



# CDR WEEKLY

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## News

 **Healthcare workers infected with HIV: updated guidance**

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### Healthcare workers infected with HIV: updated guidance



The UK Department of Health have issued revised guidance (1) for the NHS on the management of HIV infected healthcare workers and patient notification, following consultation in 2002. The new guidance replaces the previous guidance published in 1998 (2) and the consultation guidance published in 2002 (3). This guidance is based on advice from the Expert Advisory Group on AIDS (EAGA) and the UK Advisory Panel for Health Care Workers infected with Bloodborne Viruses (UKAP).

In the new document, the guidance on the management of the infected health care worker or those who consider that they may have been put at risk of acquiring HIV remains unchanged. Under this long standing policy, HIV infected HCWs should not carry out exposure prone procedures (4, ) and HCWs who have any reason to believe they may have been exposed to HIV infection must promptly seek professional advice on whether they should be tested for HIV.

Examples of how a health care worker may have been exposed to HIV infection include if they have:

- engaged in unprotected sexual intercourse between men;
- had unprotected intercourse in, or with a person who had been exposed in, a country where HIV transmission through sexual intercourse between men and women is common;
- shared injecting equipment whilst using drugs;
- had a significant occupational exposure to HIV infected material in any circumstances;
- engaged in invasive medical, surgical, dental or midwifery procedures, either as a practitioner or patient, in parts of the world where infection control precautions may have been inadequate, or with populations with a high prevalence of HIV infection.

The main change in the new guidance is in relation to patient notification following an exposure prone procedure performed by an HIV infected HCW. The new policy means that when a health care worker is found to be infected with HIV it is no longer necessary to notify routinely every patient who has undergone an exposure prone procedure performed by the health care worker. Instead, the risk of HIV transmission to patients will be assessed locally by the NHS on a case-by-case basis using a criteria-based risk assessment framework. To further refine the level of risk, risk of bleed-back is categorized into levels 1 to 3, with level 3 being the highest category of risk. In the very unusual case where there is evidence of HIV transmission from the infected HCW to a patient, notification of all patients who have undergone exposure prone procedures by that HCW should take place. In the absence of evidence of HIV transmission, all patients who have undergone category 3 procedures by an infected HCW should be notified. When only category 1 or 2 procedures have been carried out, patient notification will not be necessary, unless the other relevant considerations suggest that it should be done.

In line with Shifting the Balance of Power, Directors of Public Health of Primary Care Trusts will be responsible for deciding whether patient notification is necessary. The UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses will be available to provide advice if and when needed. The extent of the patient notification exercise will depend on the level of risk of exposure. This may mean that in some instances there is no patient notification exercise, or it is limited in scope.

#### References

1. Department of Health. *HIV Infected Health Care Workers: guidance on management and patient notification*. London: Department of Health, 28 July 2005. Available at <<http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/fs/en#5325970>>
2. UK Health Departments. *AIDS/HIV infected health care workers: Guidance on the management of infected health care workers and patient notification*. London: DH, December 1998.
3. UK Health Departments. *HIV Infected Health Care Workers: a consultation paper on management and patient notification*. London: DH, July 2002.
4. UK Health Departments. *AIDS/HIV – infected health care workers: guidance on the management of infected health care workers*. London: DH, March 1994.

## Consultation on NHS research strategy launched

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The Department of Health launched a consultation on proposals for a new modernised National Health Research Strategy on 1 August 2005. The views of research professionals, organisations, patients, and the public are being sought on the future direction of health research for the Department of Health and the NHS in England .



The proposals fall under three main groupings.

Firstly, the strategy proposes creating a National Institute for Health Research – a 'virtual' institute to work with the United Kingdom Clinical Research Collaboration to co-ordinate the research infrastructure of the NHS. This would bring together, for the first time, all elements of NHS and Department of Health research. It would not have a separate management structure or chief executive, but would bring together the work that NHS R&D undertakes. The Director of NHS R&D would chair an advisory board to provide high level strategic direction and audit for the Institute. The Institute would also form a key part of the NHS knowledge management system, creating knowledge through research and development. Funding would be from within the NHS R&D budget.

Secondly, a linked group of Academic Medical Centres would be established to serve as the nation's premier research hospitals and compete with other top clinical research institutes throughout the world. This would comprise the top five organisations that have strengths across a range of clinical areas, and a similar number of specialist academic medical centres. The centres would be selected by open competition, and the competition reopened every seven years.

Finally, the way research in the NHS is funded would be reformed. Funding would more closely follow patient involvement in health studies, giving a more a transparent system of funding that more accurately reflects the levels of health research conducted by NHS Trusts.

The web-based consultation will run for twelve weeks, closing on 21 October 2005. Further information about the consultation process, and full copies of the consultation document, can be downloaded from the Department of Health website at <<http://www.dh.gov.uk/Consultations/LiveConsultations>>

## Get the latest news from *CDR Weekly* with RSS

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*CDR Weekly* and the Health Protection Agency (HPA) website now offer RSS feeds for their updates. The RSS feed is automatically updated with the rest of *CDR Weekly*, alerting you to the latest news. The RSS connection can be found at the foot of the left-hand navigation bar i both the *CDR* and HPA pages. RSS is generally agreed to stand for Really Simple Syndication (although it is also referred to as Rich Site Summary), and was devised by NetScape in the late 1990s. It offers a way of automatically keeping up to date with changes on websites, and is a popular feature of news sites, such as the BBC.

