



# CDR WEEKLY

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- Hepatitis A cases in a travelling community in southeast England
- Laboratory confirmed case of toxigenic *Vibrio cholerae* O1 Inaba biotype El Tor in a Spanish national returning to Spain from India
- The Gonococcal Resistance to Antimicrobials Surveillance Programme – publication of annual report for 2005

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# News

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## Confirmed case of bat rabies in Oxfordshire

A routine test carried out on a female Daubenton's bat (*Myotis daubentonii*) submitted to the Veterinary Laboratories Agency (VLA) in Weybridge, Surrey, has confirmed the presence of European Bat Lyssavirus type 2 (EBLV-2) ('bat rabies').

The bat was found by members of the public on a path by the river Thames close to Abingdon Lock in Abingdon, Oxfordshire, on 12 September. It was cared for by the finders for a short time and was then taken into the care of experienced bat conservation group volunteers. The bat is believed to have died on 15 September and was sent to the VLA for routine testing. Although preliminary tests were negative, the definitive test [mouse inoculation], which takes longer to complete, produced a positive result. The people who are known to have cared for and handled the bat are receiving appropriate prophylactic medical treatment as a precautionary measure – the risk to their health is extremely small. A press statement was issued jointly by the Health Protection Agency and the Department for Environment, Food, and Rural Affairs (Defra) on 10 October [1].

In the UK there have only been four previous cases of active infection in bats, specifically in Daubenton's bats. The first was found in Newhaven, Sussex, in 1996, with subsequent cases in Lancashire in 2002 and 2003, and Surrey in 2004 [2-4]. All tested positive for EBLV-2. In addition, a bat worker in Scotland, thought to have been bitten by a bat approximately six months previously, died in November 2002 from an EBLV-2 infection [5].

The risk of infection with EBLV to the general public and domestic animals is thought to be minimal. All bats are protected species by law and should not be disturbed. Anyone finding a sick or ailing bat should not approach or handle it but seek advice from a local bat conservation group or the Bat Conservation Trust Helpline on 0845 130 0228 (or in Scotland, the Scottish SPCA on 0870 7377722). Everyone licensed to handle bats or who regularly handle bats in Great Britain should ensure that they have up to date rabies vaccination and should always wear protective gloves when handling bats. If any person is bitten by a bat, the wound should be immediately and thoroughly cleaned with soap and water. Additional cleansing of the wound site with an alcohol base or other disinfectant is also recommended and immediate medical advice must be sought. Further information on EBLV can be found on the HPA website at <[http://www.hpa.org.uk/infections/topics\\_az/rabies/ebl.htm](http://www.hpa.org.uk/infections/topics_az/rabies/ebl.htm)>.

## References

1. Confirmed case of bat rabies in Oxfordshire (Press release). London: Defra/HPA, 10 October 2006. Available at <[http://www.hpa.org.uk/hpa/news/articles/press\\_releases/2006/061010\\_bat\\_rabies.htm](http://www.hpa.org.uk/hpa/news/articles/press_releases/2006/061010_bat_rabies.htm)>.
2. CDSC. Bat brings rabies to Britain. *Commun Dis Rep CDR Wkly*, **6**(24): 205. Available at <<http://www.hpa.org.uk/cdr/archives/1996/cdr2496.pdf>>.
3. PHLS. A case of bat rabies in Lancashire. *Commun Dis Rep CDR Wkly*, **12**(40): news. Available at <<http://www.hpa.org.uk/cdr/archives/2002/cdr4002.pdf>>.
4. HPA. Bat infected with a rabies-like virus identified in the south-east of England. *Commun Dis Rep CDR Wkly*, **14**(40): news. Available at <<http://www.hpa.org.uk/cdr/archives/2004/cdr4004.pdf>>.
5. HPA. Fatal infection with European bat lyssavirus rabies-related virus in Scotland. *Commun Dis Rep CDR Wkly*, **12**(48): news. Available at <<http://www.hpa.org.uk/cdr/archives/2002/cdr4802.pdf>>.

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### Laboratory confirmed case of toxigenic *Vibrio cholerae* O1 Inaba biotype El Tor in tourists returning to Spain from India

A case of toxigenic *Vibrio cholerae* O1 Inaba biotype El Tor has been confirmed in a Spanish national returning home to Spain from India via London Heathrow airport. The woman developed severe vomiting and diarrhoea during her flight from Delhi to London and could not complete her ongoing flight to Barcelona due to her illness. On arrival in London on 1 October, she was taken off the plane and was admitted to the intensive care unit of the local acute district general hospital with profuse diarrhoea and vomiting. The patient had rice water stools and copious fluid loss, and required intravenous fluid replacement.

