



Health Protection Report

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Sexually transmitted infections in black African and black Caribbean communities in the UK, 2008

The risk of sexually transmitted infections that Africans living in the UK and, to a lesser extent, the Caribbean community, face is aggravated by late diagnosis, surveillance data published by the HPA has indicated [1]. Black African and black Caribbean communities are disproportionately affected by HIV and bacterial STIs (especially gonorrhoea), respectively. However, in both communities a significant proportion are diagnosed late, that is after a point at which optimal treatment should have started. In the case of African individuals diagnosed with HIV, almost half (42%) miss out on the benefits that come from early diagnosis.

The HPA report calls for HIV testing to be extensively promoted in the African community in the UK so that treatment can be started sooner. It also provides sexual health advice on how best to control and prevent the spread of sexually transmitted infections and HIV, including the recommendation of an annual chlamydia test for all sexually active young people.

In 2007, 40% of all new HIV diagnoses in the UK (2,691 cases) were among black Africans, the majority of whom acquired their infection heterosexually and in Africa. In contrast, new diagnoses in black Caribbeans remained low (189), representing 3% of new diagnoses in 2007.

Data presented in the report indicates that the prevalence of diagnosed HIV in black African and black Caribbean communities in England is estimated to be 3.7% and 0.4%, respectively, compared to 0.09% among the white population (see table); also that, in 2007, black Caribbeans accounted for over a quarter (26%) of heterosexually acquired gonorrhoea diagnosed in a sample of genitourinary medicine clinics in England and Wales.

Percentage of different ethnic groups living with diagnosed HIV in England 2007

	Black African	Black Caribbean	White
Number individuals aged 15-59 living with diagnosed HIV	18,719	1,538	24,368
Population aged 15-59 (2006 ONS estimates)	500,600	315,800	27,058,700
HIV Percentage aged 15-59 living with diagnosed HIV	3.7%	0.4%	0.09%

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1. *Sexually transmitted infections in black African and black Caribbean communities in the UK 2008*, downloadable at: http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1225441605082?p=1158945066450. For further information, see also HPA press release at: http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1225789252997?p=1204186170287.

Confirmed measles cases in England and Wales – an update to September 2008

The total number of laboratory confirmed cases of measles in England and Wales with onset dates between 1 January and the end of September this year has reached 956 (compared with a total of 713 at the same time last year). Sixty-eight cases had an onset date in September – a second consecutive month of decline in measles incidence nationally (figure 1). During September, the proportion of oral fluid tests that were positive was 24%, although in London 40% of all samples tested were confirmed and in the rest of England and Wales the proportion was 18%.

Regional outbreaks were reported in both England and Wales. In late August and September 2008 two separate outbreaks were reported from Wales: one cluster of cases involved travelling community in North Wales, the other linked to a secondary school in Newcastle Emlyn with two linked cases in Cardiff [1]. Other regional outbreaks with links to the travelling community are ongoing in Cheshire, Thames Valley, East and West Midlands (see table). In London, reports to HPUs were declining although cases are being seen in areas that have not been affected so far in 2008.

No cases reported in England and Wales were suspected of having been acquired abroad. However, the end of October marked the 10th week of a continuing outbreak in Gibraltar with more than 250 cases identified [2]. The measles virus genotype present in this outbreak is MVs/Enfield.GRB/14.07, which is currently also circulating in the UK. The initial source of infection in the Gibraltar outbreak was, however, traced to a worker from Spain.

Overall this year, the highest proportion of cases is in children of nursery and primary school age (see figure 2). This trend continues in September.

Table 1. Confirmed cases of measles by region and month of onset, England and Wales: January – September 2008

Month	London	East Mids	East of England	North East	North West	South East	South West	West Mids	Wales	York & Humber
Jan	60	1	8	1	1	1	0	3	1	12
Feb	44	0	4	3	0	7	0	0	0	3
Mar	67	1	1	0	0	6	1	1	1	5
Apr	92	0	8	3	1	6	15	2	0	14
May	103	1	6	0	23	6	7	3	0	5
Jun	96	0	10	1	22	7	3	5	0	3
Ju	67	1	11	0	22	17	3	7	0	2
Aug	31	8	8	0	15	17	0	6	0	2
Sep	28	3	3	0	7	3	0	5	19	0
Total	588	15	59	8	91	70	29	32	21	45

Figure 1. Number of laboratory confirmed cases in England and Wales by month of onset: January 2007 to September 2008

