

# Transmit

Health protection service bulletin

Aug/Sept 2011

## Foreword

Thank you to all who responded to our survey seeking your views on the *Transmit* bulletin. The bulletin is produced to keep health professionals up to date on a range of health protection issues and it is clear that it is valued for this purpose. We will continue to improve *Transmit* and cover the range of issues you have identified as being of high importance.

The year of 2010 saw an increase in notifications of food poisoning.

*Campylobacter* remains the most common form of bacterial food poisoning, with over 1,000 reports received in 2010. Laboratory reports of *Salmonella* also increased in 2010, while we saw the emergence of new *Salmonella enteritidis* phage type PT8.

Alongside this, we have also seen an increase of 154% in the total number of outbreaks investigated by the health protection service in the Public Health Agency (PHA).

Some of these may be explained by the more systematic notification and recording of outbreaks by the PHA duty room.



An update on brucellosis is provided in this edition and we continue to see small numbers of cases in Northern Ireland.

Data on the post-discharge surveillance for caesarean section surgical site infections are also presented here, showing an overall surgical site infection (SSI) rate of 10.7%. The health protection service will be working with Trust health professionals on this issue.

The Chief Medical Officer issued the influenza immunisation policy for Northern Ireland in July. Copies of this are available on the DHSSPS website at: [www.dhsspsni.gov.uk/hss-md-14-2011.pdf](http://www.dhsspsni.gov.uk/hss-md-14-2011.pdf) and copies of the new information materials developed by the health protection service for flu are available at: [www.fluawareni.info](http://www.fluawareni.info)

This edition also includes updates on new national guidance on the management of acute bloody diarrhoea caused by verocytotoxin-producing *E. coli* in children, and highlights local transmission of malaria in Greece, which requires travellers to take measures to prevent mosquito bites.

Don't forget to have your flu vaccine!

**Dr Lorraine Doherty**

Assistant Director of Public Health (Health Protection)

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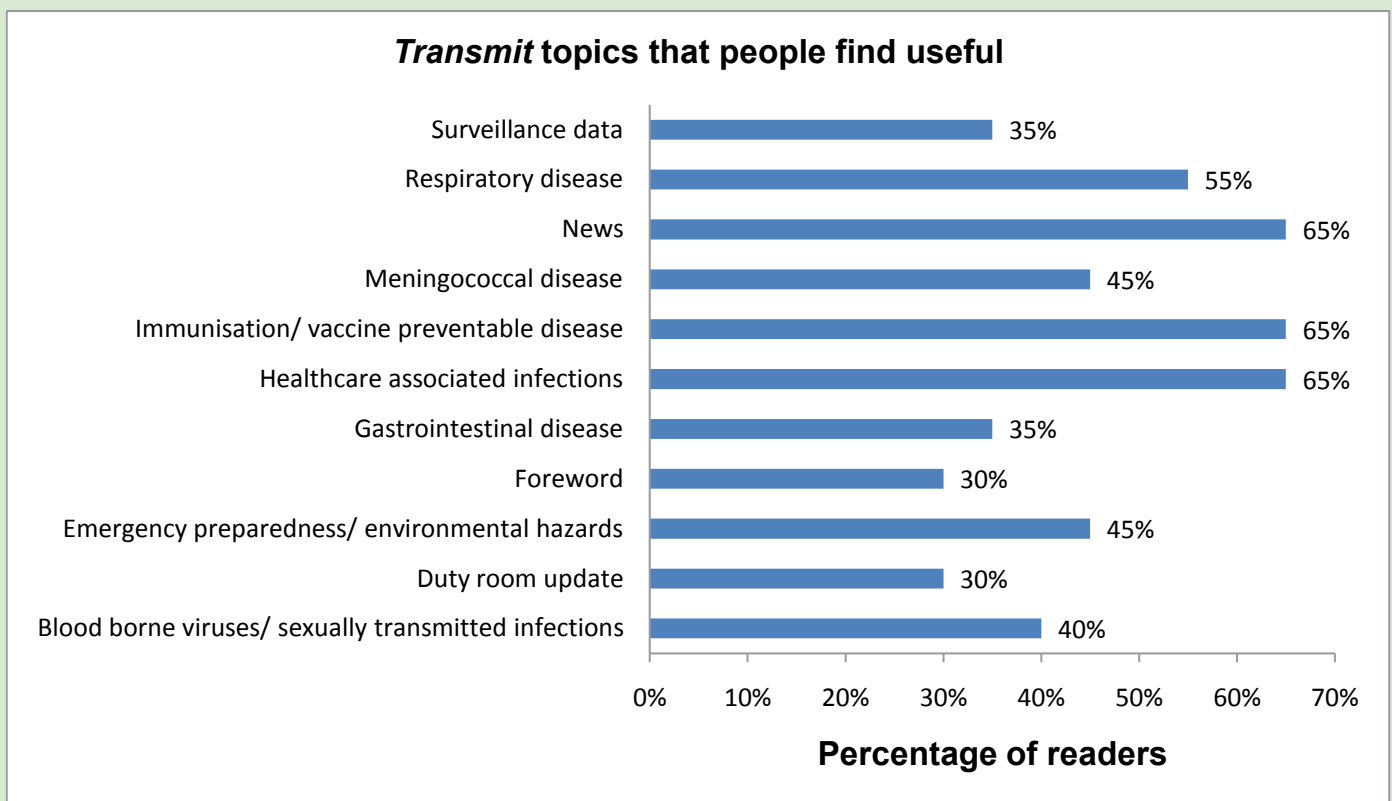
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# Transmit survey results

In the May 2011 issue of *Transmit*, readers were asked to complete a short online survey with their views on the newsletter and to suggest ways in which it could be improved. In all, 25 responses were received from readers working in a variety of fields. Many thanks to everyone who responded. Feedback will be used to improve this and future issues, and is always welcome.

Respondents were first asked about the number of issues they had seen – 20% (five respondents) had seen all 10 issues, while 28% (seven respondents) had not seen any issues. More than half of respondents (55.6%) found *Transmit* either useful or very useful in their daily work.

Readers were asked about topics they find useful. Respondents were invited to select topics from a list of those previously covered in *Transmit*. The main areas of interest were healthcare associated infections (65% were interested), immunisation and vaccine preventable disease (65% were interested) and news (65% were interested).

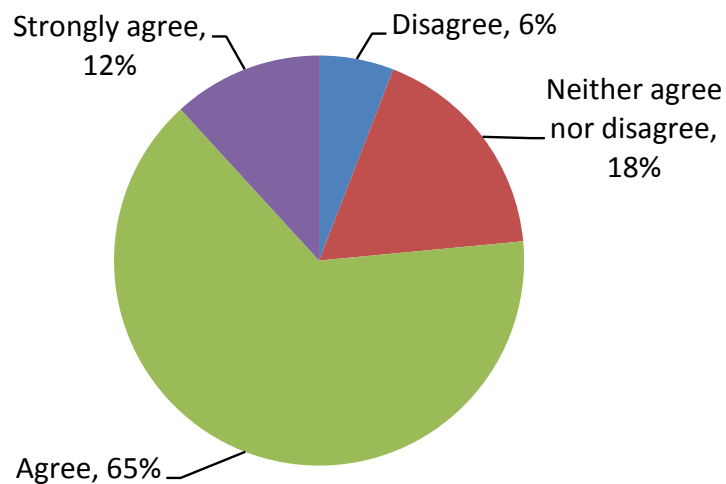


Respondents were next asked what they would like to read about in future issues of *Transmit*. Again, they were invited to select topics from a list of those previously covered in the newsletter, and some further topics suggested by consultants in health protection. There was an opportunity for respondents to suggest other topics to be considered. In total, 66.7% stated that they would like to see links to relevant guidance, with 61.9% interested in data comparing Northern Ireland with other regions and countries. More than half of respondents (57.1%) were interested in reading about respiratory disease, including influenza and TB. One further topic suggested for inclusion was mental health and wellbeing facts and news.

Respondents were questioned about how useful they found *Transmit* in their daily work – 38.9% felt it was useful and 16.7% felt it was very useful. Two respondents (11.1%) felt *Transmit* was not at all useful.

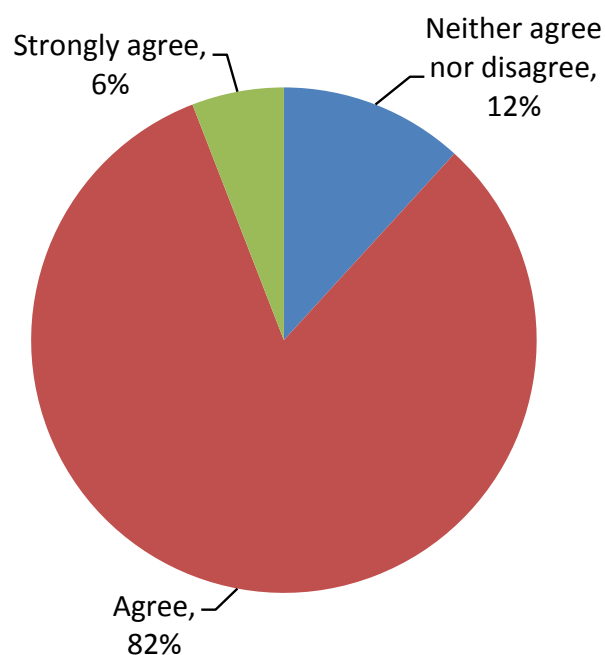
Respondents were then asked the extent to which they agreed with a number of statements about *Transmit*. In total, 64.7% agreed that it had a good balance between text and charts. A further 11.8% strongly agreed with this comment, while 5.9% disagreed.

