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[item published 28 October 2005]

Shooting Up: infections among injecting drug users in the United Kingdom 2004

The Health Protection Agency has published the third edition of *Shooting Up: infections among injecting drug users* (1). Surveillance data from across the United Kingdom (UK) on a range of bacterial and viral infections that can affect injecting drug users (IDUs) have been brought together with the national results for 2004 from the Unlinked Anonymous Prevalence Monitoring Programmes (UAPMP) survey of IDUs in contact with services.

Infections among IDUs in the UK are a continuing public health concern. In addition to the well-recognised problems with hepatitis B and C, there have been outbreaks in recent years of hepatitis A, wound botulism, and tetanus.

A key finding is that the prevalence of HIV infection among IDUs in England and Wales has probably increased in recent years. The prevalence among current IDUs participating in the UAPMP agency survey in England and Wales in 2004 was 1.5% (24 of 1574), the highest level seen among current IDUs in this survey since 1992 when the prevalence was 2.0% (40 of 2005). Although HIV infection among IDUs in the UK as a whole remains low when compared to other countries, the prevalence of HIV among IDUs has remained substantially higher in London (2), where the prevalence among current IDUs in 2004 was 4.4% (16 of 361) compared to 0.7% (8 of 1213) elsewhere in England and Wales.

42% (163 of 2521) of IDUs who took part in the UAPMP survey in England had antibodies to hepatitis C (anti-HCV) and, when combining data for 2003 and 2004, 18% (17 of 97) were anti-HCV positive in Wales and 25% (38 of 153) in Northern Ireland.

One of the aims in the *Hepatitis C Action Plan for England* (3) is to increase the proportion aware of their infection through improved uptake of voluntary confidential testing. It sets a national standard for good practice that all those attending specialist drug treatment services should be offered routine hepatitis C testing. Although most IDUs who took part in the UAPMP survey reported having accepted the offer of a test, in 2004 33% of IDUs (774 of 2351) reported never having had a voluntary confidential test for hepatitis C, compared with 51% (1532 of 2998) in 2000. Of those who were infected with hepatitis C, 49% (461 of 945) were unaware of their infection, compared to 60% (620 of 1032) in 2000. There will, however, be substantial numbers of current and former IDUs who are not in contact with services that will be unaware that they have hepatitis C.

Other data presented in the report indicate:

- That those IDUs reporting injecting crack-cocaine have higher prevalence of both HIV and hepatitis C infection, and report more injecting risk behaviours. The underlying factors for these differences are not, as yet, clear, but they are a cause for concern as crack-cocaine use has become more widespread (4).
- Behavioural data from the UAPMP survey indicates that the proportion of IDUs reporting uptake of the hepatitis B vaccine has increased markedly in recent years, with the prison vaccination programmes being a major factor in this increase.

- There is a continuing problem with the occurrence of wound botulism cases among IDUs, indicating that environmental contamination of heroin with bacterial spores remains a problem (5). There are also continuing problems with injecting site infections associated with methicillin resistant *Staphylococcus aureus* (MRSA) and severe group A streptococcal infection.
- That the increased level of needle and syringe sharing first seen in the late 1990s has continued, with around one in three IDUs reporting this activity in the last month (6). The sharing of other injecting equipment is more common, while few IDUs swab injecting sites prior to injecting.

The report makes a number of important recommendations about commissioning community-based services to reduce the harm associated with problem drug use. It recommends that primary care bodies and Drug Action Teams or local partnerships should give priority to preventing spread of infections among IDUs and reducing the harm these infections cause in line with the aims of the national drug strategies (7,8). This could be achieved through:

A. Continuing the development of high-quality needle-exchange (NEX) services for those unable to stop injecting, by:

1. ensuring sufficient distribution of injecting equipment to prevent the sharing of needles and syringes.
2. providing injecting-related equipment other than needles and syringes as appropriate.
3. ensuring that an appropriate range of NEX services are provided, including provision by drug services, retail pharmacies, and mobile or outreach services.

Trained drug workers and nurses should staff NEX services.

B. . Ensuring NEX, and other services working with IDUs, provide:

1. information and practical advice on safer injecting practices, avoiding injection site infections, prevention of blood-borne virus transmission, and on the safe disposal of used equipment
2. onsite hepatitis B vaccination services, with follow-up strategies for those who have started vaccination courses in line with national service specifications (9)
3. easy access to health checks, treatment for abscesses, and diagnostic tests for hepatitis C and HIV.

C. Developing mechanisms with local providers, to ensure that services that aim to prevent or reduce infections among IDUs, such as NEX, can respond in a timely fashion to evolving patterns of drug use (such as increased crack-cocaine use) and risk.

