



CDR WEEKLY

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New guidelines on malaria prevention for travellers from the United Kingdom

New practical guidelines on malaria prevention for travellers from the United Kingdom (UK) have been published by the Health Protection Agency [1]. These update and combine previous 2003 guidance issued in 2003 [2,3] in a new format available on the web, and as a handy reference manual.

Updates include extensively revised advice for travellers to the Indian sub-continent, and increased emphasis on bite prevention. The guidelines also highlight that awareness needs to be raised, among those travelling back to endemic countries to visit friends and relatives. The view that this group is relatively protected is a dangerous myth and their children are particularly vulnerable [4].

The guidelines are for use by healthcare workers who advise travellers, but may also be of use to prospective travellers who wish to read about the options themselves. Together with new ACMP malaria treatment guidelines being published in the *Journal of Infection* [5] it is hoped that the risk of illness and death from malaria in UK travellers can be reduced.

Each year between 1500 and 2000 people are diagnosed with malaria on their return to the UK . Anyone visiting a malarious area can become infected no matter what age or sex or ethnic background. Malaria can kill very quickly if not diagnosed in time. In 2005 there were 11 deaths from malaria in the UK [6]. These deaths and illness are, however, avoidable, as most people requiring medical attention for malaria in the UK have not taken the correct precautions needed for their visit.

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1. Chiodini P, Hill D, Laloo D, Lea G, Walker E, Whitty C, Bannister B. *Guidelines for malaria prevention in travellers from the UK*. London: Health Protection Agency, January 2007. Available at <http://www.hpa.org.uk/infections/topics_az/malaria/default.htm>.
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 4. Health Protection Agency. *Migrant health: infectious diseases in non-UK born populations in England , Wales and Northern Ireland . A baseline report – 2006*. London : Health Protection Agency, 2006.
 5. Laloo DG, Shingadia D, Pasvol G, Chiodini PC, Whitty CJ, Beeching NJ, *et al* for the HPA Advisory Committee on Malaria Prevention in UK travellers. *UK malaria treatment guidelines* . *Journal of Infection* In Press.
 6. Health Protection Agency. Malaria imported into the United Kingdom in 2005: implications for those advising travellers. *Commun Dis Rep CDR Wkly* 2006; **16** (23) News. Available at <<http://www.hpa.org.uk/cdr/archives/2006/cdr2306.pdf>>.
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Trends in Antimicrobial Resistance in England and Wales: 2004 to 2005

The Health Protection Agency has published its third report providing a detailed overview of antimicrobial resistance in a range of pathogens (bacteria, viruses, fungi, and protozoa) of public health importance [1]. The majority of the data presented relate to England and Wales, although some data from other European countries are included reflecting the participation of the HPA in the European Antimicrobial Resistance Surveillance Scheme (EARSS). Although this report focuses on data collected during 2004 and 2005, where possible, trend data over a longer period of time are also presented in order to put the most recent data into context.

References

1. HPA. *Trends in Antimicrobial Resistance in England and Wales: 2004 to 2005*. London: Health Protection Agency, 2006. Available at http://www.hpa.org.uk/publications/2006/antimicrobial_resistance/default.htm.

Outbreak of pneumonia due to *Streptococcus pneumoniae* serotype 1 in a primary school in North Tyneside – an update

Since the previous report on the outbreak of pneumococcal pneumonia with three cases occurring between 10 and 13 October in a primary school in North Tyneside [1] two additional cases have been identified within the school. Both cases presented following the half-term break, with dates of onset of 15 and 20 November, with clinical features of acute lobar pneumonia confirmed by chest radiograph. Both were urinary antigen positive for *Streptococcus pneumoniae* and further typing at HPA Centre for Infections detected *S. pneumoniae* serotype 1, as in the previously reported cases. Neither required inpatient hospital treatment.

