



CDR WEEKLY

the Communicable Disease Report Weekly

Current Issue: Volume 16 Number 24 **Published on:** 15 June 2006

NEWS STORIES:

- ▾ Lymphogranuloma venereum in the United Kingdom: an update
- ▾ Baseline study on the prevalence of Salmonella spp in laying hen flocks in the European Union
- ▾ Outbreak associated with wedding in Birmingham

CDR S SUBSCRIPTION:

To subscribe to CDR Weekly, email us at: cdr@hpa.org.uk

News

Last updated: 15 June 2006 Volume 16, No.24 Next update: 22 June 2006

▣ [Lymphogranuloma venereum in the United Kingdom: an update](#)

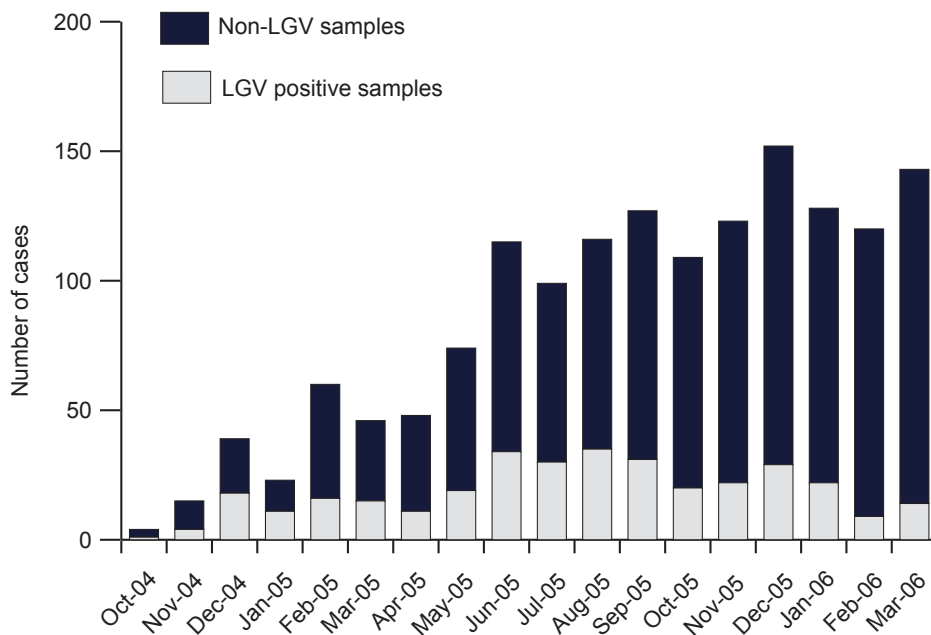
▣ [Baseline study on the prevalence of *Salmonella* spp in laying hen flocks in the European Union](#)

▣ [Outbreak associated with wedding in Birmingham](#)

▣ [Lymphogranuloma venereum in the United Kingdom: an update](#)

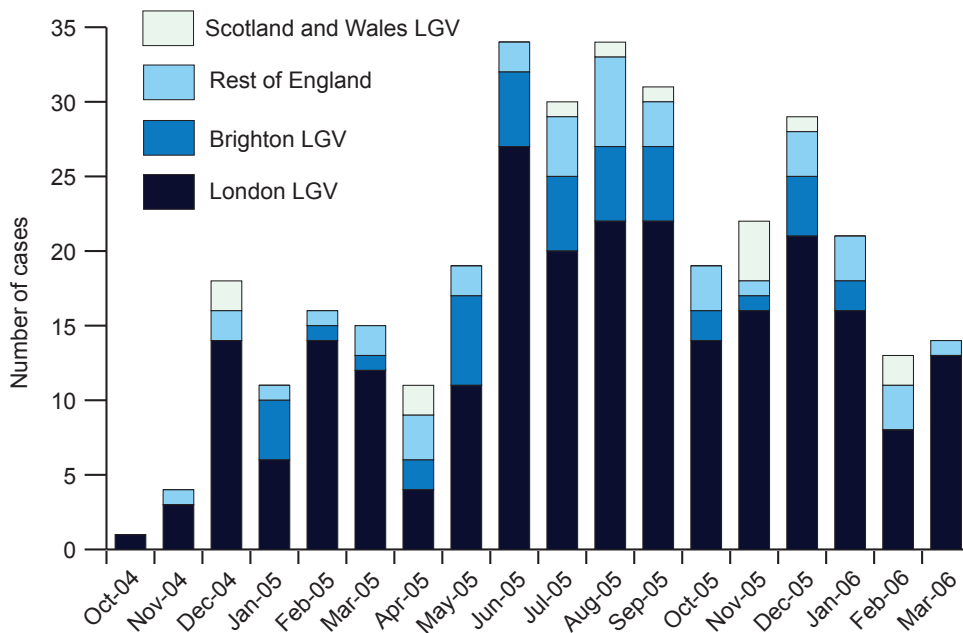
Between 4 October 2004 and 31 March 2006, the HPA Sexually Transmitted Bacterial Reference Laboratory (STBRL) confirmed 344 cases of lymphogranuloma venereum (LGV) (all serovar L2), out of 1541 specimens received for LGV diagnostic testing during this period. Chlamydia was not confirmed in 267 specimens, and 87 incorrect samples were not tested. Of the remainder, 101 could not be classified, and 742 were confirmed as other chlamydial serovars (D to K) (figure 1). Of the 344 LGV positive cases, enhanced surveillance forms were received for 316 cases, 313 from men who have sex with men (MSM) and three from heterosexual men.

