

4 June 2008  
Volume 42 No. 2008/23  
ISSN 1753-4224 (Online)

## Contents

### CURRENT NOTES

- *ST398 MRSA infections in Scotland*
- *MRSA screening programme*
- *SIGN guideline on meningococcal disease*
- *Latex allergy: occupational aspects of management*
- *Food incidents report published*
- *Ozone pollution in the United Kingdom – Consultation*
- *Orphan Zoonoses – one-day conference*

pages 203 - 206

### NOTIFIABLE TABLES

to 23/5/2008

pages 207 - 208

## CURRENT NOTES

### ST398 MRSA infections in Scotland

**42/2301** MRSA isolates with the MLST type ST398 were reported from Holland (2004) to be associated with infections in pig farmers and to have been isolated from pigs. Subsequent reports have shown this strain to be associated with farm animals and people who work with them in other parts of Western Europe and, more recently, in Canada (2007). It has been suggested that ST398 is a pig-associated strain that can be transferred to humans and cause infections in them. There have been no previous reports of ST398 isolations in the UK from animals or humans.

In 2007, the Scottish MRSA Reference Laboratory received three isolates from humans which have been shown to be ST398. MLST is not carried out on all isolates but these three were typed by MLST because they were not typable by PFGE using the restriction enzyme *smaI* – a recognised characteristic of ST398 isolates. The three isolates were identical by antibiogram (resistant only to  $\beta$ -lactams), by SCCmec typing (type III), by spa typing (type t034) and by PFGE using the enzyme *apaI*. All the isolates were negative by PCR for the Panton-Valentine Leukocidin gene. They are not identical to the commonest types of ST398 isolates described from elsewhere but indistinguishable isolates have been reported from both Europe and Canada.

Two of the Scottish isolates were from specimens sent to diagnostic laboratories by GPs; both being from umbilical swabs from infants. The third was from an orthopaedic wound in a hospital in-patient at the Southern General Hospital in Glasgow. The isolates were distributed over a seven-month period. Both the babies had been born in the SGH. All three infections were treated successfully. Epidemiological investigations confirmed that the three patients had not been in the hospital at the same time and no connections with pigs or pig farming were discovered. Further investigations discovered no obvious link between the three patients.

A single environmental MRSA isolate from the SGH discovered in December 2006 (as part of a research project unrelated to these cases) turned out to be an ST398 indistinguishable from the three patient isolates. It had been isolated from a part of the hospital unlikely to have been visited by any of the three patients.

Diagnostic Laboratories are requested to send all MRSA isolates with unusual antibiograms to the Scottish MRSA Reference Laboratory in accordance with the current referral procedure. [Source: Giles Edwards, Scottish MRSA Reference Laboratory, Stobhill Hospital, Glasgow G21 3UW, UK]

### MRSA screening programme

**42/2302** Further to *Current note* 42/1303, the pilot project to screen patients for MRSA before admission to hospital was officially launched on 2 June.

From this summer, all non-emergency admissions to hospital in three NHS board areas will be screened for MRSA as part of the pre-admission procedures.

If the pilot is successful in the pathfinder areas - NHS Ayrshire and Arran, NHS Western Isles and NHS Grampian - screening will be rolled out across the NHS in Scotland from 2009-10.

The pilot is expected to cost around £5.2 million.

An interim report on the MRSA pilot project is due by March 31, 2009. This report will determine the shape of the national programme which is due to start in 2009-10. [Source: Scottish Government News Release, 2 June 2008. <http://www.scotland.gov.uk/News/Releases/2008/06/02091748>]

### SIGN guideline on meningococcal disease

**42/2303** A new guideline published on 28 May argues that early diagnosis of invasive meningococcal disease (IMD) is the key to saving the lives of children and young people who contract the disease. The new guideline from the Scottish Intercollegiate Guidelines Network (SIGN) - part of NHS

Correspondence to:  
The Editor,  
*HPS Weekly Report*  
HPS,  
Clifton House, Clifton Place  
Glasgow, G3 7LN  
Scotland

T 0141-300 1100  
F 0141-300 1172

E [wreditor@hps.scot.nhs.uk](mailto:wreditor@hps.scot.nhs.uk)  
<http://www.eur.hps.scot.nhs.uk/>

Printed in the UK  
HPS is a division of the NHS  
National Services Scotland  
Registered as a newspaper at  
the Post Office © HPS 2008

Quality Improvement Scotland (NHS QIS) - is seen as the most comprehensive review to date of the evidence on how best to diagnose and treat IMD.

