



# Health Protection Report

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## News

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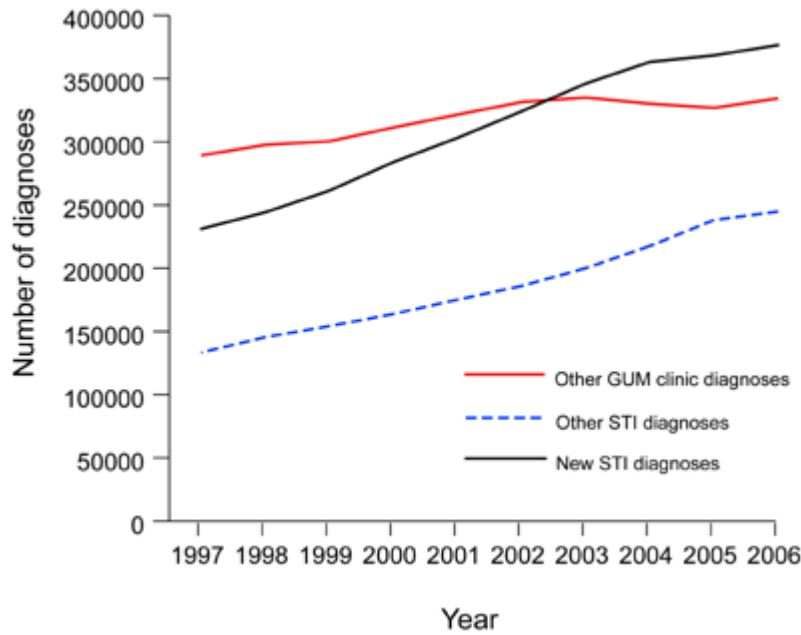
### Sexually transmitted infection diagnoses and services provided in genitourinary medicine clinics in the UK in 2006

The number of new diagnoses (table 1) of sexually transmitted infections (STIs) in genitourinary medicine (GUM) clinics in the United Kingdom (UK) rose by 2% from 368,341 to 376,508 between 2005 and 2006. (This is not the number of people with a new diagnosis of an STI, as multiple diagnoses can be made in individual patients.) Total numbers of diagnoses of STIs, which includes recurrent and follow-up presentations as well as new diagnoses, rose by 2% from 606,545 to 621,312 in 2006 (figure 1). The data present a mixed picture, with decreasing numbers of some STIs and increases in others.

<b>New STI Diagnoses</b>
Chlamydial infection (uncomplicated and complicated)
Gonorrhoea (uncomplicated and complicated)
Infectious syphilis
Genital herpes simplex (first attack)
Genital warts (first attack)
New HIV diagnosis
Non-specific genital infection (uncomplicated and complicated)
Chancroid/lymphogranuloma venerum (LGV)/Donovanosis
Molluscum contagiosum
Trichomoniasis
Scabies
Pediculus pubis
<b>Other STI Diagnoses</b>
Early latent, congenital and other acquired syphilis
Recurrent genital herpes simplex
Recurrent and re-registered genital warts
Subsequent HIV presentations (including AIDS)
Ophthalmia neonatorum (chlamydial or gonococcal)
Epidemiological treatment of suspected STIs (syphilis, chlamydia, gonorrhoea, non-specific genital infection)
<b>Other diagnoses made at GUM clinics</b>

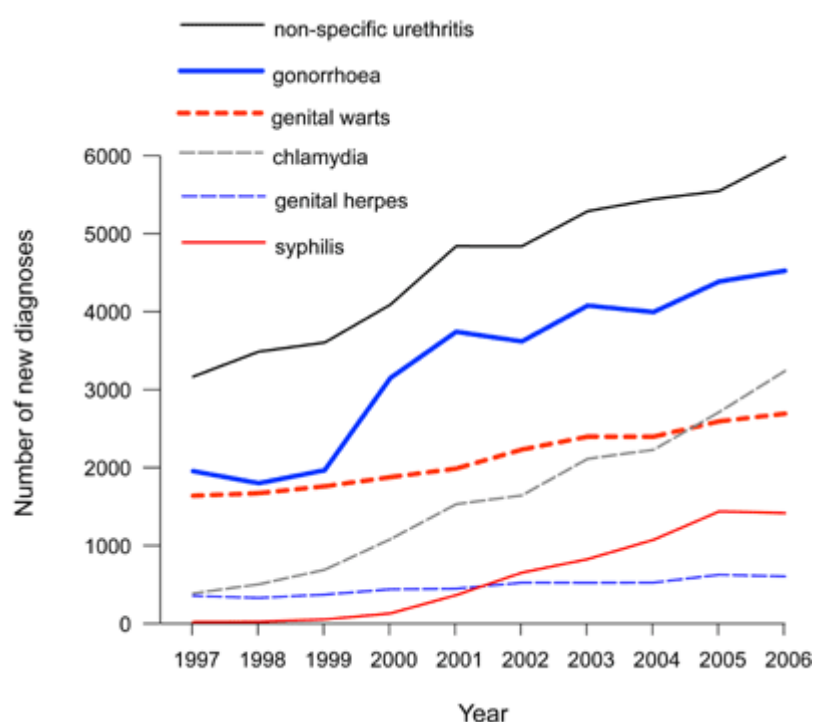
Viral hepatitis B and C
Vaginitis and balanitis (including epidemiological treatment)
Anogenital candidiasis (including epidemiological treatment)
Urinary tract infection
Cervical abnormalities
Other conditions requiring treatment at a GUM clinic
<b>Services provided</b>
HIV antibody test
Sexual health screen
Hepatitis B vaccination
Contraception (excluding condom provision)
Other episode not requiring treatment

