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Malaria risk for travellers

Falciparum malaria has recently been diagnosed in two German tourists who had returned from a holiday in Punta Cana in the Dominican Republic [1]. In accordance with German guidelines neither case had taken malaria chemoprophylaxis, though both had used insect repellents. The United Kingdom (UK) guidelines, developed by the Advisory Committee on Malaria Prevention in UK Travellers (ACMP), do recommend malaria chemoprophylaxis for travellers to the Dominican Republic [2]. The National Travel Health Network and Centre (NaTHNaC) is reiterating current advice about malaria for those travelling to endemic areas over the forthcoming holiday season [3].

Malaria occurs in most tropical and sub-tropical regions of the world, including popular winter sun destinations (such as the Dominican Republic, The Gambia, and Goa, India) as well as other countries in West Africa and the Indian sub-continent, which are regions popular with those visiting friends and relatives. A total of 1758 cases of malaria occurred in the UK in 2006, the majority acquired in West Africa [4]. Clusters of falciparum malaria cases were also reported in those returning from The Gambia during the winter months in 2005 and 2006 [5, 6].

Travellers should ensure that they see their general practitioner or a travel health advice specialist for a full risk assessment ideally at least one month before departure. If, however, a trip has been booked at the last minute, travellers should still ensure they see a travel health practitioner before departure, particularly if they are travelling to a tropical destination. Country specific travel health advice is available for all countries on the NaTHNaC website at http://www.nathnac.org/ds/map_world.aspx and the UK malaria guidelines developed by the Advisory Committee on Malaria Prevention in UK Travellers (ACMP), are available at http://www.hpa.org.uk/infections/topics_az/malaria/guidelines.htm.

Travellers who fall ill after a visit to a malarious area should seek prompt medical attention and be aware that malaria can present up to a year or more after return. Healthcare professionals should always take a travel history from anyone with a fever or flu-like illness, and be aware that absence of fever in an ill patient does not exclude the diagnosis of malaria. If the travel history includes travel to a malarious area in the past year, a blood film examination should be performed without delay.

Malaria is a notifiable disease, all malaria cases should also be reported to the Health Protection Agency Malaria Reference Laboratory. Reporting forms are available at <http://www.malaria-reference.co.uk/>.

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BPSU 21st Annual Report

The British Paediatric Surveillance Unit (BPSU) has recently published its 21st annual report [1]. The report mainly focuses on activities undertaken during the year 2006. Reference is also made to studies and activities, which commenced in the year 2007 [1].

Three new BPSU studies began during the reporting period: malaria in childhood, vitamin K deficiency bleeding (VKDB), and maternal alloimmune thrombocytopenia (FMAIT)

Six studies had their period of surveillance extended for a further year in 2006: HIV, congenital rubella, progressive intellectual and neurological deterioration (PIND), medium chain acyl CoA herpes simplex virus and childhood scleroderma. Surveillance of early onset eating disorders (EOED) ended in May 2007, though a one- year follow is currently underway.

The British Paediatric Surveillance Unit (BPSU) was set up in 1986 to facilitate research into rare childhood diseases in the UK and the Republic of Ireland. The Unit is a collaboration between RCPCH and the Health Protection Agency, The University College London – Institute of Child Health (London), Health Protection Scotland (HPS), and The Faculty of Paediatrics of the Royal College of Physicians of Ireland.

References

1. *BPSU 21st Annual Report 2006-2007*. Londo : British Paediatric Surveillance Unit, Royal College of Paediatrics and Child Health, 2007. Available at <http://bpsu.inopsu.com/publications/annual_reports/BPSU%20Annual%20report%202006-7.pdf>

Respiratory

Laboratory reports of respiratory infections made to Cfl from HPA and NHS laboratories in England and Wales: weeks 44-48/2007

Data are recorded by week of report, but include only specimens taken in the last eight weeks (i.e. recent specimens)

Table 1 Reports of influenza infection made to Cfl, by week of report: weeks 44-48/2007

Week	Week 44	Week 45	Week 46	Week 47	Week 48	Total
Week ending	04/10/07	11/10/07	18/10/07	25/10/07	02/12/07	
Influenza A	4	1	2	6	8	21
Isolation	1	–	–	2	4	7
DIF	–	–	1	1	3	5
Four-fold rise in paired sera	–	–	–	–	–	–
PCR	–	–	–	2	–	2
Other	3	1	1	1	1	7
Influenza B	2	2	1	1	1	7
Isolation	–	–	–	–	–	–
DIF	–	1	1	3	–	5
Four-fold rise in paired sera	–	–	–	–	–	–
PCR	–	–	–	–	2	2
Other	2	1	–	–	–	3
Influenza (untyped)	–	–	–	–	–	–
Isolation	–	–	–	–	–	–
DIF	–	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–	–
PCR	–	–	–	–	–	–
Other	–	–	–	–	–	–

*DIF = Direct Immunofluorescence.