D. Further improving access to diagnostic testing for hepatitis C – particularly to those who have ceased injecting – in line with strategies such as the *Hepatitis C Action Plan for England* and the proposed hepatitis C Action Plan for Scotland.

E. Developing procedures for offering tetanus vaccine and boosters to those IDUs who may need them and offering hepatitis A vaccination where this is appropriate (10).

F. Promoting a range of easily accessible drug treatment and support services that encourage drug users to reduce and cease injecting, and reduce or stop their drug use.

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H5N1 diagnosed in UK quarantined birds

Avian influenza (H5N1) has been identified in imported birds, which died on 16 October. The birds were imported from Surinam and Taiwan in September, and housed together in a quarantine facility. The virus strain identified is similar to strains found in ducks from China. The Health Protection Agency was contacted about the positive result on the 21 October, and a multi-agency incident control team was established to undertake a comprehensive risk assessment. All the quarantined birds in the facility were humanely culled on the same day.

The longest known incubation for avian influenza in humans is reported to be ten days. Individuals in contact with infected birds within ten days of the avian flu virus being diagnosed were identified and offered Oseltamivir prophylaxis and seasonal influenza vaccination. In addition, it was agreed that staff who had been in contact with infected birds outside the incubation period, such as during transportation of the birds, would be identified, and would be offered serological investigation if they had reported signs of an influenza-like-illness.

Ten individuals have been offered Oseltamivir prophylaxis and seasonal flu vaccination. Tracing of other contacts outside of the incubation period continues.

Health Protection Agency's new Pandemic Influenza Office

The Health Protection Agency (HPA) is currently coordinating many different activities that together contribute towards UK influenza pandemic preparedness. To help coordinate all these activities, the Agency has formed a Pandemic Influenza Office, based at the Centre for Infections (Cfi), Colindale, London. A pandemic influenza scientific coordinator has recently been appointed and some consultant epidemiologist time is associated with the new office. The Office can be contacted by email (pandemic.flu@hpa.org.uk). Depending on the nature of queries, we may either respond to you directly via email, direct you to relevant guidance on the HPA website, or incorporate your query into the 'Frequently Asked Questions' section of the Agency's website

The HPA has well established links with the World Health Organization (WHO) over pandemic influenza contingency planning. HPA experts from Cfi have contributed to the development of new phases incorporated in the recently revised WHO Pandemic Influenza Plan. The Agency has already developed strong links with the newly established European Centre for Disease Control (ECDC).

Further Information

HPA website pages for pandemic influenza will be developed shortly, in the meantime information can currently be accessed from the HPA website at:

Avian influenza : <http://www.hpa.org.uk/infections/topics_az/avianinfluenza/menu.htm>.

Seasonal influenza: <http://www.hpa.org.uk/infections/topics_az/influenza/flu.htm>.

The Department of Health website also provides information on pandemic influenza, which is available at: <<http://www.dh.gov.uk/PolicyAndGuidance/EmergencyPlanning/PandemicFlu/fs/en>>.

Revised Department of Health Pandemic influenza plan published

The revised Department of Health (DH) pandemic plan containing new World Health Organization (WHO) phases and health impact projections was launched on 19 October 2005 (1). The Health Protection Agency (HPA) plan is being updated with this new information (to coincide with the DH plan) and a substantial re-write will take place before the end of 2005 incorporating more points that have arisen in the past twelve months. Additionally, Cfi staff have been collaborating with others to produce infection control guidance and medical treatment guidance for pandemic influenza; these will be released shortly by the DH.

H5 strain influenza virus diagnostic testing capability is being rolled-out to regional HPA laboratories following a specialist training course for Local and Regional Services (LARS) laboratory colleagues held in June 2005 by Prof Maria Zambon (Cfi WHO National Influenza Laboratory). An external quality assessment of this process will begin in October 2005. Research and development activities involving the HPA and national and international collaborators for pandemic vaccine development are ongoing.

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The first year of the Department of Health's mandatory surveillance of surgical site infection in orthopaedic surgery

[Item published 28 October 2005]

The surveillance of surgical site infections (SSI) in orthopaedic surgery was made mandatory in England from 1 April 2004 (1). This is one of the developments referred to in the Chief Medical Officer's strategy to combat infectious diseases, *Getting ahead of the Curve* (1).

A report of the first year of mandatory surveillance has been published on the Health Protection Agency's website at <http://www.hpa.org.uk/infections/topics_az/hai/SSI_mandatory_0405report.pdf>.