**Figure 1 Trends in diagnoses made in GUM Clinics in the United Kingdom**



Sustained increases in STI diagnoses in men who have sex with men (MSM) are of particular concern. New diagnoses of all STIs in MSM have risen consistently for the last ten years, and between 2005 and 2006 increased by 3% (4386 to 4524) for gonorrhoea, by 19% (2712 to 3239) for chlamydia and by 4% (2593 to 2691) for genital warts (figure 2). These data indicate that the resurgence in sexual risk taking by MSM that began over five years ago continued unabated in 2006 and has probably lead to continuing HIV transmission within this population in the UK.

**Figure 2 New diagnoses of selected STIs in men who have sex with men**



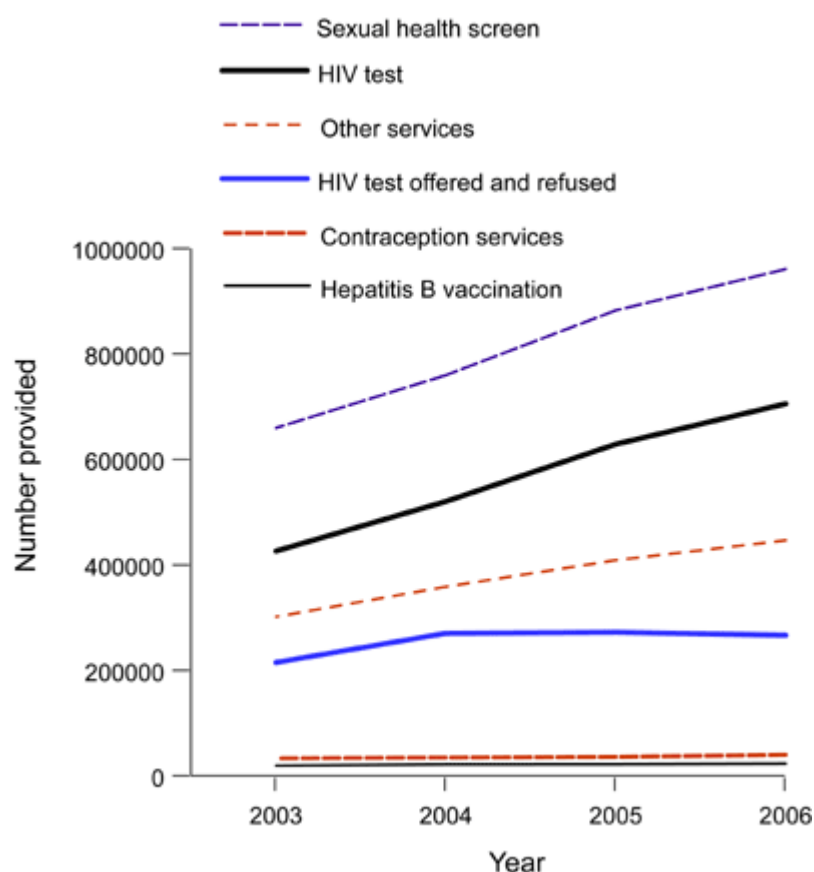
Genital chlamydia infection was the most commonly diagnosed STI in GUM clinics, with 113,585 diagnoses of uncomplicated infection made in 2006, a rise of 4% on 2005. Numbers have risen steadily in men and women since the mid-1990s, probably as a result of increased testing, improved diagnostic tests and possibly changes in sexual behaviour. The National Chlamydia Screening Programme is offering regular tests to young adults in health settings outside of GUM clinics and it is estimated that 51% of Primary Care Trusts have now begun screening, and a further 34% are about to start. It is likely, however, that there is still a substantial amount of undiagnosed infection in young men and women.