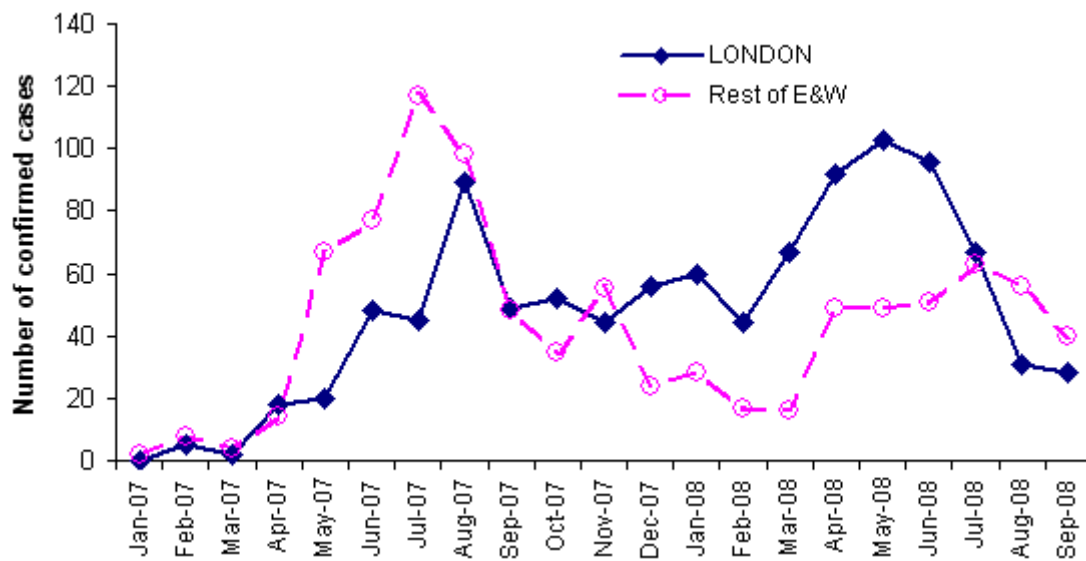
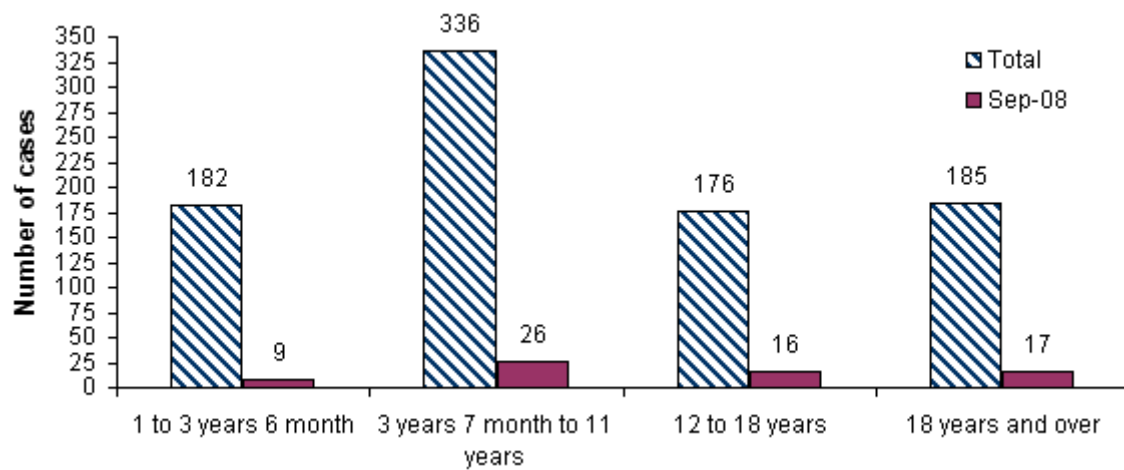


Figure 2. Confirmed cases by age groups targeted by the MMR catch-up programme, England and Wales: January 2008 to September 2008



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1. Further measles cases investigated in Newcastle Emlyn, <http://www.wales.nhs.uk/sites3/news.cfm?orgid=719&contentid=10818>.
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First European Antibiotic Awareness Day

The first European Antibiotic Awareness Day, which has as its theme the need to stop unnecessary use of antibiotics, will take place on 18 November 2008 [1]. The event is an initiative of the European Centre for Disease Prevention and Control (ECDC) and reflects the concerns of health policy makers, including Members of the European Parliament, who have called for action to increase public awareness of the problem posed by antibiotic resistance. The overall objective of European Antibiotic Awareness Day is to emphasise the importance of using antibiotics responsibly, discourage unnecessary use and encourage people to follow their doctor's instructions on how to take antibiotics appropriately. Public education is important because 80% of human antibiotic prescribing is in the community; general practitioners report that they often prescribe antibiotics not from medical necessity but because they perceive their patients want them [2].

