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News

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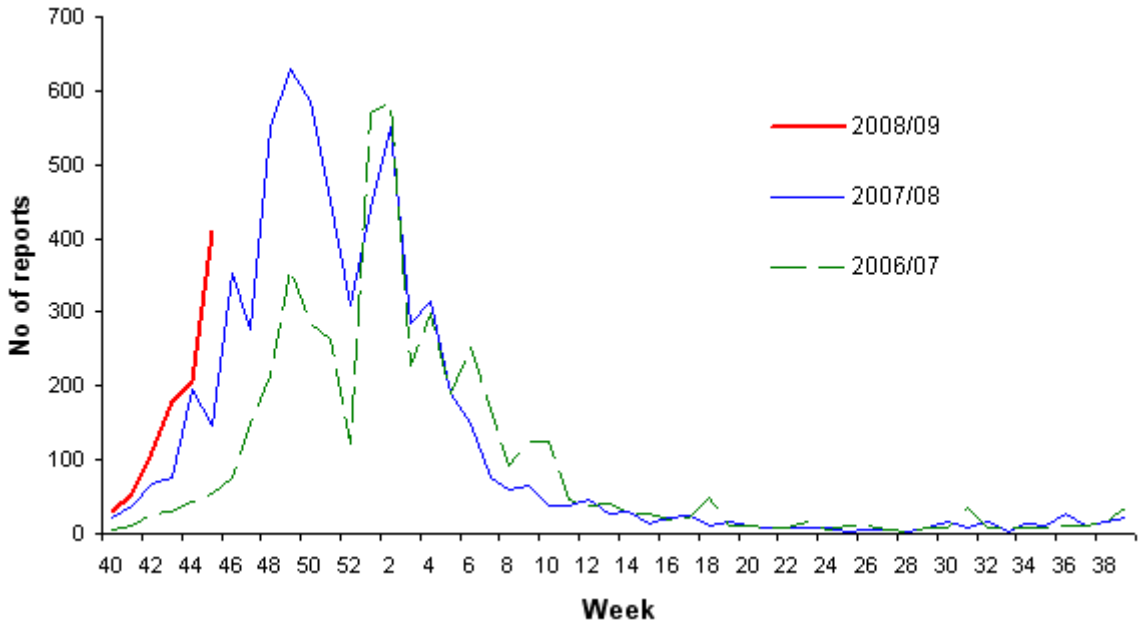
Respiratory syncytial virus activity increasing in England and Wales

Levels of respiratory syncytial virus (RSV) activity are beginning to increase, as expected for this time of year. Clinicians should now be considering the administration of prophylactic palivizumab which is licensed for use in young children at risk of severe bronchiolitis. This includes children under two years of age with chronic lung disease with oxygen dependency and infants under six months of age with severe congenital heart disease [1, 2].

In the past few weeks a sharp increasing trend has been observed in the number of RSV laboratory reports received by HPA from NHS/HPA hospital laboratories in England and Wales (see figure). RSV is the most common cause of severe respiratory illness such as bronchiolitis (inflammation of the bronchioles) in young children (aged under two years). Although RSV is the most common cause of hospital admissions due to acute respiratory illness in young children, repeat infection throughout life is common and it causes significant morbidity and mortality in the elderly population [3]. Peak numbers of RSV infections are reported in December and January every winter, although the size of the peak varies from winter to winter. Further information is available from the HPA website [4].

Levels of influenza activity in the United Kingdom continue to remain low. Consultations with general practitioners (GPs) for influenza/influenza-like illness remain well within the range of baseline activity in England, Scotland and Wales, where thresholds are used to describe levels of activity.

Figure RSV detections reported to HPA Centre for Infections from hospital laboratories in England and Wales (by week of report): 2006-2008



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1. The recommendations of Joint Committee on Vaccination and Immunisation (JCVI), 2005. Available at http://www.advisorybodies.doh.gov.uk/jcvi/mins220605.htm

2. Goddard NL, Cooke MC, Gupta RK, Van Tam JSN. Timing of monoclonal antibody for seasonal RSV prophylaxis in the United Kingdom. *Epidemiol Infec* 2007 **135**(1):159-62. Epub 2006 June 6 2006. Available at HPA website: http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194947322323.

3. Elliot AJ, Fleming DM. Influenza and respiratory syncytial virus in the elderly. *Expert Rev Vaccines*. 2008; **7**(2), 249-58: review.

4. HPA. Respiratory Syncytial Virus (RSV). Available at: http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1191942172184?p=1191942172184

Improving detection of HCV in primary care

A recent Chief Medical Officer letter [1] has highlighted the fact that, although diagnoses of the infection in England have been increasing since the publication of the Department of Health's Hepatitis C Action Plan for England in 2004, there could still be about 100,000 undiagnosed cases. The letter asks for help in improving the detection and diagnosis in primary care settings.

In most cases the infection will not be apparent for many years. In the absence of abnormal liver function tests or unexplained jaundice, the only indications for offering testing will usually be risk factors for infection. Those most at risk in the United Kingdom are those who have injected drugs at any time. Other routes of transmission include blood transfusion (before September 1991) or blood products (before 1986). Lower riskactivities include medical treatment abroad in countries where the virus is common, tattooing, mother-to-child transmission during pregnancy or childbirth, and unprotected sex with, or sharing razors or toothbrushes with, a carrier.

The DH is continuing with awareness-raising activities aimed at healthcare professionals, the general public and risk groups, and maintains a dedicated website for this purpose [2].

References

1. DH. *Improving the detection and diagnosis of hepatitis C in primary care*. 27 October 2008. London: Department of Health, 2008. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH_08972.