New diagnoses of first episodes of genital herpes and genital warts have been steadily rising since the early 1990s, and increases were again noted in 2006. Rises were most pronounced in young adults, with numbers of diagnoses in 16 to 19 year old women rising by 16% (2,416 to 2,803) for genital herpes and 5% (11,234 to 11,845) for genital warts. Rates of all STIs were highest in 16 to 24 year olds, and health promotion messages must continue to focus on this age group.

Meanwhile, new diagnoses of gonorrhoea and syphilis declined in 2006. Numbers of gonorrhoea diagnoses rose sharply in the mid 1990s, probably as a result of increasing unsafe sexual behaviour, but have been in decline in both men and women since 2003, with an overall 1% (19,248 to 19,007) drop in 2006. In 2006 there were 2766 diagnoses of infectious syphilis, a drop of 1% from 2005. This was mostly accounted for by a 19% drop among women, from 420 to 342 diagnoses. There was a 2% rise in syphilis diagnoses among men from 2384 to 2424 over the same period.

The provision of other services by GUM clinics was substantial and continued to rise between 2005 and 2006. The number of HIV tests undertaken rose by 12% from 628,810 to 705,502, and the number of sexual health screens rose by 9% from 882,593 to 960,868 (figure 3). Improved uptake of testing and screening could, if sustained, have a significant impact on the control of STIs.

**Figure 3 Trends in services provided at GUM clinics in the United Kingdom**



A full report can be seen on the HPA website at  
<[http://www.hpa.org.uk/infections/topics\\_az/hiv\\_and\\_sti/epidemiology/datatables2006.htm](http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/epidemiology/datatables2006.htm)>

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### Q fever cluster in Cheltenham

Avon, Gloucestershire, and Wiltshire Health Protection unit has received five reports of acute Q fever with onset dates between the end of May and 14 June 2007. All five confirmed cases are residents of the town of Cheltenham (Gloucestershire), population 109,800. There had been no cases reported in Gloucestershire since 2002. The cases reported in Cheltenham did not have any occupational risk factors. Although all five cases reported possible environmental risk factors, no common exposures have been identified so far.

Q fever (*Coxiella burnetii*) is thought to account for approximately 1% of community acquired pneumonia in the United Kingdom (UK) each year, and can result in serious complications such as endocarditis. The main reservoir is sheep and other animals that can shed massive numbers in placental tissues. The main reservoirs are sheep, goats and cattle. Transmission of Q fever occurs primarily through inhalation of contaminated aerosols. The organism is robust and can survive in dust and animal litter for many weeks, and in dried blood for at least six months at room temperature. The most infectious animal materials are the fluids of birth and afterbirth, followed by blood, milk, urine and faeces. Such infectious materials can be derived from livestock as above, or from domestic animals, particularly parturient cats.

Although Q fever is rare in the UK , it is more common in the south west of England and Northern Ireland, probably because of higher exposure to animal sources.

The Health Protection Unit would be grateful for information on any cases of Q fever who have visited Gloucestershire during the incubation period (two to three weeks depending on the infective dose). Please contact the [Consultant Regional Epidemiologist, Isabel Oliver](#) email: [Isabel.oliver@hpa.rg.uk](mailto:Isabel.oliver@hpa.rg.uk).

A standard questionnaire for newly diagnosed cases of Q fever can be obtained from the Emerging Infections and Zoonoses section of the Centre for Infections. Please contact Mandy Walsh on 020 8327 7483, email: [amanda.walsh@hpa.org.uk](mailto:amanda.walsh@hpa.org.uk).

