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News

HIV and other sexually transmitted infections in the United Kingdom – publication of annual surveillance report Mapping the Issues

The Health Protection Agency has published Mapping the issues, its annual surveillance report, for HIV and sexually transmitted infections in the United Kingdom (UK) (1). The report describes a worrying situation with undiminished and high levels of transmission of HIV and other sexually transmitted infections (STIs) among men who have sex with men (MSM), a steady increase in the number of HIV-infected black Africans in the UK, limited but compelling evidence that heterosexual transmission of HIV within the UK is slowly rising, and continuing high transmission of other STIs, (especially chlamydia) among young people. The report summarises current surveillance information on HIV and STIs, as well as some of the behaviours underlying transmission, and shows the distribution of the problem across different areas of the country.

The reports key findings state:

- By the end of 2004 there were an estimated 58,300 (range: 54,700 to 63,400) people living with HIV in the UK, of whom 34% (range: 29% to 39%) were unaware of their infection.
- During 2004 the incidence of HIV infection in MSM remained high at 3% per year. The prevalence of previously undiagnosed HIV infections was 4.7% among MSM attending sentinel genitourinary medicine (GUM) clinics in London and 2.8% among those aged under 25 years. Outside London, the prevalence of previously undiagnosed HIV infection among young MSM attending sentinel GUM clinics was 0.9%.
- The incidence of gonorrhoea also remained high among MSM in 2004, with 3977 infections diagnosed. More than a quarter of gonococcal isolates from MSM in 2004 were shown to be ciprofloxacin resistant, a stark increase from 11% in 2003. In addition, the syphilis epidemic among MSM continued to grow, and there has been a significant rise in the numbers of cases of a previously uncommon disease, lymphogranuloma venereum (LGV).
- Uptake of voluntary confidential HIV testing for HIV among MSM attending GUM clinics increased to 79% in 2004. Of those who could potentially have had their HIV infection diagnosed, 43% remained undiagnosed after leaving the clinic.
- There were 4287 HIV infections newly diagnosed in 2004 which were acquired through heterosexual contact. Of these, 3138 were probably infected in Africa, and the number of these known to have been born in sub-Saharan Africa remained high in 2004, when there was a total of 2315 such diagnoses, little changed from the high number of 2481 diagnoses in 2003. The prevalence of previously undiagnosed HIV infection in heterosexual sub-Saharan Africa born attendees at GUM clinics was 2.7% in London and 7.1% outside London in 2004. Women from Africa are particularly affected, with a prevalence of undiagnosed HIV infection of 8.2% in those attending GUM clinics outside London.
- In England, the overall HIV prevalence among pregnant women who were born in sub-Saharan Africa, was 2.2% in 2004, similar to the 2.4% observed in 2003. Although this prevalence of infection is of concern, the converse is also worth noting: 98% of pregnant women born in sub-Saharan Africa who gave birth to infants in England during 2004 were not infected with HIV.
- The number of diagnoses of HIV infection in people who are thought to have acquired their infection through heterosexual intercourse in the UK continued to rise steadily, from 227 in 2000 to 498 reported so far for 2004 (this number for 2004 will increase as further follow-up is undertaken of cases for which information is incomplete). In heterosexuals born in the UK, attending London GUM clinics, the prevalence of previously undiagnosed HIV infection rose from 0.25% in 2000 to 0.5% in 2004. The prevalence of HIV infection in pregnant women born in the UK increased to 0.07% in 2004, after remaining low and stable at around 0.03% in recent years.