The first Awareness Day will be marked by a range of activities across Europe including a scientific briefing and press conference in the European Parliament in Strasbourg. Activities in England – being organised by the Department of Health, the Advisory Committee on Antimicrobial Resistance and Healthcare-Associated Infection (ARHAI) and the British Society for Antimicrobial Chemotherapy – will include two London conferences.

The first conference, entitled *Antibiotic Resistance – Myth Busting*, aimed at health journalists, will be held at the Science Museum [3]. The second, at the Royal College of Paediatrics and Child Health, is entitled *Improving Antibiotic Prescribing for Children* [4]. The latter event will debate the recently issued guidance from the National Institute for Health and Clinical Excellence (NICE) on the management of upper respiratory tract infections in children and adolescents (ie that there should be no, or delayed, antibiotic prescribing for acute otitis media, acute sore throat, the common cold, acute rhinosinusitis and acute cough) [5] and will also consider the management of the septic child.

To involve the younger public in the day, the Department of Health instigated a competition for 11-14 year olds to design a poster to help raise public awareness of prudent antibiotic use. The competition website has a link into teaching resources covering microbes and antibiotic use from the European educational resource e-Bug [6]. The public poster campaign encouraging the public to have plenty of fluids and rest instead of antibiotics for coughs, colds and sore throats will also be re-launched on the day [7].

It is hoped that healthcare workers, including doctors, nurses and pharmacists, will help to raise awareness of prudent antibiotic use by undertaking local activities. This could be something as simple as downloading an Antibiotic Awareness Day poster, and putting it up in their local hospital, to contacting the local media about the day. Materials to use on the day can be found at <http://antibiotic.ecdc.europa.eu/materials.asp>.

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Anthrax and animal hide drums: summary literature review and risk assessment

Following a rare, fatal case of inhalation anthrax contracted in London as a result of exposure to spores from imported animal hides [1,2], the following summary literature review and assessment of risk of anthrax being contracted from animal hide drums has been prepared by the HPA.

Anthrax has long been associated with transmission from infected animals or contaminated animal by-products. In the United Kingdom (UK), anthrax in animals is notifiable under the *Anthrax Order 1991*, and the last cases occurred in Wales in 2006, when two cattle died. Industrially-acquired human anthrax became notifiable under the Factories Act in 1895, a time when the most important industrial risks were associated with handling wool, hair and bristles, or hides and skins. These risks remain. Between 1981 and 2007 18 cases of human anthrax were notified in England and Wales; all were cutaneous, and most had an occupational exposure although a source could not be determined in four cases. In recent years, as well as these well-recognised occupational exposures, a handful of cases have been reported in North America and the UK which have been linked to drums made from imported animal hides.

In the United States (US), in 1974, a case of ocular anthrax was acquired from goat skin bongo drums bought in Haiti. The case prompted the US Centers for Disease Control and Prevention (CDC) to conduct surveys of goat hide products and artefacts from Haiti between 1971 and 1981 which revealed positivity rates between 26% and 55% [3-7]. The next report was in 2001 when a clinical diagnosis of cutaneous anthrax was made in Canada. Although the lesion was culture negative, *Bacillus anthracis* was isolated from a sample of imported African goat hide used in a drum-making class attended by the case, and this was attributed to be the source of the infection [8-10]. In 2007 further cutaneous anthrax cases occurred in the US in a drum-maker and one of his children. Investigations revealed that the drum maker was exposed while working with a contaminated goat hide from Guinea and that his workplace and home were contaminated with anthrax spores. His child was most likely exposed from cross-contamination of the home, as the child never participated in any drum making and had no known exposure to animal hides [11].

The first documented case of inhalation anthrax associated with drum making occurred in New York City in 2006 [10]. Investigations concluded that exposure to *B. anthracis* spore-containing aerosols occurred during the mechanical scraping of a contaminated animal hide in a non-ventilated workspace, while preparing the hide for drum making. In Scotland in 2006, a fatal case of atypical inhalation anthrax was diagnosed post-mortem in a man who made and played musical instruments, including African style drums [13]. Extensive microbiological investigations did not support the initial hypothesis that he had been exposed while working with animal skins, but suggested an alternative route: that he became infected as a result of using or handling West African style drums at drumming classes or workshops. Despite the probability that other people attending the same drumming classes had also been exposed to anthrax spores, there were no other cases. It is possible that the patient had increased susceptibility to anthrax due to a previous medical condition (acute myeloid leukaemia in remission).

Imported animal hides from West Africa, particularly goat hides, remain in demand because they are prized by drum makers for their acoustic and textural qualities. African drumming is an increasingly popular activity in many countries. However, the HPA assessment is that the risk associated with imported animal hides used for drum making and drumming remains very low based on the fact that there are so few documented cases.

