Public Health England

Health Protection Report
weekly report

Volume 8 Number 31 Published on: **8 August 2014**

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Communicable disease outbreak management operational guidance

Public Health England – in collaboration with the Association of Directors of Public Health, the Chartered Institute of Environmental Health and the Food Standards Agency – has revised and updated its operational guidance for the management of communicable disease outbreaks [1].

First published in 2011, the guidance sets out in detail the roles and responsibilities of key agencies during outbreak investigations and the agreed procedures which can ensure successful implementation.

The new edition is more partnership orientated and reflects recent organisational changes within PHE and across the public health landscape. It includes:

- updated policy context across all relevant agencies
- reference to relevant PHE policies and documents including the National Incident Response Plan and Concept of Operations
- detailed descriptions of the roles and responsibilities of each organisation, updated to reflect post transition landscape
- more information on legal aspects of outbreak management
- links to guidance on the "constructive debrief" and "lessons identified" processes.

Reference

1. Communicable Disease Outbreak Management: Operational Guidance (August 2014). Downloadable from the PHE website: https://www.gov.uk/government/publications/communicable-disease-outbreak-management-operational-guidance.

Vaccine update for immunisation practitioners

The latest *Vaccine Update* [1] bulletin for immunisation practitioners and other healthcare professionals provides practical information about the national immunisation programme, including in respect of influenza, prenatal pertussis, and the ongoing roll-out of the shingles programme

The recent updating of the influenza chapter in the Green Book is noted [2], ahead of the start of the annual influenza vaccination programme in the Autumn. The main change is that four-year olds have been added to the cohort of two- and three-year old children who will routinely be offered flu vaccination in England*. Another important change is a raising of the "cut-off" definition relating to severe asthma – above which the Live Attenuated Influenza Vaccine *Fluenz Tetra* ® should not be offered. This has been changed to better reflect published data, expert advice and for clarity and should enable more asthmatic children (who are particularly vulnerable to the effects of flu) to benefit from Fluenz, which In children is considered superior to trivalent inactivated vaccines (TIV) in terms of effectiveness, duration of protection, breadth of protection and acceptability.

Other themes covered in *Vaccine Update* 217 are: changes to the HPV and prenatal pertussis programmes (including advice on best practice in delivery of the latter); the availability of updated literature/posters relating to the flu vaccination programme, and other "core immunisation publications"; and details of vaccine availability and supply arrangements during the holiday period.

* In addition to these age groups the devolved administrations will also offer influenza vaccination to children aged five years old (Scotland), all primary school children (Scotland and Northern Ireland) and children in year 7 (Wales).

References

1.*Vaccine Update* (issue 217, July/August 2014). Downloadable from the PHE website: https://www.gov.uk/government/organisations/public-health-england/series/vaccine-update.
2. PHE Immunisation against Infectious Disease: the Green Book: chapter 19 (influenza), https://www.gov.uk/government/publications/influenza-the-green-book-chapter-19.

Travel health

Volume 8 Number 31 Published on: **8 August 2014**

Ebola virus disease in west Africa: WHO declares Public Health Event of International Concern

PHE's National Travel Health Network and Centre has udpated its advice, for health professionals, taking account of the World Health Organization's Emergency Committee recommendations on the Ebola Virus Disease (EVD) outbreak in west Africa in respect of: (a) states with transmission within their borders; and (b) for states with potential or confirmed EVD cases, and those unaffected but with land borders with affected states [1,2].

The WHO recommended that affected states should conduct exit screening for unexplained illness consistent with potential Ebola infection and that EVD cases or contacts should not undertake international travel, unless the travel is part of an appropriate medical evacuation.

For unaffected states the WHO recommended that there should be no general ban on international travel or trade [2].

PHE has made no change to the current "very low" risk assessment for UK residents. No cases of imported EVD have ever been reported in the UK and the risk of a UK traveller to west Africa contracting the disease is very low unless there is direct contact with the blood or body fluids of an infected person.

“Ebola: public health questions and answers” has been added to the Health Protection Collection “Ebola virus disease: clinical management and guidance” on the PHE website [3].

The European Centre for Disease Prevention and Control is updating its Ebola and Marburg fevers health topic webpage with risk assessment information [4] and has published information for travellers in 22 languages [5].

References

1. National Travel Health Network and Centre Clinical Update (8 August 2014), http://www.nathnac.org/pro/clinical_updates/Ebola_PHEIC_080814.htm.

2. WHO (8 August 2014). Statement on the Meeting of the International Health Regulations Emergency Committee Regarding the 2014 Ebola Outbreak in West Africa, http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/.

3. “Ebola: public health questions and answers”, 8 August 2014. https://www.gov.uk/government/collections/ebola-virus-disease-clinical-management-and-guidance

4. ECDC Ebola/Marburg Health Topic page, including risk assessments and epidemiological reports: http://www.ecdc.europa.eu/en/healthtopics/ebola_marburg_fevers/pages/index.aspx.

5. Ebola virus disease: informationfor travellers: http://www.ecdc.europa.eu/en/healthtopics/ebola_marburg_fevers/information-travellers/Pages/information-travellers.aspx.