- Young people in the UK are disproportionately affected by chlamydia, gonorrhoea, and genital warts. Rates of STI diagnoses continued to increase among young people in 2004, with the highest rates of gonorrhoea diagnoses seen among men aged from 20 to 24 years (229/100,000) and women aged from 16 to19 (168/100,000).
- In England, rates of gonorrhoea diagnoses were highest in London, 104/100,000 in 2004 and within London, the highest rate was in north central London Strategic Health Authority (SHA) (117/100,000). Outside London, rates were highest in Yorkshire and Humberside (45/100,000), West Midlands (42/100,000), and North West (38/100 000) regions. London also had the highest rates of HIV-infected residents accessing HIV treatment and care services (328/100,000), with all London SHAs seeing an increase over time, but being particularly marked in south east and north east London SHAs. Elsewhere in England, rates of HIV-infected people accessing HIV-related services were highest in Greater Manchester (99/100,000), Surrey and Sussex (97/100,000), Bedfordshire and Hertfordshire (84/100,000) and Thames Valley (72/100,000) SHAs. The resurgence of syphilis in recent years has included a number of localised outbreaks among MSM and heterosexuals in London, Bristol, Manchester, Newcastle-upon-Tyne, Edinburgh, Glasgow, Nottingham, and Northern Ireland, and rates are highest in these areas.
- Rapid access to diagnostic and treatment services for sexually transmitted infections and HIV is a key part of any control programme, and data in the report show that access remains a major problem, with less than half of all GUM clinic attendees being seen within the recommended 48 hours. There is wide regional variation in this access.
- Some prevention initiatives advanced in 2004. Confidential HIV testing rates improved and high numbers of HIV-infected individuals have been maintained on anti-retroviral therapy (ARV). In England, the HIV diagnosis rate among pregnant women increased in 2004; it was estimated that at least 92% of HIV-infected women were diagnosed prior to delivery in England. As a result, the proportion of children exposed to maternal HIV infection who acquire HIV is decreasing. Additionally, in England in 2004, 90% of MSM attending GUM clinics eligible for hepatitis B vaccination received a first dose of vaccine, and roll out of the National Chlamydia Screening Programme was extended.

Mapping the Issues is also accompanied by a series of supplementary data tables and slide sets which can be found with the electronic version of the report at: <http://www.hpa.org.uk/hpa/publications/hiv_sti_2005/>.

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1. The UK Collaborative Group for HIV and STI Surveillance.. Mapping the issues. HIV and other sexually transmitted infections in the United Kingdom: 2005 London: Health Protection Agency, 24 November 2005. Available at <http://www.hpa.org.uk/hpa/publications/hiv_sti_2005/>.

AIDS epidemic update: 25 million have died of AIDS

A joint report issued in advance of World AIDS Day (1 December) by the United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (1) emphasizes both the increasing scale and impact of the global HIV epidemic, and the importance and potential of interventions in the struggle to reverse these trends.

More than 25 million people have died of AIDS since it was first recognised in 1981, and the report describes the epidemic as one of the most destructive in recorded history. In 2005 alone AIDS has killed over 3 million people, nearly a fifth of whom were children.

At 40.3 million, the number of people living with HIV is also higher than ever. Almost 5 million people are believed to have been infected during 2005. This rising trend in HIV is global, with only the Caribbean seeing no change in overall HIV prevalence.

Two-thirds of all people with HIV live in sub-Saharan Africa. For women the proportion is even higher at 77%. During 2005, 2.4 million people died of HIV-related illnesses in Sub-Saharan Africa, while 3.2 million were newly infected, bringing the total number of people living with HIV in the region to 25.8 million. The most worrying trends are seen in southern Africa, where levels of infection with HIV exceed 20% in six countries, and 30% in two: Botswana and Swaziland. For east Africa the situation is more hopeful. Sustained interventions and behavioural changes are bringing decreased levels of infection in countries such as Uganda and Kenya. HIV prevalence in west and central Africa remains stable.

Outside Africa, there is evidence of emerging epidemics in Asia, Oceania, and eastern Europe. The situation in China continues to grow more serious, while other large Asian countries such as Pakistan and Indonesia are also believed to be on the verge of serious epidemics. In eastern Europe, the number of people living with HIV has risen by a quarter (to 1.6 million) since 2003 and the number of deaths from AIDS has doubled (to 62,000). These new epidemics are associated with injecting drug use and commercial sex. Interventions are urgently needed to focus on these risky behaviours.

Access to antiretroviral treatment remains the most crucial issue in stemming the number of HIV-related deaths. This has improved in recent years and treatment is no longer the preserve of those in wealthy Western countries. Some Latin American countries now boast coverage levels of more than 80%. Access to treatment in Asia and particularly Africa, however, remains very poor. Moreover, the report makes it clear that to bring AIDS under control the underlying factors that fuel the epidemics must be tackled, particularly socio-economic inequalities and issues of human rights.