The children, aged four and five years old, are in a different reception class to the three previously reported cases. At the outset, both reception classes were considered as one cohort because of the degree of shared activity, and children in both classes were included as classroom contacts for the first three cases. Both additional cases had completed a course of rifampicin chemoprophylaxis (given in response to the first three cases) 18 and 23 days before the onset of lobar pneumonia.

With this evidence of ongoing transmission of infection amongst this cohort, further public health protection actions were recommended as a precautionary measure.

All 83 eligible (*ie* over 2 years of age) classroom and household contacts of cases were offered the 23-valent polysaccharide pneumococcal vaccine (PPV - Pneumovax II®), which includes serotype 1. In addition, throat swabs were obtained from all contacts and cases (n=89) to identify *S. pneumoniae* serotype 1 carriage, with a view to offering a further course of chemoprophylaxis to eradicate carriage. As there is no firm evidence-base, the chemoprophylaxis regimen was selected on the basis of antibiotic susceptibility, likely compliance, and the guidance for Group A streptococcal infections, *ie* a five-day course of azithromycin (12mg/kg/day – maximum 500mg) to carriers.

Out of 84 throat swabs submitted up to 19 December 2006, *S. pneumoniae* was identified in three individuals. Serotyping of these three isolates revealed serotype 1, serotype 19F and 23A. The individual with serotype 1 carriage has been given a course of azithromycin.

Of the 83 who were eligible for PPV, 70 have been vaccinated by 19 December. Two individuals did not consent and one had received PPV within the past two years. The others are awaiting vaccination.

Reference

1. HPA. Outbreak of pneumonia due to *Streptococcus pneumoniae* serotype 1 in a primary school in North Tyneside. *Commun Dis Rep CDR Wkly* [serial online]; **16** (47); news. Available at <http://www.hpa.org.uk/cdr/archives/2006/cdr4706.pdf>.

Hepatitis C in England – An Update 2006

The Health Protection Agency has recently published a report, *Hepatitis C in England – An Update 2006*, summarising current knowledge of the infection and the action being taken to tackle it [1]. The report shows that the number of people newly diagnosed with hepatitis C has increased; from 2,116

in 1996, to 7,580 in 2005. New figures also show that testing for hepatitis C has increased overall, for example, in GP surgeries', testing has increased by almost 60 per cent between 2002 and 2005.

Preliminary results from recent work to estimate the number of adults infected with hepatitis C suggest that, in 2003, around 231,000 were predicted to be anti-HCV positive. Many of these infected people do not realise they have the virus as it can take years or even decades for symptoms to appear. Early treatment, however, is effective at clearing the virus in the majority of people. It is therefore important that individuals at risk are tested by their GP or other health services.

The report also highlights the Department of Health's hepatitis C awareness campaign, FaCe It, which has now reached over 16 million people. The exhibition campaign visits cities across England and features large photographic portraits of people living with Hepatitis C.

References

1. Health Protection Agency. *Hepatitis C in England – An Update 2006*. London: HPA, 2006. Available at <http://www.hpa.org.uk/publications/2006/hepc_2006/default.htm>

The Spongiform Encephalopathy Advisory Committee (SEAC) – vacancies for three expert members

The Spongiform Encephalopathy Advisory Committee (SEAC) has vacancies for three expert members: a clinical neurologist, a quantitative epidemiologist, and a public health expert. Members of SEAC are required to be independent and leading experts within their fields, and are selected for their personal knowledge and experience. These are public appointments, not employment, although no meeting allowances, travelling expenses and subsistence allowances will be paid.

The Spongiform Encephalopathy Advisory Committee (SEAC) is appointed by Ministers and sponsored jointly by the Department for Environment, Food and Rural Affairs, the Department of Health and the Food Standards Agency. SEAC is an Advisory Non-Departmental Public Body whose role is to provide independent expert scientific advice to the Government on spongiform encephalopathy such as, Creutzfeldt-Jakob Disease, scrapie, and bovine spongiform encephalopathies. SEAC's remit is wide ranging, covering public health, food safety and animal health issues. SEAC is committed to making as much of its work open to public scrutiny as possible. More information is available at www.seac.gov.uk.