The meningococcal organism can cause both meningitis and septicaemia and is still a significant cause of mortality in children and young people. Although the incidence of IMD has fallen to between 140 and 160 cases in Scotland each year, between 2.6-10% of those who contract the disease each year die. Most deaths occur within the first 24 hours, frequently before the patient receives specialist care. This poses a challenge to those in the healthcare system to identify children and young people who will rapidly progress from early symptoms to a life-threatening state. The particular geography and population distribution in Scotland - combined with the rapid onset and progression of the disease - required the development of a guideline that ensured the most effective treatment delivered within the context of the Scottish Health Service.

Key aspects of the guideline are as follows:

- In primary care, the challenge is discriminating the few children with early meningococcal disease from the many with other less harmful viral illnesses. A flowchart is included to facilitate early management.
- Effective communication between primary, secondary and paediatric intensive care is vital to ensure rapid escalation of treatment in the early phase of invasive meningococcal disease. The guideline development group believes that the importance of these organisational aspects cannot be overestimated.
- Corticosteroids are not recommended for the treatment of children with meningococcal septicaemia, with the notable exception of steroid dose titration as rescue treatment in particular circumstances.
- Early treatment includes the administration of antibiotics as soon as meningococcal disease is suspected, and early assessment and supervision by senior clinicians.
- Severe cases will require significant resuscitation, including intravenous fluids and the capacity to support ventilation and blood pressure.
- Corticosteroids are recommended for the treatment of children with meningitis, but not with meningococcal septicaemia.

The guideline focuses on the following areas:

- Early assessment and treatment of the condition
- Hospital care
- Prevention of secondary transmission
- Follow-up care.

The SIGN guideline *Management of invasive meningococcal disease in children and young people* can be accessed at <http://www.sign.ac.uk/guidelines/fulltext/102/index.html>.

The number of cases of IMD is monitored by the HPS Meningococcal Invasive Disease Augmented Surveillance (MIDAS) scheme. Since 2000 the incidence of IMD has reduced to between 140 -160 new IMD cases each year. A number of factors including increased awareness, public health measures, early resuscitation, improved resuscitation techniques, advances in critical care, surgical interventions and investment in rehabilitation are likely to have contributed to improvements in outcome. [Source: SIGN Press Release, 28 May 2008. <http://www.sign.ac.uk/about/press/pr28-5-08.html>]

### **Latex allergy: occupational aspects of management**

**42/2304** National Health Service (NHS) Plus has released some evidence-based guidance on occupational aspects of latex allergy management.

The key findings from the evidence and recommendations made are as follows:

- the use of powder-free, low protein latex gloves as an alternative to powdered latex gloves significantly reduces the incidence of latex allergy and latex-induced asthma, as well as the prevalence of latex-related symptoms. Powdered latex gloves should therefore not be used in the workplace
- at a national and local level, a policy that encourages switching from powdered latex gloves to powder-free low protein latex gloves is a proven effective method of reducing the incidence of latex allergy
- employees with latex allergy, latex sensitivity or latex-induced asthma should use non-latex gloves.
- in employees who are latex allergic/sensitised, taking latex avoidance measures results in cessation or diminution of symptoms. Markers of sensitisation decrease regardless of whether co-workers continue to use powder-free low protein latex gloves or latex-free gloves

- in employees with latex-induced asthma or rhinitis, the use of powder-free low protein gloves by their colleagues reduces symptoms and indices of severity in the affected employee to a similar degree as the use of non-latex gloves by colleagues
- all but the most severe cases of latex allergy and latex-induced asthma can be managed without the need for redeployment, ill health retirement or termination of employment. Adjustments include careful personal avoidance of latex at work and minor changes in the workplace
- there is a lack of published primary research comparing occupational interventions for those who are sensitised to latex (without symptoms), with those with clinical latex allergy
- no reports of new cases of latex allergy arising from non-powdered low protein latex glove use were found.

It is noted that, therefore, the evidence does not support a complete ban on the use of latex gloves. Rather, institutions are advised to judge whether their needs would be met better by the use of latex-free or powder-free latex gloves, or use of both in different settings, while taking into account the desirable and undesirable properties of both materials.

The information can be accessed via the HSE's website at: <http://www.hse.gov.uk/news/2008/05/21/latex-allergy-occupational-aspects-of-management/>.

### Food incidents report published

**42/2305** On 30 May, the Food Standards Agency (FSA) published its second *Annual Report of Incidents (2007)*. The new report shows how many food incidents the Agency handled in 2007 and what action was taken to protect consumers.

New data in the report indicates that the Agency handled 1,312 investigations into food incidents in 2007, including the high profile bird flu outbreaks in East Anglia and the grounding of the MCS Napoli container ship off the south coast.

The FSA issued wide ranging advice to consumers from advising that the foot and mouth outbreak in Surrey had no impact for the human food chain to reminding people that Zam Zam water of uncertain origin should not be consumed due to potential contamination with arsenic.