References

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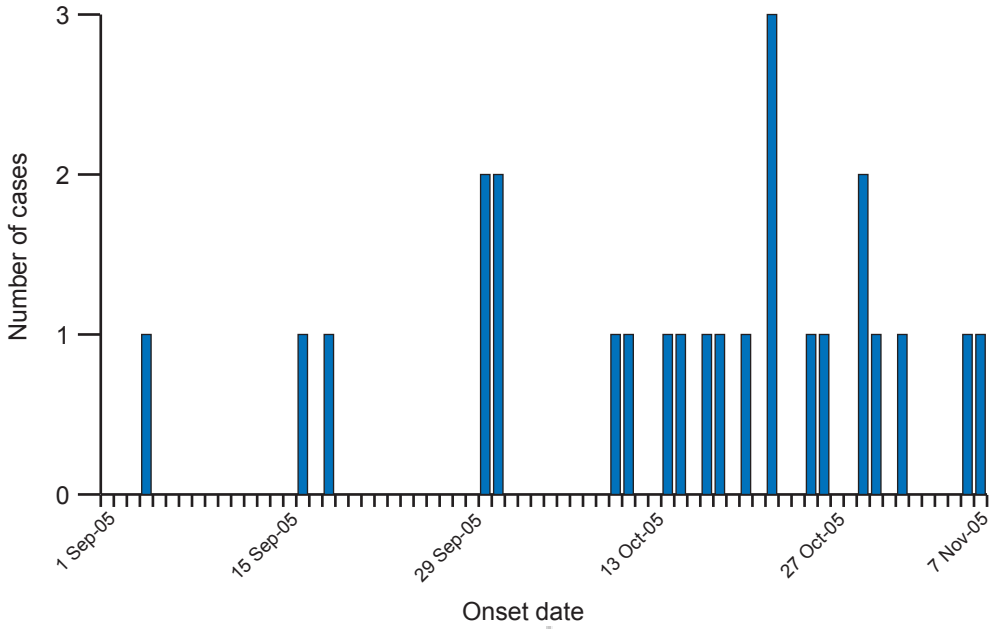
Increase in Vero cytotoxin-producing *Escherichia coli* O157 PT8 infections in England

Between 1 October and 15 November 2005 the Health Protection Agency Laboratory of Enteric Pathogens received 47 isolates of Vero cytotoxin-producing *E. coli* (VTEC) O157 phage type 8 (PT8) associated with human infection in England. This compares with 14 in the same period in 2004. Phage type 8 was the second most common phage type reported in 2004, accounting for 23% of all VTEC isolates (1).

Routine follow-up of cases revealed that 8 reported foreign travel, five were secondary cases and three were asymptomatic. Of the remaining 31 primary cases, 19 were aged under 20 years. Nineteen cases were female, nine male and three were sex unknown. The median age was 14 years (age range: 0 to 75 years). Onset dates were available for 25 cases and ranged from 4 September to 7 November 2005 (figure 1).

Figure 1 Cases of *E.coli* O157 PT8 infection in England by date of onset of illness (n=25)



Cases were distributed throughout England with reports from each NHS region. To date, no cases have been reported from Wales (figure 2). An Enter-net (2) message was issued on the 18 November 2005 and responses received do not indicate a corresponding increase in this phage type in other European countries.

Eight cases have been interviewed in depth to generate hypotheses about the source of infections. No single outlet, function, contact with animals or recreational water activity were identified. Pulsed field gel electrophoresis (PFGE) is being carried out on a selection of isolates to establish possible links between cases. Further investigations will be carried out to take into account the developing epidemiological and microbiological situation.

Figure 2 Geographical distribution of cases

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1.HPA. Vero cytotoxin-producing *Escherichia coli* O157: 2004. *Commun Dis Rep CDR Wkly* [serial online] 2005 [cited 23 November 2005]; **15**(28): enteric. Available at <http://www.hpa.org.uk/cdr/archives/2005/cdr2805.pdf>.

2.IST Fisher on behalf of the Enter-net participants. The Enter-net international surveillance network - how it works. Eurosurveillance [serial online] 1999 [cited 23 November 2005]; **4**(5). Available at <http://www.eurosurveillance.org/em/v04n05/0405-222.asp>.

Marburg haemorrhagic fever in Angola – outbreak declared over

On 7 November 2005, the Angolan health authorities announced that the outbreak of Marburg haemorrhagic fever that had killed hundreds in northern Angola since it began in October 2004 had been officially declared over (1).

The outbreak was confirmed as being caused by Marburg virus in March 2005 and was focused mainly in Uíge province, with a few cases occurring in other nearby provinces such as Cabinda, Luanda, Kuanza Norte, and Zaire (2). All of the cases reported, however, originated from, or were related to cases that had occurred in Uíge province. The epidemic peaked between 28 March and 3 April 2005; there have been no laboratory confirmation of new cases in the country since 27 July 2005. The final number of cases was 252, with 227 deaths, and 25 survivors, representing a case fatality rate (CFR) of 90%. Initial control of the outbreak was hampered by cultural differences between the medical teams and those who were affected by the outbreak, and also by civil unrest that has been occurring in the country over some years. This was overcome by recruiting local religious leaders, social experts, and anthropologists to join the teams with the World Health Organization, the Angolan Ministry of Health, Médecins San Frontières, and other non-governmental agencies, in order to assist with communication to, and education of those affected by the outbreak.

