



# CDR WEEKLY

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# News

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▾ Leptospirosis diagnosed after a fishing holiday in France

▾ New HPA survey – the ethical and social aspects of a new vCJD test for blood donors

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## Leptospirosis diagnosed after a fishing holiday in France

Leptospirosis has been diagnosed clinically in two men recently returned from a fishing holiday at a resort in the Picardie région of north-east France. One case has since been serologically confirmed. Both patients were at the same resort at the same time (mid-September), and became unwell about one week after their return to the United Kingdom.

We wish to alert clinicians and laboratory staff to the possibility of leptospirosis in other people who have been on similar activity holidays.

Leptospire infect a variety of wild and domestic animals, including rodents, cattle and pigs, which then excrete organisms in their urine. Leptospire are naturally aquatic organisms and are found in fresh water, damp soil, vegetation, and mud. Human leptospirosis thus usually occurs following exposure to water or environments contaminated by infected animal urine, and is associated with a variety of occupations and activities in which this contact occurs; farming, agricultural work and sewer maintenance. Recreational activities with possible exposure include canoeing, windsurfing, swimming in lakes and rivers, pot holing, and fishing.

Typically, symptoms develop seven to 14 days after infection, though, on rare occasions the incubation period may be short as two to three days or as long as 30 days. Symptoms vary, and are usually biphasic. There is an abrupt onset of a 'flu-like' illness with high fever, severe headache, chills, muscle aches, and vomiting. Jaundice, red eyes, abdominal pain, diarrhoea, or a rash may follow.

Diagnostic serological tests, which include a screening IgM ELISA and a confirmatory Microscopic Agglutination Test, are done at the Leptospirosis Reference Laboratory, County Hospital, Hereford, HR1 2ER (tel: 01432 277117).

Please notify CfI via the duty doctor service on (tel: 020 8200 4400) if you become aware of any related cases. The relevant authorities in France are being informed.

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## New HPA survey – the ethical and social aspects of a new vCJD test for blood donors

The Health Protection Agency has launched a consultation to look at the social and ethical implications of a blood test for variant (vCJD), should a test become available. There is currently no blood test to detect vCJD infection in people who appear to be well. Such tests may soon be developed, and this consultation aims to seek views about how these tests for vCJD could be used once they become available.

A vCJD test could be used to screen blood donors, allowing the blood services to prevent blood from people with positive tests being given to patients. This is important as there have now been three probable cases of vCJD infection being transmitted through blood transfusions and a measure such as this could further ensure the safety of blood supplies.

The consultation will explore some questions and concerns about introducing a blood test, including:

1. Should a test for vCJD be introduced when it is not known whether people with positive test results would ever develop symptoms of vCJD, and if they would, how long this would take?
2. Should the UK blood services always tell donors if their vCJD tests are positive? And how should donors' GPs be involved?
3. If donors knew that they would be tested for vCJD, and that they would be told if they tested positive for vCJD, would they be put off giving blood?

Together with an opinion research company, the HPA is asking experts, health professionals, interest groups and members of the public for views on the possible impact and implications of a blood test for vCJD. A stakeholder audit is being complemented by an on-line questionnaire. The answers will be completely confidential and anonymous.

If you would like to join in this consultation, please take part in the online poll at [http://www.hpa.org.uk/infections/topics\\_az/cjd/consultation.htm](http://www.hpa.org.uk/infections/topics_az/cjd/consultation.htm)

# Bacteraemia

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## Acinetobacter spp bacteraemia in England, Wales, and Northern Ireland: 2001 to 2005

