



# Health Protection Report

weekly report

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## News

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- ▶ Chikungunya outbreak in Italy
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### Chikungunya outbreak in Italy

The Italian Ministry of Health has reported an outbreak of chikungunya virus infection in Region Emilia Romagna, Italy (this is in northern Italy, bordering on the Adriatic). This is the first recorded outbreak associated with the transmission of this infection within Italy. As of 4 September 2006, over 150 cases and one death have been reported. Initial reports indicated that almost all of the first 135 cases came from two small villages, Castiglione di Cervia and Castiglione di Ravenna, separated by a river, near Cervia, in the Province of Ravenna. All other cases that are not associated with these two villages appear to have been exposed in the Ravenna Province.

Cases have presented with high fever (38° C or higher), joint pains (arthralgia) and tiredness, although clinical symptoms have been mild overall. Twenty-seven cases have been confirmed by laboratory tests (including six by PCR and 21 by IgM serology). The index case is suspected to be an Indian national who had travelled to Kerala, India and became symptomatic on 23 June. The first Italian case was reported on 4 July and the outbreak peaked between the 17 and 19 August. The case who died was an 83 year old man with underlying conditions.

The regional health authority in Italy has implemented insect control measures in public areas and alerted all clinicians to the symptoms and signs of chikungunya. Other control measures include raising community awareness about personal protective measures against mosquito bites.

Although the two villages where most of the cases have occurred are not tourist destinations themselves, there are many Italian and International tourists in the surrounding areas. There have been no cases reported in travellers from the UK to date.

The outbreak may continue locally and could expand to neighbouring areas as climatic conditions are favourable for the vector, *Aedes albopictus* (the Asian Tiger mosquito), to remain present for the next one or two months. The mosquito is present in at least 12 European countries. To date, however, there have been no confirmed reports of the mosquito in the United Kingdom (UK) and the public health risk of transmission in this country remains low. Further information on the Asian Tiger Mosquito can be found at [http://www.hpa.org.uk/infections/topics\\_az/aedes\\_albopictus/default.htm](http://www.hpa.org.uk/infections/topics_az/aedes_albopictus/default.htm).

Since 2005 there have been outbreaks of Chikungunya virus in the Indian Ocean, India and Sri Lanka. A large outbreak of chikungunya virus infection reported in India during 2006, involved over a million cases [http://www.who.int/csr/don/2006\\_10\\_17/en/index.html](http://www.who.int/csr/don/2006_10_17/en/index.html). Since this time there have continued to be media reports of illness in several states including Kerala <http://www.promedmail.org>, though no confirmed figures have been published.

Travellers to any affected areas are advised to take insect bite precautions, particularly during daylight hours when Aedes mosquitoes are active. Advice can be found at <http://www.nathnac.org/pro/factsheets/iba.htm>.

Most patients with chikungunya virus infection recover fully over a period of a few weeks, although between 5 and 10% of patients will experience chronic joint pain, stiffness and swelling that can persist. There is no vaccine available to protect against this infection.

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## World Rabies Day

The first World Rabies Day is on 8 September 2007. The World Rabies Day initiative involves a range of professionals from human and animal health and other corporate and non-profit partners, ranging from local to national to international level; the main goal is supporting human rabies prevention and animal rabies control through awareness and resources. The initiative was created by a group of researchers and professionals who formed the [Alliance for Rabies Control](#) in 2006.

Rabies is a global public health problem, a vaccine-preventable disease, a neglected disease and a zoonosis. Rabies is a disease of terrestrial mammals and bats transmitted to human mainly, but not restricted, through the bite of infected dogs. More than 3 billion people are thought to be at risk of rabies, especially in Africa, Asia, and Latin America. There are about 55,000 human rabies deaths per year, mainly occurring in Asia and Africa, and approximately 30-50% of the cases (and therefore deaths) are in children.

The last case of classical rabies acquired in the United Kingdom was in 1902. Since then there have been at least 25 deaths from classical rabies in the UK, all acquired abroad. All but one of these cases was infected through dog bite and received rabies post-exposure treatment. The last case of indigenous terrestrial animal rabies was in 1922. A rabies-like virus, the European Bat Lyssavirus 2, caused the death of a licensed bat handler in Scotland in 2002.

