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Hospital-associated transmission of Panton-Valentine leukocidin (PVL) positive community-associated MRSA in the West Midlands

Eight cases of Panton-Valentine leukocidin (PVL) positive community-associated MRSA (CA-MRSA) have been identified among individuals in a hospital and their close household contacts in the West Midlands. Four individuals developed an infection, two of whom died. Transmission of the CA-MRSA strain appeared to have occurred on two separate wards and went undetected until a fatal case was examined in detail. Although the occurrence of several different clones of CA-MRSA has been reported previously [1], this is the first documented report of nosocomial transmission of PVL-positive CA-MRSA in the United Kingdom (UK).

A previously healthy healthcare worker (HCW) developed an MRSA sepsis, septic shock, pneumonia and died following non-elective surgery in September 2006 (case 1). Screening of patients and staff on ward A where case 1 worked revealed another HCW carrying the same strain (case 2). This HCW had a history of skin abscesses due to MRSA and was a social contact of case 1. Four household contacts of cases 1 and 2 were found to carry the same strain (cases 3 to 6). One of these, case 5, worked as a HCW on a different ward (ward B). Subsequent screening of both patients and staff on ward B revealed another HCW working on ward B carrying the same strain (case 7). This individual had a four month history of recurrent infection of the eye lids. One further case was identified in March 2006 through retrospective analysis of MRSA isolates kept in the laboratory. The patient (case 8) developed a suspected hospital-acquired pneumonia while in ward A and died within 24 hours of the blood culture being taken that grew the organism. Extensive healthcare and community-based contact tracing has not identified further cases.

The most prevalent hospital and healthcare-associated MRSA strains found in UK healthcare settings are epidemic MRSA (EMRSA) 15 and 16, both of which are negative for PVL and usually resistant to ciprofloxacin. The MRSA strain responsible for this outbreak was susceptible to all non-beta-lactam antibiotics tested (including ciprofloxacin), positive for the PVL genes and resembled closely the South West Pacific CA-MRSA clone (multilocus sequence type ST30) [1,2]. Data from the national Staphylococcus Reference Laboratory show this is the fifth most common clone of CA-MRSA seen in England and Wales, with 13 cases of skin and soft tissue infection (SSTI) identified in 2005. This outbreak heralds the first report of nosocomial transmission and known deaths due to this strain in England and Wales.

In recent years CA-MRSA has emerged as an important pathogen among previously healthy young people in community settings worldwide. In addition to causing sporadic disease in the community, outbreaks of CA-MRSA have occurred in individuals in close contact, particularly where skin trauma is likely, for example sporting teams, military recruits and injecting drug users. Many strains of CA-MRSA encode PVL, a pore-forming cytotoxin associated with necrotic lesions or abscess formation in SSTI [3]. More rarely, infection can lead to cases of serious, life-threatening disease such as necrotising pneumonia, necrotising fasciitis and purpura fulminans which may prove fatal [3].

A recent review [4] identified 12 reports world-wide documenting nosocomial transmission of various clones of CA-MRSA. This change in the epidemiology of MRSA demands increased vigilance among healthcare personnel. To enhance the case ascertainment of PVL-positive CA-MRSA in the healthcare and community setting, we would encourage the submission of samples from patients presenting with SSTIs (particularly boils, furuncles and abscesses, especially where they are recurrent) for microbiological testing. In conjunction with this, we recommend microbiologists test MRSA for susceptibility to ciprofloxacin as a marker of putative CA-MRSA since the majority of healthcare-associated MRSA are resistant to ciprofloxacin [1]. All ciprofloxacin sensitive MRSA, accompanied by relevant clinical information, should be referred to the Staphylococcus Reference Laboratory (Centre for Infections, HPA, 61 Colindale Avenue, London, NW9 5EQ) for characterisation including PVL testing to determine if they are CA-MRSA.