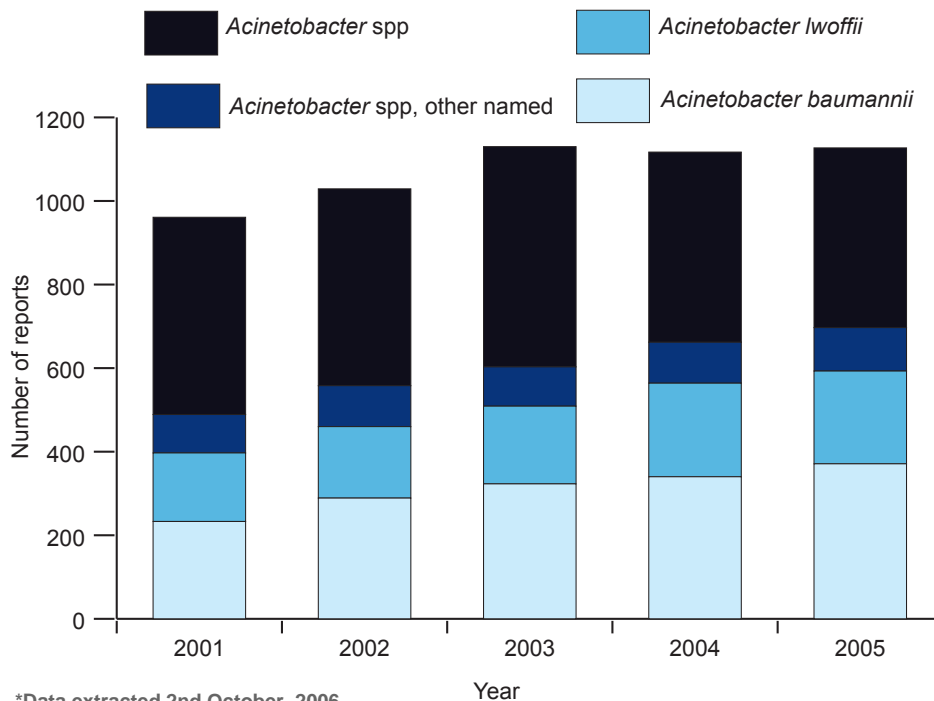
There is a 17.2% increase (table 1) in the total reports of *Acinetobacter* spp bacteraemia reported via the voluntary surveillance scheme in 2005 (1127 reports), compared to 2001 (961 reports). This increase is due in part to the inclusion, since 2002, of laboratory reports from Northern Ireland. In comparison with data collected in 2004, there was only a marginal increase (0.9%) in the number of reports of *Acinetobacter* spp bacteraemia in 2005.

**Table 1 *Acinetobacter* spp bacteraemia reports: 2001 to 2005\***

	2001	2002	2003	2004	2005
<i>Acinetobacter baumannii</i>	233	289	323	340	371
<i>Acinetobacter lwoffii</i>	164	171	186	224	222
<i>Acinetobacter junii</i>	22	24	25	26	39
<i>Acinetobacter haemolyticus</i>	17	17	24	20	26
<i>Acinetobacter calcoaceticus</i>	31	35	37	34	24
<i>Acinetobacter</i> spp, other named	22	22	8	18	15
<i>Acinetobacter</i> spp	472	471	527	455	430
<i>Acinetobacter</i> spp total	961	1029	1130	1117	1127

\*Data extracted 2 October, 2006.

**Figure 1 *Acinetobacter* spp bacteraemia reports: 2001 to 2005\***



\*Data extracted 2nd October, 2006.

- The percentage of *Acinetobacter* isolates identified to species level increased from 51% in 2001 to 62% in 2005.
- The percentage of *Acinetobacter* isolates reported with susceptibility data increased from 61% in 2001 to 79% in 2005.

- For *A. baumannii*, the only statistically significant susceptibility changes (measured by chi-square test for trend) observed from 2001 to 2005 were increased resistances to cefotaxime (from 65% to 76%) and ceftazidime (from 61% to 71%). For meropenem, too few reports were available for analysis in 2001 and 2002, but significantly increased resistance was observed between 2003 (3%) and 2005 (19%). There were no statistically significant trends from 2001 to 2005 for gentamicin (24% resistant in 2005), amikacin (21%), tobramycin (23%), ciprofloxacin (32%), or imipenem (9%).
- For *A. lwoffii*, there were no statistically significant changes in resistance rates between 2001 and 2005 for gentamicin (1% resistant in 2005), amikacin (0%), tobramycin (0%), ciprofloxacin (5%), imipenem (0%), meropenem (4%), cefotaxime (31%), or ceftazidime (20%).
- In 2005, *A. lwoffii* was more frequently reported among children (<15 years of age) than *A. baumannii*, while *A. baumannii* was more prevalent among those aged 15 years and over.

The analyses presented are based on data extracted from the Health Protection Agency's voluntary surveillance database on 2 October 2006 for the period from 2001 to 2005. The data presented here differ in some instances from data in earlier publications due to the addition of late reports to the database. We would like to thank our colleagues in microbiology laboratories across England, Wales, and Northern Ireland for their ongoing contributions.