Public Health England

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Infection Reports

Enteric

- General outbreaks of foodborne illness in humans, England and Wales: weeks 27-31/2014
- Common gastrointestinal infections, England and Wales: laboratory reports: weeks 27-31/2014
- Salmonella infections (faecal specimens) England and Wales, reports to the Public Health England (salmonella data set): June 2014
- Suspected and laboratory-confirmed reported norovirus outbreaks in hospitals: weeks 27-31/2014.
- Enteric fever surveillance quarterly report (EWNI): Q2/2014

Zoonoses

Common animal associated infections quarterly report (England and Wales): second quarter 2014

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Infection reports

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Enteric

General outbreaks of foodborne illness in humans, England and Wales: weeks 27-31/2014

Preliminary information has been received about the following outbreaks.

PHE Centre/ Health Protect'n Team	Organism	Location of food prepared or served	Month of outbreak	Cases positive	Number ill	Suspect vehicle	Evidence
South West South	*Salmonella* spp, non-typhoidal or unspecified	Other	July	10	Not known	Not known	N/k
West Midlands East	*Salmonella* spp, unspecified	Nursery	July	2	Not known	Not known	N/k
Cheshire and Merseyside	*Salmonella* spp, unspecified	Take-away	July	18	Not known	Not known	N/k
Hampshire, Isle of Wight and Dorset	*Salmonella* spp, non-typhoidal or unspecified	Restaurant	July	53	13	Not known	N/k
North East and Central London	Not known	Other	July	15	Not known	Not known	N/k
Beds, Herts and Northamtonshire	Not known	Club	July	13	–	Cold buffet sandwiches, sausage rolls, samosas and birthday cake	D
Cumbria and Lancashire	Campylobacter	Pub	July	2	Not known	Not known	N/k
Cumbria and Lancashire	*Bacillus cereus*	Take-away	July	2	Not known	Not known	N/k

D = Descriptive epidemiological evidence: suspicion of a food vehicle in an outbreak based on the identification of common food exposures, from the systematic evaluation of cases and their characteristics and food histories over the likely incubation period by standardised means (such as standard questionnaires) from all, or an appropriate subset of, cases.

Common gastrointestinal infections, England and Wales, laboratory reports: weeks 27-31/14

Laboratory reports	Number of reports received					Total reports	Cumulative total	
	27/14	28/14	29/14	30/14	31/14	23-26/14	1-31/14	1-31/13
Campylobacter	1726	1574	1392	1286	558	6536	35671	33948
Escherichia coli O157 *	14	24	23	12	16	89	339	329
Salmonella †	148	155	126	76	2	507	3047	3687
Shigella sonnei	17	28	17	16	3	81	592	520
Rotavirus	65	55	59	42	18	239	3666	14033
Norovirus	52	60	42	42	25	221	3122	5460
Cryptosporidium	45	57	37	42	22	203	1652	1730
Giardia	64	59	69	66	22	280	2014	1972

*Vero cytotoxin–producing isolates: data from CIDSC's Laboratory of Gastrointestinal Pathogens (LGP), PHE Colindale.
† Data from CIDSC-LGP.

Salmonella infections (faecal specimens) England and Wales, reports to Public Health England (salmonella data set): June 2014

Details of 343 serotypes of salmonella infections recorded in June are given in the table below.

In July 2014, 481 salmonella infections were recorded.

Organism	Cases: June 2014
S. Enteritidis PT4	8
S. Enteritidis (other PTs)	196
S. Typhimurium	106
S. Virchow	11
Others (typed)	22
Total salmonella (provisional data)	**343**

Suspected and laboratory-confirmed reported norovirus outbreaks in hospitals, with regional breakdown: outbreaks occurring in weeks 27-31/14

The hospital norovirus outbreak reporting scheme (HNORS) recorded 14 outbreaks occurring between weeks 27 and 31,,2014, all of which led to ward/bay closures or restriction to admissions. Seven (50 per cent) outbreaks were recorded as laboratory confirmed due to norovirus. For the calender year 2014 – from week 1 (January) to week 31 (week beginning 28 July) – 400 outbreaks have been reported. Ninety-three per cent (373) of reported outbreaks resulted in ward/bay closures or restrictions to admissions and 65 per cent (259) were laboratory confirmed as due to norovirus (see table following page).

Seasonal comparison of laboratory reports of norovirus (England and Wales)

In the current season † (from week 27, 2014, to week 30, 2015) to date, there were 195 laboratory reports of norovirus. This is 14 per cent higher than the average number of laboratory reports for the same period in the seasons between 2007/08 and 2011/2012 (171)* (see graphs below). The number of laboratory reports in the most recent weeks will increase as further reports are received.

† The norovirus season runs from July to June (week 27 in year one to week 26 in year two) in order to capture the winter peak in one season.