References

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New variant of *Chlamydia trachomatis* reported in Sweden: implications for diagnostic laboratories in the United Kingdom

A new variant *Chlamydia trachomatis* strain has been isolated in Sweden [1,2]. Certain commercial diagnostic platforms generate false negative results when screening specimens from patients who are infected with the new variant strain. The *Chlamydia trachomatis* cryptic plasmid (a non-chromosomal genetic element with unknown function found in all *C. trachomatis* strains) is high copy number and as such, is a popular target for commercial diagnostic platforms. This new strain has a 377bp deletion in a portion of the plasmid that is the target area for the *C. trachomatis* NAAT tests manufactured by Abbott and Roche. Consequently these Platforms, which remain unaffected by this deletion, are the Aptima Combo 2 (AC2: Genprobe), RealArt CT Kit (Artus), and the Strand Displacement Assay (SDA) (Probetec, Becton Dickinson), as they target rRNA, the omp gene and a different region of the cryptic plasmid, respectively. In Sweden, the majority of laboratories were using a Roche platform whereas information obtained from the National External Quality Assessment Scheme (NEQAS) programme showed 39% of laboratories reporting to the scheme in the United Kingdom (UK) are currently using the Roche/Abbott platforms for the detection of *C. trachomatis*. The length of time that this new variant has been circulating undiagnosed in the Swedish community is, as yet undetermined, although recent decreases in *C. trachomatis* infections have been observed and consequently concerns are that the strain is widely distributed throughout the country. There is currently no evidence that the new *C. trachomatis* variant is present within the UK. Indeed a recent large-scale study: the *C. trachomatis* NAAT evaluation programme screened 2375 urine specimens (of which 595 were positive and 131 were discordant), collected from patients attending at one of three geographically diverse sites in the UK, using four commercial platforms in a direct head-to-head comparison. Of the discordant specimens, only three urine specimens were found to be reproducibly negative on the Roche Cobas platform and positive on both the SDA and AC2 platforms. Differences in specimen status could also, however, be explained by differences in analytic sensitivity for the three platforms rather than a missing target region.

Current Recommendations to Diagnostic Laboratories in England and Wales

- Laboratories performing testing on two platforms, including either the Roche or Abbott tests, should consider using the Roche or Abbott tests for confirmation rather than primary testing;

- Laboratories who are using Roche or Abbott platforms as their only method of *C. trachomatis* detection should carry on using this approach but be vigilant for obvious decreases in the number of positive cases;
- All laboratories should look for new alerts containing updated information.

The Sexually Transmitted Bacteria Reference Laboratory (STBRL) is happy to assist with any local problems or discuss potential discrepant results that may be due to the variant strain: email stbrl@hpa.org.uk

Future studies

STBRL, in collaboration with the European Surveillance of Sexually Transmitted Infections (ESSTI, www.essti.org) collaborative group, is currently investigating this new variant strain. The following strategies will be employed to determine whether the new variant is present within the UK/Europe and if it is, ascertain its prevalence.

- Investigation of the presence of this variant in samples from different geographical locations across Europe.
- Perform trend analyses to identify unexpected decreases in the number of positive cases of *C. trachomatis*.

All findings will be made available as soon as possible.

References

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Confidential study of deaths following healthcare-associated infection (HCAI) and linkage of surveillance and mortality data – first year update

The joint project by the Health Protection Agency (HPA) and Office for National Statistics (ONS) to further understanding of mortality following MRSA infection, has reported on the progress made in establishing robust methods for both the linkage and investigation of deaths in its first year [1]. The two year project commenced in August 2005 with funding from the Department of Health [2].