For an application pack, contact Public Appointments at Defra by email at publicappts@defra.gsi.gov.uk or by telephone on 01905 768841. The application forms are also available from <www.defra.gov.uk/corporate/appointments/index.htm>. The closing date for applications is 26 January 2007.


From communicable disease to health protection – the changing face of *CDR Weekly*

As our regular readers will know, this is the last issue of *CDR Weekly*. From January 2007, *CDR* 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. The layout of the *HPR* web pages will be similar to that of the current *CDR* and the Health Protection Agency website, so online readers should feel at home. Those who currently receive a pdf version of *CDR* in their email will automatically receive *HPR*.

The *Communicable Disease Report* first appeared on 6 May 1967, superseding the previous *Weekly Summary* which had been published since the wartime days of the Emergency Public Health Laboratory Service. The original *CDR* was a 'restricted' document and was only placed in the public domain in 1991. Over 500 issues were published from 1991 to 2000 before the transition to an online journal in January 2001, although a pdf version had been available since 1995 as part of the Open Government project. Since then, over 300 issues have been published covering the transition from the Public Health Laboratory Service to the Health Protection Agency. All these past issues will, of course, remain available in the present format and location, providing a valuable week-by-week record of communicable disease issues over the past 16 years.

The *Health Protection Report* will be with you on Friday 5 January at www.hpa.org.uk/hpr.

Immunisation

Last updated: 21 December 2006, Volume 16, No. 51 (PDF file, KB)  **Next update:** 26 January 2007

-  Invasive meningococcal infections, England and Wales: laboratory reports, weeks 43-47 2006
-  COVER programme: July to September 2006

Invasive meningococcal infections, England and Wales : laboratory reports, weeks 43-47 2006

	Method of diagnosis			Total reports	Cumulative*
	CSF and blood Culture	Non-culture	Other sites	43-47/06	Total to week 47/2006
Group A	–	–	–	–	1
B	42	44	5	91	1099
C	–	–	–	–	34
W135	4	–	–	4	25
X	–	–	–	–	–
Y	4	1	–	5	31
Z/29E	–	–	–	–	2
Ungroupable	–	–	–	–	45
Ungrouped	–	3	–	3	13
Total	50	48	5	103	1250

*Latex antigen, microscopy, polymerase chain reaction combined Health Protection Agency Centre for Infections data and Meningococcal Reference Unit data.

COVER programme: July to September 2006

Quarterly vaccination coverage statistics for children aged up to five years in the United Kingdom

This report of the COVER programme presents quarterly coverage data for children in the United Kingdom (UK) who reached their first, second, or fifth birthday during the evaluation quarter, July to September 2006.

Children who reached their first birthday in the quarter would have been scheduled to receive their third-dose primary vaccinations (third-dose diphtheria, tetanus, pertussis [DTP vaccine], *Haemophilus influenzae* type b [Hib vaccine], polio vaccine, and MenC vaccine) between November 2005 and January 2006. Children who reached their second birthday would have been scheduled to receive their third-dose primary vaccinations between November 2004 and January 2005 and first measles, mumps, and rubella (MMR) vaccination between August 2005 and January 2006. Children who reached their fifth birthday would have been scheduled to receive their third-dose primary vaccinations between November 2001 and January 2002, their first MMR between July 2002 and January 2003, their pre-school diphtheria, tetanus, acellular pertussis (DTaP) booster, polio, and second-dose MMR from November 2004 onwards.

This is the fifth quarter to evaluate children at 12 months who have been routinely scheduled for the Pediacel® vaccine (commonly referred to as '5 in 1' vaccine containing DTaP/IPV/Hib) for their whole primary course .