The report gives an overview of the work done by the Agency during 2007 and shows how it works with the food industry and enforcement partners in local authorities to ensure that potentially harmful food is removed from sale and that consumers are advised as necessary.

It also gives a breakdown of all the major categories of incidents in 2007. These categories include: environmental contamination (fires spills and leaks); natural chemical contamination (mycotoxins, algal toxins and others); microbiological incidents; and on-farm incidents.

As a part of the FSA's work to make it easier to report incidents, an enhanced online incident report form was launched last year. The new form makes it easier for food and feed businesses to notify the Agency of product recalls or withdrawals. The Agency is also developing workshops for local authorities and industry to encourage them to use the Agency and its systems to help deal with any problems.

The report can be found at <http://www.food.gov.uk/multimedia/pdfs/incidents07.pdf>. [Source: FSA Press Release, 30 May 2008. <http://www.food.gov.uk/news/newsarchive/2008/may/incidents07>]

### Ozone pollution in the United Kingdom – Consultation

**42/2306** The Department for Environment, Food and Rural Affairs (Defra) is inviting views on the fifth report of the Air Quality Expert Group (AQEG). The report investigates the recent historic trends, current status and likely future changes to tropospheric ozone concentrations in the UK. The main focus is on human exposure to ozone pollution, particularly in urban areas. AQEG has also considered trends and changes to ozone precursor emissions on European and global scales.

The report is published in draft to allow expert comment before the group reaches its final conclusions. The report aims to address the key policy-related questions put to AQEG by Defra and the devolved administrations.

Technical comments on the report must be submitted by 6 August 2008 to: Air and Environment Quality Division, Defra, Area 3C, Ergon House, 17 Smith Square, London SW1P 3JR (email: [tim.williamson@defra.gsi.gov.uk](mailto:tim.williamson@defra.gsi.gov.uk)).

Copies of the AQEG report can be accessed on the Defra website at: <http://www.defra.gov.uk/corporate/consult/ozone2008/consultation.pdf>.

A copy of the consultation letter and other supporting documents can be found at: <http://www.defra.gov.uk/corporate/consult/ozone2008/index.htm>.

### Orphan Zoonoses – one-day conference

**42/2307** A one day conference is being jointly held by the Scottish Zoonoses Group and the Human Animal Infections and Risk Surveillance group and will include a range of presentations on subjects such as:

- New and emerging zoonoses: risk assessment process
- Cats and zoonoses: animal and human aspects
- *Corynebacterium ulcerans*: animal and human aspects
- Q fever: animal and human aspects and recent outbreaks
- Fascioliasis in animals and humans
- Zoonoses in fish and shellfish
- European Bat Lyssavirus in the UK

For more information please contact: Michelle Clark - Courses and Conference Administrator (tel: 0141 300 1943; email: [coursesandconferences@hps.scot.nhs.uk](mailto:coursesandconferences@hps.scot.nhs.uk)) Health Protection Scotland, Clifton House, Clifton Place, Glasgow G3 7LN.

CPD Approval has been requested and the registration fee is £55 (inc VAT). The closing date for applications is Friday 26 September 2008.

Statutory Notification of Infectious Diseases (by age)  
Week ended 23 May 2008

A National Statistics release

Infectious Disease	Age Group																			
	All ages		Under 1		1 - 4		5 - 14		15 - 24		25 - 34		35 - 44		45 - 64		65 & over		Not known	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Anthrax	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Bacillary dysentery	3	4	1	-	-	1	-	2	-	-	1	-	-	1	-	-	1	-	-	-
Chickenpox	166	161	14	9	98	107	35	32	3	5	3	1	4	2	-	1	1	8	3	
Cholera	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Diphtheria	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Erysipelas	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Food poisoning	86	78	4	-	10	4	4	7	11	7	11	7	14	15	23	27	9	11	-	-
Legionellosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Leptospirosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Lyme Disease	2	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	1	-	-
Malaria	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Measles	1	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
Meningococcal infection	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
Mumps	10	5	-	-	1	-	1	1	4	2	3	1	1	1	-	-	-	-	-	-
Paratyphoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Plague	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Poliomyelitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Puerperal fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rabies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Relapsing fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rubella	-	2	-	-	-	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-
Scarlet fever	12	16	1	-	7	3	3	8	-	-	-	2	1	2	-	1	-	-	-	-
Smallpox	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tetanus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxoplasmosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuberculosis: resp.	6	2	-	-	-	-	-	-	1	-	1	1	-	-	2	-	2	1	-	-
Tuberculosis: non-resp.	1	2	-	-	-	-	-	-	-	-	-	1	-	-	1	-	1	-	-	-
Typhoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Typhus fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Viral haemorrhagic fevers	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Viral hepatitis	10	8	-	-	-	-	-	-	1	4	3	-	4	4	1	-	1	-	-	-
Whooping cough	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
<b>TOTAL</b>	<b>298</b>	<b>280</b>	<b>20</b>	<b>10</b>	<b>116</b>	<b>116</b>	<b>43</b>	<b>51</b>	<b>20</b>	<b>18</b>	<b>22</b>	<b>13</b>	<b>25</b>	<b>25</b>	<b>26</b>	<b>30</b>	<b>16</b>	<b>14</b>	<b>10</b>	<b>3</b>

