



HIV and AIDS

Surveillance of HIV infection is based on confidential voluntary reporting of cases by clinicians to the Communicable Disease Surveillance Centre (Colindale) and the Scottish Centre for Infection and Environmental Health. The latest AIDS/HIV quarterly surveillance tables for the quarter ending March 2004 are now available on the Health Protection Agency (HPA) website at http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/hiv/epidemiology/files/quarterly.pdf

By 31 March 2004 62,629 HIV infected individuals had been reported within the United Kingdom since surveillance commenced in the 1980s. Table 1 describes the number of HIV

infected individuals and those with AIDS for England, Wales, Scotland and Northern Ireland. In England 63% of HIV infected individuals were first reported from the London region.

Table 1: HIV infected individuals^s and AIDS cases by country to 31 March 2004

Country	HIV	AIDS
England	57,703	18,701
Wales	899	298
Scotland	3,737	1,195
Northern Ireland	290	106
United Kingdom	62,629	20,300

By 31 March 2004 there were 290 reports of HIV infected individuals^s who were first diagnosed in Northern Ireland. This total excludes those initially diagnosed in Great Britain (GB) but who have returned to Northern Ireland and could be receiving treatment for their infection – these individuals are included in the GB total. To date, 31 reports have been received for 2003, compared to 19 reports received in both 2000 and 2001, and 25 in 2002 (an increase of 63% since 2000). There have

been no reports received at to date for the first quarter of 2004. Figure 1 describes the number of HIV infected individuals^s and AIDS cases by year of diagnosis since the start of HIV/AIDS surveillance.

Since HIV surveillance commenced there have been between 9-31 new cases of HIV infection being reported each year. However, the number of new reports of HIV infection has increased considerably in recent years. The mean annual number of

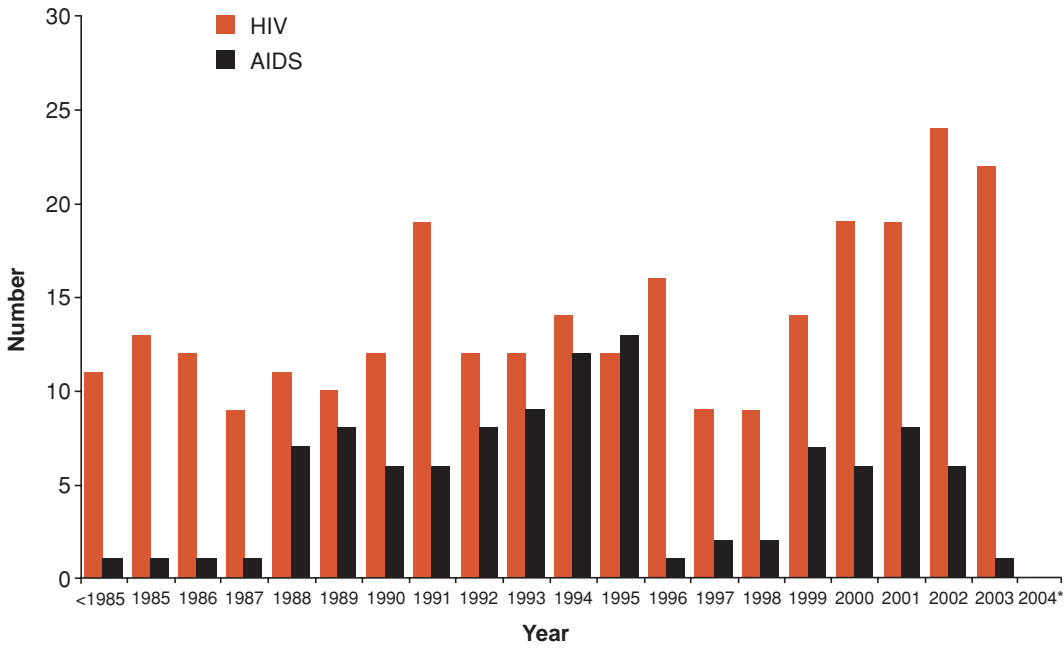
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cases reported between 1988-2002 was 14 – last year saw the highest number of cases (31) reported in a single year since surveillance began.

The effect of enhanced anti-retroviral therapy introduced in 1996 has been to delay progression to AIDS in those who have had their HIV infection previously diagnosed. There have been 106 AIDS cases diagnosed in the Province to 31 March 2004. On average, there have been 6 cases of AIDS diagnosed annually between 1988-2003. Figure 2 shows that whilst cumulative cases of HIV are increasing, cumulative cases of AIDS are increasing at a much lower rate.

Figure 1: HIV infected individuals^s & AIDS cases by year of diagnosis, 1985-2004*, Northern Ireland



*2004 data to 31 March

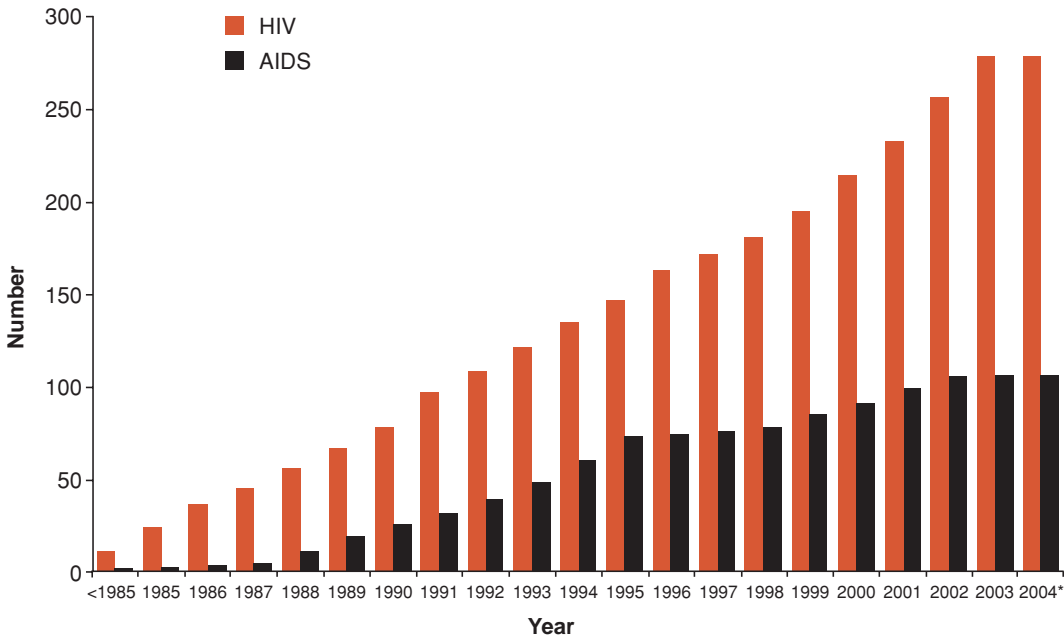
^sIndividuals with laboratory reports of infection plus those with AIDS or death reports for whom no matching laboratory report has been received.

There is an ongoing syphilis outbreak in Northern Ireland since 1 July 2000, predominately affecting men who have sex with

men. To 31 March 2004, 96 individuals have been involved in this outbreak, ten of whom were HIV positive.