The pilot phase of the data linkage study investigated whether infection records held by the HPA could be reliably linked to mortality records held by ONS. The lack of a well completed, unique identifier in infection records meant deterministic record linkage could not be applied and a probabilistic method was developed [3]. The method was developed and trialled using invasive *Streptococcus pneumoniae* infection records sampled from reports made between 1 July 2003 and 30 June 2004 linked to mortality records from 1 July 2003 to 31 March 2005. These same *S. pneumoniae* records were submitted to the NHS Central Register (NHSCR) Tracing Service for evaluation of the linkage mechanism by providing information on outcome from an independent source. Reports of invasive *S. pneumoniae* infections were used in this work because they contain full surname data (which MRSA data do not) which is required to enable matching by the NHSCR. Both methods were shown to be of similar accuracy with respect to identifying individuals who had died following infection.

Following the successful development of a probabilistic method for the linking of infection and mortality records, the method is now being used to link MRSA infection records to mortality records to enable analyses of mortality following invasive MRSA infection and certification of cause of death for these patients.

The pilot phase of the National Confidential Study of Deaths Following Healthcare-Associated

Infection is a qualitative clinical review of patients who have died following an MRSA infection, to describe and evaluate the relative importance of key events leading up to death.

Cases for the pilot phase were identified retrospectively from a random sample of death registrations with any mention of MRSA on the death certificate. Nine hospitals were visited by the study investigator and 18 patients reviewed. The data collated comprised a review of medical records, interviews with infection control staff, and consultants responsible for the patients, as well as a questionnaire to gather organisational data on the management of infection control. All data were reviewed by an independent multidisciplinary panel of six clinical experts specifically convened for the study, with the aim of reaching a consensus on the relative contribution of different factors, in particular the MRSA infection, to the patient's death [4].

The main phase of the Study will use the same methods to review a small sample of patients drawn from the linked data (ie patients with invasive MRSA infection who subsequently die in hospital). Unlike the pilot phase, sampling of cases is carried out independently of whether MRSA was documented on the death certificates.

For further information on the Data Linkage Study or Confidential Study of Deaths following HCAI please contact Nicola Potz (nicola.potz@hpa.org.uk) or David Bridger (david.bridger@hpa.org.uk), respectively, at the Department of Healthcare Associated Infection and Antimicrobial Resistance, Health Protection Agency Centre for Infections, London.

References

1. Health Protection Agency, Office for National Statistics. *National Confidential Study of Deaths Following Healthcare Associated Infection & HPA/ONS Data Linkage Study. Year 1 report (01/08/05 – 31/07/06)*. London: Health Protection Agency, 2006.
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Imported chikungunya in the United Kingdom

Between 1 January and 31 October 2006, 106 cases with evidence of chikungunya infection, have been reported by the HPA Special Pathogens Reference Unit (SPRU). Of those, 29 have been laboratory confirmed (PCR and/or virus isolation), 29 are probable cases (clinical symptoms and IgG, IgM positive), 33 are classified as suspected cases (clinical symptoms, relevant travel history and IgG positive), and 15 have had a past exposure (IgG positive with no clinical details or travel history, or IgG positive with history of past exposure).

Of the total, 67 cases reported travel to the Indian Ocean islands (57 to Mauritius, six to the Seychelles, and four to Madagascar), where a large outbreak was reported earlier in the year [1]. These cases were received at SPRU between 2 March and 31 August 2006, and the outbreak has since declined. Twenty cases (received at SPRU between 30 May and 26 October 2006) reported recent travel to India, where an outbreak began in February 2006 [2]. Over a million suspected cases have been reported in India since the outbreak began, with 1831 cases confirmed. As of 12 December 2006, twelve of the country's 31 states have been affected of which, Karnataka (298 confirmed, 762,026 suspected cases) and Maharashtra (774 confirmed, 268,321 suspected cases) have been most affected. Other states affected have been Andhra Pradesh, Tamil Nadu, Madhya Pradesh, Gujarat, Kerala, Andaman and Nicobar Islands, Government of National Capital Territory of Delhi, Rajasthan, Pondicherry, and Goa [3]. Further to this, an outbreak of suspected chikungunya has also been reported in Sri Lanka [4], although as of 31 October, no cases of chikungunya, related to travel to Sri Lanka, have been received by the SPRU.