The RSS feed It is an XML file that can be read by special news reader software or by a web service you can use from your web browser. Some web browsers also have the ability to read RSS feeds. Put the address of the RSS feed into your reader, and it will display the latest contents listing (news stories have a brief synopsis), and link that will take you to the full story. Alternatively, some readers will automatically scan a website for RSS feeds. Once connected, RSS lets the user stay in touch with many different sources of news and information automatically, as feed readers scan for updates and automatically display them.

More information on using RSS feeds can be found on the *CDR Weekly* RSS information page at <<http://www.hpa.org.uk/cdr/RSS.htm>>.

## 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 27-30/05

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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 27-30/05

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 27-30/2005**

Week	27/05	28/05	29/05	30/05	Total
Week ending	10/07/05	17/07/06	24/07/05	31/07/05	
<b>Influenza A</b>	2	1	1	4	8
Isolation	–	–	–	–	–
DIF*	–	–	–	1	1
Four-fold rise in paired sera	–	–	–	–	–
PCR	–	–	–	2	2
Other†	2	1	1	1	5
<b>Influenza B</b>	3	–	3	4	10
Isolation	–	–	–	1	1
DIF*	–	–	–	1	1
Four-fold rise in paired sera	–	–	–	–	–
PCR	–	–	1	–	1
Other†	3	–	2	2	7
<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 27-30/2005**

Week	27/05	28/05	29/05	30/05	Total
Week ending	10/07/05	17/07/06	24/07/05	31/07/05	
Adenovirus*	21	33	18	38	110
Coronavirus	–	–	–	–	–
Parainfluenza†	3	5	6	25	39
Rhinovirus	5	4	4	16	29
Respiratory syncytial virus (RSV)‡	4	1	2	6	13

\*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 27-30/2005**

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥65 years	Unknown	Total
Adenovirus*	15	14	18	46	10	6	1	110
Coronavirus	–	–	–	–	–	–	–	–
Influenza A	2	–	–	2	2	2	–	8
Influenza B	1	–	1	3	2	2	1	10
Parainfluenza†	11	10	1	8	8	1	–	39
Rhinovirus	14	8	1	3	2	–	1	29
Respiratory syncytial virus (RSV)	13	–	–	–	–	–	–	13

\*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 27-30/2005**

Week	27/05	28/05	29/05	30/05	Total
Week ending	10/07/05	17/07/06	24/07/05	31/07/05	
<i>Coxiella burnetii</i>	–	–	1	1	2
Respiratory <i>Chlamydia</i> sp*	–	1	–	7	8
<i>Mycoplasma pneumoniae</i>	9	5	17	14	45
<i>Legionella</i> sp	8	1	8	8	25

\*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 27-30/2005**

Week	27/05	28/05	29/05	30/05	Total
Week ending	10/07/05	17/07/06	24/07/05	31/07/05	
Nosocomial	–	–	–	–	–
Community	2	–	2	8	12
Travel abroad	5	1	4	–	10
Travel UK	1	–	2	–	3
<b>Total</b>	<b>8</b>	<b>1</b>	<b>8</b>	<b>8</b>	<b>25</b>
Male	3	–	6	6	15
Female	5	1	2	2	10

\*Represents non-pneumonic cases where present.

Twenty-five cases were reported with pneumonia: 15 males aged from 45 to 85 years and ten females aged from 40 to 79 years. Twelve cases had community-acquired infection. M 71y died.

Thirteen cases were travel associated: three with Spain, two with each of England, France and Greece, and one with each of Antigua, Croatia, Dubai, and Wales.

**Table 5b Reports of Legionnaires' disease (pneumonic and non-pneumonic\*) cases by region of report in England and Wales: weeks 27-30/2005**

Region	Nosocomial	Community	Travel (Abroad)	Travel	Total
North East	–	1	1	–	2
Yorkshire & the Humber	–	1	2	1	4
East Midlands	–	1	1	–	2
East of England	–	–(1†)	2	–	3
London	–	2	–	–	2
South East	–	–	1	1	2
South West	–	–	–	–	–
West Midlands	–	4	1	1	6
North West	–	1	1	–	2
Wales	–	1	1	–	2
<b>Total</b>	<b>–</b>	<b>12</b>	<b>10</b>	<b>3</b>	<b>25</b>

\*Represents non-pneumonic cases where present.

†Case with date of onset of symptoms in 2004.

[Infection Reports](#) | Diary Last updated: 4 August 2005

## Diary

For information about other conferences, courses, and events visit <http://www.hpa.org.uk/hpa/events>

### 'Killer Staph' – just media hype or a real problem?

A one day meeting of the comparative medicine section of the Royal Society of Medicine on 26 October 2005, the Society's headquarters in Wimpole Street, London. The meeting will include sessions on MRSA in animals and man, untreatable staphs, and prospects for therapy. For full details and online bookings visit the Society's website at <http://www.rsm.ac.uk/comparative>