### ***Transmit* articles have a good balance between text and charts**



Asked if *Transmit* was topical, 82.4% of readers either strongly agreed (11.8%) or agreed (70.6%). Asked if *Transmit* was the right length, 82.4% agreed and 5.9% strongly agreed.

### ***Transmit* is the right length**



A number of respondents provided further feedback on *Transmit*. Two felt that it should be circulated more widely and provided suggestions as to how this could be done. One respondent felt that some of the graphs were difficult to interpret. Other comments stated that the information provided was excellent and that *Transmit* was easy to read and informative.

The final question asked respondents to highlight their area of work. The answers included a variety of fields, including community nursing (three), hospital medicine and nursing (seven), laboratories, environmental health, midwifery and school vaccination, in addition to public health.

*Sinéad McGuinness*

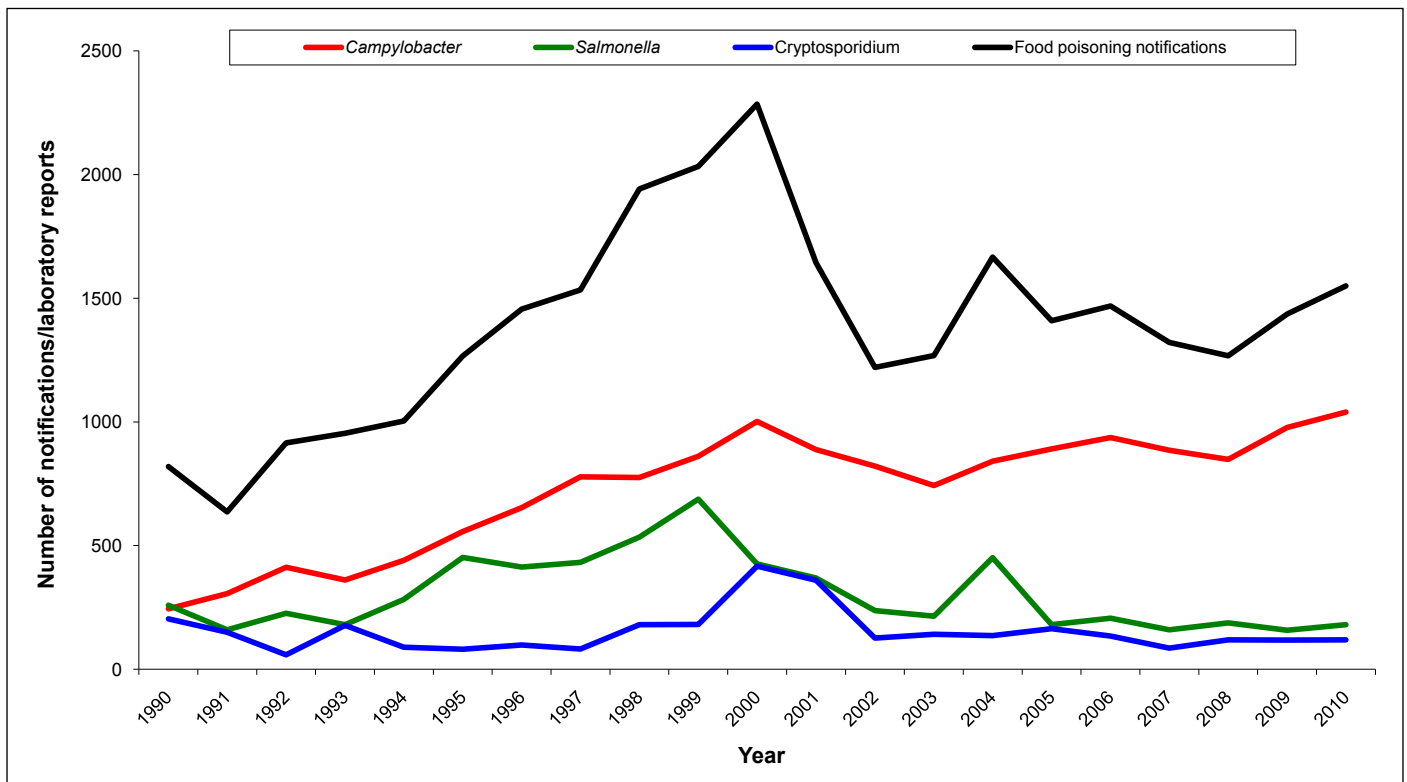
*FY2 doctor, Public Health*

# Gastrointestinal infections 2010

## Notifications of food poisoning

Notifications of food poisoning increased at a steady rate between 1991 and 2000. Between 2000 and 2002, there was a decrease of 47% (from 2,285 in 2000 to 1,220 in 2002). A slight increase (4%) in 2003 was followed by a large increase (31%) in 2004. The increase in 2004 was mainly attributable to three *Salmonella* outbreaks that year, although laboratory reports of *Campylobacter* also increased. Following a decrease of 4%, from 1,321 cases notified in 2007 to 1,267 in 2008, notifications have risen by 22% to 1,550 in 2010 (Figure 1).

**Figure 1: Food poisoning notifications and laboratory reports, 1990–2010, Northern Ireland**



## **Campylobacter**

Laboratory reports of *Campylobacter* first exceeded reports of *Salmonella* infection in Northern Ireland in 1991 and *Campylobacter* remains the most common form of bacterial food poisoning here, with 1,040 reports received in 2010. After reaching a peak of 1,002 in 2000, the number of reports declined steadily over the next three years to 743 in 2003, before they started to rise again. The 2010 figure represents an increase of 23% on 2008 (848) and is the highest in any year since 1990 (Figure 2).

