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Earthquake in south Asia: advice for relief workers

On 8 October 2005, an earthquake of magnitude 7.6 on the Richter scale struck Pakistani-administered Kashmir, north east of Islamabad, killing over 20,000 people. The first quake was followed by a series of aftershocks of magnitudes between 5.4 and 5.9. Widespread destruction has occurred in Kashmir including a number of districts in Pakistan's north west Frontier Province and northern Punjab. Muzaffarabad, Islamabad, and Rawalpindi are among the cities most affected. In Indian-administered Kashmir, the worst hit towns are Uri and Baramullah. Many areas near the Line of Control have suffered substantial damage. The city of Jalalabad in Afghanistan has also been affected and tremors were felt as far as Kabul and Delhi (1). Basic health facilities have been disrupted due to damage to buildings and loss of healthcare staff and massive damage to water and sewage systems means that waterborne diseases are the major public health concern at present. There have been no reports of any British casualties so far.

The immediate health needs among people returning to the United Kingdom (UK) from areas affected by the earthquake, are likely to be physical and psychological resulting from the trauma, shock, and loss that individuals may have experienced. Dust inhalation and exposure to the environment are all potential hazards.

It would be wise for travellers to stay out of the affected areas unless they are taking part in the relief effort. The National Travel Health Network and Centre (NaTHNaC) has issued advice on its website at: http://www.nathnac.org/pro/clinical_updates/earthquake_SouthAsia_121005.htm detailing possible hazards and risks from injury and illnesses for relief workers planning to visit the affected areas.

The risk of infectious disease in returning travellers is believed to be low at this time, although individuals returning from affected areas may be at higher risk of infectious disease because they will have been exposed to worse environmental circumstances than they expected and were prepared for. All returning travellers are advised that if they have health concerns they should seek advice from their general practitioner (GP), and should certainly do so if they experience symptoms. Information for health professionals who may see returning travellers (including questions and answers) is available on the Health Protection Agency website at http://www.hpa.org.uk/infections/topics_az/travel/current_items/Kashmir_earthquake/Kashmir_adv.htm.

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Outbreaks of infection with *Salmonella* Enteritidis PT6 infection in the north east of England associated with eggs

Between April and July 2005, seven outbreaks of *Salmonella* Enteritidis phage type (PT) 6 infection in catering premises were detected and investigated in the North East Region. Five of these outbreaks occurred in June and July. At least 68 people were affected and 42 cases of *S. Enteritidis* PT6 were confirmed in these outbreaks.

In six outbreaks, cross contamination from raw shell eggs during the preparation and/or storage of food was recorded as being the main contributory factor. In the remaining outbreak, all dishes consumed by cases contained egg. These associations were not tested using analytical methods.

The food supply chains to the premises affected were investigated by local authorities. Investigations suggested that the majority of eggs used by the affected premises at the time of the outbreaks were sourced from a single supplier based in the north east of England who, in turn, had sourced eggs from the Netherlands. Food samples (including eggs) and environmental samples were taken from three premises shortly after the outbreaks were detected. *S. Enteritidis* PT6 was recovered from salad sampled at one of the premises and two environmental samples taken from another premises yielded *Salmonella* spp, one of which was confirmed as *S. Enteritidis* PT6. *Salmonella* was not detected from any of the eggs sampled from the premises during outbreak investigations.

On 8 August, further samples of UK and non-UK produced shell eggs were obtained from the companies that had supplied the affected premises (n=2,120 eggs). Two separate batches of 360 eggs, distinguishable by their best before dates, were positive for *S. Enteritidis* PT6. The eggs were examined in pooled samples of twenty eggs. In one batch two out of 18 pooled samples were contaminated and in the other, three of 18 pooled samples were contaminated. The eggs originated from the same egg producer in the Netherlands. Plasmid profiling and pulsed field gel electrophoresis (PFGE) were carried out on the raw shell egg isolates and the human isolates from one of the outbreaks in April and two in July. The human and egg isolates were indistinguishable, suggesting that eggs from the Netherlands might have been responsible for a number of *S. Enteritidis* PT6 infections in north east England over a period of four months.