Figure 1 Samples tested for LGV , UK : 2004 to 2006



The characteristics of the outbreak are very similar to those described in other European cities. After the initial case report from Rotterdam in 2003, increased diagnoses of LGV emerged in the UK in 2004, which rapidly became the largest outbreak identified in Europe [1]. In 2004, there was an initial connection with the outbreak in the Netherlands. Since then cases have been associated with infection acquired within the UK, and the majority have been seen in London (69%) and Brighton (14%) [2] (figure 2). Cases were predominantly of white ethnicity (299, 95%) with a median age of 38 years (range 21 years to 66 years). Eighty-five per cent (263/311) of the cases presented because of symptoms, 5% (16) as contacts, 10 (3%) through referral, and 12 (4%) were detected during routine examination and for sexually transmitted infections (STIs) or HIV screening. The majority (280, 89%) had proctitis; and 23% had multiple local and systemic symptoms.

Figure 2 Laboratory confirmed cases of LGV, UK : 2004 to 2006



Co-infection with HIV was seen in 74% (233/316) of cases, including ten in which HIV had been diagnosed at about the same time as the LGV. Infection with hepatitis C (PCR) was seen in 11% of MSM, and concurrent infection with another STI was documented in 43% of cases, including gonorrhoea (61), syphilis (16), other chlamydial infection (21), hepatitis B (1), and genital herpes (6).

One hundred and twenty (38%) MSM reported meeting new sexual partners at sex on premises venues or sex parties, 28 (9%) via the Internet. Thirty per cent of MSM reported ten or more sexual partners within the previous three months. The majority of men (73%; 168/229) reported unprotected anal sex. Fisting and the use of sex toys were also reported.

It is unclear how long the present outbreak has affected MSM, the extent of the current epidemic, and the number of asymptomatic cases. Surveillance data on LGV diagnoses from UK genitourinary medicine clinics are poor and it is not possible to assess the frequency of diagnosis prior to 2004. Nevertheless, even though the clinical management of rectal symptoms in MSM has not changed over recent years, clinics that historically have seen a high proportion of MSM have experienced substantial increases in MSM presenting with symptoms of LGV. The doubling of cases over a short period of time within a confined geographic location, reaching a peak and plateau, also indicate that this is not an artefact of diagnostic and surveillance activity.

LGV background epidemiology

Lymphogranuloma venereum (LGV) is caused by *Chlamydia trachomatis* serovars L1, L2, L3 [3]. Since 2003, the epidemiology of LGV has changed from being a persistent infection with a small number of sporadic, imported infections to an invasive infection with a significant burden among HIV positive MSM.

LGV infection is associated with complex, severe symptoms that many patients have experienced over several months. There is, however, a general lack of understanding of the natural history of rectal LGV and other *C. trachomatis* serovars in MSM, particularly in the presence of HIV.

Over the past two years, LGV has emerged as a significant public health problem. The burden of this once rare STI falls on MSM particularly those living with HIV. LGV may be contributing to the HIV epidemic by facilitating transmission. Further control efforts are required, including awareness campaigns, continued detailed surveillance, and expanded chlamydia testing in MSM.

Infection control

Clinicians are advised to undertake a chlamydial test on any man reporting sex with other men who had any signs of inguinal syndrome or proctitis. If chlamydia was confirmed in the local laboratory using a standard test, the sample can be forwarded to the STBRL for confirmation of *C. trachomatis*, and if positive it can be genotyped to determine if it was an LGV associated serovar.

The establishment of laboratory diagnostic and reference facilities has been central to the outbreak response. In the absence of a commercially available nucleic acid amplification test (NAAT) for LGV associated serovars of *C. trachomatis*, the STBRL developed a reference facility based on the following case definition: a confirmed infection with *C. trachomatis*, and the presence of an LGV serovar (L1, L2 or L3) by genotyping. The STBRL is testing rectal specimens from patients with: anorectal symptoms (typically proctitis and rectal discharge), or urethral specimens from patients with inguinal lymphadenopathy who were known to be positive to *C. trachomatis*. All the molecular confirmatory tests used at STBRL are being validated.