**Further data tables and graphs about *Acinetobacter* spp bacteraemia in England, Wales, and Northern Ireland: 2001 to 2005 can be viewed at:**

[http://www.hpa.org.uk/infections/topics\\_az/acinetobacter\\_b/surveillance\\_data.htm](http://www.hpa.org.uk/infections/topics_az/acinetobacter_b/surveillance_data.htm)

# Healthcare associated Infections

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## Voluntary surveillance of candidaemia in England, Wales, and Northern Ireland: 2005

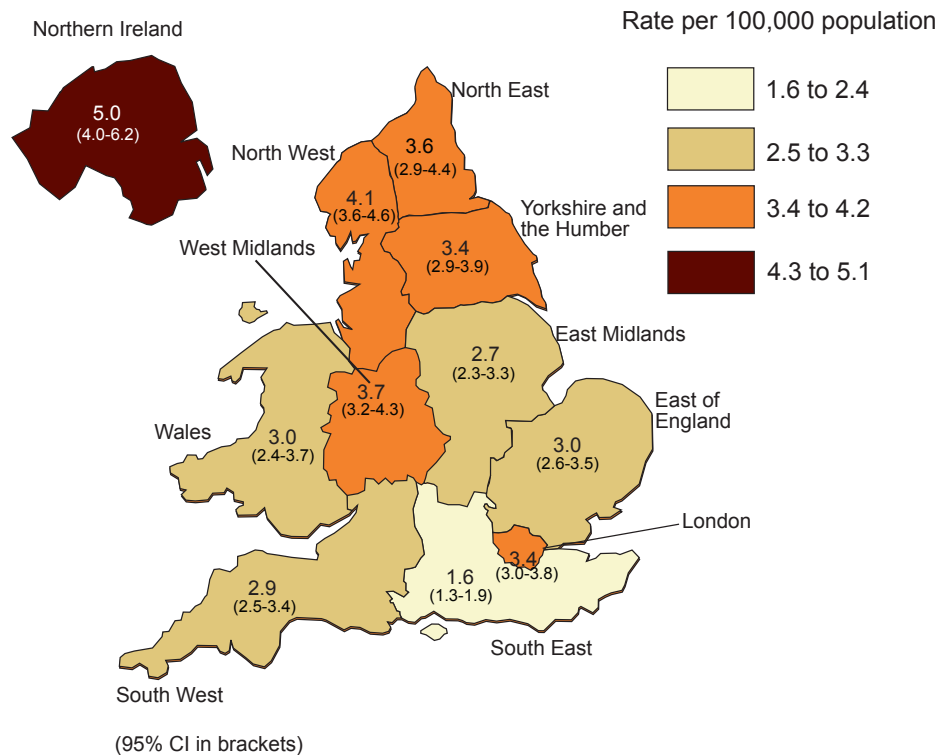
There were 1736 reports of *Candida* spp isolated from blood specimens in England, Wales and Northern Ireland in 2005 (see E-Table 1). This represents a 16.3% increase in the number of candidaemia reports made to the HPA since 2004 (1493 reports) and is consistent with the increasing trend observed since 1990 [1]. However, the increase observed between 2004 and 2005 (16.3%) is over twice that reported between 2003 and 2004 (7.6%). The overall reported rate of candidaemia increased from 2.7 per 100,000 (95% CI: 2.6-2.9) in 2004 to 3.1 per 100,000 (95% CI: 3.0-3.3) in 2005 (see E-Table 1). As reporting is voluntary, these increases may be due in part to improved ascertainment.

- The highest country-specific rate of reported candidaemia was observed in Northern Ireland: 5.0/100,000 (95% CI: 4.0-6.2).
- Within the English regions, the South East had the lowest reported candidaemia rate with 1.6/100,000 (95% CI: 1.3-1.9) whereas the North West had the highest rate of reports with 4.1/100,000 (95% CI: 3.6-4.6) (see Figure 1).
- The largest regional change in the rate of reported candidaemia since 2004 was observed in the London region, which increased from 2.2/100,000 (95% CI: 1.8-2.5) in 2004 to 3.4/100,000 (95% CI: 3.0-3.8) in 2005.
- *Candida albicans* was the most frequently reported species in 2005, accounting for 55% of candidaemia reports, with the other common species including *C. glabrata* (18%) and *C. parapsilosis* (10%). Seven other uncommon species were responsible for the remaining seven per cent of invasive *Candida* infections (see E-Table 2).
- The proportion of reports in which invasive *Candida* infection was recorded without full species information decreased slightly from 10.4% in 2004 to 9.9% in 2005.
- Candidaemia rates were higher in males than females in most age groups (see Figure 2).
- The highest age and sex-specific rate of reported candidaemia in 2005 was in males aged under 1 year at 15.4/100,000 (95% CI: 11.5-20.1) followed by males aged 75 years and over at 12.1/100,000 (95% CI: 10.4-13.9).