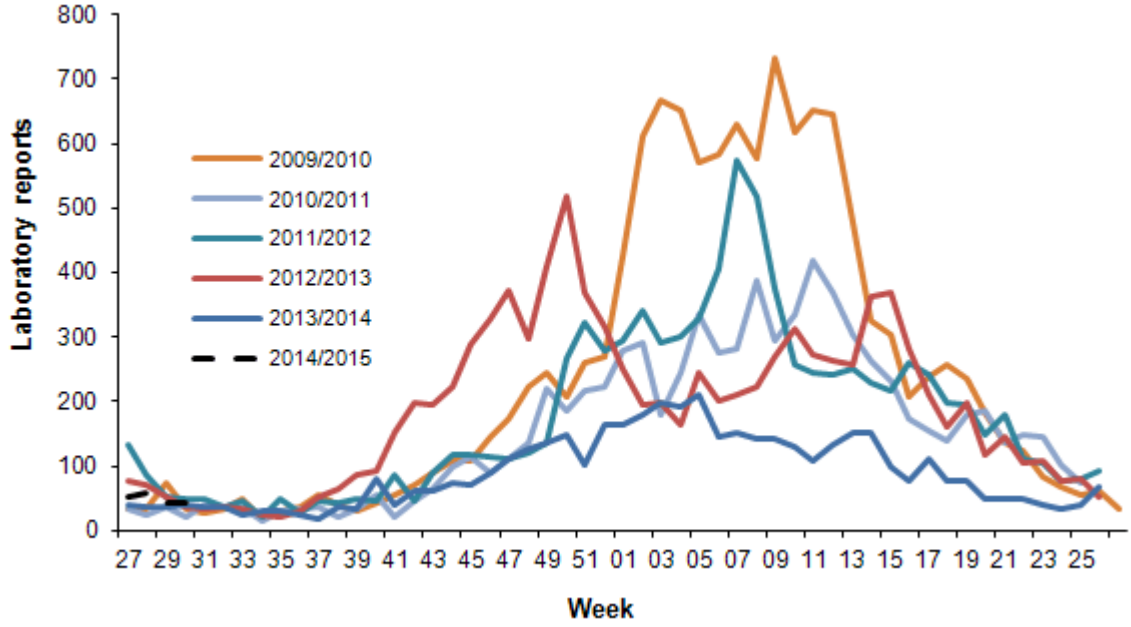
* Last season – 2012/2013 – the season began earlier than normal so comparisons between this current and last season would not be valid.

Suspected and laboratory-confirmed reported norovirus outbreaks in hospitals, with regional breakdown: outbreaks occurring in weeks 27-31/2014 (and 1-31/2013)

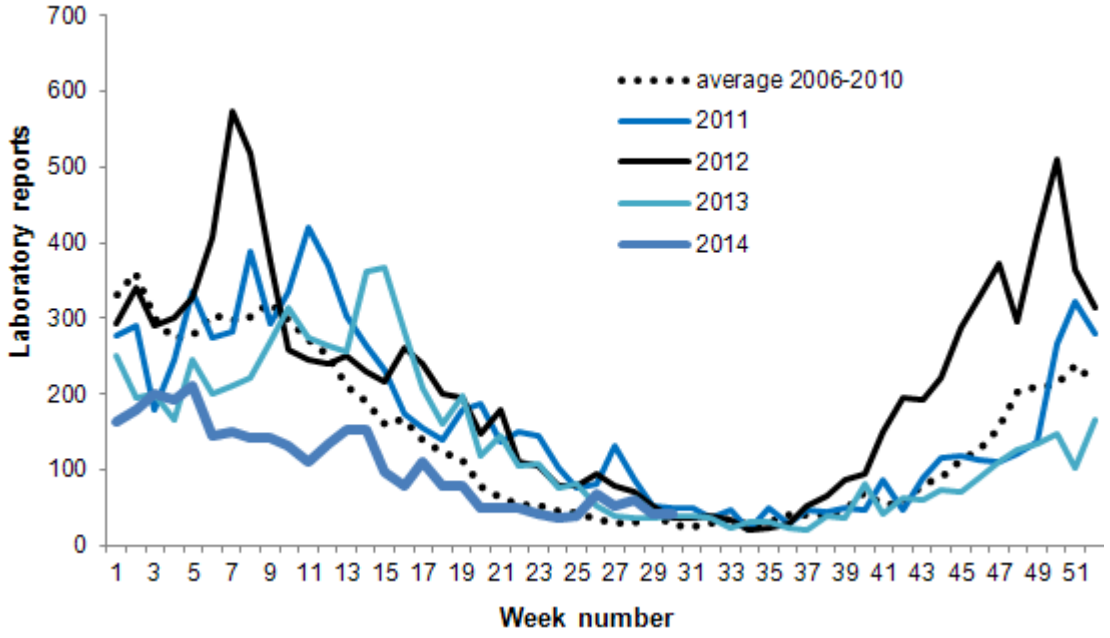
Region/ PHE Centre	Outbreaks between weeks 27-31/2014			Total outbreaks 1-31/2013		
	Outbreaks	Ward/bay closure*	Lab-confirmed	Outbreaks	Ward/bay closure*	Lab-confirmed
Avon, Gloucestershire and Wiltshire	–	–	–	45	45	27
Bedfordshire, Hertfordshire and Northamptonshire	–	–	–	–	–	–
Cheshire and Merseyside	–	–	–	1	1	1
Cumbria and Lancashire	4	4	2	16	16	9
Devon, Cornwall and Somerset	2	2	–	41	40	20
Greater Manchester	–	–	–	15	14	4
Hampshire, Isle of Wight and Dorset	–	–	–	22	22	13
Lincolnshire, Leicestershire, Nottinghamshire and Derbyshire	–	–	–	36	35	27
London	1	1	–	7	7	5
Norfolk, Suffolk, Cambridgeshire and Essex	–	–	–	–	–	–
North east	3	3	2	41	35	28
Sussex, Surrey and Kent	2	2	2	20	20	15
Thames Valley	–	–	–	12	12	4
West Midlands	–	–	–	50	49	26
Yorkshire and the Humber	2	2	1	94	77	80
Total	**14**	**14**	**7**	**400**	**373**	**259**

* Note: not all outbreaks result in whole wards closures, some closures are restricted to bays only.