Methods

Methods of data collection for COVER, sentinel MMR coverage and neonatal hepatitis B vaccination coverage are described on the HPA website
<http://www.hpa.org.uk/infections/topics_az/vaccination/cover_methods.htm>).

Results

Data were received from all Health Boards (HBs) in Scotland and Northern Ireland, Administrative Regions (ARs) in Wales, and 290/303 Primary Care Trusts (PCTs) in England (tables 1 and 2). Five of the 31 PCTs in London were unable to publish data this quarter due to ongoing problems relating to the implementation of new child health systems as reported previously [1,2,3,4]. Six of the 28 PCTs in East Midlands were also unable to submit data. Coverage for London and East Midlands published this quarter should therefore be interpreted with caution.

England and UK coverage estimates were not calculated for the previous four COVER quarterly reports due to missing data from seven London PCTs, six of these PCTs are using a new child health system, the Child Health Interim Application (CHIA), in use in ten PCTs in London. This quarter, five of these PCTs have submitted data with caveats about the data quality. Estimates for England and the UK have been calculated, but caution is needed in using these data to evaluate the vaccination programme in London because of these ongoing data quality concerns. Coverage for all antigens at all ages is always significantly lower in London compared to all other regions in England and the devolved administrations. As no England or UK coverage estimates are available for the previous quarter four quarters [4] comparisons to the 2005-06 annual data, published by Information Centre for health and social care in September, have been made instead [5]. Estimates for English regions and devolved administrations can be compared to the previous quarter [4].

Coverage at 12 and 24 months

Ninety-seven of the 324 participating PCTs/HBs/ARs (30%) achieved at least 95% coverage at 12 months for three doses of diphtheria, tetanus, pertussis, polio and Hib vaccine (DTaP/IPV/Hib3) and 104/324 (32%) for three doses of MenC vaccine (MenC) (see note on table 1 for Scotland). All countries and all English regions except London achieved at least 90% coverage at 12 months for DTaP/IPV/Hib. All countries and 7/9 English regions (all but London and East Midlands) achieved at least 90% coverage at 12 months for MenC. One hundred and sixty-nine PCTs/HBs/ARs (52%) achieved at least 95% coverage at 24 months for DTPol3, 167 (52%) for P3, and 159 (49%) for Hib3 and MenC. Only two English PCTs and one Scottish HB achieved 95% coverage for MMR at 24 months.

Compared to the estimates reported in the 2005-06 annual data UK coverage at 12 months for DTaP/IPV/Hib3 remained the same at 92.1% and UK MenC coverage increased by 0.4% to 92.0% (table 1)[5], a trend reflected in all regions and devolved administrations except for London and East Midlands where not all PCTs were able to submit data.

UK coverage at 24 months was similar to the 2005-06 annual for all antigens except for MMR1 coverage which increased by 1% to 85.9%. MMR coverage was highest in Scotland and Northern Ireland, both achieving at least 90.0%; coverage for English regions (excluding London) and Wales ranged from 84.2% to 88.0% with most regions and devolved administrations reporting increased coverage. (table 2)

Table 1 Completed primary immunisations (all antigens) by 12 months: July to September 2006

Region/Country	PCT/HB/AR* (total)	DTaP/IPV/ Hib3 %	MenC %
Regions of England			
North East	16 (16)	93.3	93.3
North West	42 (42)	93.1	93.0
Yorkshire and the Humber	34 (34)	91.0	91.2
East Midlands	22 (28)	91.0	87.7
West Midlands	30 (30)	92.8	92.5
East of England	41 (41)	93.4	93.4
London	26 (31)	80.3	80.6
South East	49 (49)	92.2	92.2
South West	30 (32)	93.3	93.6
England (Total)	290 (303)	91.4	91.2
Wales	3 (3)	95.5	95.3
Northern Ireland	4 (4)	95.9	96.0
Scotland	14 (14)	96.5	98.0†
United Kingdom	312 (324)	92.1	92

*PCTs/health boards/administrative regions.