Other European Member states have been informed of these results via Enternet (1) and the Rapid Alert System for Food and Feed (RASFF) (2). Further PFGE typing of isolates from sporadic cases and the remaining outbreaks in north east England is in progress and studies to investigate the distribution of the different plasmid profile types of *S. Enteritidis* PT6 in England, Wales and Scotland are planned.

The requirement to stamp eggs was introduced in January 2004 by European Council Regulation 2001/05 (3). In the outbreaks reported here, egg stamps allowed the accurate traceability of the salmonella-positive eggs to producer level. However, outbreak investigations should not rely on egg stamps alone when attempting to identify the origin of eggs thought to be in use at the time of exposure. Egg stamps and other labelling information should, therefore, be considered alongside European Council Regulation 178/2002 (4) which require food businesses to maintain records to ensure full traceability of a food product, even when it is no longer in the food chain.

Outbreaks of *S. Enteritidis* infection have been linked to eggs sourced outside the UK since 2002 and this prompted the formation of a multi agency outbreak control team in 2004 (5). To our knowledge this is the first series of outbreaks in England and Wales to be linked with eggs originating in the Netherlands. A national programme to eradicate *S. Enteritidis* from Dutch poultry breeding flocks was implemented in March 1989 (6) and surveillance programmes for raw shell eggs in the Netherlands show that the salmonella control programme for poultry has been successful in reducing *S. Enteritidis* in broilers almost to exclusion. However, in commercial layers in 2003, more than 6% (9% in 2001 and 14% in 1997) of the flocks remained *S. Enteritidis* positive (7). A 2001 study of Dutch produced eggs revealed that *Salmonella* was found in only 0 to 0.03%, although about 35% of human salmonellosis cases in the Netherlands are thought to be due to the consumption of eggs (8).

Irrespective of the country of origin, the consumption of foods containing raw or undercooked shell eggs remains a risk factor for salmonellosis and the current UK Food Standards Agency (FSA) advice to members of the public preparing food for people who are particularly vulnerable to salmonella infection – babies and toddlers, the elderly, pregnant women, and those who are already ill – is to make sure that eggs are cooked until the whites and yolk are solid (9). Specific FSA advice on the use of eggs was issued to catering premises, including those serving vulnerable groups, in 2003 (10).

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Outbreak of hepatitis A in Dorset in men who have sex with men

An outbreak of hepatitis A has been identified in Dorset among men who have sex with men (MSM). Since June 2005, there have been eight cases of acute hepatitis A, all in men. Dorset normally has fewer than ten notifications of acute hepatitis A per year.

Six of the eight cases have confirmed that they are homosexual or bi-sexual, with no other risk factors identified. All six live in the Bournemouth area, and are aged between 27 and 45 years. Most of them reported being sexual active among the gay scene in the Bournemouth area, using a variety of venues. This included organised gay events involving MSM from other parts of the country. As yet, no single venue has been identified as being particularly important in the aetiology of this outbreak. Detailed sexual health histories are being taken from all notified cases of acute hepatitis A, using the questionnaire produced for the recent outbreak of hepatitis A in MSM in south east London (1). One of the remaining two cases was probably travel-associated and the other denied any risk factors including having sex with men.

The Dorset team of the Dorset and Somerset Health Protection Unit is working closely with a number of agencies to advise MSM locally of the risks regarding hepatitis A, and how this might be minimised, including advice on immunisation. Those with possible signs and symptoms or known contact with someone displaying symptoms are urged to attend the local genito-urinary medicine clinic or their general practitioner (GP) for screening. All GPs in the area have been informed about the outbreak.

For further information please contact Sue Bennett, Consultant in Communicable Disease Control, Dorset and Somerset Health Protection Unit, Victoria House, Princes Road, Ferndown, Dorset BH22 9JR: tel 01202 851272, fax 01202 851273.