Seasonal comparison of laboratory reports of norovirus (England and Wales)



Current weekly norovirus laboratory reports compared to weekly average 2006-2010



Infection reports

Volume 8 Number 31 Published on: 8 August 2014

Enteric

Enteric fever surveillance quarterly report (England, Wales and Northern Ireland): second quarter 2014

This quarterly report summarises the epidemiology of laboratory confirmed cases of typhoid and paratyphoid reported in England, Wales and Northern Ireland between April and June 2014. It includes both reference laboratory and some enhanced enteric fever surveillance data; although not all enhanced surveillance data was available for the second quarter of 2014 at the time of publishing. All data for 2014 presented below are provisional; more detailed reports will be produced on an annual basis. More information about enteric fever surveillance, including previous reports, is available on the enhanced enteric fever surveillance page of the HPA legacy website [1].

National summary

In the second quarter (Q2) of 2014, 83 laboratory confirmed cases of enteric fever were reported in England, Wales and Northern Ireland (table 1), 12% lower than the first quarter of 2014 and 30% below the rolling mean (119) for Q2 2007 to 2014 (figure 1). Of note is the decrease in cases of *S*. Paratyphi A since 2012 but in the same period *S*. Typhi has remained at the same level (table 1).

Figure 1. Laboratory confirmed cases of enteric fever by organism, England, Wales and Northern Ireland: second quarter 2007-2014

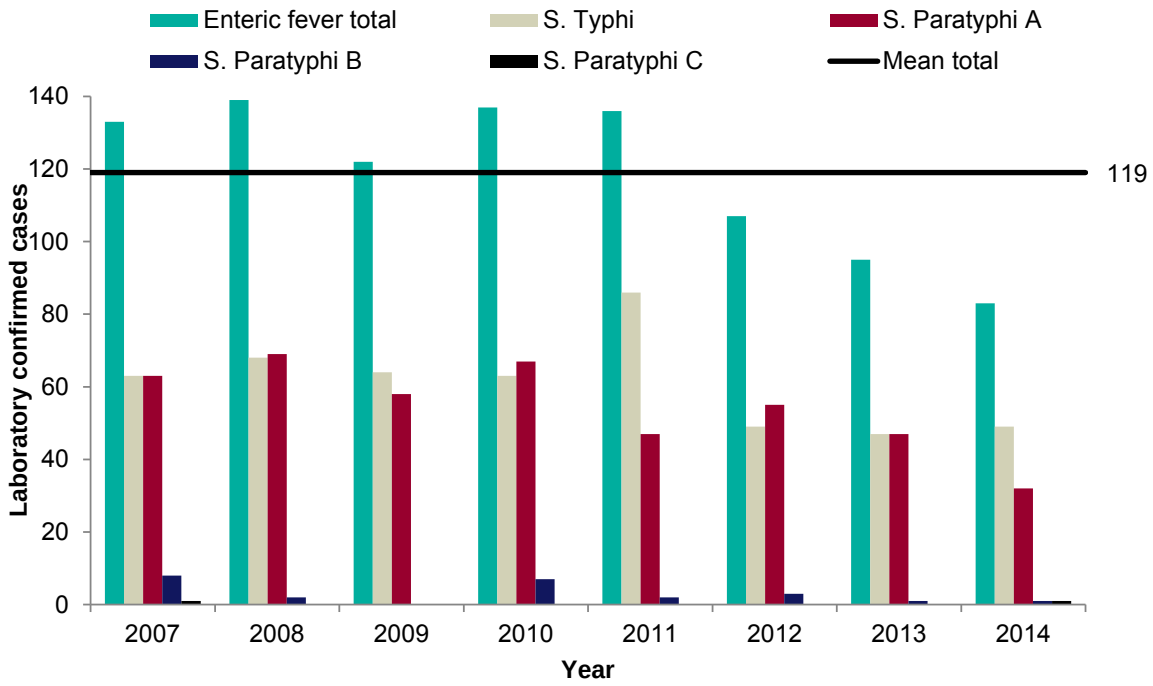


Table 1. Laboratory confirmed cases of enteric fever, England, Wales and Northern Ireland: second quarter 2007-2014

Organism	Laboratory confirmed cases							
	2014	2013	2012	2011	2010	2009	2008	2007
Salmonella Typhi	49	46	48	86	63	64	68	62
Salmonella Paratyphi A	32	47	55	48	67	58	69	61
Salmonella Paratyphi B	1	1	3	2	7	-	2	8
Salmonella Paratyphi C	1	-	-	-	-	-	-	1
Enteric fever total	**83**	**94**	**107[§]**	**136**	**137**	**122**	**139**	**133[§]**

[§] includes one case with dual infection of *S*. Typhi and *S*. Paratyphi A

Table 2. Laboratory confirmed cases of enteric fever by organism and phage type, England, Wales and Northern Ireland: second quarter 2014

Phage type	*S*. Typhi
PT E1	16
PT E9 Var.	12
Untyp.VI	4
Degr.VI	4
Untyp.VI 2	3
PT D1	2
PT A	2
PT 28	1
Untypable	1
Untyp.VI 5	1
PT D2	1
Untyp.VI 1	1
PT B1	1
Total	**49**