*V. cholerae* was isolated from her faeces on 4 October. This isolate was sent for confirmation and typing to the Laboratory of Enteric Pathogens (LEP) at the HPA Centre for Infections on 4 October and was reported to the source laboratory as a toxigenic *V. cholerae* O1 Inaba biotype El Tor on 9 October 2006.

A family member of the index case remained with her in London and developed diarrhoea on 5 October but did not require hospitalisation. *V. cholerae* O1 Inaba biotype El Tor was isolated from faeces and was sent for confirmation on 9 October 2006. Both cases have now recovered and have returned to Spain.

Both cases were part of a group of more than 100 tourists who had toured the 'Golden Triangle' in India (Delhi, Agra, and Jaipur) for one week, as part of a holiday package, and stayed in good quality hotels. It is unusual for tourists staying in such hotels to develop such serious cholera symptoms. The HPA is currently not aware that anybody else became ill on the flight from Delhi to Heathrow.

The HPA has informed the public health authorities in Spain of the case, and they have interviewed the other members of the party. The World Health Organization has been notified under the current International Health Regulations.

Around ten imported cases of cholera are diagnosed in the United Kingdom each year, mainly associated with travel to the Indian sub-continent. Prior to these two cases, LEP had received nine isolates of *V. cholerae* O1 in 2006.

This small outbreak of imported cholera involving three countries demonstrates the importance of rapid international notification of suspected cases of cholera in order to review contacts, as the incubation period can be from as little as a few hours to five days.

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### Hepatitis A cases in a travelling community in southeast England

Two suspected cases of hepatitis A have been reported in a 40 year old male and his 7 year old son who are part of a travelling community in the Thames valley area. The Thames Valley Health Protection Unit was notified when they presented at an accident and emergency unit at a district general hospital in Thames Valley on 27 September, and IgM positive confirmation for hepatitis A infection was received the following afternoon.

The father started with malaise at the end of August, one month before developing jaundice and the son developed jaundice at the same time as the father, but no earlier symptoms were identified for him. Their 8-year-old daughter developed jaundice on the following day (28 September). All nine members of the family had been on holiday in the Isle of Wight for three days around 17 August. Further investigations of risk factors during the probable time of exposure were undertaken but samples of specific foods could not be obtained.

The family live in a caravan site with the mother, who is four months pregnant and five other children aged between 2 and 13 years, two of whom had flu-like symptoms, the rest being asymptomatic.

Around 40 residents (children and adults) in the caravan site had been in regular contact with the index case and the other symptomatic children of the family while they were infectious. An incident control team was convened on Thursday 28 September, and a programme of hepatitis immunisation took place on the site on Friday 29 September, targeting household contacts and on-site contacts. Thirty-three residents and three liaison workers received hep A vaccine. Of these, sixteen were aged 1 to 15 years, sixteen were aged between 16 and 45 years and four were aged 46 years and over.

The confirmed child with jaundice had attended a special school for at least four days while infectious (within the two weeks before onset of jaundice). To prevent secondary transmission, children at school in the same class received hepatitis A vaccine [1]. Exclusion from school was advised for symptomatic children until seven days from onset of jaundice [2]. Children from the index family

attend three different schools in total. A letter from the Health Protection Unit was sent to each one of the schools to advise parent/guardians about hepatitis A prevention and control.

Although guidelines do not exclude giving vaccine to pregnant women [3-5] human normal immunoglobulin (HNIG) was advised for the pregnant wife of the index case.

Close contacts of the two cases were offered salivary testing on Tuesday 10 October in order to assess the acute infection rates and prior susceptibility in the particular settings.