It is important to raise awareness in relation to rabies to residents and travellers to rabies endemic countries and to highlight the importance of seeking medical attention as soon as possible after any exposure.

## Related Links

World Rabies Day website  
[http://www.worldrabiesday.org/about\\_rabies\\_en.php](http://www.worldrabiesday.org/about_rabies_en.php)

Health Protection Agency website – information on rabies  
[http://www.hpa.org.uk/infections/topics\\_az/rabies/menu.htm](http://www.hpa.org.uk/infections/topics_az/rabies/menu.htm)

World Health Organization website – information on rabies  
<http://www.who.int/rabies/en/>

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## Review of the basis for establishing health-based protection criteria in the areas of chemicals, ionising radiation, and non-ionising radiation

The Health Protection Agency's Centre for Radiation, Chemical and Environmental Hazards has published the conclusions of a review of the basis for establishing health-based protection criteria in the areas of chemicals, ionising radiation, and non-ionising radiation. Appendices provide detailed descriptions of the processes and procedures that have been

adopted for setting scientifically-based exposure criteria for the protection of human health in the various areas.

## **References**

1. *Comparison of Processes and Procedures for Deriving Exposure Criteria for the Protection of Human Health: Chemicals, Ionising Radiation and Non-ionising Radiation*. Chilton: HPA, 2007. Available at <http://www.hpa.org.uk/publications/PublicationDisplay.asp?PublicationID=102>

# Respiratory

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## Laboratory reports of respiratory infections made to Cfl from HPA and NHS laboratories in England and Wales: weeks 31-35/2007

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 Cfl, by week of report: weeks 31-35/2007**

Week	Week 31	Week 32	Week 33	Week 34	Week 35	Total
Week ending	05/08/07	12/08/07	19/08/07	26/08/07	02/09/07	
<b>Influenza A</b>	<b>3</b>	–	<b>3</b>	–	<b>2</b>	<b>8</b>
Isolation	–	–	–	–	–	–
DIF	–	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–	–
PCR	–	–	–	–	–	–
Other	3	–	3	–	2	<b>8</b>
<b>Influenza B</b>	<b>2</b>	–	<b>1</b>	<b>1</b>	<b>1</b>	<b>5</b>
Isolation	–	–	–	–	–	–
DIF	–	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–	–
PCR	–	–	–	1	–	<b>1</b>
Other	2	–	1	–	1	<b>4</b>
<b>Influenza (untyped)</b>	–	–	–	–	–	–
Isolation	–	–	–	–	–	–
DIF	–	–	–	–	–	–
Four-fold rise in paired sera	–	–	–	–	–	–
PCR	–	–	–	–	–	–
Other	–	–	–	–	–	–

\*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), by week of report: weeks 31-35/2007**

Week	Week 31	Week 32	Week 33	Week 34	Week 35	Total
Week ending	05/08/07	12/08/07	19/08/07	26/08/07	02/09/07	
Adenovirus*	78 <sup>†</sup>	45	45	46	15	229
Coronavirus	–	–	–	–	–	–
Parainfluenza <sup>†</sup>	40 <sup>‡</sup>	9	9	5	1	64
Rhinovirus	7 <sup>‡</sup>	5	–	3	4	19
Respiratory Syncytial Virus (RSV)	34 <sup>‡</sup>	8	9	8	7	66

\*Respiratory samples only. Excludes diagnoses made by electron microscopy (EM)

<sup>†</sup>includes parainfluenza types 1, 2, 3, 4 and untyped.

<sup>‡</sup> Includes late reports sent to Cfl from specimens taken up to 6 weeks prior.

**Table 3 Respiratory viral detections by age group: weeks 31-35/2007**

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	≥65 years	Unknown	Total
Adenovirus*	21	26	19	117	37	6	3	229
Coronavirus	–	–	–	–	–	–	–	–
Influenza A	–	–	–	2	4	2	–	8
Influenza B	–	–	–	3	1	1	–	5
Parainfluenza <sup>†</sup>	22	11	4	8	16	1	2	64
Rhinovirus	12	2	2	2	–	1	–	19
Respiratory Syncytial Virus (RSV)	41	8	1	3	7	5	1	66

\*Respiratory samples only.