Globally, the main exposure category for HIV infection is via heterosexual intercourse. The main exposure category for HIV

Figure 2: HIV^s and AIDS cases: cumulative total by year of diagnosis, 1985-2004*, Northern Ireland



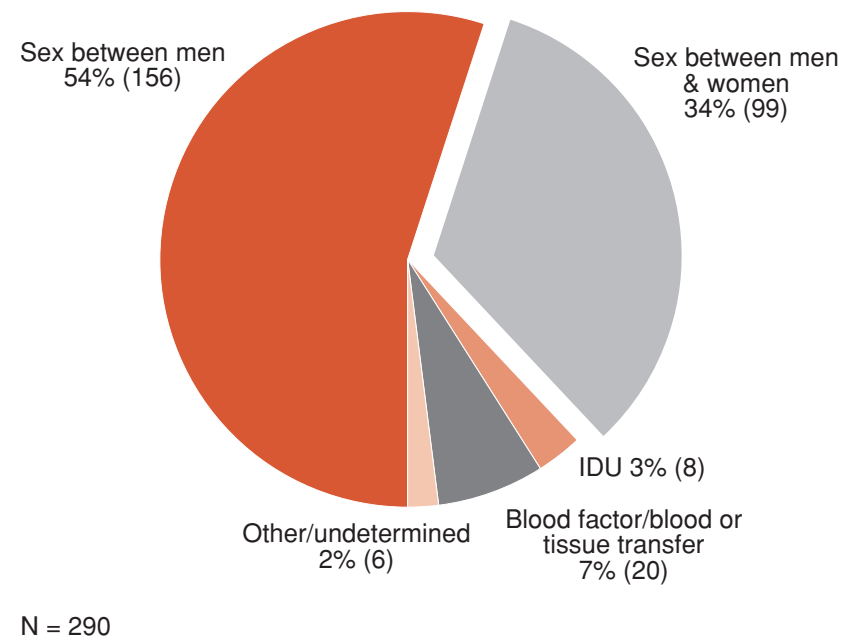
*2004 data to 31 March

^sIndividuals with laboratory reports of infection plus those with AIDS or death reports for whom no matching laboratory report has been received.

infection in Northern Ireland remains sex between men and this accounted for 156/290 (54%) reports; this proportion is very similar to that noted for the UK.

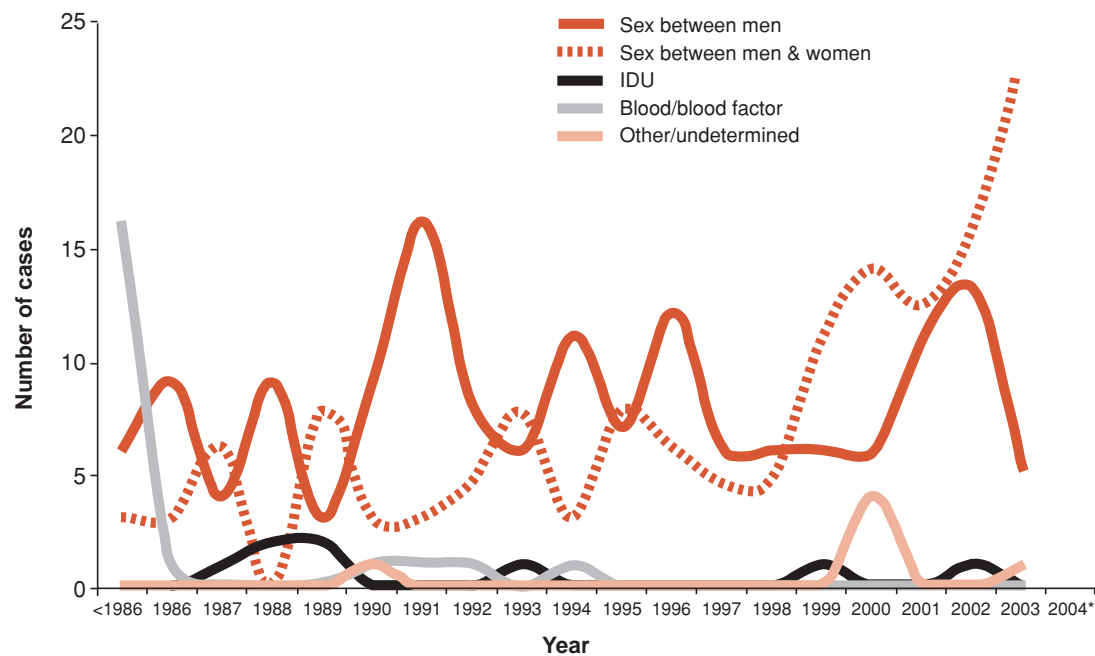
Nevertheless, the cumulative proportion of cases who acquired their infection through heterosexual intercourse is slowly increasing (27%, 28%, 29% by the end of 2000, 2001 and 2002 respectively, rising to 34% by the end of 2003). Eight (3%) are thought to have acquired HIV infection through injecting drug use, and this number has shown little change in recent years.

Figure 3: HIV infected individuals^s by exposure category to 31 March 2004, Northern Ireland



^s Individuals with laboratory reports of infection plus those with AIDS or death reports for whom no matching laboratory report has been received.

Figure 4: HIV^s infected individuals by exposure category and year of diagnosis, 1986-2004*, Northern Ireland



* 2004 data to 31 March

^s Individuals with laboratory reports of infection plus those with AIDS or death reports for whom no matching laboratory report has been received.

Table 2: AIDS cases by exposure category to 31 March 2004, Northern Ireland

Exposure category	Male	Female	Total
Sexual intercourse:			
between men	59		59
between men & women	15	12	27
Injecting drug use	2	2	4
Blood/blood factor	12	1	13
Other/undetermined	2	1	3
Total	90	16	106

Update on Ongoing Syphilis Outbreak in Northern Ireland

The re-emergence of syphilis has been documented in a series of recent outbreaks throughout Europe. Between 1999 and 2001 there have been outbreaks in Brighton, Manchester¹ and London² predominately affecting men who have sex with men (MSM). The outbreaks in Oslo³, Dublin⁴ and Antwerp⁵ were associated with anonymous sexual contact in gay saunas.

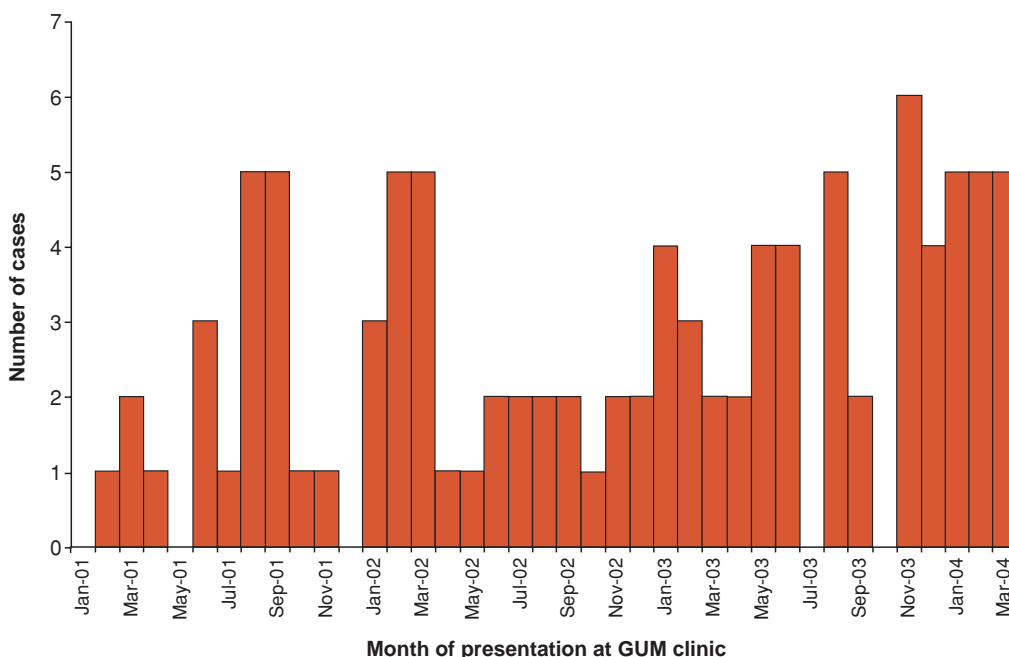
During the 1990s approximately 3 new cases of syphilis were diagnosed annually in Northern Ireland, but in September 2001 genitourinary medicine (GUM) physicians reported an increase in cases of infectious syphilis occurring in MSM leading to the establishment of an Outbreak Control Team (OCT). Any case

meeting the agreed criteria for primary, secondary or early latent syphilis and diagnosed at any GUM clinic in Northern Ireland since 1 July 2000 was deemed to meet the epidemiological case definition.

One hundred and one cases have been reported to 31 March 2004, with 15 presenting during the

January-March 2004 quarter (Figure 5). Ninety-six individuals were involved in the outbreak, with three males presenting with two distinct episodes of infection and one male presenting three times with distinct episodes of infection. All except six of the cases were male, and most (83) were men who have sex with men (MSM); five of whom were bisexual. The mean age of the cohort was 36 years, range 17-64 years. Cases were resident in all four boards in Northern Ireland and six were non-Northern Ireland residents.