## References

1. Guidelines for control of hepatitis A virus. *Commun Dis Public Health* 2001; **4**:213-27. Available at <[http://www.hpa.org.uk/infections/topics\\_az/hepatitis\\_a/guidelines.htm](http://www.hpa.org.uk/infections/topics_az/hepatitis_a/guidelines.htm)>.
- 2 Preventing person to person spread following gastrointestinal infections: guidelines for public health physicians and environmental health officers: *Commun Dis Public Health* 2004; **7**(4): 362-84. Available at <[http://www.hpa.org.uk/infections/topics\\_az/gastro/menu.htm](http://www.hpa.org.uk/infections/topics_az/gastro/menu.htm)>.
- 3 Guidelines for control of hepatitis A virus: *Commun Dis Public Health* 2001; **4**: 213-27 <[http://www.hpa.org.uk/infections/topics\\_az/hepatitis\\_a/guidelines.htm](http://www.hpa.org.uk/infections/topics_az/hepatitis_a/guidelines.htm)>.
- 4 Immunisation against infectious diseases: "The Green Book", chapter 17, Hepatitis A, Department of Health. 8 August 2006 <[http://www.dh.gov.uk/SearchLink?url=http%3A//www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/GreenBook/GreenBookGeneralInformation/GreenBookGeneralArticle/fs/en%3FCONTENT\\_ID%3D4097254%26chk%3DisTfGX&qid=green+book+&coll=10&Z=1](http://www.dh.gov.uk/SearchLink?url=http%3A//www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/GreenBook/GreenBookGeneralInformation/GreenBookGeneralArticle/fs/en%3FCONTENT_ID%3D4097254%26chk%3DisTfGX&qid=green+book+&coll=10&Z=1)> (accessed 30 September 2006).
- 5 Health Protection Agency. *Immunoglobulin Handbook – Indications and dosage for normal and specific immunoglobulin preparations issued by the Health Protection Agency*. London: HPA, September 2006. <[http://www.hpa.org.uk/infections/topics\\_az/immunoglobulin/menu.htm](http://www.hpa.org.uk/infections/topics_az/immunoglobulin/menu.htm)> (accessed 30 September 2006).

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## The Gonococcal Resistance to Antimicrobials Surveillance Programme – publication of annual report for 2005

The HPA has published The Gonococcal Resistance to Antimicrobials Surveillance Programme – Annual Report 2005 [1]. The report provides current surveillance information on antibiotic resistant gonorrhoea, in addition to some of the behaviours underlying transmission, and shows the regional distribution of resistance across England and Wales. This 2005 annual surveillance report describes a worrying situation with undiminished and high levels of ciprofloxacin resistance particularly among men who have sex with men (MSM), and those of Asian ethnicities, and significant increase in chromosomally-mediated penicillin-resistant *Neisseria gonorrhoeae* (CMRNG).

The reports key findings state:

- Twenty-two per cent of GRASP isolates were resistant to ciprofloxacin (minimum inhibitory concentration (MIC)  $\geq 1$ mg/L) in 2005, a significant increase from the 14% observed in 2004 ( $p < 0.005$ ). The prevalence ranged from 8.9% to 42% in all Government Health Regions of England and Wales in 2005.
- The prevalence of ciprofloxacin resistance remained stable in women at 6.3% and heterosexual men 11.8% in 2005. However, the prevalence significantly increased in MSM rising to 42% compared with 26% in 2004 ( $p < 0.0005$ ).
- 17.9% of isolates demonstrated penicillin resistance in 2005 ( $\geq 1$ mg/L or  $\beta$ -lactamase positive), compared to 11.4% in 2004 ( $p < 0.005$ ). Of this total 4.3% of isolates demonstrated plasmid-mediated penicillin resistance (PPNG or PP/TRNG), a decrease from the 5.9% in 2004 ( $p = 0.24$ ), whereas 11.1% of isolates demonstrated chromosomally-mediated penicillin resistance (CMRNG) in 2005, an increase from the 4.5% seen in 2004 ( $p < 0.005$ ).

- Azithromycin resistance (MIC $\geq$ 1mg/L), was identified in 2.2% of isolates in 2005, a small, non-significant, increase compared to the 1.8% observed in 2004.
- Overall, 48.0% of isolates demonstrated tetracycline resistance ( $\geq$ 2mg/L) in 2005, a small increase on the 44.4% observed in 2004 (p=0.12). Plasmid-mediated tetracycline resistance (TRNG or PP/TRNG) was observed in 7.1% of isolates in 2005, a significant decrease from the 10.1% observed in 2004 (p<0.05).
- In 2005, no isolates demonstrated resistance to spectinomycin (MIC $\geq$ 128mg/L), or decreased susceptibility to ceftriaxone (MIC $\geq$ 0.125mg/L) or cefixime (MIC $\geq$  0.25mg/L).
- Non-GUM isolates demonstrated lower prevalences of ciprofloxacin resistance (14.2%), penicillin resistance (11.5%) and tetracycline resistance (42.0%) compared to GUM isolates in 2005.