**Figure 2: Laboratory reports of *Campylobacter*, 1990–2010, Northern Ireland**

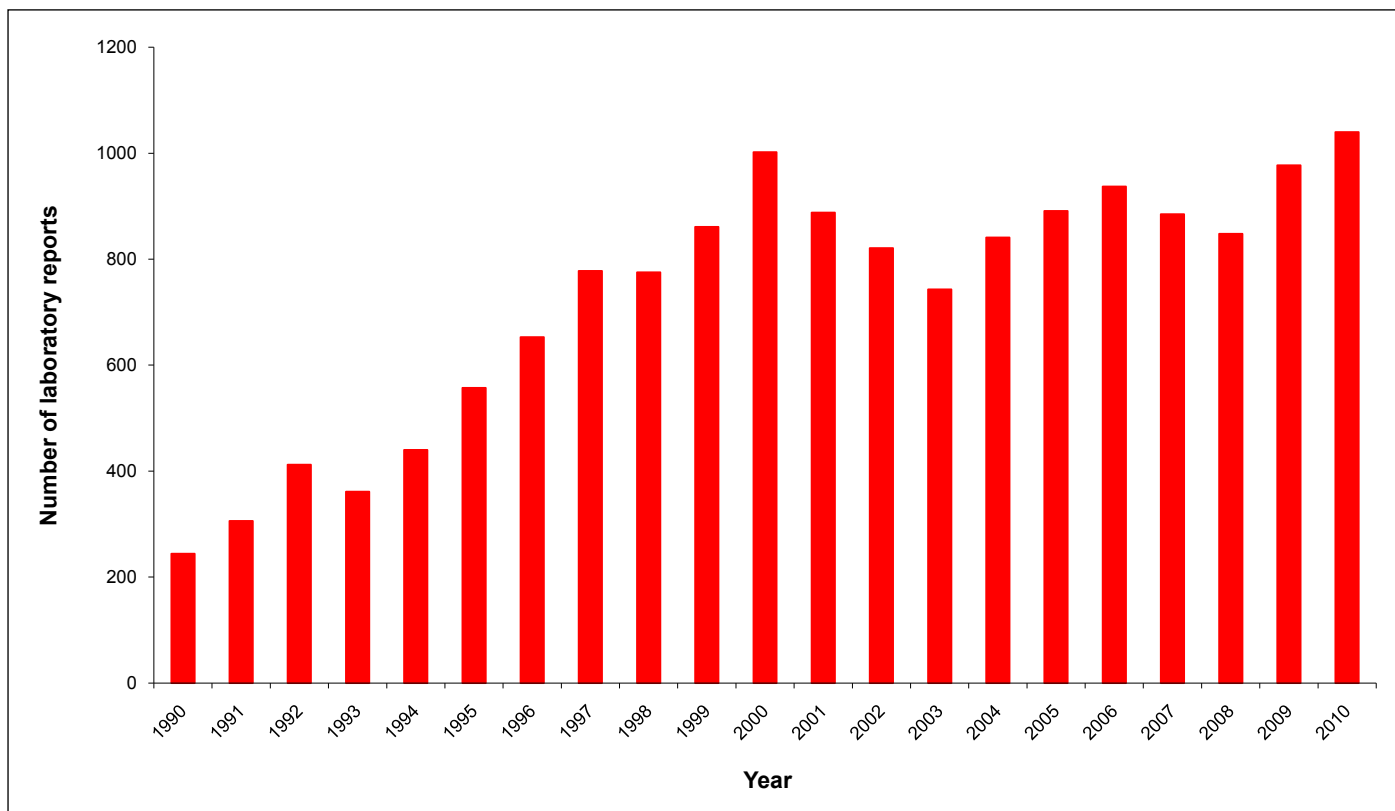
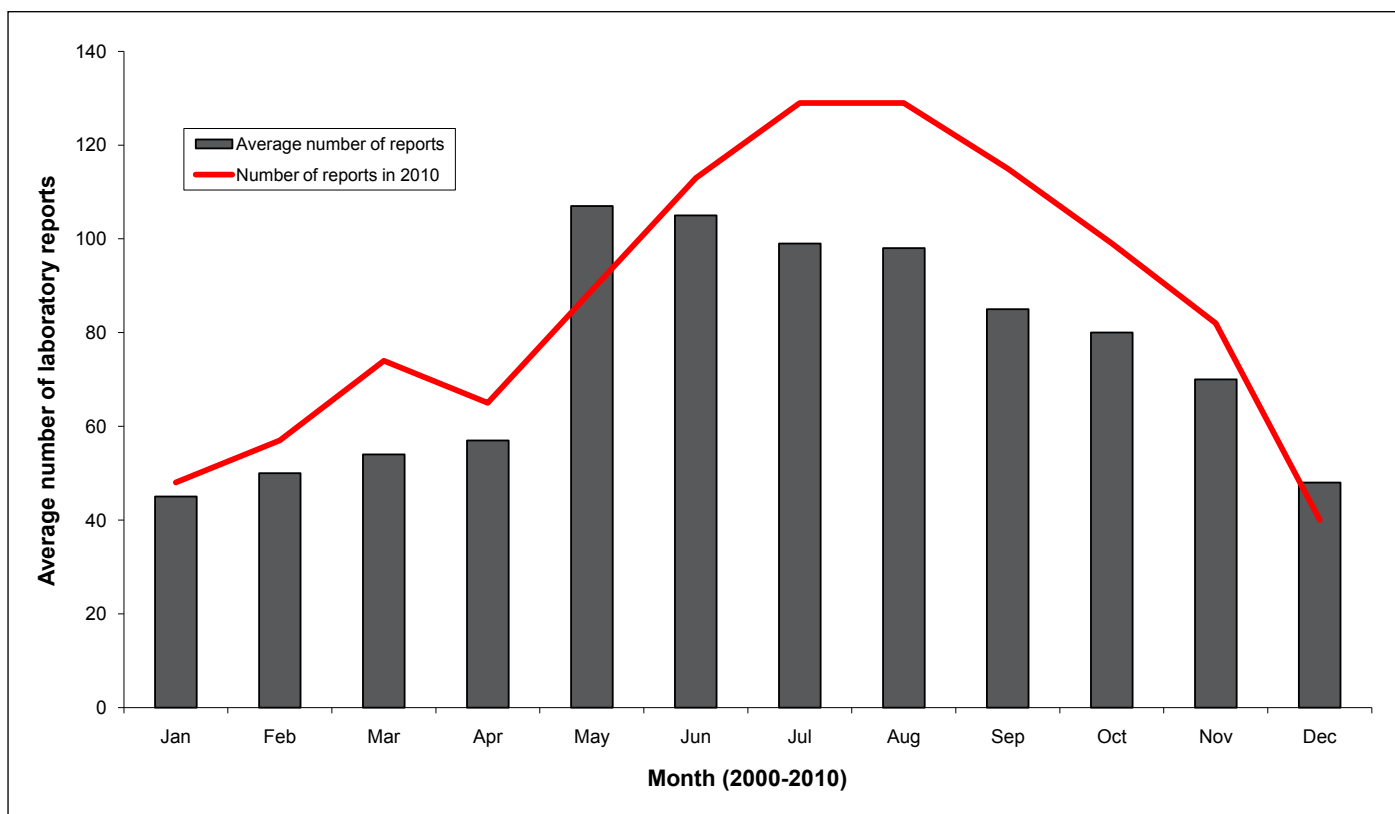


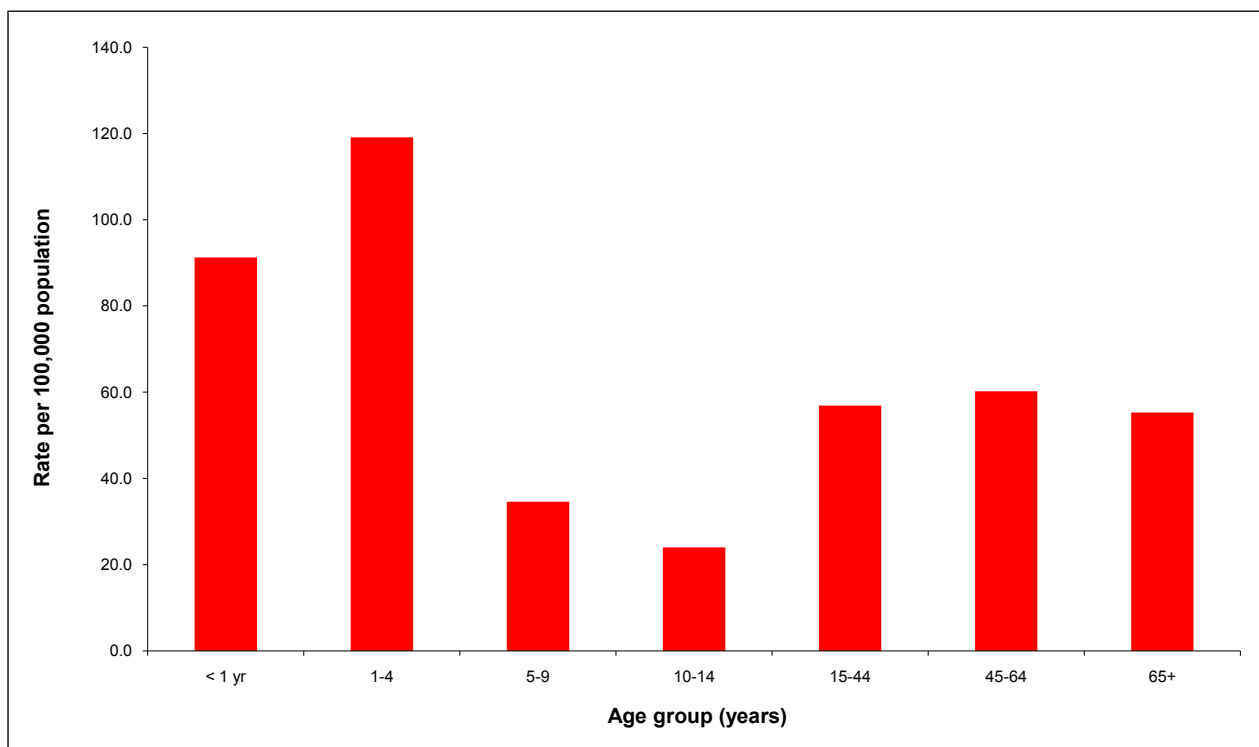
Figure 3 shows the average number of laboratory reports received each month from 2000 to 2010, and the actual number per month in 2010. *Campylobacter* numbers normally show a seasonal increase from May, with a decline in the autumn. In 2010, there was a rapid seasonal increase from April, peaking in July and August, then following the normal trend of a decline in the autumn months to the end of the year.

**Figure 3: Average number of laboratory reports of *Campylobacter*, by month, 2000–2010, Northern Ireland**



The rate of laboratory reported *Campylobacter* infection per 100,000 population in 2010 was highest in the under five years age groups (Figure 4).

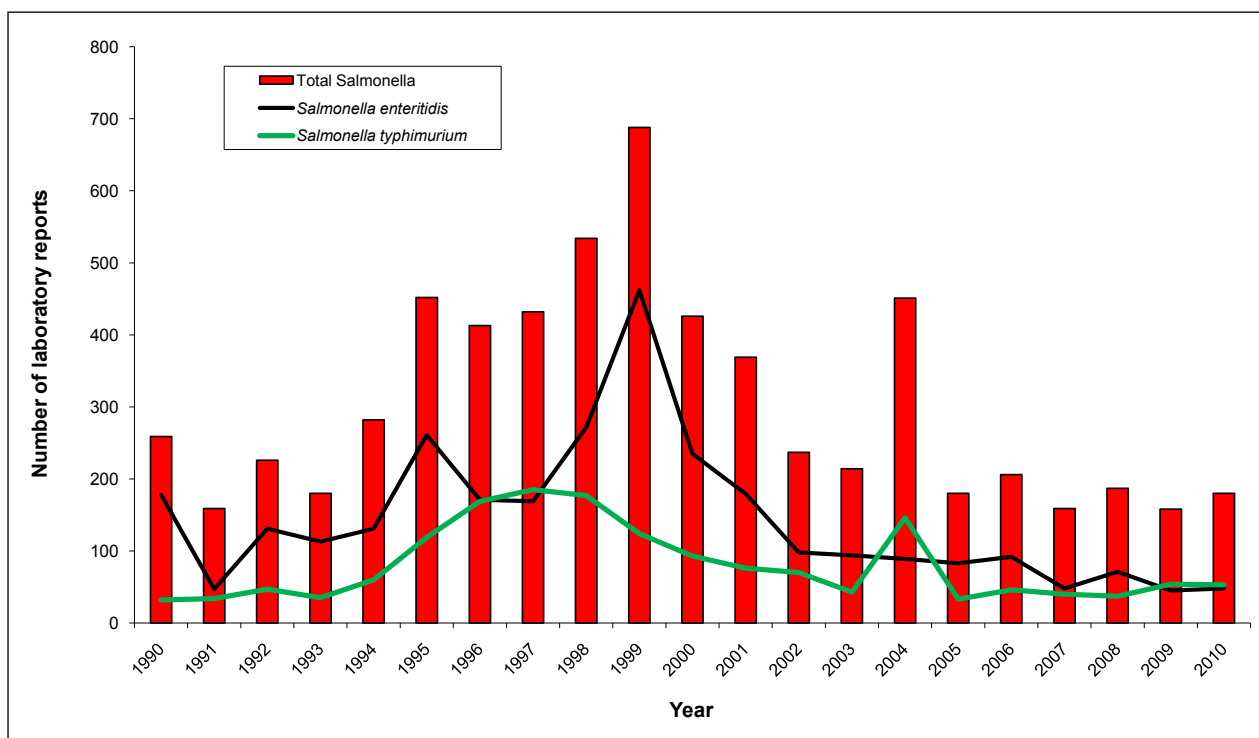
**Figure 4: Age-specific rates of *Campylobacter* per 100,000 population, 2010, Northern Ireland**