It is important to emphasise that the evidence available indicates that the risk of acquiring anthrax is primarily through making the drums, rather than playing or handling them. It is thought to be through the removal of hair from the animal hides that exposure to spores can occur leading to either cutaneous or inhalational anthrax, although this is a very rare event. Those who make, own or play animal hide drums should report any unexplained fever or new

skin lesions to their GP, describing their recent contact with drums. Equally the clinical assessment of individuals with signs or symptoms compatible with anthrax should include questioning about making and playing African drums.

Advice regarding minimising the risks of manipulating hides during drum making can be found on the HPA website at

http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1195733752819.

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Infection reports

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Respiratory

Laboratory reports of respiratory infections made to Cfl from HPA and NHS laboratories in England and Wales: weeks 40-44/2008

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

Table 1 Reports of influenza infection made to Cfl, by week of report: weeks 40-44/2008

Week	Week 40	Week 41	Week 42	Week 43	Week 44	Total
Week ending	05/10/08	12/10/08	19/10/08	26/10/08	02/11/08	
Influenza A	1	3	3	16	9	32
Isolation	–	–	–	–	1	1
*DIF	–	–	1	3	3	7
Four-fold rise in paired sera	–	–	–	–	–	–
PCR	–	2	1	10	4	17
†Other	1	1	1	3	1	7
Influenza B	–	1	3	1	1	6
Isolation	–	–	–	–	–	–
*DIF	–	1	–	–	–	1
Four-fold rise in paired sera	–	–	–	–	–	–
PCR	–	–	1	–	–	1
†Other	–	–	2	1	1	4
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 or single high serology titre), by week of report: weeks 40-44/2008

Week	Week 40	Week 41	Week 42	Week 43	Week 44	Total
Week ending	05/10/08	12/10/08	19/10/08	26/10/08	02/11/08	
Adenovirus*	7	23	13	18	7	68
Coronavirus	1	–	–	1	2	4
Parainfluenza†	5	15	4	20	15	59
Rhinovirus	42	38	30	50	52	212
Respiratory Syncytial Virus (RSV)	29	53	111	183	207	583

* Respiratory samples only.

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

Table 3 Respiratory viral detections by age group: weeks 40-44/2008

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥65 years	Unknown	Total
Adenovirus*	15	26	9	9	6	3	–	68
Coronavirus	3	–	–	–	1	–	–	4
Influenza A	1	7	1	12	9	1	1	32
Influenza B	–	–	–	3	2	1	–	6
Parainfluenza†	23	8	2	9	14	2	1	59
Rhinovirus	112	46	7	19	10	12	6	212
Respiratory syncytial virus (RSV)	460	84	2	9	8	9	11	583

* 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 40-44/2008

Week	Week 40	Week 41	Week 42	Week 43	Week 44	Total
Week ending	05/10/08	12/10/08	19/10/08	26/10/08	02/11/08	
<i>Coxiella burnettii</i>	1	–	–	–	1	2
Respiratory <i>Chlamydia</i> sp.*	2	2	2	–	5	11
<i>Mycoplasma pneumoniae</i>	8	3	11	5	8	35
<i>Legionella</i> sp.	12	9	10	8	9	48

* 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 40-44/2008

Week	Week 40	Week 41	Week 42	Week 43	Week 44	Total
Week ending	05/10/08	12/10/08	19/10/08	26/10/08	02/11/08	
Nosocomial	–	–	–	–	–	–
Community	6	4	3	5	3	21
Travel Abroad	4	4	7	3	4	22
Travel UK	2	1	–	–	2	5
Total	12	9	10	8	9	48
Male	8	6	10	5	8	37
Female	4	3	–	3	1	11

(*) Non-pneumonic case(s)

Forty eight cases were reported with pneumonia; 37 males aged from 21 to 83 yearsrs and 11 females aged from 44 to 88 years. Twenty-one cases had community acquired infection. Two deaths were reported: M 61y and F 57y.

Twenty-seven cases were travel associated: Croatia (1), Egypt (1), France (1), France/Spain (1), Germany (1), Greece (1), Hungary/United Kingdom (1), Italy (5), Portugal (1), Spain (6), Turkey (2), United Kingdom (5) and United States (1).

Table 5b Reports of Legionnaires' Disease cases by region of report in England and Wales: weeks 40-44/2008

Region/country	Nosocomial	Community	Travel abroad	Travel UK	Total
North East	–	1	2	–	3
Yorkshire & Humber	–	3	2	–	5
East Midlands	–	2	2	1	5
East of England	–	3	2	1	6
London	–	3	1	1	5
South East	–	5	5	2	12
South West	–	1	–	–	1
West Midlands	–	–	2	–	2
North West	–	1	5	–	6
Wales	–	2	1	–	3
Unknown	–	–	–	–	–
Total	–	21	22	5	48

(*) Non-pneumonic case(s)