For further details please contact either Professor Cathy Ison, email: <catherine.ison@hpa.org.uk> or Ian Simms, email: <ian.simms@hpa.org.uk>.

References

- 1 Nieuwenhuis RF, Ossewaarde JM, van der Meijden WI, Neumann HA. Unusual presentation of early lymphogranuloma venereum in an HIV-1 infected patient: effective treatment with 1g azithromycin. *Sex Transm Infect* 2003; **79**:453-5.
- 2 Health Protection Agency. Lymphogranuloma Venereum (LGV) in men who have sex with men (MSM) in the UK: an update. *Commun Dis Rep CDR Wkly* [serial online] 6 October 2005 [cited 14 June 2006] **15**(40): news. Available at: <<http://www.hpa.org.uk/cdr/archives/2005/cdr4005.pdf>>.
- 3 Mabey D, Peeling. Lymphogranuloma venereum. *Sex Transm Infect* 2002; **78**: 90-2.

Baseline study on the prevalence of *Salmonella* spp in laying hen flocks in the European Union

A preliminary report published by the European Food Safety Authority (EFSA) gives *Salmonella* levels in layer flock holdings across the European Union [1]. Tests on dust and other material found in poultry houses, as well as bird faeces, indicates the levels of *Salmonella* spp on the holding and is to be used as a base line for initiatives to reduce the levels of salmonella in layer flocks in Europe. In the UK, measures put in place by industry to reduce salmonella seem to have been very effective. For the United Kingdom (UK) the survey was carried out in 454 farms. Only 12 per cent showed evidence of any contamination.

Information submitted by the UK showed that the observed holding prevalence for *Salmonella* spp was an estimated 11.9 per cent. The most common serovar, *S. Enteritidis*, had a prevalence of 6.3 per cent and the most common phage type of SE was phage type 4. Human infections caused by this phage type have been falling progressively in the UK over the last five years. The second most common serovar was *S. Typhimurium* (ST) at 1.8 per cent. Holdings having flocks vaccinated for *Salmonella* were less likely to be positive for *S. Enteritidis* and *S. Typhimurium* in the preliminary analysis of the UK results; further work is being carried out on this aspect.

Across the European Union (EU) as a whole, 30.7% (95% CI=29.6-31.8) of farms showed evidence of contamination. The range was from a minimum of 0% (in Luxembourg, and Sweden) to a maximum of 79.5% (Portugal).

Salmonella contamination was more likely to be identified on holdings with larger numbers of laying birds than those with fewer birds, although this might reflect the sampling method. No isolates from UK flocks were resistant to ciprofloxacin or cephalosporins, which are the most likely to be used for severe salmonella infections in humans.

All EU member states were required to carry out surveys - the first to be carried out across Europe. The aims were to determine the prevalence of salmonella in the environment on commercial layer flock holdings and will form a baseline against which future surveys will be compared. The full report is scheduled to be published in October 2006.

References

1. Preliminary report on the analysis of the baseline study on the prevalence of *Salmonella* in laying hen flocks of *Gallus gallus*. The EFSA Journal 2006; 81: 1-71. Available at <http://www.efsa.eu.int/science/monitoring_zoonoses/reports/1541_en.html>.

Outbreak associated with wedding in Birmingham

An outbreak of gastro-intestinal (GI) illness occurred among guests who attended an Asian wedding in Birmingham on Sunday 28 May 2006. About 90 cases of diarrhoea occurred among the 250 to 300 guests, although it was not possible to obtain a full guest list. Guests were mainly from Birmingham and Kidderminster (Worcestershire).

Onset of illness was within 12 hours of consuming a meal consisting of lamb jalfrezi, chicken curry, roast chicken, lentil dhal, rice, salad (lettuce and tomatoes) and rasmalai (Asian sweets). Symptoms were mild, lasted less than 24 hours, and included diarrhoea and abdominal pain. Most had therefore recovered when Environmental Health (Wyre Forest District Council) were alerted on the Tuesday following the Bank Holiday. A stool sample was

obtained from one individual who was still symptomatic. Microbiological examination of the specimen included testing for *Clostridium perfringens*, but results were negative.

A satisfactory standard of food safety was found on inspection of the Sandwell caterer who supplied the main course. Records also show that the food was maintained at an adequate temperature until it was served. The rasmalai, a milk based sweet, was, however, collected from a Birmingham food supplier more than 24 hours before being served.

A second social event associated with the wedding and attended mainly by the same guests occurred in Kidderminster on Wednesday 31 May. Wyre Forest Environmental Health Officers (EHOs) were also in attendance and no known GI illness resulted from this second event. A different caterer, from Birmingham, was, however, used. Birmingham EHOs uncovered very poor food hygiene standards on inspection, resulting in closure of the food premises and prosecution of the caterer.