† Two doses before 12 months.

n/a = not available.

Table 2 Completed primary immunisations (all antigens) by 24 months: July to September 2006

Region/Country	PCT/HB/AR* (total)	DTPol3 %	P3 %	Hib3 %	MenC %	MMR1%
Regions of England						
North East	16 (16)	95	95	94.8	94.7	87.9
North West	42 (42)	95.3	95.3	95.1	95.2	87.6
Yorkshire and the Humber	34 (34)	93.7	93.7	93.5	93.7	85.7
East Midlands	22 (28)	94.5	94.4	94.4	92.8	87.6
West Midlands	30 (30)	94.6	94.6	94.4	94.6	86.9
East of England	41 (41)	95.1	95.0	94.9	94.8	84.2
London	26 (31)	86.3	86.3	86	85.4	72.5
South East	49 (49)	93.7	93.6	93.5	92.9	85.4
South West	30 (32)	96.1	96	96.1	95.9	87.2
England (Total)	290 (303)	93.9	93.9	93.8	93.4	85.0
Wales	3 (3)	96.7	96.7	96.4	96.4	88.0
Northern Ireland	4 (4)	97.1	97.1	97	97.3	90.8
Scotland	14 (14)	97.7	97.7	97.4	97.1	92.0
United Kingdom	312 (324)	94.5	94.5	94.3	94.0	85.9

*PCTs/health boards/administrative regions n/a = not available

Coverage at 5 years

Data were received from localities in England (290/303), Northern Ireland (4/4), and Wales (3/3). Data for Scotland were unavailable and therefore it was not possible to produce UK estimates for coverage at five years. Comparing this quarter to the 2005-06 annual figures, five year coverage in England for all antigens except MMR1 and MMR2 remained very similar (table 3) [5]. Coverage for MMR1 decreased 1.2% and MMR2 increased by 1.1%.

Compared to last quarter, five year coverage for Northern Ireland increased between 0.1% and 0.4% for DTPol3, P3, and MMR1 and decreased by 0.2% for MenC, 0.3% for Hib, 0.8% for MMR2, and 0.9% for DTaP/Pol4. In Wales coverage decreased between 0.3% and 0.4% for P3, Hib and MenC, and increased by 0.7% for MMR1, 1.1% for MMR2 and 0.3% for DTaP/Pol4.

Table 3 Completed primary immunisations (all antigens) by 5 years: July to September 2006

Region/Country	PCT/HB/AR* (total)	DTPol3 %	P3 %	Hib3 %	MenC %	MMR1 %	MMR2 %	DTPol4 %
Regions of England								
North East	16 (16)	95.7	95.2	95.5	95.2	89.5	78.8	85.6
North West	42 (42)	95.4	94.9	94.6	95	88.4	76.4	82.8
Yorkshire and the Humber	34 (34)	94.8	94.5	94.1	93.9	89.3	76.5	80.6
East Midlands	22 (28)	95.5	95.1	95.3	94.1	89.3	75.1	82.0
West Midlands	30 (30)	95.6	95.2	94.5	94.9	88.5	76.4	83.5
East of England	41(41)	93.9	93.4	93.5	92.1	82.2	73.1	82.4
London	26 (31)	83.1	82.8	82.6	80.2	75.2	51.7	56.7
South East	49(49)	93.6	93.1	93.3	91.9	85.1	72.3	81.7
South West	30 (32)	96.2	95.4	95.7	94.9	88.0	77.0	85.4
England (Total)	290(303)	93.9	93.4	93.3	92.5	85.8	72.9	80.3
Wales	3 (3)	95.4	94.1	94.9	94.4	87.2	75.6	84.8
Northern Ireland	4 (4)	97.5	97.0	96.2	96.1	95.3	86.2	88.0
Scotland	14 (14)	n/a	n/a	n/a	n/a	n/a	n/a	n/a
United Kingdom	312 (324)	n/a	n/a	n/a	n/a	n/a	n/a	n/a

*PCTs/health boards/administrative regions n/a = not available at time of going to press

MMR sentinel surveillance scheme coverage

For methods of data collection see

http://www.hpa.org.uk/infections/topics_az/vaccination/cover_methods.htm.