Figure 5: Epidemic Curve: month of presentation at GUM clinic (n=100)



One individual presented to the GUM clinic in February 2000 and is not included in the epidemic curve, 20 in 2001, 29 in 2002, 36 during 2003, and 15 to date in 2004.

Most people cited more than one reason for attending the GUM clinic. The majority of cases presented because they were symptomatic for syphilis or another sexually transmitted disease (STI). Twenty cases were identified through contact tracing: four of these were contacts of cases involved in the Dublin outbreak, and sixteen cases were identified as a result of contact tracing from this outbreak. One case was a pregnant woman identified through antenatal screening and her partner was subsequently identified through contact tracing. The mean time between the index case presenting at the GUM clinic and the contact case presenting at the GUM clinic was 16 days, median 12 days, range

0-52 days. Two cases, who were sexual partners, were identified by the Northern Ireland Blood Transfusion Service.

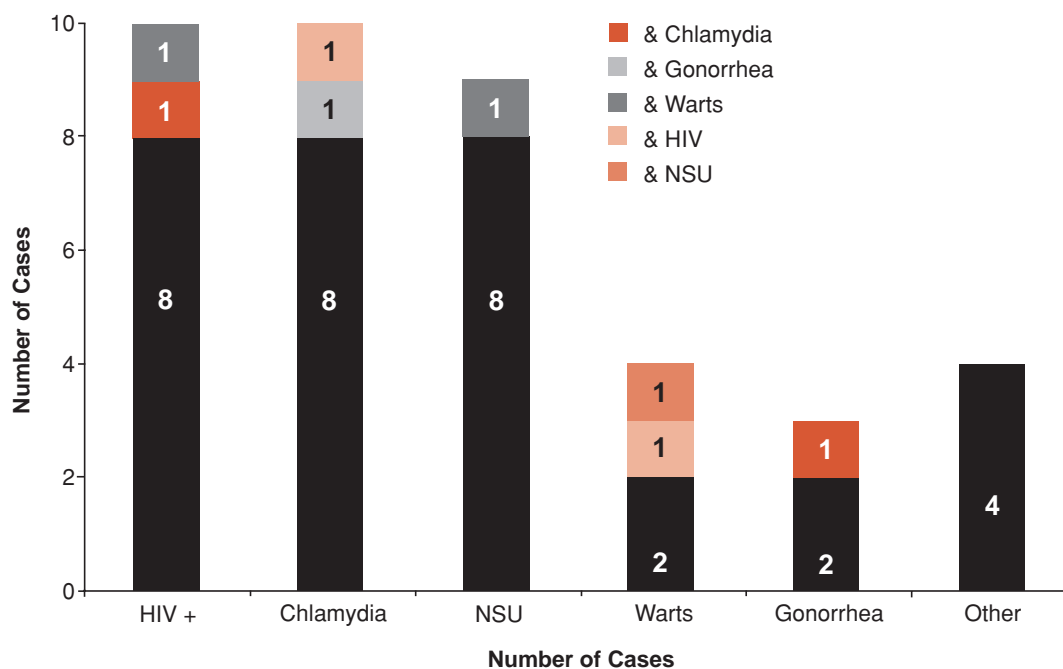
Forty four cases were diagnosed with primary syphilis, 30 with secondary syphilis, 16 with early latent syphilis and staging was unable to be confirmed in 11 cases.

High risk behaviour

Only one of the 101 cases admitted to intravenous drug use, and in general, the number of sexual contacts associated with this cohort is not large. Most (64) had 1 or 2 partners in the three months preceding infection, although one, a commercial sex worker had

between 60 and 70. Only one of the cases was a commercial sex worker (CSW), and none of the other cases admitted contact with a commercial sex worker in the three months preceding diagnosis. The CSW was also HIV positive and worked in both Northern Ireland and Republic of Ireland. Forty-five cases had only named partners in the 3 months preceding diagnosis. Thirty-six cases had concomitant sexually transmitted infections (STIs), and of these, four had two STIs in addition to syphilis infection (Figure 6). Ten cases were HIV positive (8 of whom were previously aware of their status). This is of particular concern as HIV transmission may be enhanced by syphilis co-infection.

Figure 6: Concomitant STIs during this episode (n=36)



The 4 concomitant STIs categorised as 'other' were balanitis, bacterial vaginosis (BV), scabies together with thrush and one was a hepatitis B carrier. NSU – non-specific urethritis

Nine of the 18 heterosexuals considered that vaginal intercourse was the most likely route of infection, but seven were unable to determine whether their infection was more likely to have been acquired via oral or vaginal intercourse. Data on consistency of condom use in the six months prior to presentation is available for

twelve of the heterosexuals. The majority (9/12) never used a condom for either vaginal or oral intercourse.

Five of the MSMs were bisexual, but none considered that their infection had been acquired via vaginal intercourse. Data on the most likely route of infection was

available for eighty two of the MSMs. Forty two considered that oral intercourse was the most likely route of infection and seventeen considered that anal intercourse was the most likely route. Data on consistency of condom use in the six months prior to presentation is available for 50 of the 83 MSMs. Condoms were used sporadically,

even in cases where the individual was aware that they were infected with an STI.

Cases diagnosed at the beginning of the outbreak reported sexual contacts in Dublin whereas cases

presenting more recently appear to have contracted syphilis within Northern Ireland.

Table 3: Likely location at which infection was acquired (n=75)

Dublin	Elsewhere in ROI	N Ireland	Elsewhere in UK	Outside UK/Ireland*	Unknown	Total
16	1	57	8	9	10	101

* Holland, USA, Spain, South Africa, Gran Canaria, Ibiza, Dusseldorf

Four individuals have had more than one episode of infection since the outbreak began in July 2000. Three individuals have had 2 episodes of infection while the fourth individual has had three episodes of infection.

Initiatives to raise awareness of the re-emergence of syphilis commenced in mid-October 2001 and are ongoing. As the cohort was not generally associated with a high number of sexual partners, or multiple anonymous partners, or specific locations, it was difficult to identify a target group within the general population to implement intervention strategies. However, the outbreak was identified

promptly and a strong network of organisations is continuing to provide information and raise public and professional awareness. The syphilis outbreak questionnaire was not designed to analyse perceptions of what constitutes 'safe sex', but the data collected suggests that oral sex may be perceived as being less risky than anal sex, and condoms are not always used even when the subject is aware that they have an STI. This highlights the need to reiterate the importance of using a condom for oral sex. The challenge is to raise awareness of sexual health issues, particularly in the heterosexual community, and to educate the sexually active

population about the long-term consequences of infectious syphilis and other STIs, and of the importance of prevention and early detection if at risk of infection.

For further information contact Dr Brian Smyth at CDSC (NI) or e-mail brian.smyth@hpa.org.uk.

1. CDSC. Increased transmission of syphilis in Brighton and Greater Manchester among men who have sex with men. *Commun Dis Rep CDR Wkly* 2000; 10 (43).
2. CDSC. Syphilis transmission among homosexual and bisexual men in London and Manchester. *Commun Dis Rep CDR Wkly* 2001; 11 (27).
3. Blystad et al. An outbreak of syphilis among homosexual men in Oslo, Norway. *Eurosurveillance Weekly* 1999; 47.
4. Domegan L et al. Enhanced Surveillance of Syphilis. *Epi-Insight* 2002; 3 (7).
5. De Schrijver K. Syphilis outbreak in Antwerp, Belgium. *Eurosurveillance Weekly* 2001; 19.

Enhanced Surveillance of Meningococcal Disease (ESMD)

During the month of March 2004, six cases of invasive meningococcal disease were notified through the ESMD scheme. Three of these have been identified as serogroup B infection and all occurred in children between 3 and 4 years of age. In addition, serogroup W135 infection was confirmed in a child less than 2 years of age. This is the first confirmed case of invasive W135 infection in Northern Ireland since June 2001. The remaining two notified cases are, as yet, unconfirmed. There were no deaths from meningococcal disease during March 2004.