Phage type	*S*. Paratyphi A
PT 13	8
PT 1	7
PT 1a	6
PT 4	5
RDNC	3
PT 2	2
PT 6a	1
Total	**32**

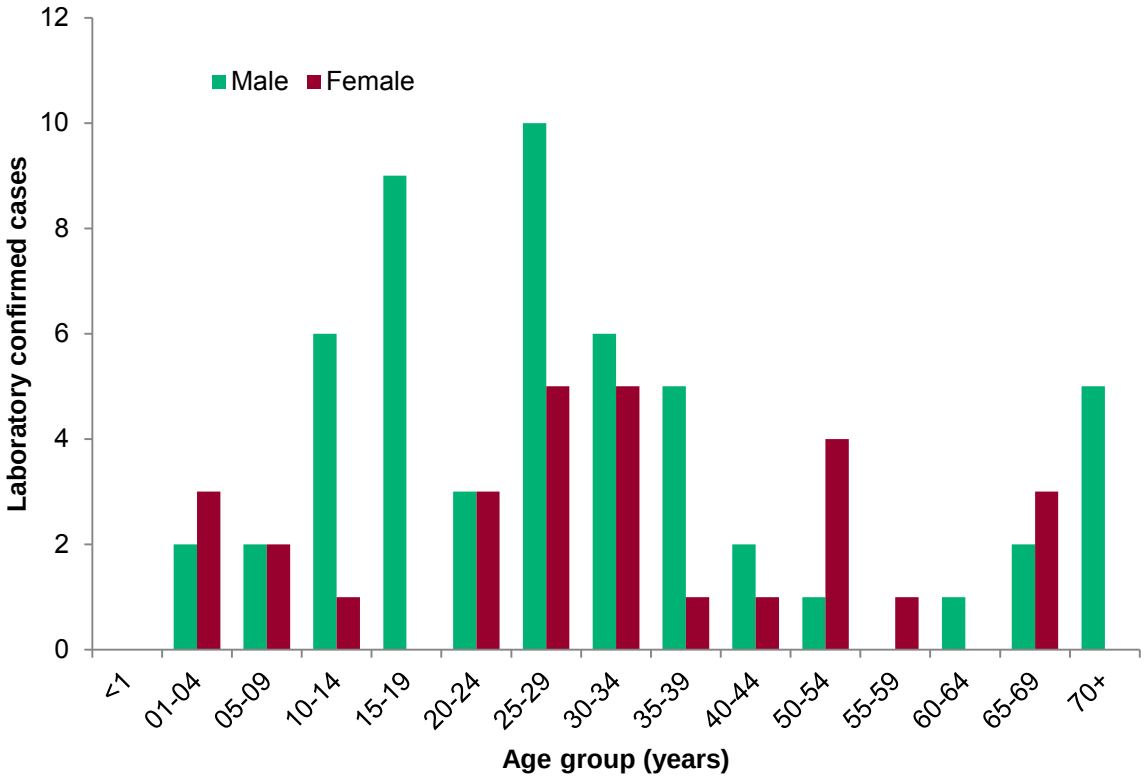
Phage type	*S*. Paratyphi B
Taunton	1
Total	**1**

In general, *S.* Typhi phage types E9 var. and E1 and *S*. Paratyphi A phage types 13 and 1 occur most frequently (table 2) [2].

Age/sex distribution

In the second quarter of 2014, the median age of cases was 28 years [range 2-75 years] and 19% were aged 16 years and under; 65% of cases were male, which is higher than the average for Q2 2007-2013 (54% male) (figure 2).

Figure 2. Laboratory confirmed cases of enteric fever by age and sex (N=83): second quarter 2014



Geographical distribution

London PHE Region reported 30% of the total cases during the second quarter of 2014; Yorkshire and the Humber reported 15 (65%) of the total cases for the North of England (table 3). Only regions are shown in this report as the numbers are too small to break the data down into PHE Centres; between one and nine cases were reported by each of the remaining 11 PHE Centres during the second quarter in 2014. PHE Centre data is available for local PHE teams on request.

Table 3. Laboratory confirmed cases of enteric fever by geographical distribution: second quarter 2014 and 2013

Region	Q2 2014	Q2 2013	% change between 2013 and 2014
London	25	27	-7%
North of England	23	17	35%
Midlands and East of England	20	25	-20%
South of England	15	19	-21%
Wales	-	6	-
Total	**83**	**94**	**-12%**

Travel history

Full travel history for enteric fever reported during the second quarter of 2014 was not available at the time of publishing. Country of travel was, however, available for 46/83 cases and, as in previous quarters, India and Pakistan were the most frequently reported countries of travel.

Data sources and acknowledgements

Data were collated and analysed by the Travel and Migrant Health Section, Centre for Infectious Disease Surveillance and Control, Colindale. Laboratory data were provided by Gastrointestinal Bacterial Reference Unit, Microbiology Services, Colindale. Other surveillance data were provided by Environmental Health Officers and local health protection colleagues in PHE through enteric fever enhanced surveillance.