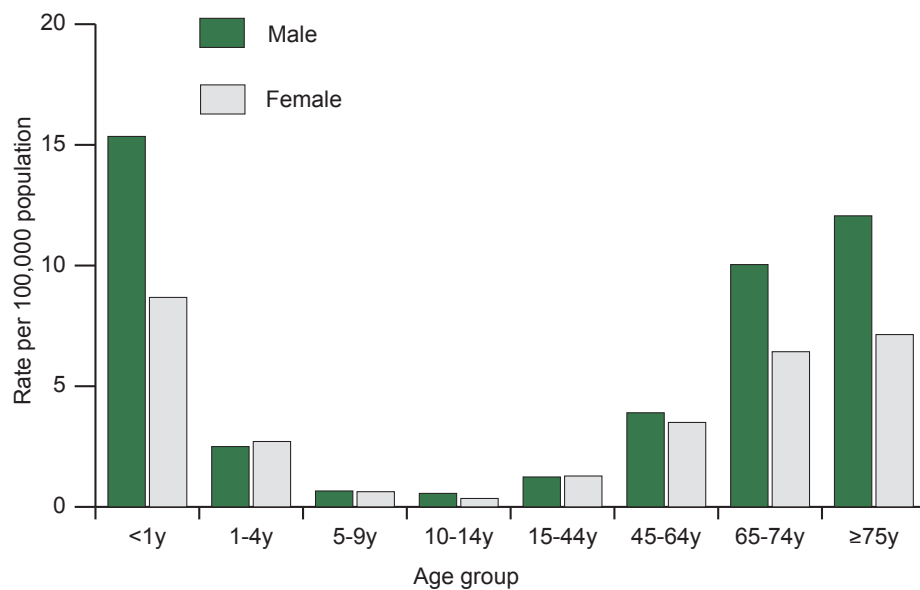
Reporting to species level is important for monitoring changes in the epidemiology of these infections, with different species being associated with infections in different patient groups and with differing levels of antifungal susceptibility [2]. For assistance with identification, laboratories can submit isolates to the Mycology Reference Laboratory in Bristol, <<http://www.hpa.org.uk/srmd/mycology/index.htm>>.

The analyses presented are based on data extracted from LabBase2\* on the 22 September 2006 for the period from 2002 to 2005. Further data tables can be viewed in the full text online version: <[http://www.hpa.org.uk/infections/topics\\_az/fungal\\_infections/epi\\_data.htm](http://www.hpa.org.uk/infections/topics_az/fungal_infections/epi_data.htm)>.

**Figure 1 Region-specific rates of candidaemia reports, England, Wales, and Northern Ireland: 2005**



**Figure 2 Age-specific rates of candidaemia per 100,000 population; England, Wales, and Northern Ireland: 2005**



Further data tables and commentary about Candidaemia in England, Wales, and Northern Ireland: 2005 can be viewed at:

[http://www.hpa.org.uk/infections/topics\\_az/fungal\\_infections/epi\\_data.htm](http://www.hpa.org.uk/infections/topics_az/fungal_infections/epi_data.htm)

#### References

1. Lamagni TL, Evans BG, Shigematsu M, Johnson EM. Emerging trends in the epidemiology of invasive mycoses in England and Wales (1990-1999). *Epidemiol Infect* 2001; **126** : 397-414.
2. Hobson RP. The global epidemiology of invasive Candida infections – is the tide turning? *J Hosp Infect* 2003; **55** : 159-68.

#### Footnote

\*Labbase2 is the database that collects laboratory reports of all micro-organisms isolated at nearly 400 NHS and other laboratories throughout England and Wales. The database is managed and accessed at the Centre for Infections.

# Diary of events

Last updated: 17 October 2006

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## 17th National Immunisation Conference for Health Care Workers

The University of Manchester and Stockport Medical Education Centre invite you to attend the 17th National Immunisation Conference for Health Care Workers to be held on Friday, 1 December 2006.

The Conference is for any health worker involved with immunisation and will be of interest to Clinical Medical Officers, General Practitioners, Health Visitors, Practice Nurses, Occupational Health Practitioners, Paediatricians, Microbiologists, School Nurses, and District Immunisation Co-ordinators.

It will begin at 9.00 a.m. to 5.00 p.m. at The Manchester Conference Centre (Weston Building, UMIST, Sackville Street, Manchester).

### Registration

The Conference fee is £75 for nursing staff and £100 for doctors, managers and other staff. This includes refreshments on arrival, all refreshments during the day including a hot/cold 2 course buffet lunch, delegate pack and certificate. CPD approval will be applied for.

To register please contact: telephone 0161 419 4684 or fax 0161 419 4686.