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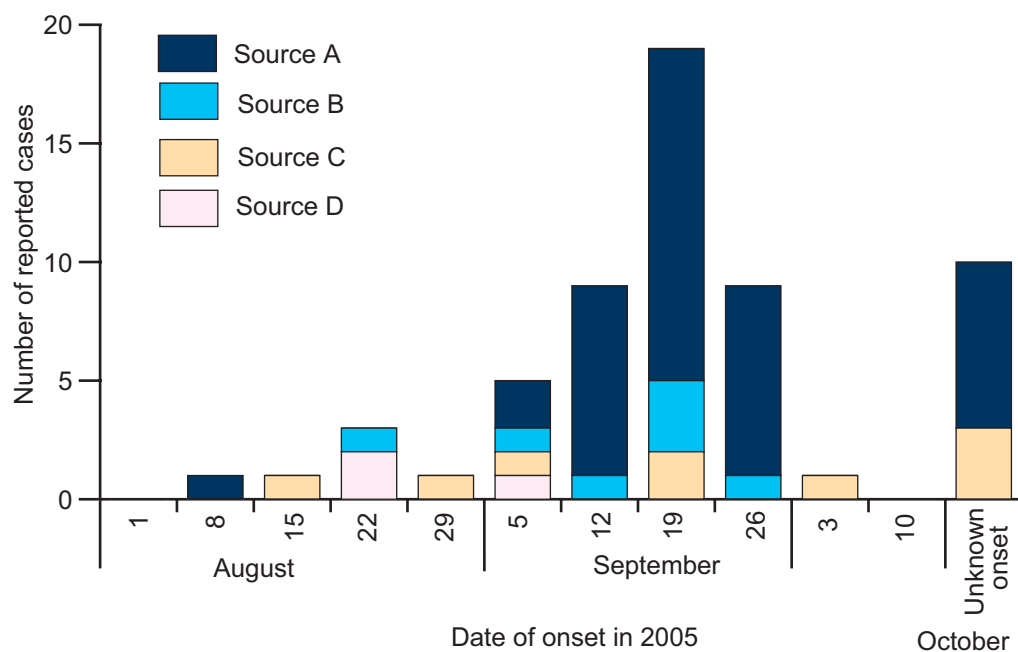
An outbreak of cryptosporidiosis in south east Hampshire

In August 2005, the Health Protection Unit in Portsmouth noted an increase in cases of cryptosporidiosis in South East Hampshire. Seasonal increases have been seen in this area in 1999, 2000, 2001 and 2002 in November and December. In 2002 a case control study showed a statistically significant association between illness and consumption of unboiled tap water. This year, the increase has been earlier in the year and larger than previously observed with 32 cases reported in September 2005, compared with four in September 2004 and one case in September 2003.

Cases were defined as people living in south east Hampshire with onset of diarrhoea after 1 August 2005 and the presence of *Cryptosporidium* oocysts in a faecal sample. Travel related cases and secondary cases were excluded.

By 10 October there were 59 cases that met the case definition. Of these, 40 were resident in an area that received its water supply from a specific surface water source, Source A (figure). Sources B, C, and D are alternative water sources, predominantly groundwater sources, which supply the other areas of south east Hampshire and did not experience the same marked rise in the number of Cryptosporidiosis cases.

Figure 1 Cryptosporidiosis cases by date of onset and water supply zone: 1 August to 11 October 2005



Source A is a water source that has been assessed as being at risk from *Cryptosporidium*. Monitoring by the water company showed oocysts in both the raw and treated water. Levels in treated water were, however, always below the treatment standard of one oocyst per 10 litres of water.

The UK Cryptosporidium Reference Unit confirmed that all isolates were *Cryptosporidium hominis* indicating a human origin. This species was also found in cases linked to the same drinking water supply in previous years

Treated sewage is discharged into the river from which source A water is abstracted and low water levels may have reduced dilution and led to higher oocyst levels in the raw water. Historically, abstraction volumes had been high due to the coincidental loss of an alternative local water source. This may have resulted in breakthrough of oocysts into treated water despite treatment by coagulation and rapid gravity filtration with activated charcoal. Following an outbreak control meeting, and when the monitoring revealed oocysts still present in the treated water, the water company took prompt action to remove source A water from the water supply in order to protect public health and preserve the population's confidence in the water supply.