This report contains data on the incidence of surgical site infection (SSI) by risk groups, causative micro-organisms and distribution of rates by Trust. The rates of SSI by individual NHS Trusts have been published on the Department of Health's website at <<http://www.dh.gov.uk/hcai>>.

The key points of the report:

- Data on 41, 242 procedures has been collected by 146 Trusts in this first year of mandatory surveillance of surgical site infection
- Most Trusts have undertaken surveillance in the hip and knee replacement categories of procedure, and a quarter of Trusts collected data throughout the whole year
- The average number of procedures per Trust per quarter varies between 50 and 100 depending on the category of procedures
- In most Trusts the rates of SSI in orthopaedic surgery are low
- The rates of SSI increase with the number of risk factors present in the patient
- Rates of SSI are higher in hip hemiarthroplasty. This is partly explained by patients undergoing these procedures being at greater risk of infection and because they tend to have a longer post-operative stay in hospital, increasing the chance that SSIs will be detected
- Most of the SSIs reported affected the superficial layers of the wound, but approximately a quarter involved the deeper tissues
- *Staphylococcus aureus* is recognised as a major cause of SSI and was responsible for half of the infections. Nearly a third of SSI were due to methicillin resistant *S. aureus* (MRSA).

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Immunisation

Laboratory reports of invasive meningococcal infections, England and Wales: weeks 26 to 30

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Laboratory Reports of Haemophilus influenzae by age group and serotype, England and Wales: April to June 2005 (2004)

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Laboratory reports of invasive meningococcal infections, England and Wales: weeks 26 to 30

	Method of diagnosis			Total reports	Cumulative*
	CSF and blood Culture	Non-culture	Other sites	26-30/05	Total to week 30/2005
Group A	–	–	–	–	1
B	38	44	5	87	865
C	–	2	–	2	22
W135	4	2	–	6	19
X	–	–	–	–	–
Y	1	–	–	1	30
Z	–	–	–	–	–
29E	–	–	–	–	1
Ungroupable	–	–	–	–	–
Ungrouped	–	1	–	1	39
Total	43	49	5	97	977

*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: April to June 2005 (2004)

Serotype	Age					Total
	<1 year	1-5 years	5-14 years	≥15 years	Not known	
b	4(4)	9(3)	6(5)	18(20)	–(–)	37(32)
nc	6(8)	13(3)	4(1)	61(27)	8(4)	92(43)
a,e,f	–(1)	1(2)	–(2)	6(5)	–(–)	7(10)
not typed	4(3)	2(2)	1(1)	24(11)	–(–)	31(17)
Total	14(16))	25(10))	11(9))	109(63)	8(4)	167(102)

HIV/Sexually Transmitted Infections (STIs)

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

United Kingdom (UK) data from the Health Protection Agency Centre for Infections, Health Protection Scotland, and the Institute of Child Health (London).

Seven thousand two hundred and seventy-five HIV diagnoses have now been reported for 2004, and a further 3894 for the first three quarters of 2005. These numbers are expected to rise as further reports are received. They bring the cumulative total of HIV diagnoses in the United Kingdom (UK) to 74,977 since surveillance began in 1982. To date, 21,732 individuals have been diagnosed with AIDS, of which 13,282 (61%) have died. A further 3316 individuals have died without having had a report of an AIDS-defining condition.

As mentioned, surveillance of HIV is subject to reporting delay. By the end of September in any year however, it is estimated that over 95% of diagnoses for the previous year will have been received, and so in this HIV/AIDS update we present near-complete figures for 2004.

Route of infection

Table 1 describes new diagnoses of HIV infection over time by probable route of infection. Of the 7275 HIV diagnoses reported for 2004, 30% (2185) were infections acquired through sex between men, while 59% (4287) had been acquired through sex between men and women. Almost two-thirds (2720) of the latter were women. This may be partly due to the fact that women are more likely to be tested routinely, for instance during antenatal or pre-fertility treatment screening. The number of diagnoses among injecting drug users remained low with 128 reported. Investigations are still ongoing to establish the route of infection for 7% (521) of diagnoses reported for 2004.