### Salmonella

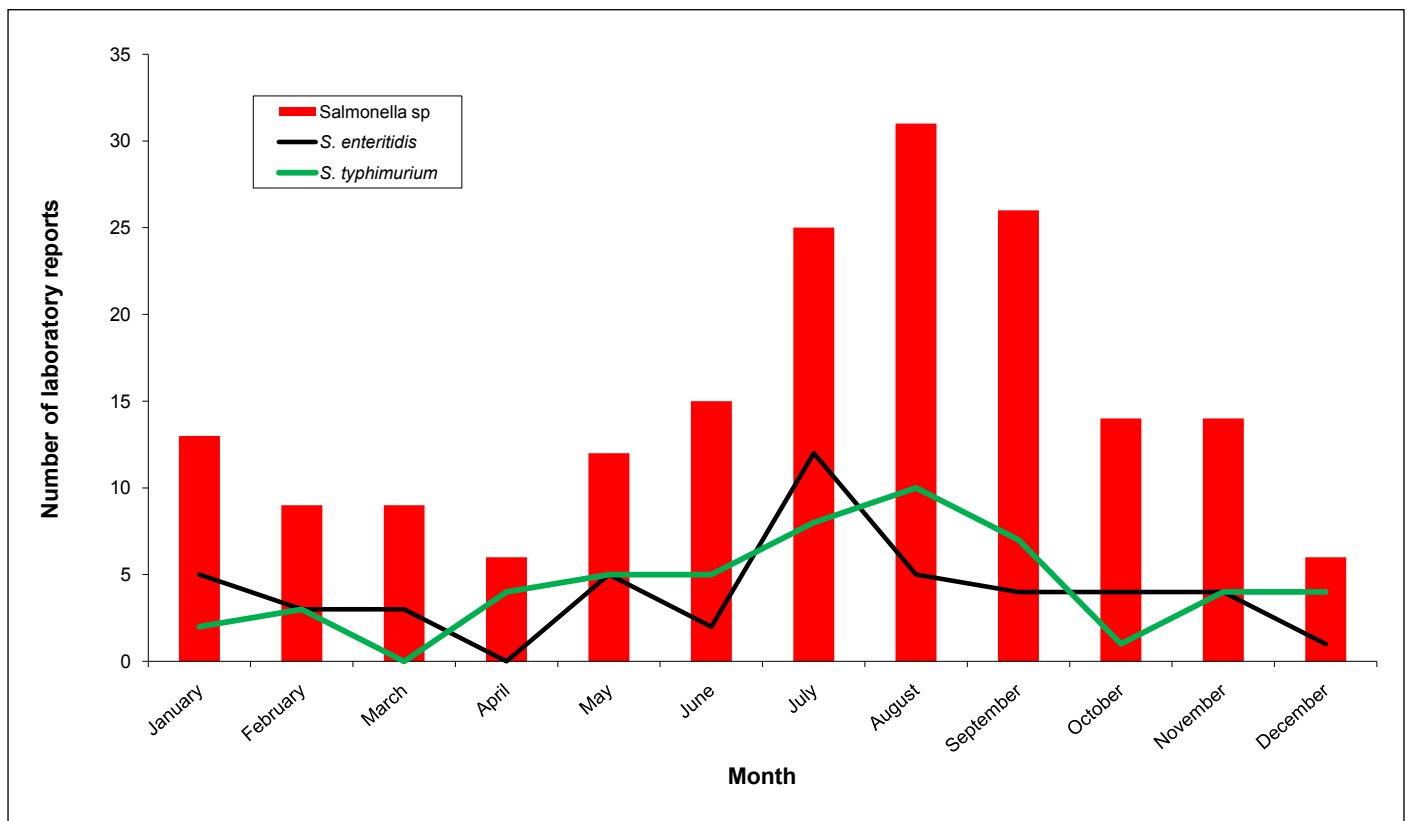
There were 180 laboratory reports of *Salmonella* in 2010, an increase of 14% on the number reported in 2009 (158). Laboratory reports of *Salmonella* reached a peak of 688 in 1999 but, since then, they have steadily decreased, apart from the outbreaks in 2004 when occurrences of *Salmonella typhimurium* DT 104, *Salmonella virchow* and *Salmonella newport* accounted for more than half of the 451 laboratory reports received that year (Figure 5).

**Figure 5: Laboratory reports of *Salmonella*, 1990–2010, Northern Ireland**



Laboratory reports of *Salmonella* (all types) in 2010 increased during the summer, rising to 31 reports in August. Reports of *S. enteritidis* peaked in July, whereas reports of *S. typhimurium* peaked in August (Figure 6).

**Figure 6: Laboratory reports of *Salmonella* by month, 2010, Northern Ireland**



The rate of laboratory reported *Salmonella* per 100,000 population in 2010 was highest in adults, particularly those aged 15–44 years (Figure 7).

**Figure 7: Age-specific rates of *Salmonella* per 100,000 population, 2010, Northern Ireland**

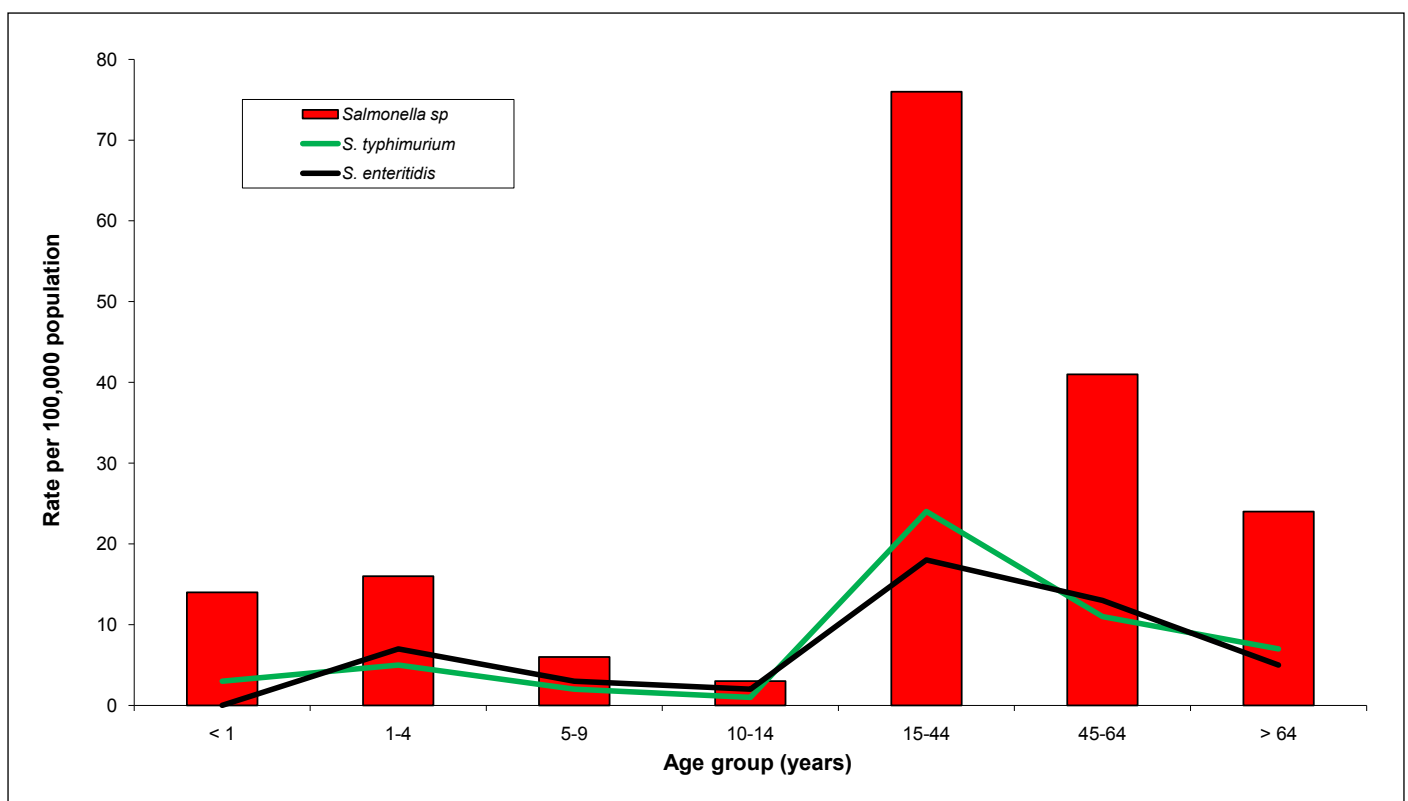


Table 1 lists serotypes for which more than one report was received between 2005 and 2010. *S. enteritidis* and *S. typhimurium* have been the two most frequently reported serotypes in Northern Ireland.