Cryptosporidiosis has been characterised by spring and autumn peaks in incidence. There has been an general increase in cryptosporidiosis in England and Wales during September and October 2005 with cases increasing in several regions. This mirrors a pattern seen in previous years and has been regarded as a seasonal effect. There is some evidence that the autumn cases are related to travel overseas and swimming, but it is unclear where the main burden of disease lies. There has, however, been some success in reducing the spring peak in disease, intervention in the autumn peak might be similarly successful.

SOPHID 2004 results

A summary report of the 2004 Survey of Prevalent HIV Infections Diagnosed (SOPHID) data for 2004 is published in CDR Weekly this week in the HIV/STIs Infection Report section at <http://www.hpa.org.uk/cdr/pages/hiv_STIs.htm>.

The 2004 data shows that 40,265 people were seen for HIV-related care in England, Wales, and Northern Ireland in 2004 – a 14% increase from 2003 and more than double that seen in 1999. The rate of increase, however, peaked between 2001 and 2002 (20%) and slowed between 2003 and 2004 (14%) to a rate similar to that between 1999 and 2000 (13%).

For the first time since 1998, the increase in the overall number accessing HIV services was less than the previous year. The increase from 2002 to 2003 was 5147 (30,281 to 35,428) compared with a slightly lower increase from 2003 to 2004 of 4837 (35,428 to 40,265).

Endoscope decontamination

The Department of Health has issued a report on decontamination of endoscopes from the Endoscope Task Force in the chief executive bulletin on its website (1).

On 23 June 2004, the Medicines and Healthcare Regulatory Agency (MHRA) issued a medical device alert on flexible and rigid endoscopes (2) which required NHS Trusts to review their endoscope decontamination processes and to report problems identified with decontamination processes. The alert was issued in response to a decontamination incident in Northern Ireland (3). The incident, the failure to decontaminate adequately a flexible gastrointestinal endoscope, led to a look back exercise which did not yield any cases of cross infection. A survey of other units in the Province brought several other instances of inappropriate decontamination to light. An Endoscope Task Force was established to look into the decontamination of flexible endoscopes and make recommendations to the Chief Medical Officer.

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ORION statement on transparent reports of outbreaks and hospital infection studies issued for consultation

The ORION statement (Guidelines for Transparent Reporting of Outbreak Reports and Intervention studies Of Nosocomial infection) on transparent reports of outbreaks and hospital infection studies has been issued for consultation.

The objective of the ORION statement is to raise the standards of research and publication in hospital epidemiology, to facilitate synthesis of evidence and promote transparency of reporting. The guidelines are aimed at researchers, editors, reviewers, and grant assessment panels. They have been produced by the teams that carried out the systematic review of isolation policies in the hospital management of methicillin-resistant *Staphylococcus aureus* (MRSA) for the Health Technology Assessment Board and the Cochrane review of interventions to improve antibiotic prescription practices in hospital patients. The draft statement is issued for national consultation. The consultation will end on 30th November 2005.

The document is available on the website of University College London
<<http://www.ucl.ac.uk/medicalschooll/news/latest/newsitem.shtml?200509300>>.

Enteric

- ▣ General outbreaks of foodborne illness in humans, England and Wales: weeks 36-40/05
- ▣ Salmonella infections, (faecal specimens) England and Wales, reports to the HPA (salmonella data set): August 2005
- ▣ Common gastrointestinal infections, England and Wales, laboratory reports: weeks 36-40/05
- ▣ Less common gastrointestinal infections, England and Wales: laboratory reports, weeks 27-39/05

General outbreaks of foodborne illness in humans, England and Wales: weeks 36-40/05

Preliminary information has been received about the following outbreaks.

Health Protection Unit	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
Leeds	Campylobacter	Restaurant	August	5	4	None	
Leeds	Campylobacter	Café	August	2	2	None	
Bradford	<i>Clostridium Perfringens</i>	Caterer	August	9	3	None	
Leeds	<i>Clostridium Perfringens</i>	Residential Institution	July	24	4	None	
Nottingham	<i>Clostridium Perfringens</i>	Residential Institution	August	6	6	None	
Wales	<i>Escherichia coli</i> O157	Community	Sept	157	97	Cooked meats	D
Essex	<i>Salmonella</i> Enteritidis PT4	Restaurant	Sept	3	3	None	
Suffolk	S. Enteritidis PT4	Café	August	2	2	None	
Thames Valley	S. Enteritidis PT8	Function	Sept	2	2	None	
Thames Valley	S. Typhimurium DT135	Restaurant	Sept	2	2	None	

*Phage type unknown at time of publication.