References

1. HPA legacy website. Enhanced surveillance of enteric fever, http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/TravelHealth/GeneralInformation/trav30Enhancedsurveillanceofentericfever/
2. Health Protection Report. Archived enteric routine data reports, http://www.hpa.org.uk/hpr/archives/Infections/2012/enteric12.htm

Infection reports

Volume 8 Number 31 Published on: 8 August 2014

Zoonoses

Common animal associated infections quarterly report (England and Wales) – second quarter 2014

This quarterly report, produced by the Emerging Infections and Zoonoses Section at Public Health England Centre for Infectious Disease Surveillance and Control, and the Health Protection Division of Public Health Wales, summarises confirmed cases of zoonoses reported in England and Wales between April and June 2014 (second quarter; weeks 14-26).

Animal associated infections in England and Wales: laboratory reports to LabBase (unless otherwise specified) by specimen date, weeks 14-26/14

Disease (Organism)	Reports for weeks 01-13		Reports for weeks 14-26	
	2014*	2013	2014*	2013
Anthrax (*Bacillus anthracis*)	–	1	–	–
Brucellosis** *(Brucella spp.)*	2	1	2	6
Hepatitis E**	218	147	243	155
Hydatid** (*Echinococcus granulosus*)	6	3	1	3
Leptospirosis** *(Leptospira spp.)*	5	14	6	5
Lyme borreliosis** # (*Borrelia burgdorferi*)	136	106	188	201
Pasteurellosis *(Pasteurella spp.)*	105	136	164	168
Psittacosis (*Chlamydophila psittaci)*	4	7	10	5
Q-fever *(Coxiella burnetii)*	11	8	14	11
Toxoplasmosis**# *(Toxoplasma gondii)*	88	70	96	86

* Provisional data.
** Enhanced surveillance system.
# Based on date specimen received

Anthrax

There were no cases reported in the second quarter of 2014.

Brucellosis (data from the Brucella Reference Laboratories)

There were two reports of brucellosis reported during the second quarter of 2014, compared with six during the second quarter of 2013. Both infections were confirmed as *Brucella melitensis*, one was in a 49 year old and the other in a 75 year old (the sex of each case was not recorded); both are understood to be from countries where brucellosis is endemic.

Hepatitis E (data from Public Health Laboratory Birmingham, and Blood Borne Virus Unit Colindale)

There were 243 cases of Hepatitis E in the second quarter of 2014 compared to 155 in the same quarter of 2013. This is consistent with the on-going increase in cases observed since 2010[1].

One hundred and fifty-two cases (63%) were male (aged 20-93 years, median 58) and 89 (37%) were female (aged 19-93 years, median 58). Older men predominate and this is a persisting observation, although the excess remains unexplained. Cases were reported from all regions. The majority of cases (76%, n=184) had no apparent travel history.

Laboratory confirmed cases of Hepatitis E infection (week 14-26, 2014)

	Weeks 14-26/14			
Age Group	Male	Female	Unknown	Total
0-14	–	–	–	–
15-24	1	2	–	3
25-44	35	19	2	56
45-64	60	40	–	100
>64	56	28	–	84
Total	**152**	**89**	**2**	**243**

Hydatid disease (data from the Parasitology Reference Laboratory)

One report of hydatid disease was received during the second quarter of 2014, compared with three cases during the second quarter of 2013. The case was a 72 year old female whose infection is believed to have been acquired outside the UK.

Leptospirosis (data from the Leptospira Reference Unit)

There were six cases of leptospirosis reported in the second quarter of 2014, compared with 5 in the second quarter of 2014. Of these, five cases were known to have been indigenously acquired, two were occupationally acquired, one in a builder, the other in a farmer following immersion in a canal. Two infections were identified in triathletes who competed in the 2014 ‘Enduroman’ contest in Dorset around the late May Bank Holiday. Of the five indigenous cases, four were males aged 20 and 54 year and one female aged 32 years. One infection was acquired overseas and identified by serology in a 53 year old male who had been fishing in France. Five cases were identified by PCR and infecting serovars were not determined.

Confirmations by PCR (undertaken by the Leptospira Reference Unit [LRU] and the Rare and Imported Pathogens Laboratory, Porton) remain a developmental test with limited technical validation. Clinicians are asked to submit a second specimen from the patient to the LRU, together with exposure and clinical histories, as this increases the likelihood that the infecting serovar can be identified.

Lyme disease (data from the Rare and Imported Pathogens Laboratory, Porton)
Data are presented here for the first 6 months of 2014
Note: Specimens sent for Lyme borreliosis referral testing should be accompanied by a completed referral form: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317134852210

Three hundred and twenty-four serologically confirmed cases of Lyme borreliosis were reported during the first 6 months of 2014 (136 in Q1 and 188 in Q2). Case sera were submitted from hospitals in regions throughout England and Wales; South of England reported the most cases (147), and Wales reported the fewest (6). Twenty-one (6%) cases reported overseas travel (Poland n=9, Germany n=4, USA n=2, France n=2 and one each from Slovenia, Austria, Italy and Slovakia). Cases were reported from all age groups (see below). Clinical presentations were available for 141 (43%) cases: 75 (23%) tick bite, 41 (12%) erythema migrans, 18 (5%) myalgia/ arthralgia, 11 (3%) facial palsy, nine (2%) influenza-like illness, nine (2%) arthropathy/ arthritis and eight (2%) fatigue. Some cases reported multiple symptoms.