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

How infection was probably acquired	Sex	1995 and earlier	1996	1997	1998	1999	2000	2001	2002	2003*	2004*	Jan to Sep 2005*	Total
Sex between men	M	18,911	1556	1412	1366	1370	1507	1759	1879	2007	2185	1197	35,149
Sex between men and women	M	2524	358	454	521	603	759	1072	1378	1580	1567	730	11,546
	F	2934	480	562	642	842	1255	1819	2393	2894	2720	1263	17,804
Injecting drug use	M	2086	120	123	96	79	72	96	88	98	100	61	3019
	F	962	54	48	35	34	41	36	27	46	28	14	1325
Blood transfusion or blood factor products	M	1437	10	16	4	11	10	14	14	15	10	3	1544
	F	134	11	13	6	11	15	11	20	17	12	4	254
Mother to infant	M	182	29	50	48	35	58	55	55	77	56	29	674
	F	184	33	33	52	42	46	46	64	64	70	19	653

Other	M	13	2	1	2	6	3	8	2	3	1	1	42
	F	15	1	–	2	2	3	1	4	2	4	1	35
Undetermined	M	489	26	23	22	22	23	24	21	23	15	3	691
	F	56	6	6	9	4	5	4	8	5	2	–	105
Follow-up ongoing	M	114	16	12	20	24	31	62	132	227	293	305	1236
	F	30	2	7	7	11	23	35	110	159	211	264	859
Total†		30,071	2704	2760	2832	3096	3851	5042	6195	7217	7274	3894	74,936

* Numbers will rise as further reports are received.

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

Diagnoses of infections acquired through sex between men and women began to exceed those of infections acquired through sex between men in 1999. Men having sex with men (MSM) remain the group most at risk of acquiring HIV within the UK and there is evidence of continuing HIV transmission. Numbers of HIV diagnoses among MSM continued to increase in 2004, reaching 2185. This is likely to be the result of increase HIV testing, continued HIV transmission and better reporting in some areas. Probable country of infection was reported for nearly half of diagnoses among MSM (1043). Of these, 83% (865) were infected in the UK.

Table 2 provides more detailed information about infections thought to have been acquired through sex between men and women. Eighty-two per cent (3515/4287) were probably infected abroad. Of this group, 89% (3136/3515) were infected in Africa, mainly in south eastern Africa. Eleven per cent (466/4287) of all heterosexually infected patients had probably been infected in the UK. Two-thirds, (309/466) had partners who had probably been infected outside Europe, predominantly in Africa.

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

How HIV infection was probably acquired	1996	1997	1998	1999	2000	2001	2002	2003	2004*	2005*	Total
Exposure to 'high risk' partner(s)											
Sexual intercourse between men	11	12	12	12	13	27	29	17	18	5	335
Injecting drug use	44	62	58	34	27	44	30	33	23	11	795
Blood factor treatment (eg, for haemophilia)	8	1	1	1	2	–	2	8	–	–	96
Blood/tissue transfer (eg, transfusion)	3	5	3	3	1	4	3	0	1	1	40
Exposure to presumed heterosexually infected partner(s):											
Exposure abroad:											
Africa	552	646	756	1005	1513	2243	2952	3457	3136	1292	21,100
Latin America/Caribbean	24	30	32	66	69	93	143	157	128	33	900
Asia	44	52	78	76	111	101	121	141	162	65	1103
North America	8	11	14	7	8	9	6	7	4	8	171
Europe	42	47	43	51	43	47	66	83	82	36	782
Australasia	1	2	4	7	2	5	3	5	0	2	41

Country(ies) not known	9	3	15	0	2	1	1	1	3	2	68
Exposure in the UK to partner(s) presumed infected											
Outside Europe	45	79	86	96	140	185	236	300	309	116	1800
Within Europe	36	52	46	58	56	65	47	72	64	56	832
Country(ies) not known	7	4	6	9	7	18	39	48	93	93	372
Partner(s) exposure category undetermined:											
Investigation continuing	0	2	7	16	15	47	87	142	258	270	847
Investigation closed	4	8	3	5	5	2	6	3	6	3	75
Total	838	1016	1164	1446	2014	2891	3771	4474	4287	1993	29,357

* Numbers will rise as further reports are received.

Region of infection

The epidemic continues to be geographically concentrated, with London and the South East accounting for 55% (3969) of all diagnoses reported for 2004. This proportion has been declining since 2001. Differences in the pattern of diagnoses are seen between regions. The North West region has historically had the highest proportion of newly diagnosed individuals infected through sex between men (46%, 272/593), although this year, Northern Ireland had a higher proportion: 54% (34/63). The East of England region reported the highest proportion infected through sex between men and women (78%, 442/567). These differences reflect the resident populations of these areas.