This is the largest outbreak of Marburg haemorrhagic fever reported to date. Previously, the largest outbreak had occurred in the Democratic Republic of the Congo between 1998 and 2000, when 149 cases and 123 deaths (CFR 83%) were reported (3). Despite intensive investigations extending over several years, research has failed to find an animal reservoir of the virus where it may occur between human outbreaks.

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2. Health Protection Agency. Marburg haemorrhagic fever in Angola – update. *Commun Dis Rep Wkly*

[serial online] 2005 [cited 21 November 2005]; **15**(14): News. Available at <http://www.hpa.org.uk/cdr/archives/archive05/News/news1405.htm#marburg>.
3. World Health Organization. Marburg virus disease in Angola – update. Disease Outbreak News [online] [cited 23 March 2005] Geneva: WHO, 2005. Available at <http://www.who.int/csr/don/2005_03_23/en/>.

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Immunisation

Laboratory reports of invasive meningococcal infections, England and Wales: weeks 31 to 35

	Method of diagnosis			Total reports	Cumulative*
	CSF and blood Culture	Non-culture	Other sites	31-35/05	Total to week 31/2005
Group A	–	–	–	–	**1**
B	28	31	8	67	**917**
C	1	–	–	1	**22**
W135	1	–	–	1	**20**
X	–	–	–	–	**–**
Y	1	–	1	2	**32**
Z	–	–	–	–	**–**
29E	–	–	–	–	**1**
Ungroupable	–	–	–	–	**–**
Ungrouped	–	1	–	1	**37**
Total	**31**	**32**	**9**	72	**1030**

Laboratory cases of pertusis infection, England and Wales

Table 1 Laboratory confirmed cases of pertussis infection England and Wales by age group: April to June 2005

Age Group	PCR and/or serology only	Culture	Total
<3 months	11	21	**32**
3-5 months	2	2	**4**
6-11 months	1	3	**4**
1-4 years	5	2	**7**
5-9 years	4	1	**5**
10-14 years	1	–	**1**
≥15 years	22	2	**24**
Not known	–	–	**–**

Total	**46**	**31**	**77**

*All data are provisional.

Since January 2002, infants ≤6 months of age with suspected pertussis have been offered PCR testing through the Health Protection Agency's Respiratory and Systemic Infecions Reference Laboratory (RSIL). Adults with a cough persisting for more than 21 days and children with a cough persisting for more than 14 days, have been offered serology testing through RSIL. These cases are likely to have been culture negative, and testing with PCR and/or serology have increased case ascertainment.

Table 2 Laboratory confirmed cases of pertussis infection England and Wales by age group*: January to March 2005

Quarter 2003	PCR and/or serology only	Culture	PCR/serology reports as a % of total	Total
Jan to Mar	39	45	46	**84**
Apr to Jun	46	31	60	**77**

*All data are provisional.

The apparent increase particularly in adult cases is explained by the availability of enhanced diagnostic methods, which have been increasingly used during the year, as illustrated by the increasing proportion of reports diagnosed by PCR and or serology.

Laboratory confirmed cases of measles, mumps and rubella, England and Wales: July to September 2005

Date presented here is for the third quarter of 2005 (July to September 2005). Cases include those confirmed by oral fluid IgM antibody tests and routine laboratory reports (tables 1 and 2). Analyses are by date of onset. Regional breakdown figures relate to Government Office Regions rather than regional health authorities (pre-April 2002 definitions) as used previously in this section. Quarterly figures for cases confirmed by oral fluid antibody detection only from 1995 are available from:

<http://www.hpa.org.uk/infections/topics_az/measles/data_not_confirmed.htm> ,
<http://www.hpa.org.uk/infections/topics_az/mumps/data_quarter.htm>
<http://www.hpa.org.uk/infections/topics_az/rubella/data_rub_not.htm>

and annual total numbers of confirmed cases by health region and age from:

<http://www.hpa.org.uk/infections/topics_az/measles/data_reg_age.htm>
<http://www.hpa.org.uk/infections/topics_az/mumps/data_reg_age.htm>
<http://www.hpa.org.uk/infections/topics_az/rubella/data_reg_age.htm>

Table 1 Total confirmed cases of measles, mumps, and rubella, and oral fluid IgM antibody tests in cases notified to ONS*: weeks 27-39/2005