Nearly 800,000 United Kingdom residents travelled to India in 2005, a 21% increase compared to 2004 [5]. Although the chikungunya outbreak appears to be in decline [6], travellers to India and Sri Lanka should be aware of the risk of infection, which is transmitted by mosquitoes of the *Aedes* species (the same mosquito that transmits dengue fever, which is also prevalent in India). *Aedes* mosquitoes are active during daylight hours (particularly around dusk and dawn) and prevention

relies on bite avoidance. Further information about this can be found on the National Travel Health Network and Centre (NaTHNaC) website at < <http://www.nathnac.org/pro/factsheets/iba.htm> >.

Further information about chikungunya can be found on the HPA website at <http://www.hpa.org.uk/infections/topics_az/Chikungunya/default.htm >.

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Changing face of *CDR Weekly*

From 5 January 2007 the *Communicable Disease Report (CDR) Weekly* will be superseded by a new publication, the *Health Protection Report (HPR) Weekly*, to reflect the full range of the Health Protection Agency's work. *HPR Weekly* will retain all the content currently available in *CDR Weekly*, with the addition of information on chemicals, radiation, and emergency planning. These will each be represented initially by quarterly reports, as well as in news and current events. Publication will be at 10:00 on Friday morning, rather than on Thursday evening. The full content of *CDR* will remain available online, and be fully linked to from *HPR*.

Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) – vacancies for a Chair and 14/15 expert members and one lay member

Expert advice to Government on antimicrobial resistance and healthcare associated infections is currently provided through two different committees: the Specialist Advisory Committee on Antimicrobial Resistance (SACAR) and the Steering Group on Healthcare Associated Infection (SG-HCAI).

The Department of Health now plans to establish a new independent body to advise across both areas, providing integrated and more streamlined advice in these two interrelated fields. This new Advisory Non-Departmental Public Body will be known as the Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI), and has vacancies for a chair and up to 15 expert and one lay member. These are public appointments, not employment, and although no fees are payable, travelling expenses and subsistence allowances will be paid.

Further information is available on the HPA website at <http://www.hpa.org.uk/infections/topics_az/hai/ARHAIadvert.pdf>.

Enteric

Last updated: 14 December 2006, Volume 16, No. 50 Next update: 12 January 2007

Enteric Routine Data Reports

- ▣ General outbreaks of foodborne illness in humans, England and Wales: weeks 45-48/06
 - ▣ Salmonella infections, (faecal specimens) England and Wales, reports to the HPA (Salmonella data set): October 2006

 - ▣ Common gastrointestinal infections, England and Wales: laboratory reports: weeks 45-48/06

 - ▣ General outbreaks of foodborne illness in humans, England and Wales: quarterly report: April to June 2006

 - ▣ Salmonella serotypes recorded in the Health Protection Agency Salmonella data set: July to September 2006 (provisional)
-

▣ General outbreaks of foodborne illness in humans, England and Wales: weeks 45-48/06

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
Northumberland, Tyne and Wear	S. Enteritidis PT1	Restaurant	October	3	3	–	–
Cumbria and Lancashire	S. Enteritidis PT8	Restaurant	October	9	8	–	–
Essex	S. Enteritidis PT14B	Restaurant	October	2	2	–	–

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): October 2006

Details of serotypes of 1667 Salmonella infections recorded in October are given in the table below. In November 2006, 1172 S. infections were recorded and preliminary information was received about three outbreak (see table above).