Data collected from September to November 2006 for children in the four age cohorts is summarised in table 4. The range for the three months was from 74.2% to 76.8%, at 16 months, 82.5% to 82.6% at 20 months, 84.2% to 85.1% at 24 months, and 87.7% to 88.6% at 36 months).

Table 4 Monthly sentinel estimates of measles, mumps, and rubella (MMR) coverage at 16, 20, 24, and 36 months: July to September 2006

Evaluation month	Number of PCTs/trust	Age at vaccination			
		16 months	20 months	24 months	36 months
Sep 06	39	76.8	82.5	84.8	88.2
Oct 06	39	75.2	82.6	85.1	88.6
Nov 06	38	74.2	82.6	84.2	87.7

Hepatitis B vaccine coverage data in England

The data presented below represents coverage for three doses of hepatitis B vaccine in those infants born to HBsAg positive mothers who reached the age of one year in this quarter (ie those

born between July to September 2005), and coverage of four doses of vaccine in infants who reached two years of age (*ie* those born between July to September 2004).

Table 5 Neonatal hepatitis B coverage in England : July to September 2006

Region	Returns with data	12 month denominator	Coverage at 12 months	24 month denominator	Coverage at 24 months
North East	11	–	–	–	–
North West	27	27	70%	32	63%
Yorkshire & the Humber	30	36	83%	36	58%
East Midlands	11	16	81%	10	40%
West Midlands	26	65	74%	32	31%
East of England	35	28	71%	28	14%
London	17	152	74%	144	64%
South East	43	28	82%	33	58%
South West	23	6	50%	4	25%
Total	223	358	75%	319	54%

Data were received for 222/303 (73%) PCTs in England, the highest reporting level since mandatory reporting was introduced in April 2005, and 32 more than reported in the last quarter [4]. Coverage in England for three doses in those aged one year reached 75% overall, 1% up on last quarter [4] (table 5). Although this is lower than the coverage obtained for routine antigens at this age (table 1), the population at risk are highly mobile and high uptake is difficult to achieve [5-9]. The largest number of infants at risk is in London where coverage was 74% at 12 months (table 5). Coverage in England for four doses in those aged 24 months was lower at 54%; a decrease of 1% on last quarter. As data systems are still being established in some areas, it is likely that 24 month data is less complete and therefore that this represents an under-estimate of coverage at this age.

Comments

The HPA has been cautious and not published national quarterly data since September 2005 due to missing data from London PCTs using a new child health system, CHIA, supplied to ten PCTs in London as this may have led to a spurious increase in coverage which would be misleading. This is the first COVER report in over a year where UK and England coverage estimates have been produced as five of these PCTs have submitted data this quarter. However, there are still issues of data quality with the output from this system. CHIA is unable to schedule appointments and identify defaulters for re-invitation and follow-up and this may have led to falls in vaccination coverage as well as poorer data quality. Unlike the previous system, CHIA has not been generating automated COVER reports, the method used to produce vaccination coverage data, and this may have led to inflated denominators and apparently decreased coverage, particularly at 12 and 24 months. Two of the CHIA PCTs have submitted COVER data based on the GP EMIS system rather than the CHIA system, although this is incomplete as not all practices are represented. Consequently, London coverage data should still be interpreted with caution. Data for the five other CHIA PCTs is still not available for publication. HPA has previously stated that the missing quarters' data would be published as soon as it becomes available. If the next annual data are supplied before the missing quarters become available, then these data will supplant the missing quarter.