Between 1 January 2004 and 31 March 2004, CDSC (NI) received 20 notifications of invasive meningococcal disease through the enhanced surveillance of meningococcal disease (ESMD) scheme. Of these 20 cases, 13 (65%) have been laboratory

confirmed: 9 (69%) cases were identified as serogroup B, 1 case as serogroup C, 1 case as serogroup W135 and 2 cases were ungrouped or identified as other serogroups. The confirmed serogroup C infection occurred in a young child who had received a full course of

Men C vaccine more than 3 years prior to the onset of disease. To date, there has been one death attributed to meningococcal disease (in a child aged under 1 year who presented with septicaemia), although this has not been laboratory confirmed.

These figures are substantially lower than for the same period of last year, when 32 cases were notified. 23 (72%) cases were laboratory confirmed: 20 (87%) cases were identified as serogroup B, 2 cases as serogroup C and 1 case was ungrouped. No deaths occurred between January and March 2003.

Table 4: Meningococcal disease by Health and Social Services Board, Northern Ireland, January to March 2004

HSSB	Confirmed			Not confirmed	Total
	B	C	Other and ungrouped		
E	2	1	1	3	7
N	3	0	1	1	5
S	2	0	1	2	5
W	2	0	0	1	3
Total	9	1	3	7	20

Table 5: Meningococcal disease: case and death by age, Northern Ireland, January to March 2004

Age group	Confirmed			Not confirmed	Incidence per 100,000 population*	Death
	B	C	Other and ungrouped			
0-2	1	0	1	4	9.0	1
3-4	3	1	1	0	10.5	0
5-14	0	0	1	3	1.6	0
15-17	2	0	0	0	2.5	0
18-24	1	0	0	0	0.6	0
>24	2	0	0	0	0.2	0
?	0	0	0	0	0	0
Total	9	1	3	7	1.2	1

*age-specific incidence rate

Table 6: Meningococcal disease: case and death by age, Northern Ireland, for March 2004

Age group	Confirmed			Not confirmed	Total	Death
	B	C	Other and ungrouped			
0-2	0	0	1	1	2	0
3-4	3	0	0	0	3	0
5-14	0	0	0	1	1	0
15-17	0	0	0	0	0	0
18-24	0	0	0	1	0	0
>24	0	0	0	0	0	0
?	0	0	0	0	0	0
Total	3	0	1	2	6	0

Figure 7: Monthly cases of Meningococcal disease from January 2003 to March 2004

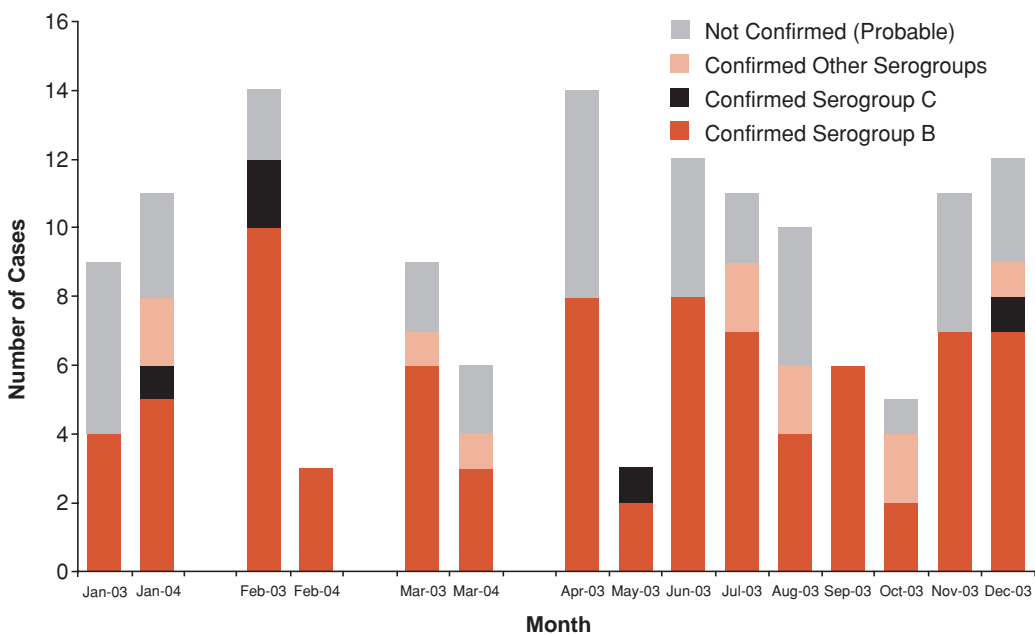
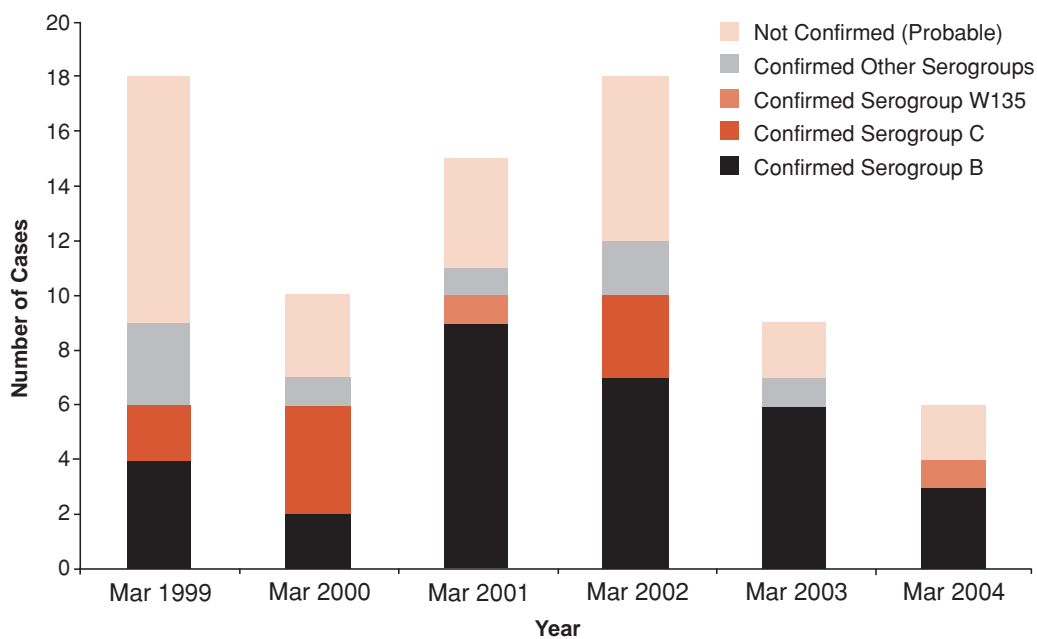


Figure 8: Cases of Meningococcal Disease in the month of March, 1999-2004



Update on Mumps Outbreak

There have been 361 mumps notifications this year to 2 June in contrast to 180 notifications for all of 2003. Of the 361 notifications 152 were laboratory confirmed. The outbreak remains mainly within the Southern and Eastern Boards which account for 303 (84%) of notifications.