	October 2006
S. Enteritidis (PT4)	255
S. Enteritidis (other PTs)	852
S. Typhimurium	193
S. Virchow	38
Others (typed)	329
Total Salmonella (provisional data)*	1667

*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 45-48/06

Laboratory reports	Number of reports received				Total reports 45-48/06	Cumulative total to	
	45/06	46/06	47/06	48/06		48/06	48/05
<i>Campylobacter</i>	825	738	655	382	2600	42,092	43,866
<i>Escherichia coli</i> O157*	18	16	9	5	48	1007	944
<i>Salmonella</i> †	320	231	228	186	965	11,284	10,863
<i>Shigella sonnei</i>	11	15	10	5	41	574	861
Rotavirus	34	39	47	32	152	13,027	13,226
Norovirus	63	82	75	38	258	4061	2545
Cryptosporidium	108	115	72	49	344	3286	4185
Giardia	57	46	60	34	197	2667	2740

*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.

General outbreaks of foodborne illness in humans, England and Wales: quarterly report: April to June 2006

Health Protection Unit	Organism	Location of food prepared or served	Number ill	Cases positive	Suspect vehicle	Evidence
West Yorkshire	<i>Clostridium perfringens</i>	Residential Institution	13	1	None	–
Birmingham & Solihull	<i>E. coli</i> O157	Restaurant	6	2	None	–
Leeds	<i>E. coli</i> O157	Shop retailer	30	30	Cooked roast beef	M
Surrey & Sussex	<i>S. Enteritidis</i> PT4	School	148	43	Haloumi/pepper kebabs	S
Tees	<i>S. Enteritidis</i> PT4	Private House	10	5	Meat pizza	S
Bedfordshire & Hertfordshire	<i>S. Enteritidis</i> PT13A	Function	50	31	Egg bagels	S
Greater Manchester	<i>S. Enteritidis</i> PT14B	Restaurant	12	12	Various foods	M

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 serotypes recorded in the Health Protection Agency Salmonella data set: July to September 2006 (provisional)

All serotypes recorded in the HPA Salmonella data set in the third quarter of 2006 are listed below. There were more than ten reports of 29 serotypes, two to ten reports of 61 serotypes, and one report of 53 serotypes

More than ten reports of the following Salmonella serotypes were received: July to September 2006

Serotype	No. of reports	Serotype	No. of reports	Serotype	No. of reports
S. Agona	22	S. Ibadan	24	S. Oranienburg	16
S. Ajijoba	107	S. Infantis	42	S. Saint-Paul	17
S. Anatum	11	S. Java	16	S. Schwarzengrund	13
S. Bareilly	13	S. Kentucky	42	S. Senftenberg	12
S. Braenderup	30	S. Kottbus	18	S. Stanley	30
S. Corvallis	21	S. Mbandaka	23	S. Thompson	29
S. Derby	19	S. Mikawasima	14	S. Typhimurium	427
S. Enteritidis	2844	S. Montevideo	35	S. Unnamed	53
S. Hadar	29	S. Muenchen	11	S. Virchow	127
S. Haifa	15	S. Newport	80		

Between two and ten reports of each of the following Salmonella serotypes were received: July to September 2006

Serotype	No. of reports	Serotype	No. of reports	Serotype	No. of reports
S. Abony	3	S. Galiema	2	S. Muenster	6
S. Adelaide	5	S. Give	6	S. Napoli	3
S. Agama	9	S. Gold-Coast	6	S. Nima	2
S. Agbeni	3	S. Grumpensis	2	S. Ohio	9
S. Albany	2	S. Halle	2	S. Orion	2
S. Altona	3	S. Heidelberg	10	S. Oslo	3
S. Apapa	2	S. Herston	2	S. Panama	4
S. Arizonae	10	S. Hull	4	S. Plymouth	2
S. Blockley	9	S. Hvitvingfoss	5	S. Poona	4
S. Bovis-Morbificans	4	S. Indiana	5	S. Potsdam	2
S. Brandenburg	10	S. Isangi	2	S. Reading	3
S. Bredeney	8	S. Istanbul	2	S. Richmond	5
S. Butantan	2	S. Javiana	7	S. Rissen	5
S. Carmel	2	S. Kedougou	6	S. Rubislaw	2
S. Chester	7	S. Litchfield	2	S. San-Diego	3
S. Coeln	2	S. Livingstone	4	S. Singapore	2
S. Colindale	3	S. London	2	S. Stanleyville	4
S. Cubana	2	S. Manhattan	4	S. Uganda	3
S. Durham	10	S. Mississippi	5	S. Wassenaar	2
S. Eastbourne	2	S. Monschau	2	S. Weltevreden	10
S. Emek	8	S. Monschau	2		