As no England or UK coverage estimates are available for the previous quarter four quarters [4] comparisons have been made instead to the 2005-06 annual data, published by Information Centre for health and social care in September this year [5]. Estimates for English regions and devolved administrations can be compared to the previous quarter [4].

UK coverage data for all antigens evaluated at 24 months this quarter was similar to that observed in the 2005-06 annual statistics, with the exception of MMR. MMR coverage continues to improve, increased by 1% to 85.9% compared to 2005-06 annual, and is now at the highest level recorded since January to March 2001, when coverage was 86.4% [11]. The monthly MMR sentinel surveillance data suggests that this trend should continue into the early part of 2007 as estimated coverage at 20 months has risen consecutively for each of the last nine monthly evaluations. The introduction of the new pneumococcal booster in September 2006 may have temporarily affected MMR uptake at 16 months as the October and November evaluations are lower than figures reported consecutively in the previous six months [1,4]. This is consistent with some PCTs having

reported that they have delayed MMR1, normally scheduled at around 13 to 15 months of age, by a month or two to accommodate the pneumococcal catch-up programme. If the delay in immunisation is only a month or two then routine 24 month MMR1 coverage should not be affected.

As of 1 October 2006, the new PCT configurations in England (except London) came into effect [12]. In relation to COVER report data, any changes to PCT responsible populations should not be made until after the October to December 2006 quarter data have been submitted.

Neonatal hepatitis B vaccination

Reporting of neonatal hepatitis B vaccination has improved and almost 75% of all English PCTs provided data this quarter, the highest reporting level since mandatory reporting was introduced in April 2005. However, many PCTs that sent in returns had zero cases in this period. It is unclear whether these latter returns represent valid data for areas with a low prevalence of infection or missing data. It is hoped that PCTs will increasingly give these returns the priority level to match their status; the quality of neonatal hepatitis B reporting should also improve as more areas establish new data systems which can capture these data.

Relevant links for country specific coverage data

Wales

<<http://www.wales.nhs.uk/sites/page.cfm?OrgID=368&PID=2278>>

Scotland

<<http://www.show.scot.nhs.uk/scieh/>>

Northern Ireland

<<http://www.cdscni.org.uk/surveillance/Coveragestats/default.asp>>

England

<<http://www.ic.nhs.uk/pubs/immstats2005to2006>>

Other relevant links

<http://www.hpa.org.uk/infections/topics_az/vaccination/vac_coverage.htm>

<<http://www.mmrthefacts.nhs.uk/>>

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Bacteraemia

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- Results of the voluntary reporting scheme for bacteraemia due to *Enterococcus* spp, England, Wales, and Northern Ireland: 2005
 - Uncommon pathogens involved in bacteraemia, England, Wales, and Northern Ireland: 2001 to 2005
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Results of the voluntary reporting scheme for bacteraemia due to *Enterococcus* spp, England, Wales, and Northern Ireland: 2005

This report covers voluntary reports of bacteraemia due to *Enterococcus* spp (including Group D streptococci) made to the Health Protection Agency in 2005 from laboratories in England, Wales, and Northern Ireland. Age-specific rates of enterococcal bacteraemia were calculated using Office of National Statistics 2005 mid-year resident population estimates as denominators. Data were extracted on 25 October 2006, by which time ascertainment for 2005 should be near complete. Data were analysed and displayed according to current regional boundaries, and are provisional..

Where the percentage resistance to a specific antibiotic is given, the denominator excludes those reports without any susceptibility information for that antibiotic.