M (microbiological): identification of an organism of the same type from cases and in the suspect vehicle, or vehicle ingredient(s), or detection of toxin in faeces or food; D (descriptive): other evidence, usually descriptive, reported by local investigators as indicating the suspect vehicle or food; S (statistical): a significant statistical association between consumption of the suspect vehicle(s) and being a case.

Salmonella infections (faecal specimens), England and Wales, reports to the HPA (salmonella data set): August 2005

Details of serotypes of 1440 Salmonella infections recorded in August are given in the table below. In September 2005, 1622 salmonella infections were recorded and preliminary information was received about four outbreaks (see table above).

	August 2005
S. Enteritidis (PT4)	280
S. Enteritidis (other PTs)	688
S. Typhimurium	156
S. Virchow	38
Others (typed)	278
Total Salmonella (provisional data)*	1440

*Figures quoted from the Health Protection Agency salmonella data set are for isolates confirmed and typed by Laboratory of Enteric Pathogens (LEP).

Common gastrointestinal infections, England and Wales, laboratory reports: weeks 36-40/05

Laboratory reports	Number of reports received					Total reports 36-40/05	Cumulative total to	
	36/05	37/05	38/05	39/05	40/05		40/05	40/04
<i>Campylobacter</i>	1001	787	786	619	138	3331	32,163	35,506
<i>Escherichia coli</i> O157*	32	21	19	92	54	218	731	589
<i>Salmonella</i> †	350	402	440	299	361	1852	7903	10,169
<i>Shigella sonnei</i>	14	11	7	10	1	43	626	580
Rotavirus	22	24	13	26	9	94	12,849	13,642
Norovirus	3	11	7	11	1	33	2286	1798
Cryptosporidium	185	152	111	96	25	569	2142	2655
Giardia	56	62	51	37	14	220	1884	2415

*Vero cytotoxin-producing isolates (data from Health Protection Agency's Laboratory of Enteric Pathogens (LEP).

† Data from Health Protection Agency's Laboratory of Enteric Pathogens.

NA= Not available at time of publication.

Less common gastrointestinal infections, England and Wales: laboratory reports, weeks 27-39/04

Laboratory reports	Total reports	Cumulative total to	Cumulative total to
	27-39/05	1-39/05	1-39/04
Astrovirus	2	16	12
Calicivirus	11	119	155
<i>Shigella flexneri</i>	53	216	183
<i>Plesiomonas</i> spp.	18	31	29
<i>Vibrio</i> spp.	8	21	25
<i>Yersinia</i> spp.	5	19	14
<i>Entamoeba histolytica</i>	18	60	104
<i>Blastocystis hominis</i>	70	227	311
<i>Dientamoeba fragilis</i>	25	88	191