One each of the following Salmonella serotypes were received: July to September 2006

Serotype	Serotype	Serotype
S. Abaetetuba	S. Glostrup	S. Oritamerin
S. Alachua	S. Hartford	S. Portsmouth
S. Alagbon	S. Havana	S. Putten
S. Amsterdam	S. Houten	S. Quiniela
S. Arechavaleta	S. Kibi	S. Salford
S. Arkansas	S. Kingston	S. Suelldorf
S. Berkeley	S. Koketime	S. Takoradi
S. Bonariensis	S. Kua	S. Tel-El-Kebir
S. Brunei	S. Larochelle	S. Thomasville
S. Cerro	S. Legon	S. Utah
S. Chingola	S. Matopeni	S. Vitkin
S. Coleypark	S. Mbao	S. Wangata
S. Drypool	S. Meleagridis	S. Widemarsh
S. Dublin	S. Miami	S. Windermere
S. Dubrovnik	S. Minnesota	S. Winneba
S. Eboko	S. Mkamba	S. Worthington
S. Ekpoui	S. Ngozi	S. Zanzibar
S. Freetown	S. Nijmegen	

Emerging infections/CJD

Last updated: 14 December 2006, Volume 16, No. 50 Next update: March 2007

Creutzfeldt-Jakob disease (CJD) update report

This six-monthly report provides an update on reports of incidents of potential iatrogenic (healthcare-acquired) exposure to CJD via surgery, and on the National Anonymous Tonsil Archive. Data is correct as of 12 December 2006.

For numbers of CJD case reports, readers should consult data provided by the national CJD Surveillance Unit (NCJDSU), Edinburgh [1]. The latest quarterly analysis of vCJD reports (onsets and deaths) is also available from the NCJDSU website [2].

Reports of incidents of potential iatrogenic exposure to CJD via surgery 01 January 2000 to 30 June 2006

There were 281 incidents in this period: 53 surgical incidents were reported to the CJD Incidents Panel (Panel) in 2005 and 28 in the first half of 2006 (table 1). Surgical incidents occur when instruments considered potentially contaminated with the CJD agent during use on an index patient have been subsequently re-used on other patients. A patient whose surgery results in potential contamination of instruments with prions is referred to as the index patient. Table 1 shows the number of CJD surgical incidents reported to the Panel from January 2000 to June 2006 by the diagnosis of the index patient.

Table 1 CJD surgical incidents reported to the CJD Incidents Panel: between January 2000 and June 2006, by diagnosis of index patient

CJD status of index patient	2000	2001	2002	2003	2004	2005	Jan-Jun 2006	Total
Sporadic (possible, probable or definite)	7	19	21	23	18	17	15	120 (43%)
vCJD (possible, probable or definite)	6	14	22	5	5	1	1	54 (19%)
Familial including 'at risk' familial	–	2	2	7	1	3	3	18 (6%)
At risk' vCJD blood component recipient	–	–	–	–	3	10	1	14 (5%)
At risk' - vCJD plasma product recipient	–	1	2	–	9	17	5	34 (12%)
At risk' - other	–	–	3	2	1	2	1	9 (3%)
CJD type unclear/ CJD unlikely	1	1	–	4	1	1	2	10 (4%)
Not CJD	2	1	4	7	3	1	–	18 (6%)
Other	–	–	1	1	1	1	–	4 (1%)
Total	16	38	55	49	42	53	28	281 (100%)

Investigation of surgical incidents may result in advice to remove surgical instruments from clinical use (to quarantine, destroy, or donate for research). Such advice is generally only given for instruments considered to be potentially contaminated with the CJD agent that have not undergone sufficient number of cycles of use and decontamination since their use on an index patient. Hospitals are asked to consider sending any instruments to be permanently removed from use to the Surgical Instrument Store (held by the Health Protection Agency, Centre for Emergency Preparedness and Response, Porton Down) for research.