†'Other' = 'Antibody detection - Single high titre' or 'method not specified'.

Table 2 Respiratory viral detections by any method (culture, direct immunofluorescence, PCR, four-fold rise in paired sera, single high serology titre), by week of report: weeks 44-48/2007

Week	Week 44	Week 45	Week 46	Week 47	Week 48	Total
Week ending	04/10/07	11/10/07	18/10/07	25/10/07	02/12/07	
Adenovirus*	16	12	25	23	27	103
Coronavirus	1	–	–	–	1	2
Parainfluenza †	27	16	25	26	26	120
Rhinovirus	51	21	28	33	36	169
Respiratory Syncytial Virus (RSV)	196	146	352	276	550	1520

*Respiratory samples only. Excludes diagnoses made by electron microscopy (EM)

†includes parainfluenza types 1, 2, 3, 4 and untyped.

Table 3 Respiratory viral detections by age group: weeks 44-48/2007

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥65 years	Unknown	Total
Adenovirus*	29	17	13	32	9	2	1	103
Coronavirus	–	–	–	–	–	2	–	2
Influenza A	1	3	5	7	2	2	1	21
Influenza B	1	1	1	1	2	1	3	10
Parainfluenza†	57	29	17	6	5	4	2	120
Rhinovirus	90	34	19	15	8	2	1	169
Respiratory Syncytial Virus (RSV)	1228	202	16	19	19	20	16	1520

*Respiratory samples only.

†includes parainfluenza types 1, 2, 3, 4, and untyped.

Table 4 Laboratory reports of infections associated with atypical pneumonia, by week of report: weeks 44-48/2007

Week	Week 44	Week 45	Week 46	Week 47	Week 48	Total
Week ending	04/10/07	11/10/07	18/10/07	25/10/07	02/12/07	
<i>Coxiella burnetii</i>	3	1	4	–	–	8
respiratory <i>Chlamydia</i> sp.*	6	2	1	1	1	11
<i>Mycoplasma pneumoniae</i>	14	17	20	19	18	88
<i>Legionella</i> sp.	11	5	9	8	9	42

*Includes *Chlamydia psittaci*, *Chlamydia pneumoniae*, and *Chlamydia* sp detected from blood, serum, and respiratory specimens.

Table 5a Reports of legionnaires' disease cases in England and Wales, by week of report: weeks 44-48/2007

Week	Week 44	Week 45	Week 46	Week 47	Week 48	Total
Week ending	04/11/07	11/11/07	18/11/07	25/11/07	02/12/07	
Nosocomial	–	–	–	–	1	1
Community	6	4	4	3	3	20
Travel Abroad	5	1	5	5	3	19
Travel UK	–	–	–	–	2	2
Total	11	5	9	8	9	42
Male	8	4	7	7	7	33
Female	3	1	2	1	2	9

Forty-two cases of legionnaires' disease with pneumonia were reported; 33 males aged from 28 to 83 years and nine females aged from 47 to 91 years. Twenty cases had community acquired infection and one case had hospital acquired infection. Three deaths were reported in two males aged 45 and 56 years and a female aged 58 years.

Twenty-one cases were travel associated: China (1), Cruise (1), Cuba (1), Egypt (1), France/Spain (1), Greece (1), India (1), Italy (1), Jamaica (1), Kazakhstan (1), Peru (1), Portugal (1), Spain (3), Turkey (3), United Kingdom (2) and United States of America (1).

Table 5b Reports of legionnaires' disease cases by region of report in England and Wales: weeks 44-48/2007

REGION	Nosocomial	Community	Travel Abroad	Travel UK	Total
North East	–	–	2	–	2
Yorkshire & Humber	1	2	3	1	7
East Midlands	–	3	1	–	4
East of England	–	2	–	–	2
London	–	2	–	–	2
South East	–	2	4	1	7
South West	–	2	1	–	3
West Midlands	–	4	3	–	7
North West	–	2	1	–	3
Wales	–	1	4	–	5
Unknown	–	–	–	–	–
Total	1	20	19	2	42