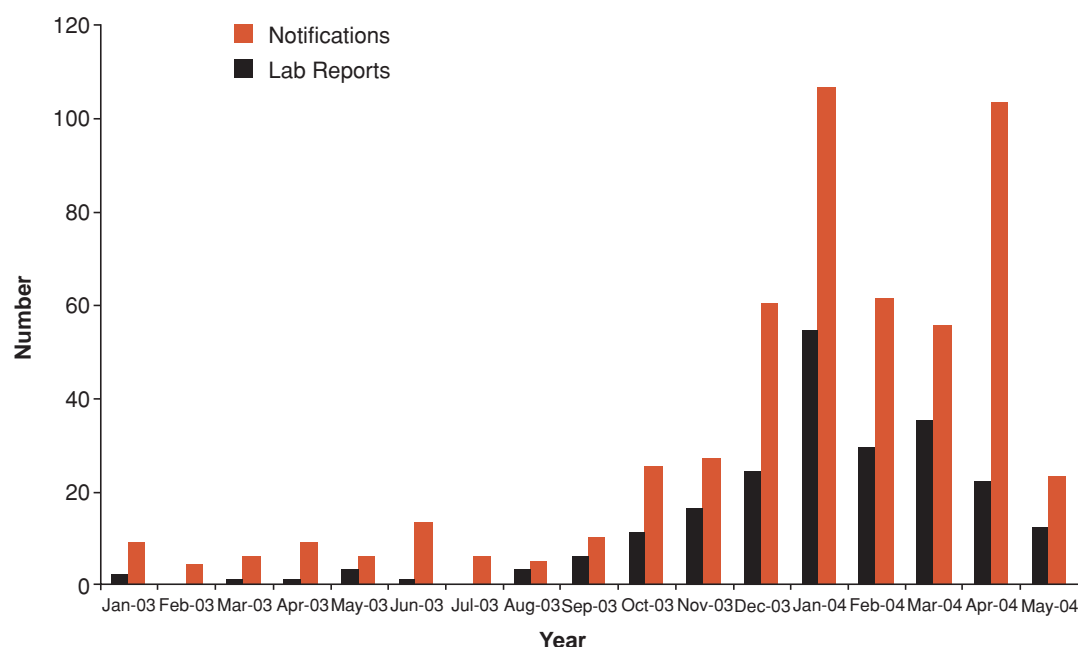
Fig 9 describes the epidemic curve and the rise in notifications commencing in October 2003. It is too early to state if the current

outbreak is declining as the Easter school holidays may have temporarily reduced transmission among teenagers. 77% of

confirmed cases this year are in teenagers.

The vast majority of confirmed cases of mumps are in those who have not had two doses of MMR vaccine. Only six confirmed cases occurred in those aged under 10 years reflecting the high coverage of two MMR doses in this cohort.

Figure 9: 'Epidemic' Curve: Mumps Laboratory Reports*, (Salivary & Blood), by Month of Specimen Date, 2003-2004 (2 June), Northern Ireland



*includes 152 cases for which no lab report has been received at CDSC (NI) but has been confirmed by CCDC

Table 7: Vaccination Status of Provisional Laboratory Confirmed Mumps Cases, by age group, 2004, Northern Ireland (n=152)

Age group	No Vaccine	MMR Only	MR Only	MMR & MR	MMR1 & MMR2	Not Known
<10	4	0	0	0	2	0
11-14	1	5	0	11	8	1
15-19	5	5	16	51	3	11
>20	12	0	10	0	0	7
Total	22 (14%)	10 (7%)	26 (17%)	62 (41%)	13 (9%)	19 (13%)

Enhanced Surveillance of Influenza in Northern Ireland (ESINI)

Summary 2003-2004

The principal aim of the project is to provide early warning of influenza virus circulation in Northern Ireland. The scheme involves the weekly compilation of data from sentinel GP practices, out-of-hours Co-Operatives (Co-Ops) and the Northern Ireland Regional Virus Laboratory.

During the 2003/04 season, 23 GP spotter practices took part in ESINI, representing 140,757 patients throughout Northern Ireland (approximately 8.3% of the population).

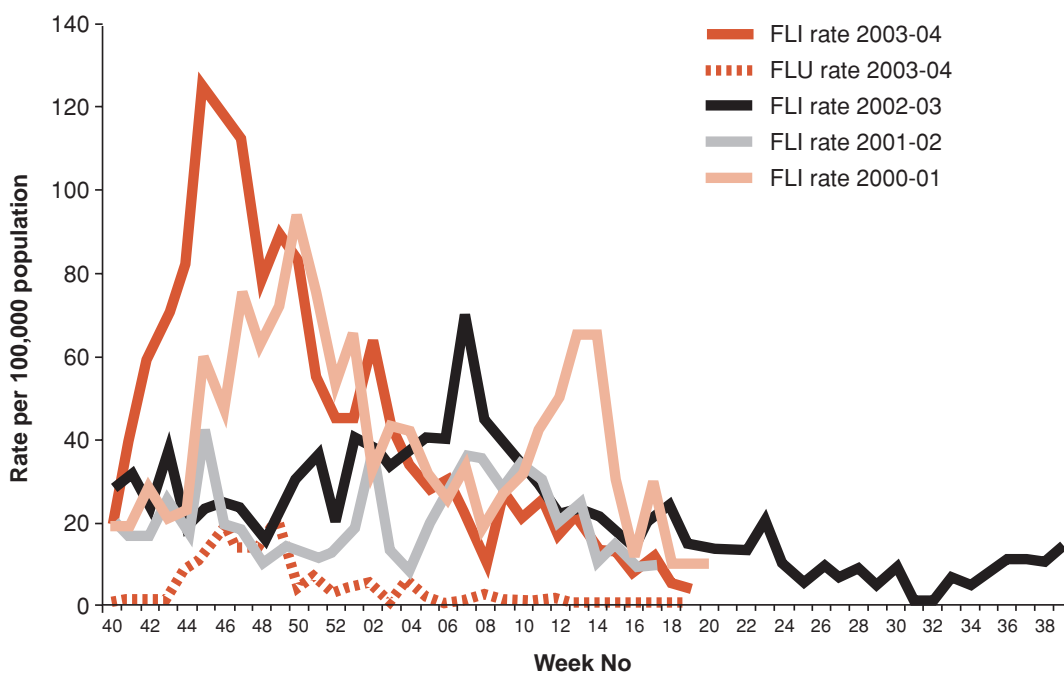
Out-of-hours Co-Operatives were, once again, involved in provision of

information for ESINI. Five Co-Ops, covering approximately 1,236,428 people (73.2% of the population), undertook to supply weekly data on numbers of calls received and the age/sex breakdown of those calls.

Sentinel GPs

At the end of the 2002/03 season (mid-May 2003), sentinel GPs were requested, for the first time, to continue the submission of consultation data for 'flu and 'flu-like illness (FLI) during the summer months. As can be seen from Figure 10, consultation rates began to rise in Week 35 (late August 2003). From Week 40, the rate rose rapidly and, in Week 45, was higher than that recorded at any time since the commencement of the ESINI scheme (145 per 100,000 population).

Figure 10: GP Consultation rates for Clinical 'Flu and 'Flu-Like Illness



During 2003/04, fifteen GP surgeries agreed to take part in an enhanced study which entailed

nasal and throat swabbing of patients presenting with clinical influenza. A total of 169 swabs were submitted to the Regional

Virus Laboratory by sentinel GPs between Week 40 of 2003 and Week 20 of 2004.

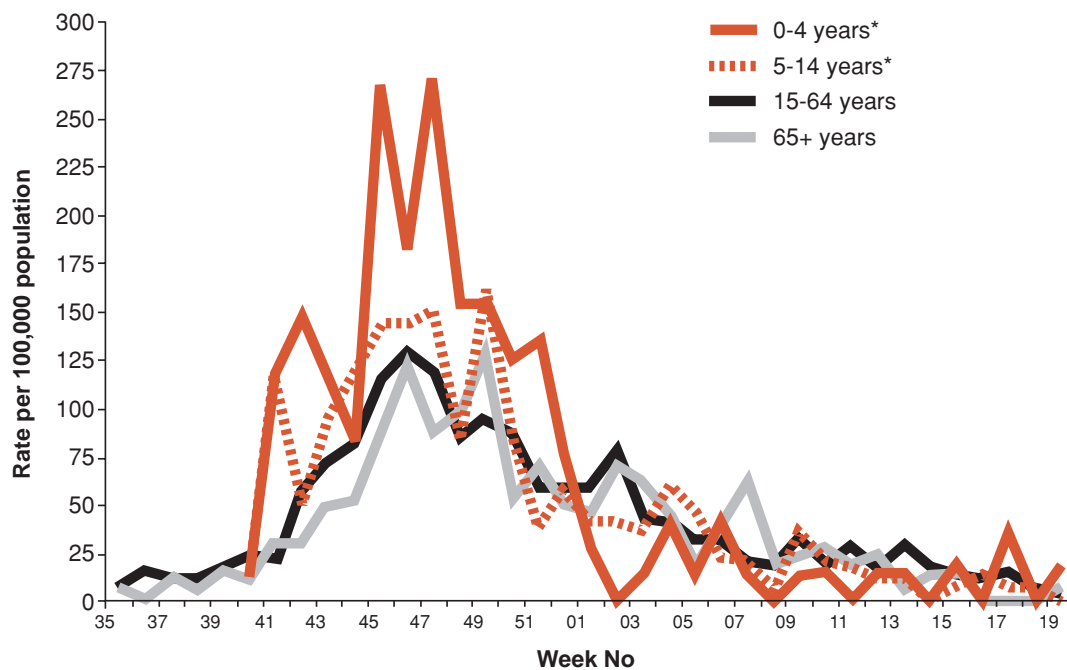
In Week 41, the first two cases of influenza A H3 were confirmed in the Province – one from a 58 year old (swab submitted by a sentinel GP), the other from a 12 year old hospitalised child. These were further identified, by sequencing, as the Fujian strain of Influenza A H3N2 – the strain that predominated in South Africa and Australia during the Southern

Hemisphere winter of 2003. By Week 03 of 2004, GP consultation rates were falling to the levels expected for the time of year and the last influenza A H3N2 infection was confirmed in Week 06 (mid February).

