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News

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Confirmed H5N1 avian influenza in wild swans in Dorset

The Department for the Environment Food and Rural Affairs (Defra) has confirmed highly pathogenic H5N1 avian influenza three dead wild mute swans at premises in the Chesil Beach area of Dorset [1,2].

A Wild Bird Control Area and Monitoring Area has been established by Defra around the premises, encompassing Chesil Beach and Portland Bill, and the shape of these is based on expert ornithological advice. This is to prevent the potential for further spread to neighbouring flocks and/or farms. There are no current restrictions on the general public's access to, or use of, the countryside.

Despite this incident the current level of risk to humans from H5N1 avian influenza remains extremely low. The Health Protection Agency is working closely with Defra and local NHS partners to ensure that all the necessary actions are being taken to protect those people who may have been exposed to the sick or dead birds. Antiviral drugs and seasonal influenza vaccine will be offered where appropriate to people who have been in close contact with the infected swans.

The current level of risk to human health from avian flu is extremely low and there is no need for local residents to restrict or change their everyday activity. Most human H5N1 infections so far have occurred through direct contact with live or dead infected poultry or very rarely via wild birds.

Members of the public who find dead or sick birds (three or more of the same species or five or more of different species in the same place) should not approach the birds and are asked to notify Defra on 08459 33 55 77 – see www.defra.gov.uk for operating hours. This helpline can also provide further information on avian influenza.

References

1. *Confirmed H5N1 avian influenza in wild swans in Dorset (press release).* London : Health Protectin Agency, 10 January 2008. Available at <http://www.hpa.org.uk/hpa/news/articles/press_releases/2008/080110_avflu.htm>.

2. *Avian Influenza H5N1 confirmed in Dorset (press release).* London : Department for the Environment Food and Rural Affairs, 10 January 2008. Available at <http://www.defra.gov.uk/news/latest/2008/animal-1001.htm>.

Further Information on Avian Influenza

http://www.hpa.org.uk/infections/topics_az/influenza/avian/default.htm

Use of antiviral drugs for influenza

On 9 January 2008 the UK Department of Health issued a letter to all general practitioners in England to inform them that the use of antiviral drugs for the treatment or prophylaxis of influenza was now recommended, in line with the NICE guidance (http://www.nice.org.uk) [1].

The most recent influenza surveillance data for England show that the overall rate for influenza has exceeded the threshold at which the use of antivirals is triggered.

The overall GP consultation rate for influenza-like illness in England and Wales based on RCGP data, has increased from 20.3 per 100,000 in week 52/2007 to 31.4 per 100,000 in week 01/2008. The rise in the consultation rate is most evident in those aged 15 to 44 years.