	Cases			Oral fluid	IgM antibody	Results		
	Notified	Tested	Percentage tested	Total positive	Recently vaccinated	Confirmed	Other lab confirmed	Total confirmed cases
Measles	470	353	75.1	14	3	11	3	**14**
Rubella	250	177	70.8	–	–	–	9	**9**

*ONS = Office for National Statistics

Table 2 Total confirmed cases of mumps weeks 27-39/05

All aged excluding 15-24 year olds							15-24 year olds	All ages
	Oral fluid IgM antibody results							
Notified	Tested	Percentage tested (%)	Total positive	Recently vaccinated	Confirmed (a)	Other lab confirmed (b)	Notified, assumed confirmed (c)	Total confirmed (a+b+c)
3252	1536	47.2	603	2	601	277	4655	**5533**

As previously reported, the cohort at an increased risk of mumps because they have either received no measles, mumps, and rubella (MMR) vaccine, or only one dose were born between 1981 and 1990 (1). In 2004, the number of notified cases and the proportion of oral fluid samples tested and confirmed increased dramatically. The overall confirmation rate for the year was around 60% and over 75%, by far the majority, of those born between 1981 and 1986 (ie, aged between 18 and 23 years) were confirmed by IgM. False negative results can occur in a small proportion of cases particularly if the sample is taken early, and, therefore, it is likely that virtually all cases in this age range are genuine mumps (2). The Health Protection Agency (HPA), therefore, recommended at the beginning of February 2005 that, during this period of increased mumps incidence, oral fluid samples should not be taken from individuals with clinical mumps who were born between 1981 and 1986, and that they should be managed as if they were a confirmed case. Samples, however, should continue to be taken from cases in all other age groups or where it is clinically important to confirm the diagnosis (eg, where a complication has been observed) (2). As a result of these recommendations to limit testing temporarily, the number of laboratory confirmed cases in this age group will be artificially low and underestimate the true burden of infection. For the purpose of reporting, therefore, all notified cases of mumps in this age group are being counted as confirmed. The age group has been expanded to include the 15 to 24 years age group due to the manner in which notification data are aggregated (table 2).

Measles

Fourteen cases of confirmed measles with onset dates in the third quarter of 2005 were reported compared to twenty-three cases in the second quarter of 2005 (3). Twelve were children aged under 15 years (two aged under 1 year, five aged from 1 to 4 years; four aged from 5 to 9 years; and one aged 10 to 14 years). Two adults aged 16 and 27 years were also reported. One case had received a single dose of MMR vaccine, the remaining cases, with known vaccination status, had no documented history of vaccination with MMR.

Cases were reported from two regions of England; London (12) and the South East (2).. One case had a history of recent travel to Thailand and Japan, but there was no sample available for genotyping from this case. A health-care worker subsequently contracted measles from this case. The first case confirmed in London in this quarter was a nine year old with a history of recent travel but the destination is unknown. A B3 genotype was identified from this case. There was an outbreak of measles in a nursery in London. There were four confirmed cases, two in children aged under 1 year and two aged 1 year, which were confirmed by oral fluid testing. A B3 strain was identified from all four cases. A further four confirmed cases of measles with a B3 genotype were identified in London; two cases were siblings aged ten and eight years respectively. In addition a D4 genotype was identified from two cases in siblings also in London.

The small number of cases in this quarter and the variety of genotypes circulating is a good indicator that only limited indigenous measles transmission is currently occurring.

Mumps

Five thousand five hundred and thirty-three cases of mumps with onset dates in the third quarter of 2005 were either laboratory confirmed or assumed to be genuine mumps due to their age compared to 16,878 in the second quarter of 2005 (table 3) (3). The total number of mumps cases notified in this quarter decreased by 64% from 21,984 in the second quarter of this year to 7907. The number of cases reported decreased in all regions during this quarter. The largest decrease was seen in the North West with 2000 fewer cases reported compared to the second quarter (2738 to 738). The age group affected by the epidemic commonly attend universities and colleges and the fall in the number of cases in this quarter coincided with the educational institutes breaking up for the summer vacation. The start of the new academic year, however, has been followed by a small increase in the number of mumps cases notified each week.