Early in the 2003-04 season, it became apparent that children were the group most affected by

influenza and FLI infection. In particular, those under 4 years of age. As there had been very little influenza in circulation for a number of years, the potential for developing immunity was restricted and young children were, essentially, a naive population. Figure 11 shows the combined age-specific rate for 'flu and FLI in all four age groups.

Figure 11: Age-specific Rates of Clinical 'Flu-like illness 2003-04



Co-Operatives

For most of the season, Co-Op call rate data for 2003/04 followed a very well-defined pattern throughout the normal period of surveillance, with peaks in call rates occurring during the holiday periods of Christmas/New Year, St Patrick's Day and Easter (Figure 12). The main exception to this yearly pattern occurred early in the season – at the same time as GP consultation rates were rising rapidly. Call rates recorded during the period from Week 40 to Week 48 of 2003/04 were higher than historical data would have predicted. Examination of the raw data also indicates that a higher than normal proportion of calls

recorded by Co-Ops during this time related to children aged 0-14, particularly those aged 0-4 years. In the absence of coding, the increased rates recorded during this period cannot be attributed solely to an increase in respiratory disease. However, the Co-Op data does correlate well with the increase in GP consultation rates for clinical 'flu and FLI in those aged 0-14 during the same period.

Virus activity in Northern Ireland

In comparison to the previous three years, influenza virus activity was relatively high in Northern Ireland during the early part of the 2003/04 season. Sequence data on one of the

earliest isolates showed it to be A/Fujian/411/2002 (H3N2)-like. Of the 169 swabs submitted for testing by sentinel GPs, 39 were found positive for influenza A H3 infection and a further 34 were found positive for the presence of one or more other respiratory viruses. An additional 77 influenza A H3 infections were confirmed through routine laboratory testing – the majority of which were in hospitalised children. Thirty-six of these 77 cases were babies under 1 year of age and a further 12 cases were aged between 2 and 4 years. Approximately one-third of patients with influenza were also co-infected with one or more of the following respiratory viruses;

adenovirus, rhinovirus, parainfluenza virus type 2 and RSV.

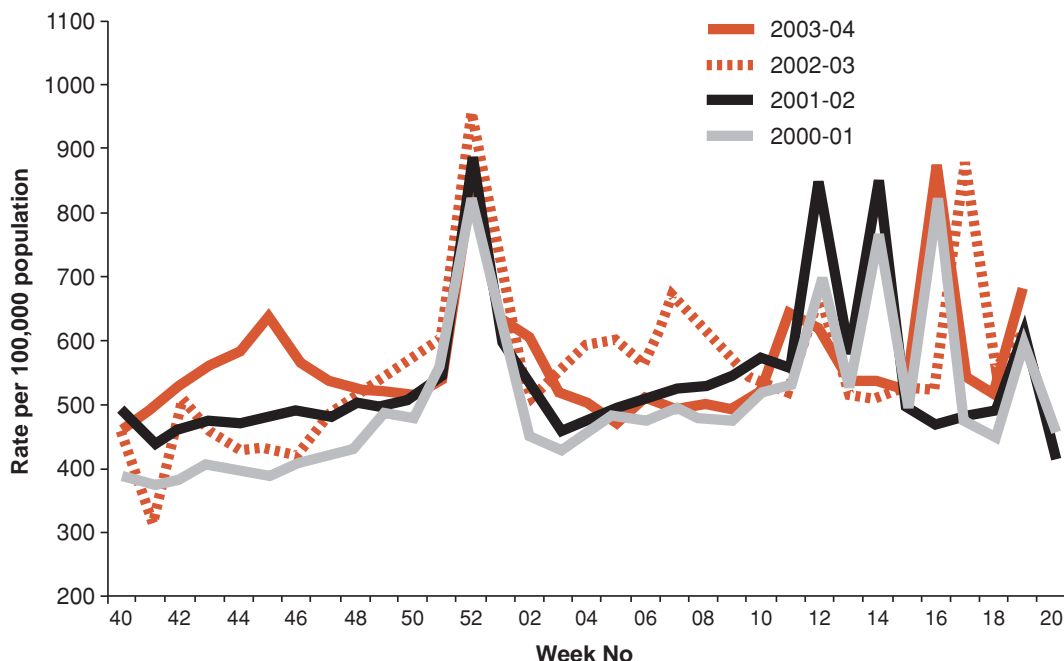
Respiratory virus infections, other than influenza, were also laboratory confirmed in almost 500 individuals across Northern Ireland during the 2003/04 season. The majority of these were hospitalised

patients and, of these, almost two-thirds were under 1 year of age. Approximately one-sixth of all patients with positive results (other than for influenza) had dual or triple respiratory virus infections - most frequently a combination of RSV plus adenovirus and/or rhinovirus. The other main respiratory pathogens detected were

parainfluenza virus type 2 and metapneumovirus.

The full ESINI 2003-2004 Report is available from: hilary.kennedy@hpa.org.uk
It will also be available shortly at: <http://www.cdscni.org.uk/>

Figure 12: Total calls to GP Co-Operatives in Northern Ireland



Five Nations Health Protection Conference

Formerly Called:

Annual Conference On Epidemiology And Control Of Communicable Diseases And Environmental Hazards

**Monday 1 November to Wednesday 3 November 2004 to be held at
MANCHESTER TOWN HALL, Albert Square, Manchester**

The annual conference will address a wide range of health protection issues that have arisen in the past year and provide fresh perspectives on established areas of disease prevention and communicable disease control, dealing with non-communicable environmental threats and health emergencies.

Short papers on recent outbreaks

and surveillance initiatives will also be presented. The conference organising committee is drawn from HPA/CDSC in England, National Public Health Service for Wales and CDSC, Northern Ireland, the Scottish Centre for Infection and Environmental Health, the National Disease Surveillance Centre, Ireland, the Public Health Medicine Environmental Group, Consultants in Communicable

Disease Control and Consultants in Public Health Medicine.

Further details available from:
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Vaccination Coverage Statistics for Children in Northern Ireland

The vaccination coverage statistics for Northern Ireland (COVER/Körner Programme) are now available for the third quarter of 2003. The statistics give detailed coverage data and numbers of children in the four Boards in Northern Ireland. The tables below show the coverage data for Northern Ireland and the United Kingdom as a whole by the first and second birthday.