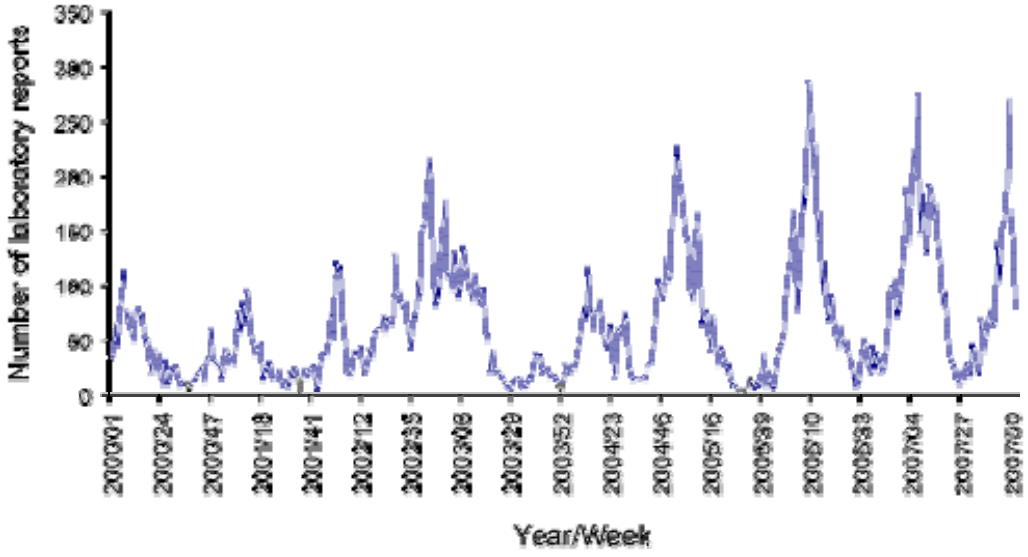
References

1 . *Influenza Season 2007/08 – Use of antivirals Department of Health Gateway Reference Number 7824.* London: Department of Health, January 2008. Available at <http://www.info.doh.gov.uk/doh/embroadcast.nsf >.

Norovirus update January 2008

The Health Protection Agency Centre for Infections received 1922 laboratory reports of norovirus during the final three months of 2007 (weeks 39-52). This compares with 935 received during the equivalent period of 2006. Figure 1 shows the seasonal pattern of norovirus infections. The number of laboratory reports for norovirus normally increases in the winter months. In the last four years the number of reports for norovirus increased rapidly at the beginning of the winter, with an almost equally rapid decline at the early part of the following spring. The total number of norovirus infections was highest in the years 2002-2003 because the season extended into the summer of 2002. A lower peak in norovirus laboratory reports was observed compared with other years but the longer season resulted in a higher number of reports accumulating over the year. Detailed virological studies showed that a new strain of the virus emerged during this period to cause illness across the globe. In more recent years the number of reports has risen rapidly but seasons have been shorter in duration.

Figure Laboratory reports of norovirus 2000-2007 (England and Wales)



Several factors are thought to have contributed to the increase in the number of cases reported during this winter season. As the graph shows the number of reports received during the peak week of this season is lower than those recorded in the last two years. However the norovirus season started uncharacteristically early and this explains the higher cumulative figure. Higher reporting levels were expected for this season because improvements have been made in the methods for detecting the virus used by clinical laboratories. The increased sensitivity in testing may have resulted in more cases being diagnosed. In addition there is also thought to be an increased level of awareness of the infection and symptoms by both the public and physicians, hence more cases are being identified. As the norovirus season has not yet come to an end it would be expected that further cases will be reported in the coming weeks and the HPA will continue to monitor the trends in reporting. Laboratory reported cases representing only a small fraction of the number of cases that actually occur.

Norovirus is highly contagious, however, one of the ways to protect against the infection or to help prevent yourself or others becoming infected, is by practising good hygiene. This includes thorough hand washing especially after using the toilet, and any contaminated surface should be thoroughly disinfected after an episode of illness. Food preparation should also be avoided until 48 hours after symptoms have disappeared. The infection is self-limiting usually only lasts a few days hence the majority of cases are not reported to the clinician.

Unfortunately there is no specific treatment for norovirus apart from letting the illness run its course, therefore it is important to drink plenty of fluids to prevent dehydration especially in the very young or elderly.

It is not unusual to see outbreaks occurring in hospitals, as the virus quickly spreads in confined environments. Taking action early in an outbreak by closing a ward to new admissions can help control outbreaks. A study by the Health Protection Agency has shown that outbreaks of norovirus are shortened when control measures at healthcare settings are implemented quickly, such as closing wards to new admissions within four days of the beginning of the outbreak and implementing strict hygiene measures [1].

The latest figures for the number of laboratory reports are given in the infection reports in this issue of *Health Protection Report* (Vol 2 No 2).

References

Lopman BA, Reacher MH, Vipond IB, Hill D, Perry C, Halladay T, et al. Epidemiology and cost of nosocomial gastroenteritis, Avon, England, 2002-2003. *Emerg Infect Dis* [serial online]. October 2004 [cited 10 January 2008]. Available at <http://www.cdc.gov/ncidod/EID/vol10no10/03-0941.htm>.

Group A streptococcal infections in maternity units

There have been two maternal deaths due to group A streptococcal infection associated with a maternity unit in the south of England which have attracted considerable press interest recently.