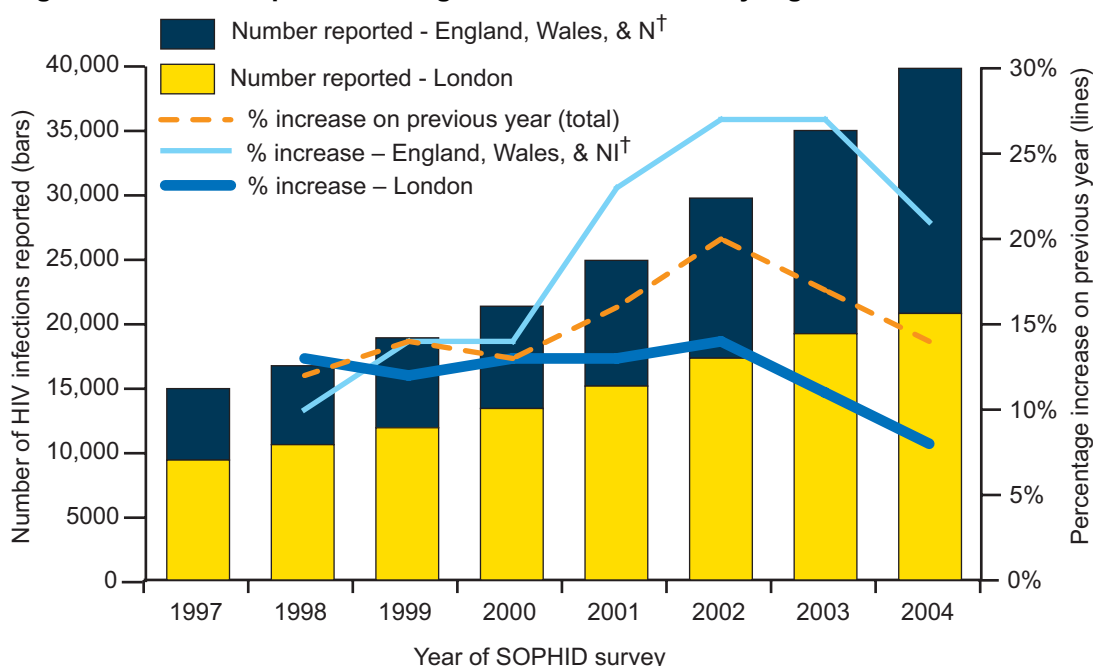
HIV/Sexually Transmitted Infections (STIs)

Prevalence of diagnosed HIV in England, Wales, and Northern Ireland: SOPHID 2004 results
Published 13 October 2005, Volume 15 Number 41

Prevalence of diagnosed HIV in England, Wales, and Northern Ireland: SOPHID 2004 results

The 2004 Survey of Prevalent HIV Infections Diagnosed (SOPHID) shows that there were 40,265 individuals seen for HIV-related care in England, Wales, and Northern Ireland (E, W, & NI) in 2004 – a 14% increase from 2003 and more than double that seen in 1999. However, the rate of increase peaked between 2001 and 2002 (20%) and slowed between 2003 and 2004 (14%) to a rate similar to that between 1999 and 2000 (13%) (figure 1). For the first time since 1998, the increase in the overall number accessing HIV services was less than the previous year. The increase from 2002 to 2003 was 5147 (30,281 to 35,428) compared with a slightly lower increase from 2003 to 2004 of 4837 (35,428 to 40,265).

Figure 1 Increase of prevalent diagnosed HIV infections by region of residence*



*Excludes people with area of residence unknown or outside England and Wales. †NI = Northern Ireland.

SOPHID aims to collect epidemiological information on all HIV-infected individuals accessing HIV services in E, W, & NI within a calendar year. Reports are requested from each treatment site, and collated at the Health Protection Agency Centre for Infections. Reports of infected children collected by the Institute of Child Health are also included. Duplicate reports are removed and each individual is allocated to an area of residence.