Completed Primary Immunisations by 12 months and 24 months COVER/Körner: Data Northern Ireland (Oct-Dec 2003)

Board	No of children in cohort	% Coverage at 12 months							No of children in cohort	% Coverage at 24 months						
		Dip3	Tet3	Pol3	Pert3	Hib3	MMR	MenC		Dip3	Tet3	Pol3	Pert3	Hib3	MMR	MenC
Eastern	1898	92.8	92.8	92.7	92.5	93.1	0.0	93.8	1891	95.4	95.4	95.0	94.9	95.1	86.1	95.6
Northern	1402	97.1	97.1	97.0	96.8	97.1	0.4	96.9	1339	97.4	97.4	97.0	96.9	97.2	89.2	97.3
Southern	1063	96.5	96.5	96.3	96.3	96.6	0.1	96.5	1157	97.9	97.9	97.6	97.7	98.0	91.6	98.1
Western	1031	96.5	96.5	96.4	96.0	96.4	0.0	96.6	990	97.5	97.5	97.3	97.1	97.4	90.4	97.4
NI Total	5394	95.4	95.4	95.4	95.0	95.5	0.0	95.7	5377	96.8	96.8	96.8	96.4	96.7	88.9	96.9

Compared with the July to September 2003 quarter, uptake rates for all vaccines at 12 months have increased by 0.1-0.3 percentage points. Uptake rates for Dip3, Tet3 and Hib3 at 24 months have decreased by 0.1-0.2 percentage points. Uptake rates for Pol3 and MenC have remained stable. Pert3 and MMR uptake rates have increased by 0.1 and 1.7 percentage points respectively. The MMR uptake level in Northern Ireland remains considerably higher than the UK level (see Fig 13).

Country	% Coverage at 12 months				% Coverage at 24 months				
	Dip3	Pert3	Hib3	MenC	Dip3	Pert3	Hib3	MenC	MMR
England	90.6	90.3	90.6	90.2	93.6	93.2	93.5	92.9	80.2
Wales	94.5	93.4	94.4	94.1	96.0	94.7	95.8	95.6	81.0
Scotland	95.6	95.4	95.4	94.7	97.3	97.0	97.0	96.3	87.6
UK	91.3	91.0	91.4	90.9	94.1	93.7	94.0	93.4	81.1

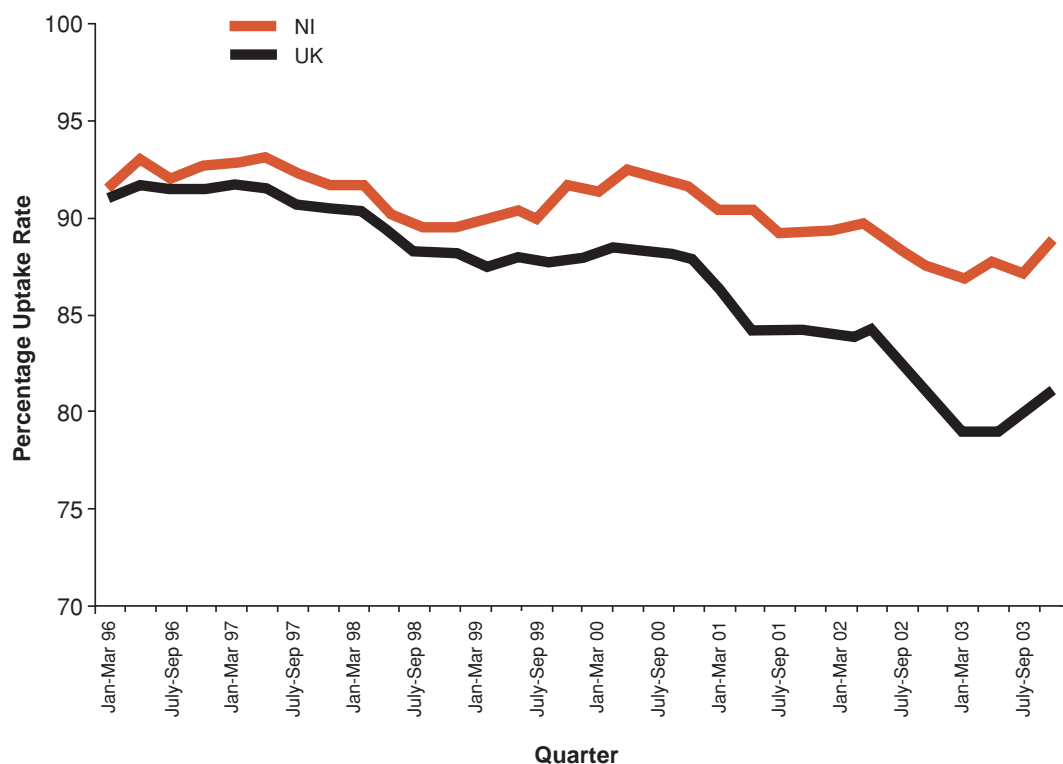
Vaccine Coverage at 5 years (Oct – Dec 2003)

Board	Dip3	Pert3	Hib3	Dip4	MMR1	MMR2	MenC
Eastern	96.1	95.2	95.3	84.7	94.5	83.0	94.4
Northern	98.0	97.6	97.4	91.6	96.6	90.0	96.7
Southern	97.8	97.0	97.1	92.3	96.7	90.4	96.6
Western	98.1	97.2	96.7	91.6	96.1	87.6	96.3

NI	97.3	96.5	96.5	89.3	95.8	87.1	95.8
England	93.7	92.9	93.0	80.7	90.3	75.6	88.3
Wales	95.2	93.2	94.8	84.3	91.3	76.7	92.6
Scotland	Not available						
England, Wales & NI	93.9	93.0	93.3	81.2	90.5	76.1	88.8

Compared with last quarter's data, uptake of Dip3, Pert 3, Hib3, MMR1 and Men C have decreased by 0.3-0.9 percentage points. Uptake of Dip4 and MMR2 have increased by 0.6 and 0.7 percentage points respectively.

Figure 13: MMR Vaccination Uptake Rate at 24 months, NI and UK, 1996-2003



Foodborne and gastrointestinal outbreaks

January – March 2004

Outbreak surveillance is primarily based on reports received from Consultants in Communicable Disease Control (CCDCs). Viral or suspect viral infections were thought to be the cause of all of the outbreaks of gastro-enteritis reported to CDSC (NI) during the first quarter of 2004.

One outbreak was considered to be foodborne. This outbreak affected 6 people at a Belfast golf club. The causative organism was not identified.

There were fifteen other gastrointestinal outbreaks reported, affecting at least 501 people. Five outbreaks occurred in hospitals and the other ten occurred in nursing/

residential homes. The organism was not identified in four outbreaks in nursing homes in the Northern and Western Boards, but the remainder were caused by viral infections. These infections can spread rapidly in institutions such as hospitals and residential/nursing care facilities. Small round structured virus (SRSV) was found to be the causative organism in seven outbreaks. The numbers of laboratory confirmed cases in the outbreaks were much lower than the number of cases who were ill, as a diagnosis can usually be made quickly and confidently based on clinical and epidemiological evidence, particularly if vomiting is a prominent symptom. Once the organism has been identified by the laboratory, no useful purpose is normally served by analysing further specimens.

Table 8: General outbreaks¹ of foodborne and other gastrointestinal illness reported to CDSC (NI), January - March 2004*

Foodborne outbreaks						
Month	Board	Location	Organism	Suspect vehicle ²	No. ill ³	Cases +ve
Jan	E	Golf Club	?	Foodborne	6	?

Other gastrointestinal outbreaks						
Month	Board	Location	Organism	Suspect vehicle ²	No. ill ³	No +ve
Jan	E	Nursing Home	?Viral	Person/person	5 residents, 9 staff	?
Jan	N	Nursing Home	SRSV	Person/person	22 residents/6 staff	?
Jan	W	Nursing Home	Unknown	Unknown	16	0
Jan-Feb	N	Nursing Home	?Viral	Unknown	26 residents, 20 staff	?
Jan-Apr	E	Nursing Home	Viral	Person/person	11	n/a
Feb	N	Hospital	SRSV	Person/person	?	5
Feb	N	Nursing Home	Unknown	Person/person	32 residents, 14 staff, 1 visitor	?
Feb	N	Nursing Home	Unknown	Person/person	7 residents	?
Mar	N	Nursing Home	Unknown	Person/person	13 residents, 3 staff	?
Mar	N	Hospital	SRSV	Person/person	41 residents, 18 staff	4
Mar	N	Hospital	SRSV	Person/person	179 patients, ? Staff	?
Mar	S	Hospital	SRSV	Person/person	?	?
Mar	S	Hospital	SRSV	Person/person	7	2
Mar	E	Nursing Home	Viral	Person/person	48	49
Mar	E	Nursing Home	SRSV	Person/person	23	1

*Data Provisional

¹General outbreaks involve members of more than one household;

²Local investigations may not provide conclusive evidence of vehicles of infection. Vehicles are therefore designated 'suspect';

³The number known to be ill.