**Table 1: Frequently reported serotypes of *Salmonella*, 2005-2010, Northern Ireland**

2005* Total <i>salmonella</i>	180	2006 Total <i>salmonella</i>	206	2007* Total <i>salmonella</i>	159	2008* Total <i>salmonella</i>	187	2009 Total <i>salmonella</i>	158	2010* Total <i>salmonella</i>	180
<i>enteritidis</i>	83	<i>enteritidis</i>	92	<i>enteritidis</i>	48	<i>enteritidis</i>	71	<i>enteritidis</i>	45	<i>enteritidis</i>	48
<i>typhimurium</i>	33	<i>typhimurium</i>	46	<i>typhimurium</i>	40	<i>typhimurium</i>	37	<i>typhimurium</i>	54	<i>typhimurium</i>	53
<i>virchow</i>	7	<i>virchow</i>	5	<i>Schwarzengrund</i>	3	<i>virchow</i>	8	<i>newport</i>	6	<i>java</i>	5
<i>gold-coast</i>	4	<i>Schwarzengrund</i>	5	<i>infantis</i>	3	<i>agona</i>	5	<i>virchow</i>	4	<i>infantis</i>	5
<i>saint-paul</i>	4	<i>agona</i>	5	<i>montevideo</i>	3	<i>stanley</i>	5	<i>javiana</i>	3	<i>bareilly</i>	5
<i>kentucky</i>	3	<i>montevideo</i>	4	<i>arizonae</i>	2	<i>kentucky</i>	4	<i>kottbus</i>	3	<i>saint-paul</i>	4
<i>kottbus</i>	3	<i>infantis</i>	3	<i>hadar</i>	2	<i>oranienburg</i>	4	<i>oranienburg</i>	3	<i>haifa</i>	4
<i>muenchen</i>	3	<i>dublin</i>	2	<i>kentucky</i>	2	<i>dublin</i>	2	<i>saint-paul</i>	3	<i>newport</i>	3
<i>stanley</i>	2	<i>java</i>	2	<i>panama</i>	2	<i>hadar</i>	2	<i>arizonae</i>	2	<i>montevideo</i>	3
		<i>manhattan</i>	2	<i>saint-paul</i>	2	<i>infantis</i>	2	<i>gold-coast</i>	2	<i>mbandaka</i>	3
		<i>newport</i>	2	<i>senftenberg</i>	2	<i>kottbus</i>	2	<i>heidelberg</i>	2	<i>kottbus</i>	3
		<i>stanley</i>	2	<i>stanley</i>	2	<i>newport</i>	2	<i>java</i>	2	<i>arizonae</i>	3
		<i>weltevreden</i>	2	<i>tennessee</i>	2	<i>saint-paul</i>	2	<i>muenchen</i>	2	<i>stanley</i>	2
						<i>thompson</i>	2				

\* Totals include *S. typhi* or *S. paratyphi* as follows: 1 *S. typhi* and 2 *S. paratyphi* in 2005; 2 *S. typhi* and 2 *S. paratyphi* in 2007; 1 *S. typhi* and 1 *S. paratyphi* in 2008; 2 *S. paratyphi* in 2010.

### ***Salmonella enteritidis***

Until 2008, *S. enteritidis* was the most commonly reported serotype in Northern Ireland, accounting for 40–50% of the total *Salmonella* reports in recent years (with the exception of 2004). Reports peaked at 462 in 1999 but have since declined by 90% to 48 reports in 2010.

Until 2002, *S. enteritidis* (phage type) PT 4 was the predominant phage type in Northern Ireland. However, between 2003 and 2006, the predominant phage type was PT 1, in 2007 it was PT 14B, in 2008 it was PT 21, and in 2009 it was PT1 and PT 14B. Phage type PT8 has emerged with 12 reports in 2010. (Table 2)

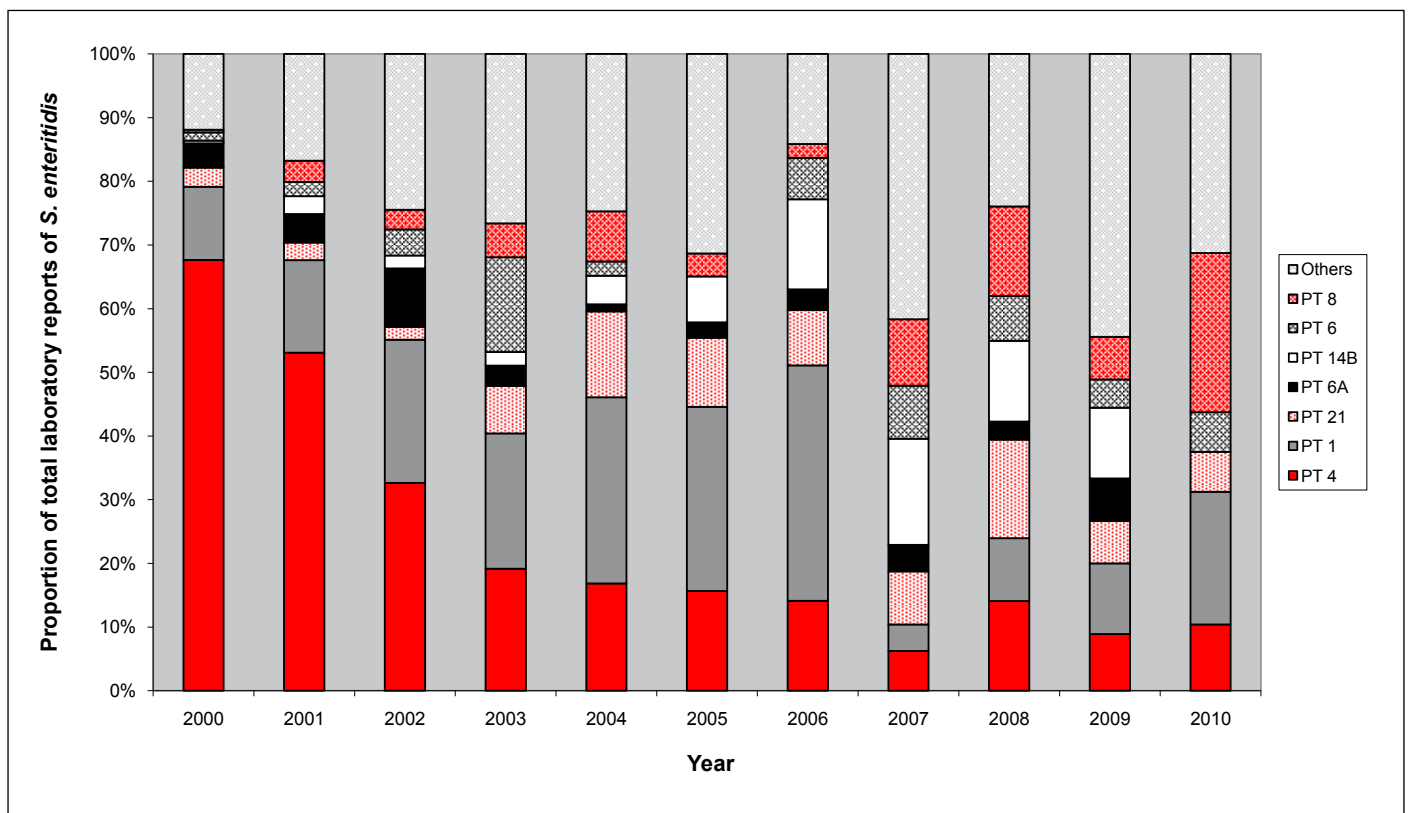


**Table 2: Most frequently reported *Salmonella enteritidis* phage types reported from 2005–2010 in Northern Ireland**

2005		2006		2007		2008		2009		2010	
<i>S. enteritidis</i>	83	<i>S. enteritidis</i>	92	<i>S. enteritidis</i>	48	<i>S. enteritidis</i>	71	<i>S. enteritidis</i>	45	<i>S. enteritidis</i>	48
PT 1	24	PT 1	34	PT 14B	8	PT 21	11	PT 1	5	PT 8	12
PT 4	13	PT 14B	13	PT 8	5	PT 4	10	PT 14B	5	PT 1	10
PT 21	9	PT 4	13	PT 21	4	PT 14B	9	PT 4	4	PT 4	5
PT 14B	6	PT 21	8	PT 6	4	PT 1	7	PT 21	3	PT 6	3
PT 8	3	PT 6	6	PT 4	3	PT 8	10	PT 6A	3	PT 21	3

Between 2005 and 2006, reports of PT 1 increased by 42% from 24 to 34, and reports of PT 14B more than doubled from six to 13. Reports of PT 21 more than doubled from four in 2007 to 11 in 2008, but dropped to three in 2010. This year, the list is headed by PT8 (Figure 8).

**Figure 8: Laboratory reports of *Salmonella enteritidis* phage types, 2000–2010, Northern Ireland**



***Salmonella typhimurium***

In the years 2009 and 2010, reports of *S. typhimurium* exceeded reports of *S. enteritidis*. There were 54 reports received in 2009, an increase of 46% on 2008 (37 reports) (Table 3). The most reported phage type in 2010 was DT 193, with 10 cases, a rise of 66% on 2009.