<sup>†</sup>includes parainfluenza types 1, 2, 3, 4, and untyped.

**Table 4 Laboratory reports of infections associated with atypical pneumonia, by week of report: weeks 31-35/2007**

Week	Week 31	Week 32	Week 33	Week 34	Week 35	Total
Week ending	05/08/07	12/08/07	19/08/07	26/08/07	02/09/07	
<i>Coxiella burnetii</i>	5 <sup>†</sup>	2	1	1	1	10
respiratory Chlamydia sp.*	4 <sup>†</sup>	–	1	4	4	13
<i>Mycoplasma pneumoniae</i>	23 <sup>†</sup>	8	9	3	8	51
Legionella sp.	16	24	14	12	3	69

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

<sup>†</sup> includes late reports sent to Cfl from specimens taken up to 6 weeks prior.

**Table 5a Reports of legionnaires' disease cases in England and Wales, by week of report: weeks 31-35/2007**

Week	Week 31	Week 32	Week 33	Week 34	Week 35	Total
Week ending	05/08/07	12/08/07	19/08/07	26/08/07	02/09/07	
Nosocomial	–	1	–	–	–	1
Community	10	16	9(1†)	2	1	38
Travel Abroad	4	7	3	9	2	25
Travel UK	2	–	2	1	–	5
<b>Total</b>	<b>16</b>	<b>24</b>	<b>14</b>	<b>12</b>	<b>3</b>	<b>69</b>
Male	12	18	11	6	3	50
Female	4	6	3	6	–	19

\* Non-pneumonic case(s).

† 2006 case(s).

Sixty-nine cases of legionnaires' disease were reported with pneumonia; 50 males aged between 19 and 77 years and 19 females aged between 41 and 86 years. Thirty-eight cases had community acquired infection. Four deaths were reported in M 65y, M 77y, F 51y and F 74y.

Thirty cases were associated with travel: six with cruises, five with each of Turkey and the United Kingdom, four with Spain, three with Greece, two with Morocco, and one from each of China & Hong Kong, Cuba, France, France/Germany, and Malta (1).

**Table 5b Reports of legionnaires' disease cases by region of report in England and Wales: weeks 31-35/2007**

Region	Nosocomial	Community	Travel Abroad	Travel UK	Total
North East	–	–	–	–	–
Yorkshire & Humber	–	3	2	–	5
East Midlands	–	4	3	–	7
East of England	–	4	–	2	6
London	–	11	4	–	15
South East	–	5(1†)	8	3	16
South West	–	–	1	–	1
West Midlands	1	7	3	–	11
North West	–	2	2	–	4
Wales	–	2	1	–	3
Unknown	–	–	1	–	1
<b>Total</b>	<b>1</b>	<b>38</b>	<b>25</b>	<b>5</b>	<b>69</b>

• Non-pneumonic case(s).

†2006 cases.

# Diary

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## An Introduction to Health Protection

A six-day course for health professionals to be held on 24, 25 October, and 7, 8, 28, and 29 November 2007

**Venue:** University of Kent, Canterbury campus

**Cost:** £420

This course is being run as a collaboration between the Kent Health Protection Unit (Health Protection Agency) and the Kent Institute of Medicine and Health Sciences ( University of Kent ).

The postgraduate level course is designed to provide an introduction to health protection for public health specialists, nurses and trainees. It would also benefit other professionals who have a particular interest in health protection, or who wish to develop a career in health protection, in the future. It is suitable for individuals both with and without prior experience of health protection.

This course aims to enable health professionals to develop an understanding of the principles of the control of infectious diseases and environmental hazards, so as to be able to undertake a health protection role within their organisation. It also covers the principles of out of hours health protection.

To make your booking please contact Katharine Whyte, Training Co-ordinator, Kent Health Protection Unit, tel: 01622 713157; fax: 01622 791644; Email: [katharine.whyte@maidstonewealdpct.nhs.uk](mailto:katharine.whyte@maidstonewealdpct.nhs.uk).