	Weeks 01-26/14	
Age group	Male	Female
0-14	13	10
15-24	6	29
25-34	26	26
35-44	34	25
45-54	31	33
55-64	31	19
65-74	11	12
75+	11	7
Total	**163**	**161**

Pasteurellosis
One hundred and sixty-four cases of pasteurellosis were reported in the second quarter of 2014, compared with 168 in the same quarter of 2013: *Pasteurella multocida* (128 cases, 78%), *Pasteurella pneumotropica* (13 cases, 8%), and *Pasteurella* sp. (23 cases, 14%). One of the cases had a duel infection with *Pasteurella multocida* and *Pasteurella* sp.

Seventy-two of the cases were male (0-91 years, median 56) and 79 were female (2-88 years, median 64). Gender and age was unknown for 13 cases. The North of England reported the most cases (46), and Wales reported the fewest (12). Of the two cases giving an animal exposure both reported dog bites.

	Weeks 01-13/14		**Weeks 14-26/14**		
Age group	Male	Female	Male	Female	Unknown
0-14	4	3	4	3	-
15-29	4	7	7	4	-
30-39	3	6	7	3	-
40-49	9	8	11	13	-
50-59	3	7	16	10	-
60-69	8	11	10	16	-
70-79	6	13	12	18	-
80+	2	12	5	12	-
Unknown	-	-	-	-	13
Total	**38**	**67**	**72**	**79**	**13**

Psittacosis

Ten cases of psittacosis were diagnosed in the second quarter of 2014, compared with five during the second quarter of 2013. Eight cases were male (aged 31-74, median 45) and two were female (aged 39 and 49). Seven of the cases were from the South of England, two from the North of England and one from Wales.

Note: Serological tests for respiratory chlamydophila infections cannot consistently distinguish psittacosis. The cases reported above have been identified by reporting laboratories as infection with *Chlamydia psittaci*.

Q fever (data from the Rare and Imported Pathogens Laboratory, Porton, and Bristol Reference Laboratory)

There were 14 cases of Q fever reported in the second quarter of 2014, compared with 11 in the second quarter of 2013. Nine cases were male (aged 19-74 years, median 53) and 5 were female (aged 19-80, median 63). Seven cases were reported by the South of England, three by the North of England, two by Midlands and the East of England and one each by London and Wales.

Toxoplasma (Data from the Toxoplasma Reference Unit)

There were 96 laboratory-confirmed cases of *Toxoplasma* infection in the second quarter of 2014, compared with 86 cases in the second quarter of 2013. One case reported ocular symptoms. Nine cases occurred in pregnant women and there were two confirmed congenital cases, one of which formed a mother-child pair with one of the pregnant cases.

Tables: Laboratory confirmed cases of Toxoplasma infection (week 14-26, 2014)

Age group	Male	Female	Unknown	Total
Foetus	–	–	–	–
0	–	1	1	2
1-9	–	1	–	1
10-14	–	2	–	2
15-24	5	3	–	8
25-44	27	35	2	64
45-64	10	7	1	18
>64	1	–	–	1
Unknown	–	–	–	–
Total	**43**	**49**	**4**	**96**

Age group	Con-genital	Pregnant	HIV	Organ donor	Organ recipient	Other (Immuno-competent)	Other (Immuno-suppressed)	Unknown*	Total
Foetus	–	–	–	–	–	–	–	–	–
0	2	–	–	–	–	–	–	–	2
1-9	–	–	–	1	–	–	–	–	1
10-14	–	–	–	–	–	2	–	–	2
15-24	–	–	1	–	–	7	–	–	8
25-44	–	9	3	2	2	44	3	1	64
45-64	–	–	5	1	–	11	1	–	18
>64	–	–	–	–	–	1	–	–	1
unknown	–	–		–	–	–	–	–	–
Total	**2**	**9**	**9**	**4**	**2**	**65**	**4**	**1**	**96**

* No clinical details or information given.

Other zoonotic organisms

Other zoonotic infections of interest diagnosed in the second quarter of 2014 were as follows:

- Three cases of *Capnocytophaga sp.* infection; all in females aged 61, 71 and 87 years. All the infections were bacteraemias.
- Three cases of *Mycobacterium marinum,* one in a female aged 48 and two in males aged 26 and 64 years. All had tissue infections.

Reference

1. http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HepatitisE/Surveillance/

Infection reports

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Emerging infections/CJD

CJD biannual update (2014/2), with updated guidance on decontamination of gastrointestinal endoscopy equipment

This six-monthly report provides an update on the enhanced surveillance of potential iatrogenic (healthcare-acquired) exposures to Creutzfeldt-Jakob Disease (CJD). The data is correct as at 30 June 2014. For numbers of CJD case reports, readers should consult data provided by the National CJD Research and Surveillance Unit (NCJDRSU, http://www.cjd.ed.ac.uk/data.html).

Following the enhanced surveillance report, an update on the guidance for the decontamination of equipment for gastrointestinal endoscopy is presented.

Monitoring of patients 'at increased risk' of CJD

Individuals who have been identified as at increased risk of CJD as a consequence of their medical care are informed of their exposure and asked to follow public health precautions to avoid potentially transmitting the infection to others. They are also followed-up to help determine the risks of CJD transmission to patients through different routes and to ascertain whether any people who may have been exposed to increased CJD risks go on to develop CJD.