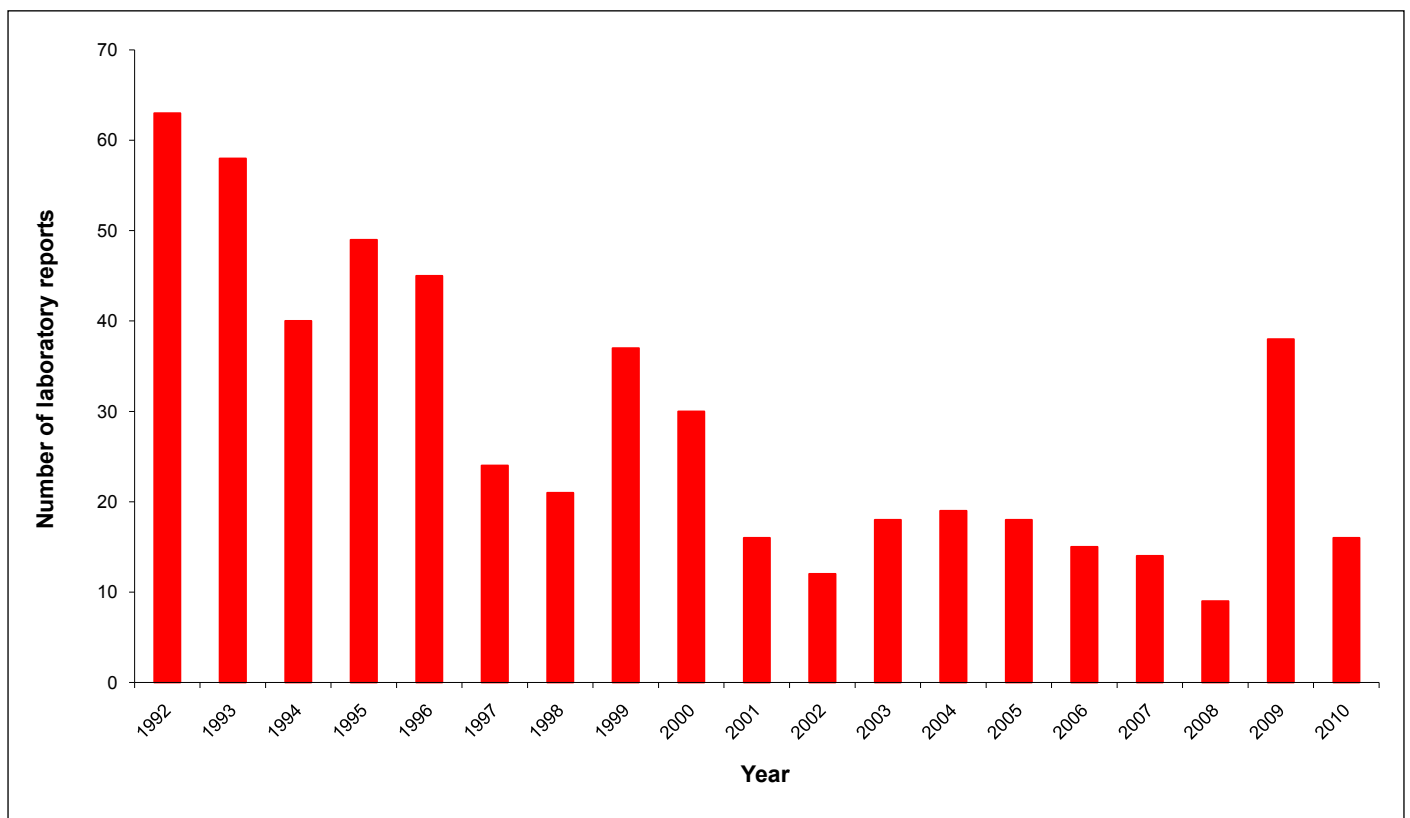
**Table 3: Most frequently reported *Salmonella typhimurium* phage types reported from 2005-2010 in Northern Ireland**

2005		2006		2007		2008		2009		2010	
<i>S. typhimurium</i> 33		<i>S. typhimurium</i> 46		<i>S. typhimurium</i> 40		<i>S. typhimurium</i> 37		<i>S. typhimurium</i> 54		<i>S. typhimurium</i> 53	
DT 104	4	DT 104B	12	DT 193	6	DT 104B	11	DT 8	13	DT 193	10
DT 193	3	DT 104	11	DT 104B	5	DT 104	5	DT 191	6	DT 8	10
DT 8	2	DT 193	6	U 311	4	DT 193	5	DT 193	6	DT 120	6
DT 135	2	DT 56	2	DT 1	2	U 311	2	DT 104	5	DT 104	5
DT 104B	2	RDNC	2					U 302	3	U 311	4

**Giardiasis**

*Giardia* laboratory reports show an overall decline from 1992 to 2008. The last three years have seen a marked year-to-year variation, from nine reports in 2008 to 38 in 2009, dropping to 16 in 2010 (Figure 9).

**Figure 9: Laboratory reports of *Giardia lamblia* (all specimen types), 1992-2010, Northern Ireland**



# Foodborne and gastrointestinal outbreaks 2010

During 2010, the PHA recorded one foodborne outbreak, with 246 other gastrointestinal outbreaks, which were thought to be caused by person to person transmission. This compares with no foodborne and 97 other gastrointestinal outbreaks in 2009. This is an apparent increase of 154% in the total number of outbreaks. Some of this increase can be explained by the more systematic recording of outbreaks in the community.

One hundred and thirty nine non-food-related outbreaks (57%) were attributed to Norovirus. Ninety six (39%) had no identified cause and 10 (4%) were attributed to *C. difficile* (Table 4). Norovirus infections can spread rapidly in facilities such as hospitals, hostels and nursing or residential homes.

Overall, 121 outbreaks occurred in a hospital, while 119 occurred in an institutional setting. Of those outbreaks attributed to Norovirus, 94 (68%) were hospital-based, 42 (30%) were within residential institutions and the other three (2%) were in a variety of settings. Where the organism was unknown, 20 (21%) were in the hospital setting and 74 (77%) were in a residential institution (Table 4).



There was an additional outbreak within the community setting, which was attributed to *E. coli* O157 VTEC. Within the figures, there was an outbreak that was caused by both *C. difficile* and Norovirus, which has been counted twice.

**Table 4: Distribution of location of outbreaks**

	<b>Norovirus</b> (% of all Norovirus)	<b><i>C. difficile</i></b> (% of all <i>C. difficile</i> )	<b>Unknown</b> (% of all unknown)	<b>Total in location</b> (% in location)	<b>% of all outbreaks</b>
Hospital	94 (68%)	7 (70%)	20 (21%)	121	49%
Residential	42 (30%)	3 (30%)	74 (77%)	119	49%
Other	3 (2%)	0 (0%)	2 (2%)	5	2%
Total outbreaks	139	10	96	245	100%
% of all outbreaks	<b>57%</b>	<b>4%</b>	<b>39%</b>	<b>100%</b>	

**Notes**

1. One *E. coli* O157 outbreak is not included in the table, hence total outbreaks = 246.
2. One dual outbreak of *C. difficile* and Norovirus is counted as two separate outbreaks.

In Norovirus outbreaks, once the causative organism is identified, it is not normal practice for all other symptomatic individuals to be tested. Therefore, in Norovirus outbreaks, the number of symptomatic individuals is considerably greater than the number of laboratory confirmed cases.

# Duty room updates

## Brucellosis

Brucellosis, caused by bacteria of the genus *Brucella*, is a highly infectious zoonotic disease. While it is endemic in a number of countries throughout the world, human cases are rare in the UK and Ireland. In 2009, Northern Ireland had four laboratory reports of *Brucella* infection in humans.

Animal infection is caused by a number of *Brucella* species. *B. melitensis*, *B. abortus* and *B. suis* most commonly affect humans.

Transmission is usually via contact with infected animals or their milk. Those involved in working with animals are considered most at risk. Inhalation of aerosols from infected products of conception, and contamination of cuts and breaks in the skin can lead to infection in farmers and vets. Abattoir workers may inhale infected dust or droplets, and accidental aerosol generation can affect laboratory staff. Ingestion of unpasteurised milk and milk products puts members of the public at risk. Visitors to countries where the infection is endemic are encouraged not to consume these products on their travels. Spread of infection between humans is rare.

The incubation period for *Brucella* infection is up to six months, but usually 5–30 days. Individuals may have a variety of symptoms. In acute disease, which can last for weeks, these symptoms include fever, debilitation, weight loss, sweating, headache, lethargy and anorexia. Spinal osteomyelitis and arthritis in large joints are common. Neurological involvement, while rare, is important. Endocarditis affects up to 2% of patients. A number of individuals develop chronic or relapsing disease with malaise, depression and further joint involvement.