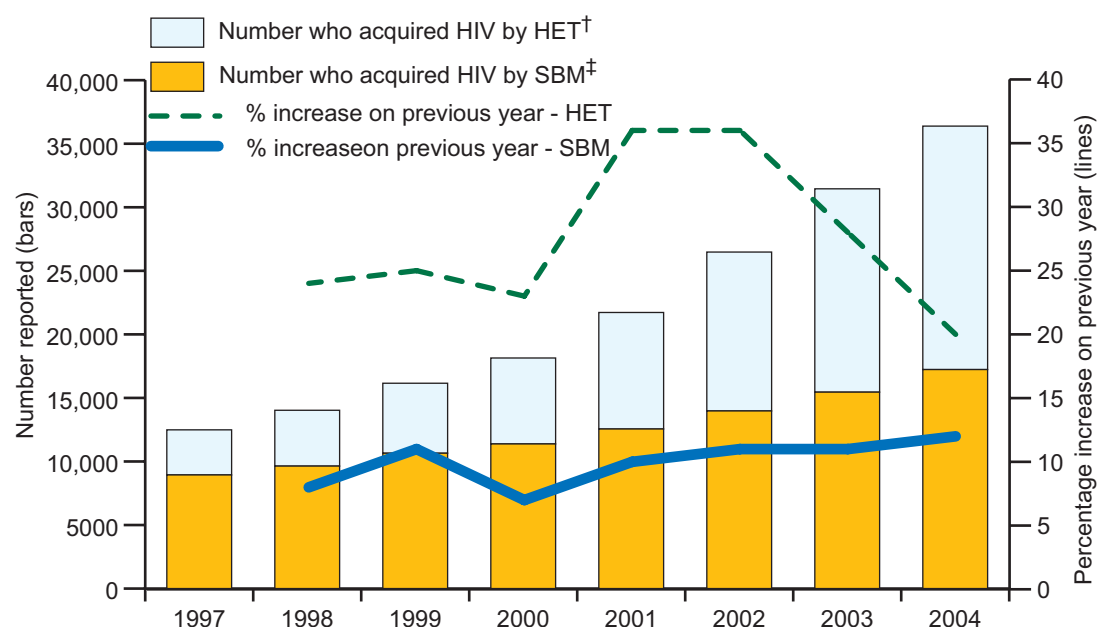
Prevalence of diagnosed HIV infection in 2004 was calculated by dividing the numbers reported to SOPHID by mid-year population estimates (provided by the Office for National Statistics). Overall in E, W, & NI there were 74 people per 100,000 population living with diagnosed HIV. Prevalence was higher in males than females (100/100,000).

versus 48/100,000) and higher in the London region than in the rest of E,W, & NI - excluding London - (278/100,000 versus 40/100,000; this figure ranged in the rest of E, W, & NI from 14/100,000 in NI to 56/100,000 in the South East region). Analysed by sex, age, group, and region, more than one in every 120 men aged between 40 and 54 years in London were living with diagnosed HIV (prevalence of 845/100,000).

Between 1999 and 2004, the proportion of individuals reported to SOPHID who acquired their HIV infection through heterosexual contact increased from 29% (5506) to 48% (19,153), and the proportion of individuals infected through sex between men fell in this period from 56% to 43%, although absolute numbers rose from 10,650 in 1999 to 17,233 in 2004. Correspondingly, black-African individuals increased from 20% to 37% (3902 to 15,008) and white individuals fell from 63% to 51% (12,115 to 20,382). Females now account for 33% (13,436) of all individuals accessing HIV services in 2004. The proportion of adults receiving combination antiretroviral therapy remained stable at around two-thirds.

The number of people seen for care that probably acquired HIV through heterosexual intercourse increased by 20% from 2003 to 2004 compared with an increase of 12% in those who acquired their infection through sex between men. However, this was the lowest rate of increase among heterosexuals and the highest rate of increase among men who have had sex with men (MSM) since 1997 (figure 2). Consequently, there have been more heterosexuals living with diagnosed HIV than MSM since 2003 (together these accounted for 90% of all diagnosed individuals in 2004). Black African people comprised 69% of the heterosexual total in 2004.

Figure 2 Increase of prevalent diagnosed HIV infections by probable route of infection*



*Excludes people with other and unknown probable routes of exposure. †HET= Heterosexual sex. ‡SBM=Sex between men.

London continues to be a focus of the HIV epidemic in the UK, although only half of diagnosed individuals now live in the capital. Although the number of diagnosed individuals continued to increase in London, the rate of increase remained steady at 13% between 1997 and 2002, but then slowed down to 8% in 2004. Since 2000, the rate of increase in the rest of E, W, & NI has been at least 10% higher than in London, but also slowed from 27% in 2002 to 2003 compared with 21% in 2003 to 2004 (range: 15% in the South East to 29% in the West Midlands).

These trends are consistent with increased numbers of new diagnoses, which appear to have levelled-off, and no marked rise in the number of deaths (1). The rise in new diagnoses has been attributed, in particular, to the migration of infected individuals from high prevalence countries (2) (most of whom at the time of migration will be unaware of the fact that they are HIV infected). As shown by the figures above, this effect on the number of prevalent diagnosed infections has been greatest outside London, with consequent impact on services and resources. With a continued focus on HIV testing to reduce the proportion of HIV-infected individuals that are undiagnosed (3), the number of prevalent diagnosed infections may be expected to continue to increase. There is also no sign of a decrease of transmission among MSM in the UK (4) and, therefore, an expectation that the number of prevalent diagnosed infections acquired through sex between men will continue to rise.