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

Country and region of diagnosis	1995 or earlier	1996	1997	1998	1999	2000	2001	2002	2003*	2004*	2005*	Total
England												
North East	440	24	35	22	30	37	56	99	148	139	78	1108
Yorkshire & Humber	949	90	84	84	91	103	182	309	436	455	235	3018
East Midlands	601	49	46	62	90	103	198	256	330	360	224	2319
East of England	769	57	75	88	97	186	316	487	545	567	250	3437
London	18,324	1706	1739	1768	1958	2333	2782	2991	3269	3121	1825	41,816
South East	2422	226	212	206	219	363	497	709	862	848	445	7009
South West	988	79	92	104	105	104	136	180	206	223	136	2353
West Midlands	952	63	101	112	104	178	215	423	495	483	257	3383
North West	1745	189	149	189	208	239	419	429	536	593	102	4798
England (total)	27,190	2,483	2,533	2,635	2,902	3,646	4,801	5,883	6,827	6,789	3,552	69,241
Wales	458	36	46	30	34	46	64	78	109	104	71	1076
Northern Ireland	146	16	9	9	14	19	20	27	32	63	29	384
Scotland	2272	163	165	153	147	139	153	200	245	315	239	4191
UK Total	30,066	2,698	2,753	2,827	3,097	3,850	5,038	6,188	7,213	7,271	3,891	74,892
Channel Isles / Isle of Man	40	6	8	6	1	1	5	7	4	4	3	85

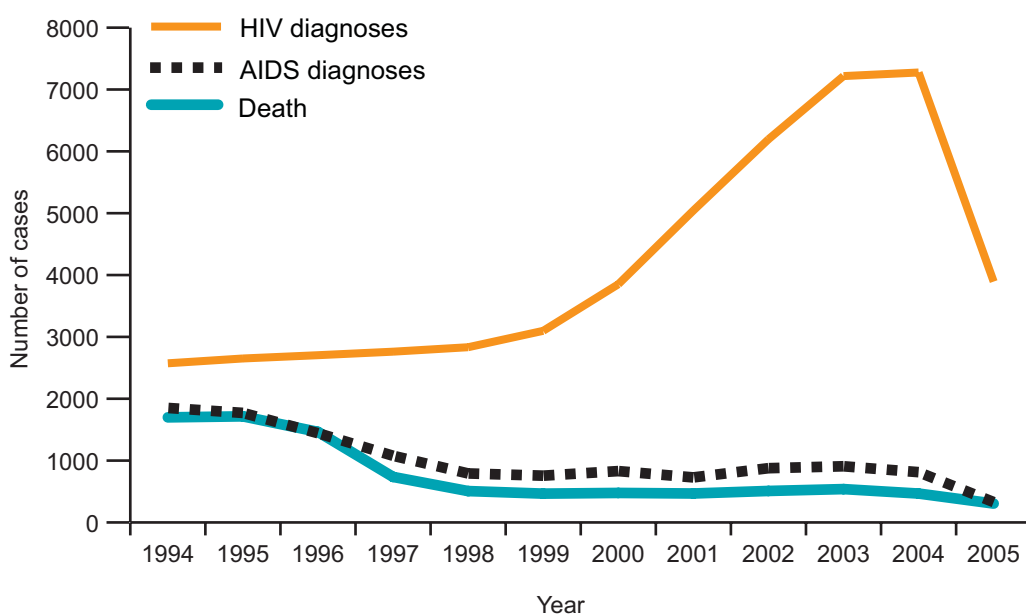
UK total HIV diagnoses	30,106	2,704	2,761	2,833	3,098	3,851	5,043	6,195	7,217	7,275	3,894	74,977
UK total AIDS diagnoses	13,178	1443	1078	792	756	830	728	877	908	813	329	21,732
UK total deaths†	10,416	1464	736	507	466	477	468	509	539	467	305	16,354

*Numbers will rise as further reports are received.

†Total includes 244 deaths where year of death is not known (including all deaths in children).

The number of AIDS cases and HIV-related deaths declined after the introduction of HAART (Highly Active Anti-Retroviral Therapy) in the mid-1990s (figure). The efficacy of treatment has led to a fall in the number of patients who develop AIDS-defining conditions. It has also improved outcomes for those who develop such conditions. The traditional paradigm where individuals move from HIV to AIDS to death has changed since the introduction of HAART, as people may have their AIDS defining illnesses successfully treated. Physicians may no longer consider it as meaningful to define patients in terms of their disease stage, and consequently may be less likely to report an AIDS diagnosis. AIDS defining illnesses are more likely to be reported if the HIV and AIDS diagnosis are simultaneous. Of 813 AIDS diagnoses reported for 2004, 89% (722) 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 of National Statistics in England and Wales, and the General Register Office in Scotland. Reporting of deaths is subject to reporting delay. So far for 2004, deaths have been reported for 467, of which 223 (48%) had been reported with AIDS.

Figure: HIV diagnoses and deaths in HIV infected individuals, UK reports to end of September 2005*



*Numbers, particularly for recent years, will rise as further reports are received.