2. www.nhs.uk/hepc.

Carbon Monoxide Awareness Week

A wide range of initiatives take place during Carbon Monoxide Awareness Week – 17 to 23 November 2008 – which is timed to coincide with increasing use of domestic fossil fuel and wood burning fires, water heaters and central heating boilers. Malfunctioning and inadequate maintenance of these appliances has been responsible for approximately 50 fatalities, and approximately 200 known non-fatal cases of CO poisoning, each year over the past decade. Related information is available on the HPA, Health and Safety Executive and Department of Health websites:

HPA website (from 17 November): www.hpa.org.uk/carbonmonoxide
HSE website: http://www.hse.gov.uk/gas/domestic/co/coawareweek.htm
DH website:
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH_090128

Health Protection Matters, Autumn 2008

Three of the main areas of HPA activity – protection against harmful exposure to radiation and to chemical and biological agents hazardous to health – are covered in the latest edition of the HPA's magazine for non-specialists, *Health Protection Matters*. The Autumn 2008 edition includes feature articles on patient safety (in dental practice and in general medicine), the current state of knowledge about the health effects of low-frequency electromagnetic radiation 20 years after the Stewart report, and the pros and cons of the computer-based bioinformatics techniques that are being increasingly used as an alternative to traditional diagnostic methods in clinical microbiology.

Health Protection Matters can be viewed and downloaded from the Journals and Bulletins pages within the Publications section of the main HPA website.

Infection reports

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Enteric

General outbreaks of foodborne illness in humans, England and Wales: weeks 41-44/2008

Preliminary information has been received about the following outbreaks

Health Protection Unit	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
West Yorkshire	Campylobacter	Hotel	May	7	3	–	–
West Midlands East	*S.* Enteritidis PT12	Residential Institution	July	2	2	–	–
SW Peninsular - Devon	*Salmonella* Enteritidis PT6	Residential institution	Sept	4	4	–	–
Norfolk, Suffolk, Cambridge	*Salmonella* Enteritidis PT6	Residential Institution	Sept	4	4	Raw egg drink	D
Bradford	*S.* Enteritidis PT4	Restaurant	Oct	4	4	–	–
South Yorkshire	*S.* Typhimurium PT193	Public House	Sept	16	9	Egg mayonnaise sandwiches	S

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), September 2008

Details of serotypes of 1047 Salmonella infections recorded in September are given in the table below. In October 2008, 568 Salmonella infections were recorded and preliminary information was received about five outbreaks (see table above).

Organism	Cases September 2008
S. Enteritidis PT4	103
S. Enteritidis (other PTs)	503
S. Typhimurium	188
S. Virchow	31
Others (typed)	222
Total Salmonella (provisional data)	**1047**

Common gastrointestinal infections, England and Wales: laboratory reports, weeks 41-44/2008

Laboratory reports	Number of reports received				Total reports	Cumulative total	
	41/08	42/08	43/08	44/08	41-44/08	01-44/08	01-44/07
Campylobacter	1001	974	973	632	3580	42521	45292
Escherichia coli* O157	9	28	32	12	81	860	646
Salmonella †	174	135	108	47	464	8093	10312
Shigella sonnei	37	26	19	7	89	671	909
Rotavirus	55	52	29	38	174	13331	12465
Norovirus	90	69	66	59	284	4713	4231
Cryptosporidium	135	128	143	90	496	3233	2615
Giardia	53	64	69	47	233	2752	2567

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

Typhoid and paratyphoid, England and Wales: laboratory reports, July to September 2008

Organism and phage type	Infection acquired abroad				Excreters and carriers
	Number of cases	Yes	No	Not reported	
***S.* Typhi**					
A	1	1	–	–	–
B1	1	–	–	1	–
D1	6	3	–	3	–
D2	2	–	–	2	–
E1	21	10	–	11	–
E9 variant	16	10	–	6	–
E10	1	1	–	–	–
J1	2	1	–	1	–
O	1	–	–	1	–
40	1	1	–	–	–
53	2	1	–	1	–
Degraded	2	2	–	–	–
Degraded Vi-2	2	1	–	1	–
Untypable	6	2	–	4	–
Untypable Vi-1	2	–	–	2	–
Untypable Vi-2	4	2	–	2	–
Untypable Vi-7	1	–	–	1	–
Total	**71**	**35**	**–**	**36**	**–**
***S.* Paratyphi A**					
1	10	8	–	2	–
1A	6	4	–	2	–
2	8	6	–	2	–
3	7	7	–	0	–
4	11	5	–	6	–
6A	2	2	–	0	–
13	12	7	–	5	–
Untypable	1	1	–	0	–
Total	**57**	**40**	**–**	**17**	**–**
***S.* Paratyphi B**					
Dundee	1	–	–	1	–
Taunton	7	2	–	5	–
Total	**8**	**2**	**–**	**6**	**–**

Seventy-one cases of *Salmonella* Typhi infection were reported in the third quarter of 2008. Thirty five cases were infected abroad (Indian subcontinent 27, Nigeria 2, Iraq 2, Ghana 1, Sierra Leone 1, Africa unspecified 1, Country unspecified 1). In 36 cases the country of infection was not stated.

Fifty-seven cases of *S.* Paratyphi A infection were reported. Forty cases were infected abroad (Indian subcontinent 38, Brazil 1, Country unspecified 1). In 17 cases the country of infection was not stated.

Eight cases of *S.* Paratyphi B infection were reported, two were infected abroad (Pakistan 1, Country unspecified 1). In six cases the country of infection was not stated.