SARS update

The World Health Organisation declared on 18 May that the chain of human-to-human transmission in China appears to have been broken as it is more than three weeks since the last case was placed in isolation. Investigations are continuing to ascertain the cause of the outbreak which appears to centre on the National Institute of Virology in Beijing where experiments have been undertaken using live and inactivated SARS coronaviruses. Two researchers at the Institute developed SARS in late March and mid-April though neither were directly involved in experiments using live SARS coronavirus.

This incident involved a total of 9 cases including one fatality. Several hundred people were placed in quarantine or isolation. In addition to the two laboratory researchers there were then two cases (one a nurse) in the second generation of cases and both were close personal

contacts of one of the researchers. In the third generation there were five cases all of whom were a contact of the nurse.

This was the most serious incident since the first global SARS outbreak ended in July 2003. The

Department of Health, Social Services and Public Safety reminded clinicians to be vigilant, though the risk of transmission of infection to Northern Ireland appeared to be low, and of the Northern Ireland SARS interim contingency plan.

References:

<http://www.wpro.who.int/sars/>
<http://www.dhsspsni.gov.uk/publications/2004/hssmd16-2004.pdf>

Laboratory Reports

Hepatitis: Laboratory Reports Quarter 1 (Jan - Mar 2004)

	Number of Reports received	
	Quarter 1 2004	Quarter 1 2003
Hepatitis A	4	0
Hepatitis B	23	12
Hepatitis C	31 (1)	17 (4)
Hepatitis E	1	0

The figure in brackets represents those reports for which an association with intravenous drug use was noted on the laboratory request form.

Comment:

Hepatitis A

There were four reports of Hepatitis A during the first quarter of 2004. Two were male aged 42 and 56 years; two were female aged 4 and 77 years.

Hepatitis B

Twenty-three cases of Hepatitis B were reported during this reporting

period ten of which were classified as acute Hepatitis B infection. Eleven were male, aged between 36 to 55 years. Twelve cases were female aged between 11 and 47 years.

Hepatitis C

There were 31 reports of Hepatitis C during quarter one of 2004. Nineteen were male aged between 19 to 68 years; Ten were female

aged between 22 and 83 years. The sex was not known in 2 cases and the age was not known in one of these cases.

Hepatitis E

There was one reported case of Hepatitis E during weeks 1 – 12 of 2004. The case was male, aged 42 years.

Mycobacteria: Laboratory Reports, Weeks 01-12

	Number of Reports received			Cumulative total	
	04/01-04	04/05-08	04/09-12	04/01-12	03/01-12
<i>M. abscessus</i>	1	1	0	2	0
<i>M. avium-intracellulare</i> group	0	3	1	4	2
<i>M. chelonae</i>	0	0	0	0	1
<i>M. gordonae</i>	0	0	1	1	0
<i>M. kansasii</i>	0	0	0	0	3
<i>M. malmoense</i>	0	0	0	0	5
<i>M. tuberculosis</i>	3	1	6	10	1
<i>M. sp</i>	1	0	0	1	0
Total	5	5	8	18	12

Comment:

Two cases of *M. abscessus* were reported during weeks 1- 12 of 2004. One was isolated from sputum and one from CSF. One case was male aged 23 years and the other was female aged 82 years.

There were four reports of *M. avium-intracellulare* group during this reporting period. Three

were isolated from sputum and one from lymph nodes. Two cases were male and two were female. Ages ranged from 2 years to 78 years.

One case of *M. gordonae* was isolated from sputum during this twelve week reporting period. The patient was male aged 55 years.

There were ten reports of *M. tuberculosis* during weeks 1 – 12 of 2004. Seven were isolated from

sputum, one from pus (source unknown), one from pleura and one from upper gastro-intestinal tract. Six cases were male, three were female and one was sex unknown. Ages ranged from 1 year to 81 years.

One case of *Mycobacterium sp* was isolated from urine/kidney during this reporting period. The patient was male, aged 70 years.

Reports of Positive blood cultures: Laboratory Reports, Weeks 01-16

	2004/01-16	2003/01-16
Gram negative bacteria		
<i>Acinetobacter</i> sp	8	8
<i>Aeromonas</i> sp	2	2
<i>Brucella</i> sp	0	2
<i>Campylobacter</i> sp	0	0
<i>Citrobacter</i> sp	4	10
<i>Enterobacter</i> sp	23	21
<i>Escherichia coli</i>	206	170
<i>Haemophilus influenzae</i>	2	6
<i>Haemophilus</i> sp	0	2
<i>Klebsiella</i> sp	40	49
<i>Legionella</i> sp	0	0
<i>Leptospira</i>	0	0
<i>Neisseria meningitidis</i>	1	8
<i>Neisseria</i> sp	0	1
<i>Proteus</i> sp	26	35
<i>Providencia</i> sp	1	3
<i>Pseudomonas aeruginosa</i>	16	24
<i>Pseudomonas</i> sp	18	16
<i>Salmonella</i> sp	2	1
<i>Serratia</i> sp	17	27
Other gram negative bacteria	12	7
Totals	378	392
Gram positive bacteria		
Corynebacterium sp & Diphtheroids	4	0
Staphylococci:		
<i>S. aureus</i>	195	161
coagulase negative	122	118
Streptococci and enterococci:		
group A	13	11
group B	17	18
group C	1	1
group G	2	2
<i>Enterococcus</i> sp	61	59
α- and non-haemolytic	16	27
<i>S. pneumoniae</i>	58	70
Other gram positive bacteria	6	1
Totals	495	468
Anaerobic bacteria		
Anaerobic cocci	1	3
<i>Bacteroides</i> sp	18	17
<i>Clostridium</i> sp	12	12
Other anaerobic bacteria	1	3
Totals	32	35
Grand Total	905	895

Foodborne and Gastro-intestinal Tract Infections: Laboratory Reports, Weeks 09-16

	Number of Reports received		Cumulative total	
	04/09-16	03/09-16	04/01-16	03/01-16
<i>Campylobacter</i>	78	70	174	174
<i>C. difficile</i> Toxin	188	151	424	301
<i>C. perfringens</i>	1	3	5	8
<i>E. coli</i> O157	0	1	3	1
<i>Salmonella</i> total	6	12	15	26
<i>S. enteritidis</i> (PT 4)	2 (2)	1	6 (2)	2
<i>S. typhimurium</i> (DT 104)	1	5	2	16 (2)
<i>Salmonella</i> other	3	6	7	8
<i>Shigella</i>	1	1	3	2
<i>Cryptosporidium</i>	28	19	36	24
<i>Giardia</i>	2	2	7	2
Adenovirus (faeces)	28	15	51	25
Enterovirus (faeces)	1	5	4	7
Rotavirus	156	241	171	398
SRSV	28	29	36	88

Salmonella (other than *enteritidis* or *typhimurium*):

Salmonella sp 3

Comment:

The following were associated with foreign travel:

Campylobacter sp, female, age 54 years, Republic of Ireland;
Campylobacter sp, female, age 55 years, United Arab Emirates;
 Rotavirus, female, age 2 years, Lanzarote; *Salmonella* sp, male, age 18 years, Spain.

Laboratory reports of *C. difficile* toxin, *E. Coli* O 157, *Shigella*, *Cryptosporidium*, *Giardia* and Adenovirus are showing an increase compared with the same period last year. The increase in *Cryptosporidium* reports is particularly due to one laboratory changing its practice to examine all faecal specimens for *Cryptosporidium*.

Cumulative reports of total *Salmonella* maintain a decline with 15 laboratory confirmed cases reported to week 16 of 2004 – a reduction of 42%.

Reports of Rotavirus and SRSV have more than halved. Reported of *C. perfringens* and Enterovirus have decreased by 38% and 43% respectively.

Contributing Laboratories

Altnagelvin	Mater
Antrim	Musgrave Park
Belfast City	Regional Mycology
Belvoir Park	Regional Virus
Causeway	Royal Victoria
Craigavon	Tyrone County
Daisyhill Ulster	
Erne	

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Monthly numbers are provisional and should not be used to indicate trends.

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