### References

1. Health Protection Agency. The Gonococcal Resistance to Antimicrobials Surveillance Programme – Annual Report 2005. London: HPA, 12 October 2006. Available at <[http://www.hpa.org.uk/infections/topics\\_az/hiv\\_and\\_sti/stigonorrhoea/publications/GRASP\\_2005\\_Annual\\_Report.pdf](http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/stigonorrhoea/publications/GRASP_2005_Annual_Report.pdf)>.

# Enteric

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## Enteric Routine Data Reports

▣ [General outbreaks of foodborne illness in humans, England and Wales: weeks 36-39/06](#)

▣ [Salmonella infections, \(faecal specimens\) England and Wales, reports to the HPA \(salmonella data set\): August 2006](#)

▣ [Common gastrointestinal infections, England and Wales, laboratory reports: weeks 36-39/06](#)

▣ [Less common gastrointestinal infections, England and Wales, laboratory reports: weeks 27-39/06](#)

## ▣ [General outbreaks of foodborne illness in humans, England and Wales: weeks 36-39/06](#)

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
North East and Central London	S. Enteritidis PT 21	Restaurant	August	3	1	Tortilla	D
Greater Manchester	S. Enteritidis PT 8	Restaurant	September	–	8	–	–

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 2006

Details of serotypes 1362 of Salmonella infections recorded in August are given in the table below. In September 2006, 1630 Salmonella infections were recorded and preliminary information was received about two outbreaks (see table above).

	August 2006
S. Enteritidis (PT4)	264
S. Enteritidis (other PTs)	619
S. Typhimurium	131
S. Virchow	40
Others (typed)	308
<b>Total <i>Salmonella</i> (provisional data)*</b>	<b>1362</b>

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

## Common gastrointestinal infections, England and Wales, laboratory reports: weeks 36-39/06

Laboratory reports	Number of reports received				Total reports 36-39/06	Cumulative total to	
	36/06	37/06	38/06	39/06		36/06	39/05
<i>Campylobacter</i>	984	788	633	396	2801	32,621	35,873
<i>Escherichia coli</i> O157*	28	29	31	32	120	811	664
<i>Salmonella</i> †	489	391	348	238	1466	8024	8160
<i>Shigella sonnei</i>	10	11	15	8	44	422	727
Rotavirus	32	23	23	13	91	12,668	12,929
Norovirus	20	18	31	5	74	3610	2337
Cryptosporidium	171	162	92	59	484	2183	2596
Giardia	65	47	76	40	228	1919	2079

\*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.

 **Less common gastrointestinal infections, England and Wales, laboratory reports: weeks 27-39/06**

Laboratory reports	Total reports	Cumulative total to	Cumulative total to
	27-39/06	1-39/06	1-39/05
Adenovirus*	19	33	18
Astrovirus	5	47	120
Sapovirus	–	4	19
<i>Shigella boydii</i>	18	85	86
<i>Shigella dysenteriae</i>	14	36	46
<i>Shigella flexneri</i>	37	228	244
<i>Plesiomonas</i>	12	31	34
Vibrio	5	17	25
Yersinia	–	8	21
<i>Entamoeba histolytica</i>	17	64	73
<i>Blastocystis hominis</i>	55	185	340
<i>Dientamoeba fragilis</i>	18	70	143

\*includes adenovirus EM and group F.

# Diary of events

Last updated: 12 October 2006

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

 National Conference – *Topics In Microbiology Management “Management Matters”*

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## National Conference – *Topics In Microbiology Management “Management Matters”*

For anyone with an interest in the management of microbiology laboratories, the Health Protection Agency is hosting the National Conference – *Topics In Microbiology Management “Management Matters”*. It will be held on 9-10 November 2006 at the HPA Colindale Centre for Infections, north west London, in the Wilson Lecture theatre.

### Programme

9 November:

Morning Session – Quality in the New NHS

Afternoon Session - How to write a Business Case (David Bailey)

10 November:

Morning Session – Carter & Beyond

### Speaker profile:

David Bailey is an NHS accountant with 21 years experience of creating successful business cases. He has worked in primary care, mental health, acute and teaching hospital settings and is author of The NHS Budget Holder's Survival Guide as well as NHS Finance In A Nutshell. He is well known as a lively and provocative speaker.

### Registration

Cost of the Conference is £70 to include lunch, wine reception and tradeshow, and evening meal on Thursday. For full programme and application form please email Janet Norcup:

[Janet.Norcup@HPA.org.uk](mailto:Janet.Norcup@HPA.org.uk)