- In 2005 there were 7066 laboratory reports (table 1) of enterococcal bacteraemia, compared to 6533 reports in 2004. This represents an 8% increase, a level of increase which has not been observed for bacteraemias caused by other species in the same period.
- In 2005, *E. faecalis* accounted for 63% and *E. faecium* for 28% of reports where enterococci were identified to species level; these results are similar to those noted in 2004. However, examination of reported resistance patterns, particularly ampicillin/amoxycillin and dalfopristin/quinupristin, has highlighted continuing possible misidentification of enterococci.
- More than half of the *E. faecalis* and *E. faecium* reports were in those aged 65 years and over.
- Susceptibility reporting indicated that 3% of *E. faecalis* and 25% of *E. faecium* bacteria were resistant to vancomycin. The former will be an overestimate if some *E. faecium*, in which vancomycin resistance is more common, are being misidentified as *E. faecalis*.
- Resistance or intermediate resistance to linezolid was reported in 12 (1%) of 1123 enterococci reports that contained susceptibility information for this antibiotic. Linezolid resistance remains uncommon and it is important to confirm this resistance: any such isolates should be forwarded to the Health Protection Agency's Antibiotic Resistance Monitoring and Reference Laboratory (ARMRL). Investigation of unusual resistance reports is a function of this reference service.
- In addition to voluntary surveillance of enterococcal bacteraemia, mandatory surveillance of bacteraemia specifically due to glycopeptide-resistant enterococci (GRE) commenced in October 2003. The most recent publication of these results can be found at <http://www.hpa.org.uk/infections/topics_az/hai/mandatory_report_2006.htm>. Information on the mandatory GRE bacteraemia surveillance scheme at <http://www.hpa.org.uk/infections/topics_az/enterococci/mandatory_surveillance.htm>.

Table 1 Laboratory reports of bacteraemia due to *Enterococcus* spp, England, Wales, and Northern Ireland: 2003 and 2005

	2003	%*	2004	%*	2005	%*
<i>Enterococcus faecalis</i>	2768	64.7	2916	63.6	3106	62.8
<i>Enterococcus faecium</i>	1070	25	1255	27.4	1403	28.4
Streptococci Group D	222	5.2	161	3.5	153	3.1
<i>Enterococcus gallinarum</i>	97	2.3	106	2.3	143	2.9
<i>Enterococcus durans</i>	51	1.2	52	1.1	51	1
<i>Enterococcus avium</i>	39	0.9	58	1.3	44	0.9
<i>Enterococcus casseliflavus</i>	21	0.5	28	0.6	35	0.7
<i>Enterococcus raffinosus</i>	5	0.1	4	0.1	8	0.2
<i>Enterococcus hirae</i>	4	0.1	3	0.1	3	0.1
<i>Enterococcus</i> not fully identified	2010		1950		2120	
	6287		6533		7066	

*As a percentage of all reports where enterococci were identified to species level.

Further data tables and graphs about *Enterococcus* spp bacteraemias, England, Wales, and Northern Ireland: 2005 can be viewed at <

http://www.hpa.org.uk/infections/topics_az/enterococci/voluntary_surveillance_results.htm >

Uncommon pathogens involved in bacteraemia, England, Wales, and Northern Ireland: 2001 to 2005

This report concerns bacteria identified from blood samples and reported voluntarily by laboratories in England, Wales, and Northern Ireland, from 2001 to 2005. The reports were made to the Health Protection Agency's Centre for Infections. Data were extracted on 23 November 2006, by which time ascertainment for 2005 should be near complete. Data are provisional.

This report covers uncommon pathogens involved in bacteraemias. Uncommon pathogens are defined as organisms from genera with small numbers of reports in 2005.

Some of these voluntary reports provide further details on clinical history, such as history of recent surgery, recent travel history, and risk factors (eg, use of an intravascular line). This limited information does not include details of the clinical significance of the infection, whether or not it was acquired in the community or in hospital, or whether or not it was identified and treated as the cause of the clinical condition.

A list of uncommon pathogens reported between 2001 and 2005 can be

<http://www.hpa.org.uk/infections/topics_az/bacteraemia/Uncommon/Uncommon_2001_2005.htm>

Specific queries about this report can be sent to hcai.amrddivision@hpa.org.uk