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News

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Zika virus – epidemiological and guidance update

As of 5 February, 36 countries and territories worldwide have reported confirmed cases of locally-acquired Zika virus (ZIKV) infection in the last nine months (see PHE [Zika webpage](#) for latest information) [1].

The outbreak in the Americas continues to spread rapidly, with 27 countries within Central and South America and the Caribbean currently affected by active ZIKV transmission (see [PHE Map](#)).

Within continental Europe, no autochthonous ZIKV cases have been reported. However, active ZIKV transmission is ongoing in a number of the outermost European territories (French Guiana, Guadeloupe, Martinique, Saint Martin and Curacao) [2].

In the UK, the risk of autochthonous, vector-borne ZIKV virus transmission is deemed to be negligible due to climatic factors (that preclude the *Aedes* mosquito vector surviving). As at 4 February, five imported cases associated with the current outbreak have been reported in the UK (from Colombia, Guyana/Suriname and Mexico/Venezuela) [1].

Recent increases in congenital anomalies (particularly microcephaly), Guillain-Barré syndrome, and other neurological and autoimmune syndromes are being reported in areas where ZIKV outbreaks have occurred. The association of these illnesses with ZIKV is temporal and causality has yet to be proven, however evidence is accumulating. Further information about these findings is available from WHO [3].

On 1 February, the first meeting was convened of the WHO International Health Regulations Emergency Committee (EC) concerned with clusters of microcephaly cases and other neurological disorders in some areas affected by ZIKV. Following a review of the evidence currently available, the EC advised that the recent cluster of microcephaly cases and other neurological disorders reported in Brazil, following a similar cluster in French Polynesia in 2014, constitutes an “extraordinary event” and a public health threat to other parts of the world, and therefore constitutes a Public Health Emergency of International Concern [4].

Declaring the PHEIC, the EC recommended a range of precautionary measures for affected countries and issued temporary recommendations which include: improved surveillance and control of Zika in at risk countries, and measures for travellers and pregnant women. They also found that there is currently no public health justification for restrictions on travel or trade to prevent the spread of ZIKV [4].

Current advice

The PHE [Zika webpage](#) [1] is a regularly updated resource for epidemiological information and guidance. Current guidance documents include:

- [an interim algorithm for assessing pregnant women with a history of travel during pregnancy to areas with active \(ZIKV\) transmission](#)
- [guidance on ZIKV infection for primary care clinicians.](#)

Also included on the webpage are links to [current travel advice provided by NaTHNaC](#) and a recent [statement by NHS Blood and Transplant on blood donation deferral](#), in England and North Wales, affecting those who have travelled to countries where the Zika virus is endemic.

References

1. NICE (January 2016). [Tuberculosis: prevention, diagnosis, management and service organisation \(NICE Guideline 33\): methods, evidence and recommendations.](#)
 2. [NICE Guideline NG33: information for the public.](#)
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Infection reports / Respiratory

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Laboratory reports of respiratory infections made to PHE from PHE and NHS laboratories in England and Wales: weeks 1 to 4, 2016

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 CIDSC, by week of report

Week	Week 1	Week 2	Week 3	Week 4	Total
Week ending	10/1/16	17/1/16	24/1/16	31/1/16	
Influenza A	228	180	325	465	1197
Isolation	27	21	18	58	124
DIF *	38	12	18	54	122
PCR	132	128	267	318	845
Other †	31	19	22	34	106
Influenza B	18	23	31	26	98
Isolation	–	–	2	2	4
DIF *	1	3	5	5	14
PCR	8	16	19	19	62
Other †	9	4	5	–	18

* 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, genomic, electron microscopy, other method, other method unknown), by week of report

Week	Week 1	Week 2	Week 3	Week 4	Total
Week ending	10/1/16	17/1/16	24/1/16	31/1/16	
Adenovirus *	83	83	80	82	328
Coronavirus	35	53	40	83	211
Parainfluenza†	98	95	59	61	313
Rhinovirus	269	197	232	295	993
RSV	640	390	345	251	1626

* Respiratory samples only. † Includes parainfluenza types 1, 2, 3, 4 and untyped.

Table 3. Respiratory viral detections by age group: weeks 1-4/2016

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥65 years	Un-known	Total
Adenovirus *	58	82	31	85	51	20	1	328
Coronavirus	36	30	16	36	38	55	–	211
Influenza A	86	176	75	421	419	232	3	1412
Influenza B	3	5	9	45	22	18	–	102
Parainfluenza †	70	47	20	35	54	87	–	313
Respiratory syncytial virus	816	173	55	148	188	244	2	1626
Rhinovirus	333	187	74	118	122	158	1	993

* 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

Week	Week 1	Week 2	Week 3	Week 4	Total
Week ending	10/1/16	17/1/16	24/1/16	31/1/16	
<i>Coxiella burnettii</i>	1	–	–	–	1
Respiratory <i>Chlamydia</i> sp. *	1	1	1	–	3
<i>Mycoplasma pneumoniae</i>	25	30	30	22	107
<i>Legionella</i> sp.	14	2	10	6	32

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

Table 5 Reports of Legionnaires Disease cases in England and Wales, by week of report

Week	Week 1	Week 2	Week 3	Week 4	Total
Week ending	10/1/16	17/1/16	24/1/16	31/1/16	
Nosocomial	–	–	–	–	0
Community	7	–	8	3	18
Travel Abroad	4	2	1	3	10
Travel UK	3	–	1	–	4
Total	14	2	10	6	32
Male	10	1	8	4	23
Female	4	1	2	2	9

Thirty-two cases were reported with pneumonia. Twenty-three males aged 35 - 95 years and nine females aged 35 - 78 years. Eighteen cases had community-acquired infection. Four deaths were reported in three males aged 45 - 87 years and a female aged 62 years.

Fourteen cases were reported with travel association: Belgium (1), Indonesia/Singapore (1), Malta/United Kingdom (1), Malaysia/Singapore/Thailand (1), Spain (1), United Arab Emirates (5), and United Kingdom (4).

Table 6. Reports of Legionnaires Disease cases in England and Wales, by PHE Centre: weeks 1-4/2016

Region/Country	Nosocomial	Community	Travel Abroad	Travel UK	Total
North of England					
North East	–	–	2	–	2
Cheshire & Merseyside	–	1	–	–	2
Greater Manchester	–	–	–	–	0
Cumbria & Lancashire	–	–	–	–	0
Yorkshire & the Humber	–	2	1	1	4
South of England					
Devon, Cornwall & Somerset	–	–	–	–	0
Avon, Gloucestershire & Wiltshire	–	2	–	–	2
Wessex	–	1	–	–	1
Thames Valley	–	1	–	–	1
Sussex, Surrey & Kent	–	–	2	–	2
Midlands & East of England					
East Midlands	–	1	–	–	1
South Midlands & Hertfordshire	–	–	–	–	0
Anglia & Essex	–	1	–	–	1
West Midlands	–	7	2	–	9
London Integrated Region					
London	–	–	3	1	4
Public Health Wales					
Mid & West Wales	–	1	–	1	2
North Wales	–	–	–	–	0
South East Wales	–	1	–	–	1
Miscellaneous					
Other	–	–	–	1	1
Not known	–	–	–	–	0
Total	0	18	10	4	32