Regional and Strategic Health Authority (SHA) level SOPHID tables are available on the HPA website (5). Tables

specific to Regions, SHA, and Primary Care Trusts (PCT) are sent to relevant health professionals locally including SHA and PCT sexual health leads, consultants in communicable disease control (CCDCs), regional epidemiologists, regional directors of public health, SHA directors of public health, as well as colleagues in Wales and Northern Ireland.

For further information contact the Health Protection Agency Centre for Infections, tel: 020 8327 7769; email: <sophid@hpa.org.uk>.

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Diary [The practical management of antibiotic resistance](#)**The practical management of antibiotic resistance**

The Royal Society of Medicine is organising a road show of one-day conferences on the practical management of antibiotic resistance. The conference will give an understanding of the impact of antibiotic prescribing and a clearer understanding of antibiotic prophylaxis resistance in hospitals and in the specialist patient.

Who should attend:

Surgeons, critical care specialists, microbiology lab staff, microbiologists, pharmacists, infections disease specialists. It will be held at four different venues:

- **London** – Tuesday 10 January 2006, The Royal Society of Medicine
- **Manchester** – Thursday 9 February 2006, The Manchester Royal Infirmary Postgraduate Centre
- **Glasgow** – Thursday 23 March 2006, University of Glasgow
- **Cardiff** – Tuesday 25 April 2006, Cardiff University Hall Conference Centre

Topics include:

- The scale of the problem
- Why do bacteria become resistant?
- The medical need for new antibiotics
- The cost of getting it wrong
- New antimicrobials should be kept in reserve
- Targeted use of new antimicrobials saves lives
- Optimal treatment of MRSA
- Treatment of gram negative bacteraemia
- Infection in the compromised patient
- Intelligent prophylaxis in the surgical patient

Reception

For further information please contact: Mr Simon Timmis, Academic Conference Department, Royal Society of Medicine, 1 Wimpole Street, London, W1G 0AE (tel: 020 7290 3844 or email: simon.timmis@rsm.ac.uk).

Or book online at <http://www.rsm.ac.uk/academ/XA-anti.htm>.

National Standards MethodsLast updated: **20 October 2005**Next update due: **6 October 2005**

Standard Method updates – September 2005

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The development of National Standard Methods and Algorithms is undertaken under the auspices of the Health Protection Agency (HPA) in conjunction with the NHS and the National Public Health Service for Wales (NPHSW), and with professional societies including the Association of Medical Microbiologists, Association of Clinical Microbiologists, Institute of Biomedical Science, Clinical Virology Network, and the Scottish Microbiology Association. Over 200 methods are available from the HPA Standards Unit website which covers bacteriology, virology/serology, food, water, and environmental microbiology.

National standard methods are educational and encourage participating laboratories to retain an enquiring attitude. In addition, they are designed to help ensure that laboratories provide a good clinical and public health microbiology service. Evidence of using standard operating procedures is an essential requirement of accreditation schemes. For more information, please contact the HPA Standards unit, email: [<standards@hpa.org.uk>](mailto:standards@hpa.org.uk).

Access to the National Standard Methods website

The National Standard Methods are available in both PDF and Microsoft Word format, available at [<http://www.hpa-standardmethods.org.uk>](http://www.hpa-standardmethods.org.uk). Only the direct PDF file links are available below, and to access a complete list of all available standards including access to the MS Word versions, visit: [<http://www.hpa-standardmethods.org.uk/pdf_sops.asp#Notes>](http://www.hpa-standardmethods.org.uk/pdf_sops.asp#Notes).

Standard Method updates – September 2005**Guidance notes**

- **QSOP 57** *The Microbiological Examination of Water Samples (first issue)*

National Standard Methods - Food

- **F 13** *Detection of *Salmonella* species (re-issue)*

On behalf of the Evaluations and Standards Laboratory and the National Working Groups developing SOPs, algorithms, and guidance note.