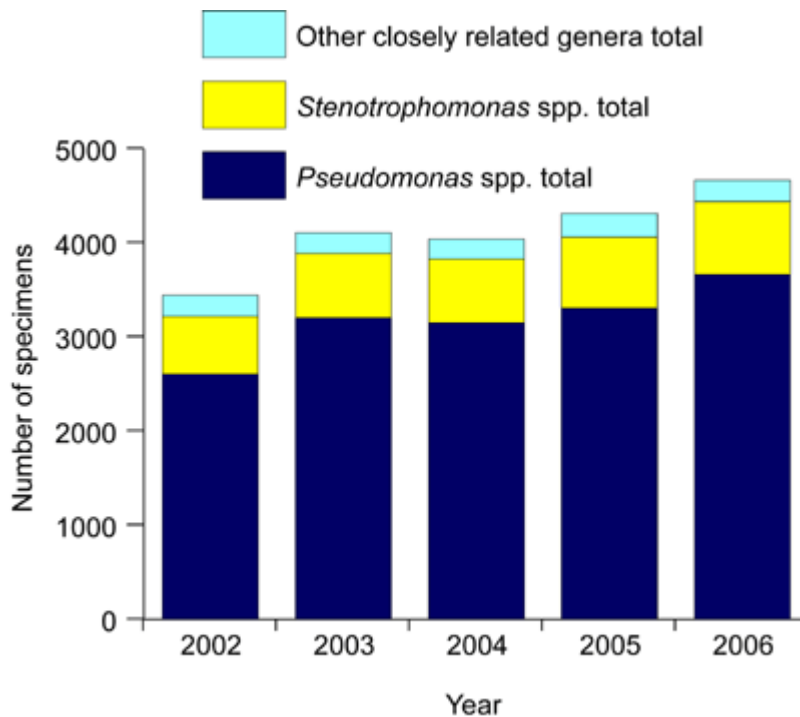
## Bacteraemia

Last updated: 20 July

### *Pseudomonas* spp and *Stenotrophomonas maltophilia* in England , Wales and Northern Ireland: 2002 to 2006

There has been a 6% increase (figure 1) in the reported cases of bacteraemia for *Pseudomonas* spp, *Stenotrophomonas* spp. and other closely related species reported via the voluntary surveillance scheme in 2006 (4664 reports), compared to 2005 (4313 reports). Data are provisional as of 3 July 2007 and the number of bacteraemia reports for these species are expected to increase due to late reporting .

**Figure 1 *Pseudomonas* spp and *Stenotrophomonas* spp and other closely related species bacteraemia reports: 2002 to 2006\***



\* Data extracted 3 July 2007.

Since 2002 there has been a 35% increase in bacteraemia reports for *Pseudomonas* spp., *Stenotrophomonas* spp. and other closely related species, an increase which is comparable to the 34% increase in reports for all bacteraemia (71,053 to 95,300) via the voluntary surveillance scheme during the same time period. The increase may be due to either increased incidence and/or increased ascertainment.

Most cases (57%) of *Pseudomonas* spp. bacteraemia in 2006 occurred in people aged 65 years and over, predominantly in males (59%). The percentage of reports for *P. aeruginosa* bacteraemia including susceptibility tests for at least one antimicrobial agent has increased from 77% in 2002 to 90% in 2006.

Almost all bacteraemia due to *Stenotrophomonas* spp. in 2006 were attributed to *S. maltophilia* (773 of 774 reports). Two thirds of reported cases of *Stenotrophomonas* spp. bacteraemia occurred in people aged under 65 years of age, with distribution almost equal among men and women (48% vs 52%, respectively).

Other bacteraemia reported in 2006 for other closely related species include *Sphingomonas paucimobilis* (63 reports), *Flavimonas oryzihabitans* (31 reports), and *Burkholderia cepacia* (31 reports).

#### Antimicrobial resistance:

Since 2002, there been no significant changes in resistance to the following antimicrobials in reported cases of *P. aeruginosa* bacteraemia: ciprofloxacin (12%), ceftazidime (6%) or piperacillin/tazobactam (4%). Resistance to gentamicin has decreased from around 9% prior to 2004 to 5% in 2006. For the carbapenems, there have been observed increases in resistance to imipenem (from 8% in 2002 to 11% in 2006) and meropenem (from 6% in 2002 to 11% in 2006). These changes should be interpreted with caution as the number of resistant-positive specimens is low. The percentage of reports with susceptible data for any of these medications has increased from 77% in 2002 to 90% in 2006.

For *S. maltophilia*, there were increased resistances reported from 2002 to 2006 for gentamicin (from 46% to 61%), ceftazidime (from 11% to 20%), and piperacillin/tazobactam (10% to 14%). The rates of resistance to ciprofloxacin and co-trimazole remain unchanged at around 63% and 4%, respectively. The percentage of reports with susceptibility data for any of these medications has increased from 67% in 2002 to 79% in 2006.

The analyses presented are based on data extracted from the voluntary surveillance database on 3 July 2007 for the period 2002 to 2006. The data presented here differ in some instances from data in earlier publications due to the addition of late reports to the database.

Further information and data is available at

[http://www.hpa.org.uk/infections/topics\\_az/pseudomonas/hpr/default.htm](http://www.hpa.org.uk/infections/topics_az/pseudomonas/hpr/default.htm)

## Diary

### Laboratory Diagnosis of Diphtheria Workshop

A workshop on the Laboratory Diagnosis of Diphtheria will be held at the Health Protection Agency Centre for Infections from 3 to 5 October. The workshop will be held over two and a half days and will comprise of an afternoon of a series of presentations and discussions about the clinical, epidemiology and public aspects of diphtheria and related infections. The next two days will be practical based in diagnostic laboratory areas including primary culture, screening tests and identification methods.

For overseas participants from Diphtheria Reference Laboratories, phenotypic and molecular toxigenicity testing and serological assays will also be covered.

The registration fee for the workshop is £200 excluding travel and accommodation. For further details, please email [DIPNET@hpa.org.uk](mailto:DIPNET@hpa.org.uk)