Table 3 Confirmed cases of mumps by age group and region, England and Wales: weeks 27-39/05

	Age group								
Region	**<1y**	**1-4y**	**5-9y**	**10-14y**	**15-19y**	**20-24y**	**≥25y**	**NK**	**Total**
North East	1	–	3	11	246	148	44	3	**456**
North West	–	6	19	34	347	237	91	4	**738**
Yorkshire & the Humber	–	5	22	55	412	229	45	–	**768**
East Midlands	–	2	2	10	200	119	38	1	**372**
West Midlands	1	3	5	18	274	160	26	5	**492**
East of England	1	7	2	13	199	156	52	–	**430**
London	–	17	8	24	250	200	64	2	**565**
South East	3	1	5	22	287	189	65	–	**572**
South West	1	8	5	26	187	150	40	4	**421**
Wales	–	4	4	23	431	234	16	–	**712**
Not known	–	–	–	2	–	–	5	–	**7**
Total	**7**	**53**	**75**	**238**	**2833**	**1822**	**486**	**19**	**5533**

Rubella

Nine confirmed cases of rubella were reported in this quarter. All of the cases were reported by regional laboratories through the LabBase* reporting system. Three were in adult males (aged 21, 22, and 35 years), and one case was a 13 year old child. The remaining five cases were women of childbearing age (aged 18 to 30 years) although no information on their pregnancy status was reported through LabBase. Rubella remains a rare disease in England and Wales with only 14 (provisional) confirmed cases throughout 200

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3. HPA. Laboratory confirmed cases of measles, mumps and rubella, England and Wales: April to June 2005 *Commun Dis Rep CDR Wkly* [serial online] 2005 [cited 17 November 2005]; **15**(38): Immunisation. Available at <http://www.hpa.org.uk/cdr/archives/2005/cdr3805.pdf>.

*LabBase is the database that is used to collect laboratory reports of all micro-organisms isolated at nearly 400 NHS and other laboratories throughout England and Wales. The database is managed and accessed at the HPA Centre for Infections.

Enhanced surveillance of meningococcal disease: July to September 2005

In the third quarter of 2005 (July to September 2005), enhanced surveillance of meningococcal disease (ESMD)* identified 383 cases of invasive meningococcal disease in the nine English regions, Wales, and Northern Ireland. This is a decrease of 33% on the total of 573 in the previous quarter and a decrease of 9% on the total of 423 in the equivalent quarter of 2004. The London region reported the highest number of cases this quarter (59), although the highest rate was seen in Northern Ireland (table 1).

Table 1 Meningococcal disease by region: July to September 2005

Region	B	C	Other	Infection not confirmed	Total	Rate per 100,000*
North East	5	–	1	17	**23**	**0.90**
Yorkshire & the Humber	18	–	2	18	**38**	**0.75**
East Midlands	11	–	–	14	**25**	**0.58**
East of England	19	–	1	10	**30**	**0.55**
London	14	1	2	42	**59**	**0.79**
South East	8	–	2	24	**34**	**0.42**
South West	23	–	1	23	**47**	**0.93**
West Midlands	10	–	–	23	**33**	**0.62**
North West	21	–	2	35	**58**	**0.85**
Wales	11	–	–	9	**20**	**0.68**
Northern Ireland	11	–	–	5	**16**	**0.94**
Total	**151**	**1**	**11**	**220**	**383**	

*Rate calculated using mid 2004 ONS population statistics.

In England and Wales, a clinical diagnosis of invasive meningococcal disease was reported for 353 cases compared to 254 cases of meningitis and septicaemia officially notified to the Health Protection Agency Centre for Infections during the same period. This implies that approximately 72% of clinically diagnosed meningococcal disease is formally notified, although cross-checking to compare the identity of those notified to those reported in ESMD has not been carried out. Thus, under-notification may be even higher. The overall case fatality ratio (CFR) in cases identified in ESMD (in England, Wales, and Northern Ireland) with a clinical diagnosis of meningitis alone was 1 per 100 cases, whereas the CFR for cases with septicaemia alone was 7 per 100 cases (table 2). The case fatality ratio of confirmed meningococcal disease (all diagnoses) was 4 per 100 cases.