Public Health follow-up activities include clinical monitoring, General Practitioner (GP) updates, and post mortem investigations to determine whether asymptomatic individuals in these groups have been infected with the CJD agent. Some individuals also provide blood or tissue specimens for research purposes. A number of different organisations are involved in these activities: Public Health England (PHE) formerly the Health Protection Agency (HPA), Health Protection Scotland (HPS), UCL Institute of Child Health/Great Ormond Street Hospital (ICH), NHS Blood and Transplant (NHSBT), National CJD Research and Surveillance Unit (NCJDRSU), National Prion Clinic (NPC), and the UK Haemophilia Centre Doctors' Organisation (UKHCDO).

The PHE CJD Section currently holds data on the following groups of ‘at risk' patients:

- recipients of blood components from donors who subsequently developed vCJD
- blood donors to individuals who later developed vCJD
- other recipients of blood components from these blood donors
- recipients of certain plasma products between 1990 and 2001 (non-bleeding disorder patients)
- certain surgical contacts of patients diagnosed with CJD
- highly transfused recipients.

Data on the following risk groups are not held by PHE, but are held by other organisations:

- bleeding disorder patients who received plasma products between 1990 and 2001 (UKHCDO)
- recipients of human derived growth hormone before 1985 (ICH)
- patients who could have received a dura mater graft before August 1992 (data not currently collected)
- people who have been treated with gonadotrophin sourced from humans before 1973 (data not currently collected)
- family risk of genetic prion disease (NPC).

The data from the UKHCDO are likely to be an underestimate of the true number of ‘at risk' patients with bleeding disorders who received UK-sourced clotting factors, as there was incomplete reporting of identified ‘at risk' patients by haemophilia centres to the UKHCDO database. Notified ‘at risk' patients are given the option of removing their details from the UKHCDO database, and are then removed from the ‘at risk' totals.

The data on ‘at risk' patients who received human-derived human growth hormone held by the ICH is a slight underestimate of the total as a small number of these patients are not included in the ICH follow-up.

Table 1. Summary of all ‘at risk’ groups on which data are collected (as at 31 December 2013)

'At risk' Group	Identified as 'at risk'	Number notified as being 'at risk'		Cases	Asymptomatic infections [b]
		All	Alive		
Recipients of blood from who later developed vCJD	67	27	14	3	1
Blood donors to who later developed vCJD	112	108	104	–	–
Other recipients of blood components from these donors	34	32 [c]	19 [c]	–	–
Plasma product recipients (non-bleeding disorders) who received UK sourced plasmsa products 1980-2001	11	10	4	–	–
Certain surgical contacts of patients diagnosed with CJD	196	161 [d]	140 [e]	–	–
Highly transfused patients	11	10	5	–	–
Total for 'at risk' groups where PHE holds data	**431**	**348** [f]	**286** [f]	**3**	**1**
Patients with bleeding disorders who received UK-sourced plasma products 1980-2001 [a]	3,977	National information incomplete	National information incomplete	–	1
Recipients of human-derived growth hormone [a]	1,883	1,883	1,503	75	–
Total for all 'at risk' groups [a]	**6,291**	**At least 2,231**	**At least 1,789**	**78**	**2**

a. These are minimum figures. Central reporting for bleeding disorder patients is incomplete, and seven patients have opted out of the central UK Haemophilia Centre Doctors' Organisation database. A small number of ‘at risk’ growth hormone recipients are not included in the Institute of Child Health study. Not all of ‘at risk’ growth hormone recipients have been notified. There is no central record of who has been informed.
b. An unsymptomatic infection is when an individual does not exhibit any of the signs and symptoms of CJD in life but abnormal prion protein indicative of CJD infection has been found in tissue obtained from them. In these cases the abnormal prion protein was identified during post mortem after the individuals had died of other causes.
c. One patient notified by proxy.
d. Five of these were notified by proxy.
e. Three of these were notified by proxy.
f. Includes patients notified by proxy.

Updated guidance on decontamination of equipment for gastrointestinal endoscopy

The British Society of Gastroenterology has updated its guidance on decontamination of equipment for gastrointestinal endoscopy [1]. The update includes revised advice for management and decontamination of endoscopes after they have been used for procedures on individuals at risk of variant CJD.

This aligns with Department of Health guidance, CFPP 01-06, published in April 2013 [2], which recommended that:

- there is no longer a requirement to quarantine endoscopes following an “invasive” procedure on patients at risk of vCJD (with very few exceptions);
- a single quality assured decontamination cycle following recommended guidelines is considered sufficient, but the endoscope should be decontaminated separately from others with a single-use disinfectant; routine traceability data should be available to demonstrate thorough reprocessing;
- ‘single use' accessories should always be used in preference to reusable accessories.

The ACDP TSE specific guidance on endoscopy, *Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection: Annex F* [3], which builds on the recommendations from the BSG guidance, has been updated.

References

1. BSG Guidance on Decontamination of Equipment for Gastrointestinal Endoscopy (2014). Available at: http://www.bsg.org.uk/clinical-guidelines/endoscopy/guidelines-for-decontamination-of-equipment-for-gastrointestinal-endoscopy.html.

2. Management and decontamination of flexible endoscopes (CFPP 01-06) (2013): Policy and Management. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192522/Decontamination_of_flexible_endoscopes.pdf.

3. Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection: Annex F (2014). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270734/Annex_F_Endoscopy.pdf.