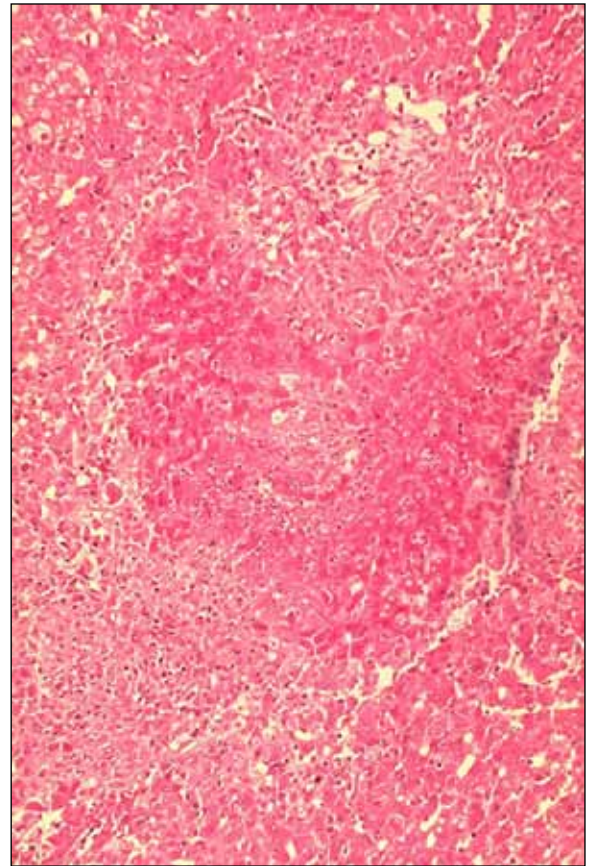
Brucellosis should be suspected where there is epidemiological linkage to infected animals and clinical symptoms are consistent with disease. Laboratory diagnosis is based on serology and treatment is with antibiotics, often used in combination. Recovery takes weeks to months.

In brucellosis, public health action has a number of aims. Identification of potential links with other cases and infected animal herds helps determine the source of infection, reducing the risk of further cases in humans. Supportive advice is offered to clinicians to facilitate case investigation and treatment. Information is gathered for surveillance of disease.

Further information on brucellosis is available on the Health Protection Agency website [www.hpa.org.uk](http://www.hpa.org.uk) and on the website of the Department of Health, Social Services and Public Safety: [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)

*Sinéad McGuinness*

*FY2 doctor, Public Health*



# Routine reports

## Quarterly reporting of surgical site infection (SSI), quarter 1 (Q1) 2011

This report is a summary of procedure-associated data collected by hospitals participating in the Surveillance of Surgical Site Infections (SSI) programme. Surveillance of surgical site infections, with feedback of appropriate data to service providers, is an important component of strategies to reduce SSI incident and risk.

- SSI results are reported and accessed via a secure internet site.
- The results are uploaded quarterly.
- The website creates interactive tables and charts.
- Usernames and passwords are issued for the website.
- Multiple users can access results at the same time, with the same password.
- Results can be exported to a variety of programmes (eg Excel, Word).

## Caesarean section SSI surveillance quarterly report (January–March 2011)

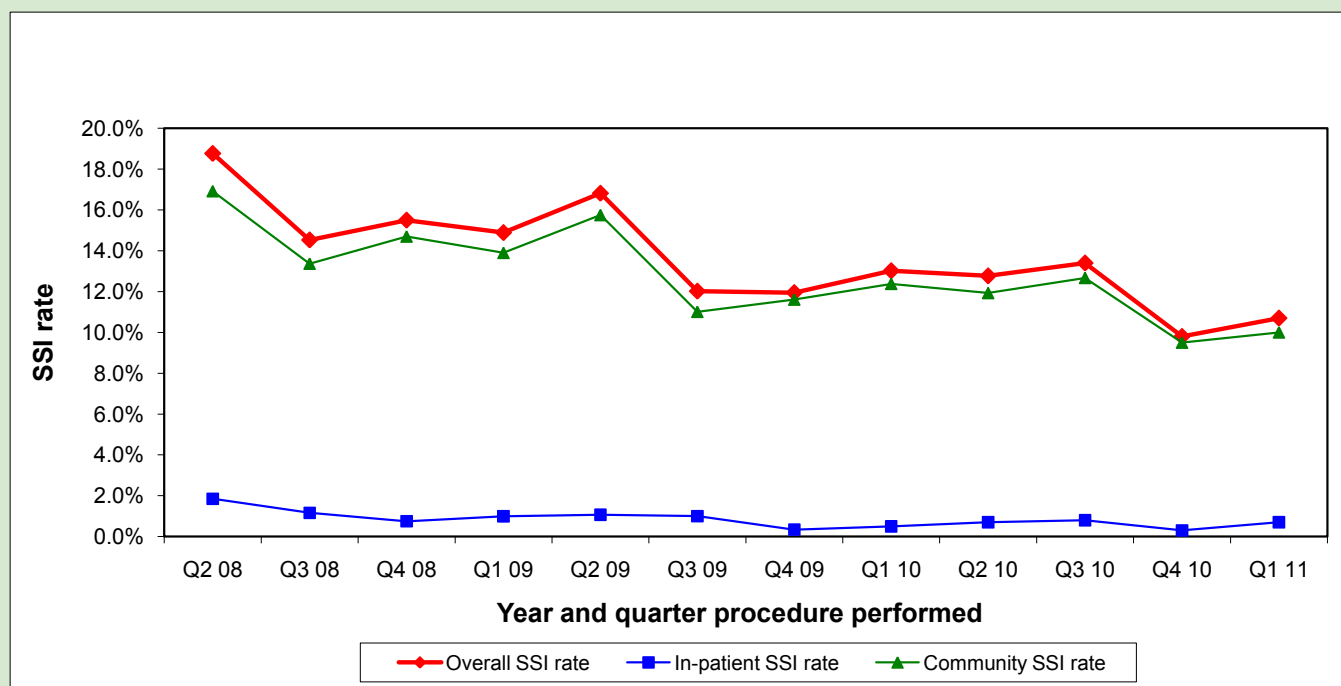
**Table 5: Caesarean section SSI surveillance, percentage compliance per quarter, by Health and Social Care Trust (HSCT)\***

	Q2 08 (%)	Q3 08 (%)	Q4 08 (%)	Q1 09 (%)	Q2 09 (%)	Q3 09 (%)	Q4 09 (%)	Q1 10 (%)	Q2 10 (%)	Q3 10 (%)	Q4 10 (%)	Q1 11 (%)
Northern Ireland	35.1	43.2	50.1	58.4	68.5	76.1	78.3	80.6	80.3	82	77.6	74.2
South Eastern HSCT	12.3	25.8	40.8	75.4	73.7	79.4	81.5	85.6	83.3	85.1	87.5	73.1
Western HSCT	59.2	73.7	83.7	93.8	96.3	99.3	100	100	98.4	100	100	100
Northern HSCT	29.7	32.8	30.8	60.7	93.9	92.6	95.3	90.2	89.3	89.4	82	73.2
Southern HSCT	26.7	36.1	47.4	37.3	45.8	66	71.1	73.2	77.3	70.9	75.6	72.5
Belfast HSCT	44.3	49.2	49.4	50.2	57.4	62.1	62.1	68.1	67.5	76.4	61.5	62.7

\* Compliance = number of returns/number of Caesarean sections performed x100

Compliance in quarter 1 2011 has fallen in all Trusts, with the exception of the Western (100%) and Belfast Trusts (62.7%). Percentage compliance is based on matched returns (from in-hospital and community forms). Reported compliance is likely to increase, as outstanding surveillance forms are returned for analysis.

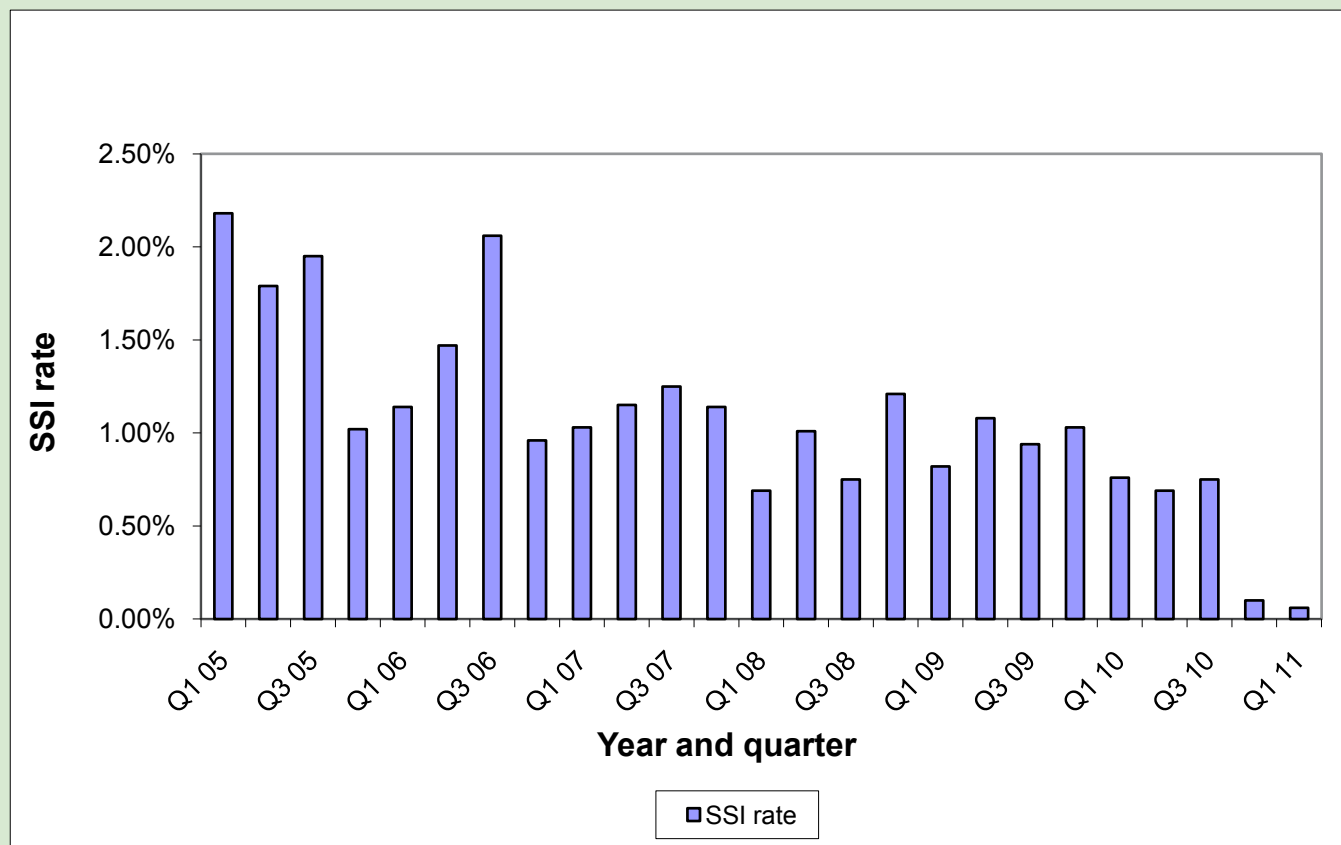
**Figure 10: Northern Ireland Caesarean section SSI rates, quarter 2 2008 to quarter 1 2011**