At present there is no evidence from the national laboratory reporting system of a generalised increase in invasive group A streptococcal infection over and above the normally expected seasonal increase seen at this time of year.

Group A streptococcal infections occur primarily as sporadic cases in the community. However, although unusual, clusters may occur in hospitals including maternity units. Colleagues are reminded that early recognition, rapid diagnosis and prompt and appropriate antimicrobial therapy on the basis of clinical suspicion are critical. Suspected or confirmed outbreaks should be reported to the local Health Protection Unit.

Invasive disease isolates and those from suspected clusters or outbreaks should be submitted to the Respiratory and Systemic Infection Laboratory at the Health Protection Agency, Centre for Infections, 61 Colindale Avenue, London NW9 5HT.

Guidelines for the management of close community contacts of invasive group A streptococcal disease are available on the Agency's website at: <http://www.hpa.org.uk/cdph/issues/CDPHvol7/No4/guidelines1_4_04.pdf>.

Enteric

Enteric Routine Data Reports

- General outbreaks of foodborne illness in humans, England and Wales: weeks 49-52/07
- Salmonella infections, (faecal specimens) England and Wales, reports to the HPA (Salmonella data set): November 2007
- Common gastrointestinal infections, England and Wales: laboratory reports: weeks 49-52/07

- Less common gastrointestinal infections, England and Wales: laboratory reports weeks 40-52/07

General outbreaks of foodborne illness in humans, England and Wales: weeks 49-52/07

Health Protection Unit	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
Cumbia and lancashire	*Salmonella* Typhimurium DT104	School	Dec	12	3	Christmas dinner	D
Northumberland, Tyne & Wear	Scombrotoxin	Residential Institution	Sept	5	–	Tuna suspect	D

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): November 2007

Details of 1027 serotypes of salmonella infections recorded in November are given in the table below. In December 2007, 478 salmonella infections were recorded and preliminary information was received about one outbreak (see table above).

	November 2007
S. Enteritidis (PT4)	130
S. Enteritidis (other PTs)	369
S. Typhimurium	137
S. Virchow	37
Others (typed)	327
Total Salmonella (provisional data)*	**1027**

*Figures quoted from the Health Protection Agency salmonella data set are for isolates confirmed and typed by Laboratory of Enteric Pathogens (LEP).

Common gastrointestinal infections, England and Wales, laboratory reports: weeks 49-52/07

Laboratory reports	Number of reports received				Total reports	Cumulative total to	
	49/07	50/07	51/07	52/07	49-52/07	48-52/07	52/06
Campylobacter	740	649	501	238	**2128**	**50171**	**46762**
Escherichia coli* O157	3	13	12	4	32	**718**	**923**
***Salmonella*†**	167	140	104	58	**469**	**11828**	**12541**
Shigella sonnei	9	9	5	1	**24**	**961**	**652**
Rotavirus	56	62	70	51	**239**	**12854**	**13423**
Norovirus	203	164	142	79	**588**	**5563**	**4593**
Cryptosporidium	43	32	19	5	**99**	**2989**	**3680**
Giardia	40	46	37	12	**135**	**2920**	**2952**

*Vero cytotoxin–producing isolates (data from Health Protection Agency's Laboratory of Enteric Pathogens (LEP).
† Data from Health Protection Agency's Laboratory of Enteric Pathogen

Less common gastrointestinal infections, England and Wales: laboratory reports weeks 40-52/07

Laboratory reports	Total reports 40-52/2007	Cumulative total to 52/2007	Cumulative total to 52/2006
Adenovirus*	16	59	73
Astrovirus	10	23	85
Sapovirus	2	4	12
Shigella boydii	26	119	40
Shigella dysenteriae	16	46	102
Shigella flexneri	89	337	334
Plesiomonas	10	46	42
***Vibrio* spp.**	22	100	74
Yersinia spp	2	51	13
Entamoeba histolytica	13	68	96
Blastocystis hominis	123	588	411
Dientamoeba fragilis	27	135	128

*includes Adenovrius EM faeces and Adenovirus group F