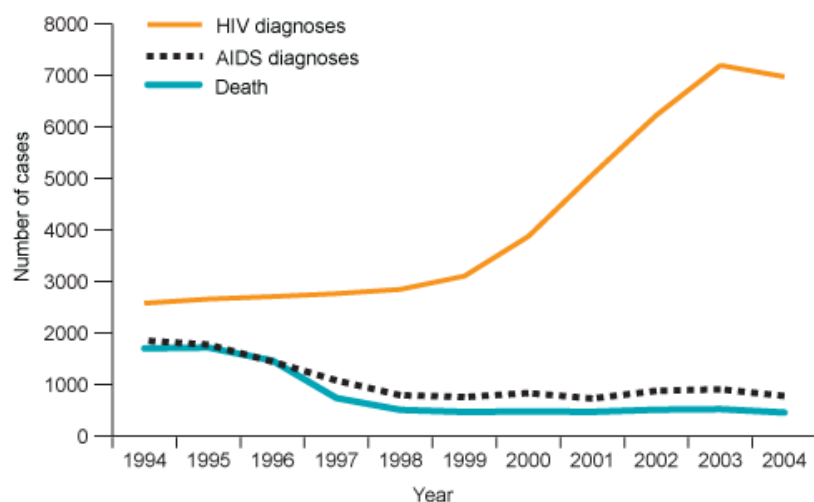
*Figures include all reports received since surveillance of AIDS (and subsequently of HIV infection) began in the early 1980s.

† Numbers will rise as further reports are received.

‡ Total includes 243 deaths where year of death is not known (including all deaths in children).

After the introduction of HAART (Highly active antiretroviral therapy) in the mid 1990s numbers of AIDS cases and deaths declined, with relatively constant numbers after 1997 (table 3 and figure). There has also been a reduction in AIDS reporting since the advent of HAART and AIDS defining illnesses are more likely to be reported if the HIV and AIDS diagnoses are simultaneous. In 2004, of the 777 AIDS diagnoses so far reported, 87% (677) were made at the same time as the HIV diagnosis*. In addition to reporting of deaths from clinicians, mortality data are obtained from the Office for National Statistics in England and Wales and the General Register Office in Scotland. So far in 2004, 456 deaths have been reported, of which 214 (47%) had been previously reported with AIDS. Reporting of deaths is subject to reporting delay.

Figure: HIV diagnoses and deaths in HIV infected individuals, UK reports to end of 2004, reported by end of June 2005



* Simultaneous HIV and AIDS diagnoses are defined as individuals who were diagnosed with AIDS within three months of their HIV diagnosis.