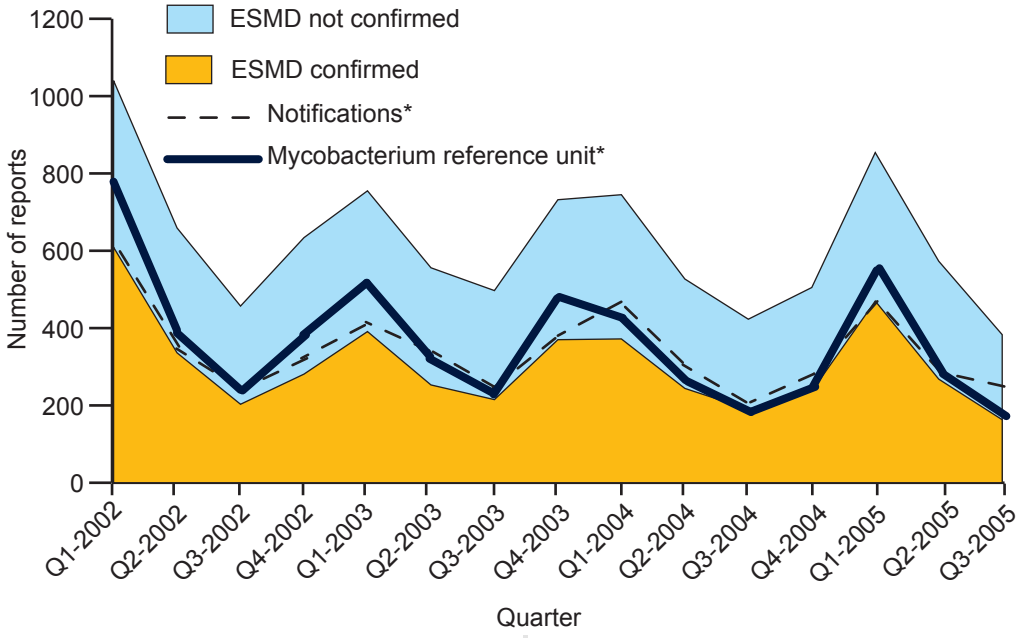
Table 2 Clinically diagnosed cases (deaths) of meningococcal disease: England, Wales, and Northern Ireland: July to September 2005

Region	Meningitis	Septicaemia	Meningitis & Septicaemia	Not meningitis or septicaemia	Total
North East	8	6	8	1	**23**
Yorkshire & the Humber	11	16(2)	11	–	**38(2)**
East Midlands	18(1)	4(2)	3(1)	–	**25(4)**
East of England	15(1)	7(1)	3	–	**25(2)**
London	24	21(1)	1	11	**57(1)**
South East	13	8(2)	10(1)	–	**31(3)**
South West	15	24	6	–	**45**
West Midlands	12	19(2)	1(1)	1	**33(3)**
North West	21	22	12	2	**57**

Wales	1	18(1)	–	–	**19(1)**
Northern Ireland	5	8	2	1	**16**
Total	**143(2)**	**153(11)**	**57(3)**	**16**	**369(16)**

One hundred and sixty-three of the 383 cases (43%) identified in ESMD were confirmed as *Neisseria meningitidis* infection, compared to 183 reports of laboratory confirmed meningococcal disease made to the Meningococcal Reference Unit (MRU) in the same period (figure 1). Matching has not yet been carried out between these two data sets.

Figure 1 Number of confirmed and unconfirmed reports made to ESMD compared to notifications and MRU: Jan 2002 to Sep 2005

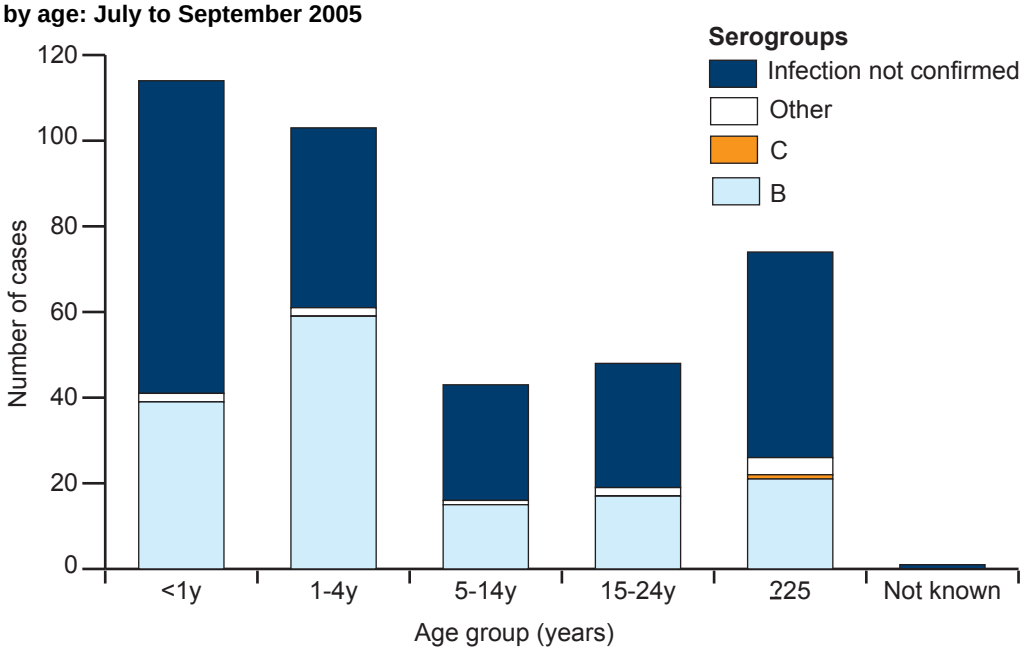


*Notifications and MRU do not contain data from Northern Ireland.