The overall Caesarean section SSI rate for quarter 1 2011 was 10.7%. This represents a slight increase on the previous reported rate of 9.8% during quarter 4 2010. Overall trends indicate a decrease in SSI rates following Caesarean section.

**Northern Ireland orthopaedic SSI surveillance quarterly report (January–March 2011)**

**Figure 11: Northern Ireland orthopaedic SSI rates, quarter 1 2005 to quarter 1 2011**



Rates of orthopaedic SSI have fallen in both quarter 4 2010 and quarter 1 2011. This, however, may change in subsequent SSI reports as outstanding surveillance forms are returned for analysis.

## The seasonal influenza vaccination programme 2011/12

Chief Medical Officer's letter on the seasonal influenza vaccination programme 2011/12:  
[www.dhsspsni.gov.uk/hss-md-14-2011.pdf](http://www.dhsspsni.gov.uk/hss-md-14-2011.pdf)

The vaccination programme will be officially launched on 30 September. However, all GPs will have received their first delivery of vaccine by 23 September and can begin offering the vaccine once they have received it.



### Important points to note

- All pregnant women should be offered the vaccination by their GP. The vaccine should be offered at all stages of pregnancy – first, second and third trimester.
- An egg-free vaccine will be available for those aged over 18 who have a confirmed anaphylaxis to egg or an egg allergy with uncontrolled asthma (BTS SIGN step 4 or above). Children who meet these criteria should be referred to a paediatric unit for vaccination under controlled conditions (a letter giving details has been sent to all practices).
- All other egg allergic patients (adults and children) can be vaccinated in general practice using either Inactivated Influenza Vaccine from Sanofi Pasteur or Fluarix from GSK. These are the two main vaccines that will be distributed to general practice from the start of the campaign.
- The licensed indication for Enzira vaccine no longer includes children aged under five years (note advice that Enzira is not recommended for children under nine years).
- GPs should ensure that those with chronic neurological disease (especially children and young people) are prioritised.

Copies of the flu vaccine leaflets are available at:  
[www.fluawareni.info](http://www.fluawareni.info)



## **The management of acute bloody diarrhoea potentially caused by verocytotoxin-producing *Escherichia coli* in children**

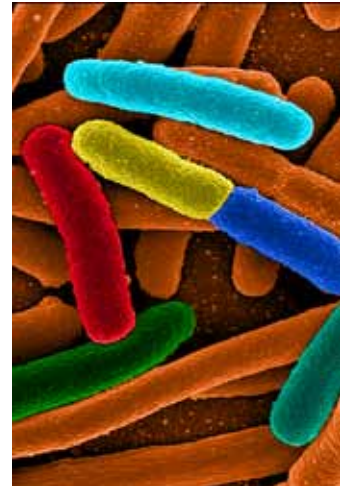
The Health Protection Agency (HPA) published the above guidance in July, endorsed by the Royal College of Paediatrics and Child Health and the Royal College of General Practitioners. The HPA summarises this guidance as follows:

Acute bloody diarrhoea in children is rare and is commonly associated with intestinal infections, especially verocytotoxin-producing *E. coli* (VTEC) and *Campylobacter* species.

Urgent advice should be sought from a paediatric specialist when a child up to the age of 16 years presents at primary care or an emergency department having suffered a single acute episode of bloody diarrhoea. This is to ensure that a prompt diagnosis is made, including consideration of infection by VTEC and other serious treatable disorders. Prompt management, including good infection control procedures, will help ensure that the risk of further spread of disease is minimised if VTEC is present.

Clinicians should have a high index of suspicion that VTEC infection is present where the patient has been:

- in recent close contact with ruminant animals (principally cattle, goats, sheep), their faeces, or faecally contaminated environments (such as at open farm visits);
- in recent close contact with another known or suspected case of VTEC;
- in a location where an outbreak of VTEC infection is known, or suspected, to be present locally.



Where VTEC infection is considered in the differential diagnosis, clinicians should be mindful of the potential contraindications concerning the use of anti-motility drugs and certain analgesics. Active fluid resuscitation should be used and specialist guidance sought before initiating antibiotic treatment.

The full guidance is available at: [www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb\\_C/1309968502688](http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1309968502688)

## **Local transmission of malaria in Greece**

The Health Protection Agency warned recently that since June 2011, six cases of malaria have been reported in Greece. All six cases were reported in people who had no history of travel to a country where malaria is common. Five of these cases were Greek adults and one was a Roma child. This is the third consecutive year that a small number of cases have been reported in Greece as a result of local transmission.



The risk to holiday-makers remains extremely low, so there is no need to take anti-malarials when visiting Greece, but travellers should be advised to take measures to prevent being bitten. There were also more than 200 cases of West Nile virus, another mosquito-borne infection, reported in Greece last year. Bite prevention will lower the risk of acquiring both West Nile virus and malaria. These diseases are carried by different species of mosquito, both of which predominantly bite during the evening and night.

It is also important to be aware of the possibility of mosquito-borne illnesses in travellers returning from Greece with relevant symptoms, and to ensure they are tested appropriately.

[www.hpa.org.uk/NewsCentre/NationalPressReleases/2011PressReleases/110823malariaingreece/](http://www.hpa.org.uk/NewsCentre/NationalPressReleases/2011PressReleases/110823malariaingreece/)



## Hepatitis C in the UK: 2011

This report has been published by the Health Protection Agency and is available at:  
[www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb\\_C/1309969907625](http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1309969907625)

## Further JCVI advice on the pneumococcal vaccination programme for people aged 65 years and older

This DHSSPS letter is available at: [www.dhsspsni.gov.uk/hss-md-15-2011.pdf](http://www.dhsspsni.gov.uk/hss-md-15-2011.pdf)

JCVI has advised that the existing routine universal PPV programme for those aged 65 years and older should continue, but be kept under review.

## Updated HIV figures published by the Health Protection Agency

Data released on 1 September 2011 by the Health Protection Agency show that almost 70,000 people were accessing HIV-related care in the UK at the end of 2010, an increase of 4,100 (6%) on 2009. Men who have sex with men (MSM) remain the group most at risk of becoming infected with HIV in this country, with 3,000 new diagnoses made in 2010 – the largest annual number of new HIV diagnoses in this group since the HIV epidemic began.

[www.hpa.org.uk/NewsCentre/NationalPressReleases/2011PressReleases/110901HIVdiagnosesdata/](http://www.hpa.org.uk/NewsCentre/NationalPressReleases/2011PressReleases/110901HIVdiagnosesdata/)



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### Updated HIV figures published today

1 September 2011

Data released today by the Health Protection Agency shows that almost 70,000 persons were accessing HIV-related care at the end of 2010, an increase of 4,100 (6%) compared to 2009. An estimated 60% were being treated as advised under the current national guidelines.

Men who have sex with men remain the group most at risk of becoming infected with HIV, with 3,000 new diagnoses made in 2010 – the largest annual number of new HIV diagnoses in this group since the HIV epidemic began.

Dr Valerie Dwyer, head of HIV at the Health Protection Agency, said:

"Despite progress in delivering treatment, preventing transmission is still a priority, with HIV costs to the NHS, which were an estimated £454 million in 2010 – an increase of £48 million from the previous year.

"The best way to prevent all sexually transmitted infections, including HIV, is to practice safe sex. This means using a condom with all new sexual partners until you have both been tested and given the all-clear."

**Notes to editors**

The full set of data is available from the HIV pages.

**New HIV Diagnoses**

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/newHIVDiagnoses/>

**Number of persons accessing HIV care**

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/accessingHIVCare/>

Last reviewed: 1 September 2011

## Further information for health professionals and other agencies:

Health protection duty room  
Public Health Agency  
4<sup>th</sup> Floor  
12–22 Linenhall Street  
Belfast  
BT2 8BS

Tel: 028 9055 3994 or 028 9055 3997  
Email: [pha.dutyroom@hscni.net](mailto:pha.dutyroom@hscni.net)



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