Instruments were quarantined or permanently removed from use on other patients in 55 incidents reported between January 2000 and June 2006. 11 of these incidents were reported in 2005 and four incidents were reported in the first half of 2006. The Panel may advise contacting and informing some

patients of their possible exposure to CJD in a surgical incident. Such advice is generally only given for patients who have definitely been exposed to potentially contaminated instruments which have been used on risk tissues in certain index patients. The Panel advises that these patients should be considered 'at-risk of CJD for public health purposes' and asked to take certain precautions (i.e. not to donate blood or other tissues and to inform their medical and dental carers prior to any invasive procedures) in order to reduce the risk of transmitting the CJD agent to other patients. Since 2000, 16 incidents have given rise to advice to contact and inform subsequent patients of their potential exposure to CJD (Table 2). The Panel advised that 70 patients should be contacted and informed that they are 'at-risk' of CJD for public health purposes. Subsequently, based on updated risk assessments, 14 patients have been re-assessed and are no longer considered to be 'at-risk' of CJD for public health purposes.

Table 2 Panel advice to inform patients that they are 'at-risk' of CJD/vCJD: 1 January 2000 to 30 June 2006

Diagnosis of index patient	Procedure on index patient	Number of Incidents	Number of 'at risk' patients (subsequently denotified)
Sporadic CJD	Brain biopsy	2	27 (-)
	Cataract surgery	9	29 (11)
vCJD	Appendicectomy	1	2 (-)
	Cataract surgery	1*	2 (1)
'at risk' vCJD	Invasive endoscopy	3	10 (2)
Total		16	70 (14)

*The index patient was a blood component recipient with evidence of vCJD infection. Information about the CJD Incidents Panel can be found on the HPA website [3].

The National Anonymous Tonsil Archive

The National Anonymous Tonsil Archive (NATA) is currently receiving approximately 400 tonsil pairs per week from hospitals in England and Scotland. By the end of November 2006, 35,600 tonsil pairs had been collected (figure 1). A further 3000 tonsil pairs from the Medical Research Council Prion Unit, has brought the total number of tonsil pairs in the archive to 38,600. In addition, 1375 collection forms have been completed and returned without accompanying tonsil tissue of which 896 were due to patient objection and 479 specimens having to be retained for analysis as part of the patients' care.

Out of the 100 NHS Hospital Trusts that perform over 200 tonsillectomies per year in England, 88 send tonsil pairs to NATA on a regular basis (figure 2). There are 120 hospitals sites within these trusts taking part in NATA. Approximately 50,000 tonsillectomies are currently performed annually in England.

Scotland; where just over 5000 tonsillectomies are performed each year, joined the project in January 2006. This part of the project is being coordinated by Health Protection Scotland. There are 14 hospitals in Scotland which carry out more than 200 tonsillectomies per year and already 11 of these hospitals have started collecting tonsils for NATA. Tonsil tissue collected in Scotland is being transported to the Health Protection Agency Centre for Infections for inclusion in the archive.