Serogroup B *N. meningitidis* was detected in 92.6% (151/163) of confirmed cases identified in ESMD, serogroup C in 0.6% (1/163) and the remaining 6.7% included other serogroups (11/163). The latter consisted predominantly of serogroup W135 (5/11) followed by, in no particular order, ungrouped (2/11), non-groupable (2/11), and serogroup Y (2/11).

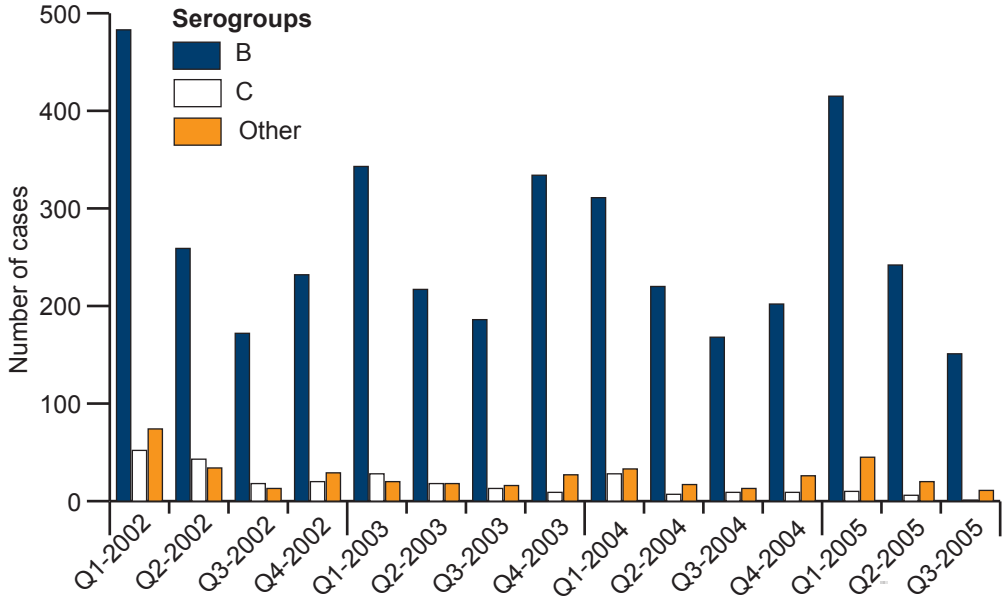
Sixty-three per cent of all confirmed cases were in children aged 5 years and under. Serogroup B accounted for 96% of these infections, serogroup W135 for 2% and non-groupable and ungrouped cases combined accounted for 2%. No serogroup C infections occurred in this age group of children (figure 2).

Figure 2 Serogroups of *N. meningitidis* identified in cases in England, Wales, and Northern Ireland by age: July to September 2005



Unlike last quarter, meningococcal disease attributed to serogroup B has decreased by 10% (151 cases compared to 168 in 2004) this quarter compared to the equivalent period in the previous year (figure 3). Similarly, other serogroups and unconfirmed cases of meningococcal disease have decreased by 15% (11 cases compared to 13 in 2004) and 6% (220 cases compared to 233 in 2004), respectively. The number of cases of serogroup C meningococcal disease continued to decrease (one case compared to nine cases in 2004) this quarter compared to the equivalent period in 2004.

Figure 3 Number of cases of meningococcal disease due to serogroups B, C and other serogroups: Jan 2002 to September 2005



Routine surveillance data have shown an increase of 18% in clinical notifications this quarter compared to the equivalent quarter last year (254 compared to 215 in 2004) , while laboratory reports have decreased by 8% (183 compared to 199 in 2004).

Footnotes

*Regional ESMD began on 1 January 1998 in five regions of England and was extended to include all English regions, Wales, and Northern Ireland from 1 January 1999. The national enhanced surveillance system relies upon consultants in communicable disease control (CCDC) reporting confirmed and probable cases of meningococcal disease occurring in their district each week. Data are collated at regional level and sent on to the Health Protection Agency, Centre for Infections, Immunisation Department each month. These data are subsequently published quarterly in *CDR Weekly*. Additionally, CCDCs are asked to report details of any clusters of meningococcal disease occurring in educational establishments.