Figure 1 Number of tonsil pairs collected for NATA monthly: January 2004 to November 2006

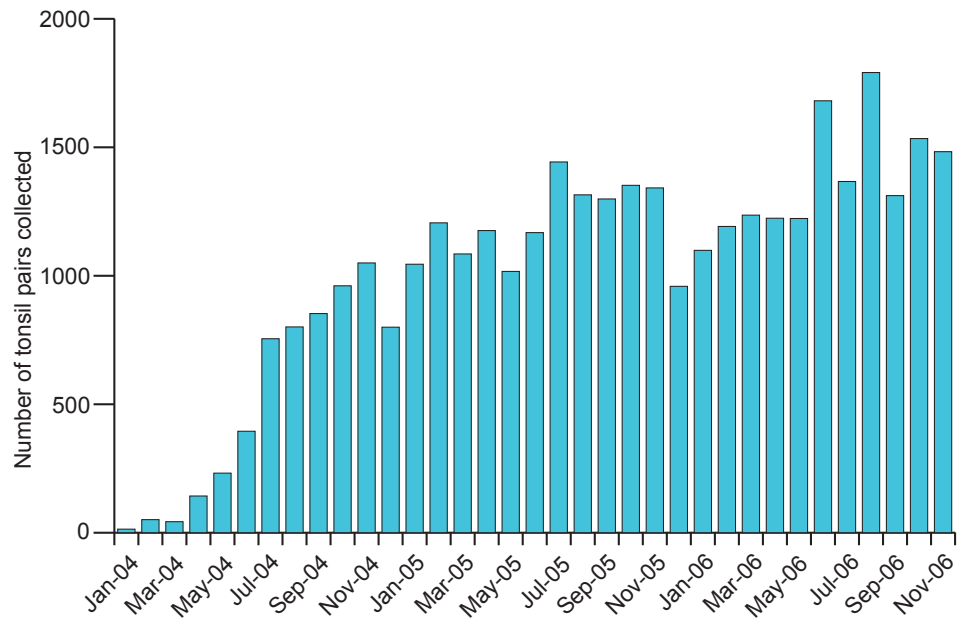
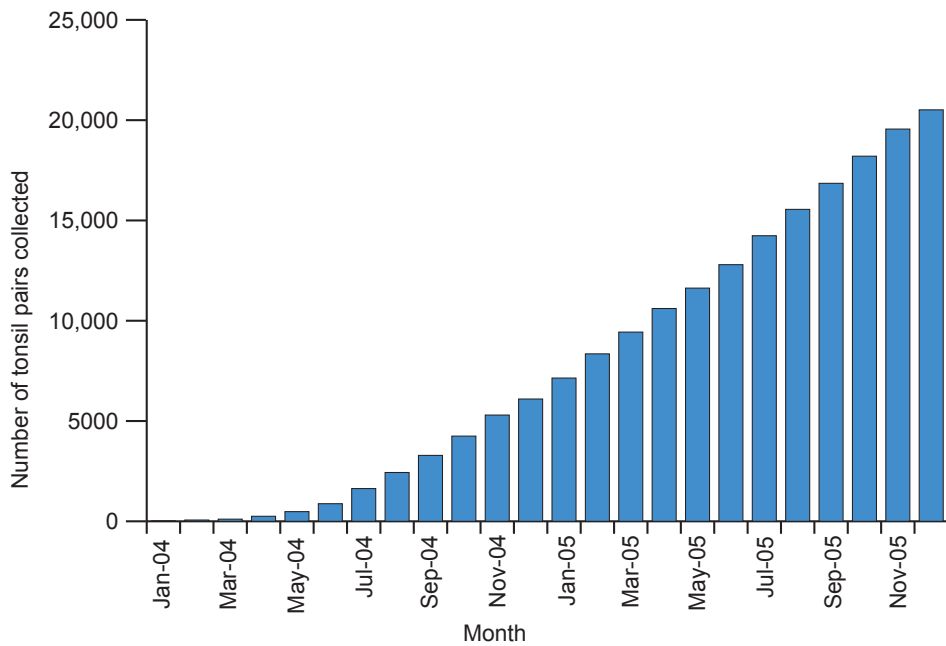


Figure 2 NHS Trusts in England and hospital sites currently sending tonsils to NATA



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