## Statutory Notification of Infectious Diseases (by NHS board)

### Week ended 23 May 2008

Infectious Disease	NHS BOARD AREA														Current week	Previous week	Current week last year	Total from 1st week of year	
	AA	BR	DG	FF	FV	GR	GG	HG	LN	LO	OR	SH	TY	WI				2007	2008
Anthrax	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Bacillary dysentery	-	-	-	-	-	-	2	-	-	4	-	-	1	-	7	-	1	55	36
Chickenpox	18	12	43	30	14	42	61	12	57	-	-	-	38	327	350	455	11480	4858	
Cholera	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6	2	
Continued fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Diphtheria	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Erysipelas	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6	11	
Food poisoning	9	9	3	9	13	19	28	7	22	28	-	3	14	164	155	159	2005	2092	
Legionellosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	5	9	
Leptospirosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	
Lyme Disease	-	-	-	-	-	-	-	2	-	-	-	-	1	3	-	3	43	33	
Malaria	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	2	8	
Measles	-	-	-	-	-	-	-	1	1	-	-	-	-	2	2	4	79	136	
Meningococcal infection	-	-	-	-	-	-	-	-	-	1	-	-	-	1	2	1	75	49	
Mumps	2	-	-	1	2	-	6	-	1	-	-	-	3	15	14	75	1736	389	
Paratyphoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	
Plague	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Poliomyelitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Puerperal fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Rabies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Relapsing fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Rubella	-	-	-	-	-	1	-	-	1	-	-	-	-	2	3	10	65	37	
Scarlet fever	1	-	-	2	6	2	13	3	1	-	-	-	-	28	28	2	159	549	
Smallpox	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Tetanus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Toxoplasmosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Tuberculosis : resp.	-	-	-	-	1	-	-	-	6	-	-	-	1	8	2	6	90	98	
Tuberculosis : non-resp.	1	-	-	-	-	-	-	-	1	-	-	-	1	3	1	1	40	32	
Typhoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	
Typhus fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Viral haemorrhagic fevers	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Viral hepatitis	-	-	1	1	-	-	-	1	4	-	-	-	11	18	10	13	476	595	
Whooping cough	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4	2	37	35	
<b>TOTAL</b>	<b>31</b>	<b>21</b>	<b>47</b>	<b>43</b>	<b>36</b>	<b>64</b>	<b>110</b>	<b>26</b>	<b>94</b>	<b>33</b>	<b>-</b>	<b>3</b>	<b>70</b>	<b>578</b>	<b>572</b>	<b>733</b>	<b>16361</b>	<b>8972</b>	

Source: Health Protection Scotland, NHS National Services Scotland

Amendments: add 3 Food poisoning (GR 1 x wk 16 2008, DG 1 x wk 18 2008, FV 1 x wk 20 2008); 5 Scarlet fever (DG 1 x wk 3 2008, 1 x wk 11 2008, 1 x wk 13 2008, 2 x wk 16 2008); 162 Viral hepatitis (GG 1 x wk 2 2008, 36 wk 7 2008, 43 x wk 10 2008, 36 x 13 2008, 9 x wk 15 2008, 2 x wk 17 2008, 31 x wk 18 2008, LN 4 x wk 20 2008) delete 2 Tuberculosis : respiratory (GR 1 x wk 8 2007, GR 1 wk 17 2007); 1 Mumps (GR 1 wk 20 2008); 149 Viral hepatitis (GG 1 x wk 1 2008, 44 x wk 3 2008, 8 x wk 4 2008, 21 x wk 5 2008, 12 x wk 8 2008, 12 x wk 9 2008, 18 x wk 11 2008, 5 x wk 12 2008, 7 x wk 14 2008, 21 x wk 16 2008); 1 Whooping cough (GR 1 x wk 7 2008)

## NHS BOARD ABBREVIATIONS

AA Ayrshire & Arran  
BR Borders  
DG Dumfries & Galloway

GG Greater Glasgow & Clyde  
FF Fife  
FV Forth Valley

LN Lanarkshire  
GR Grampian  
HG Highland

SH Shetland  
LO Lothian  
OR Orkney

TY Tayside  
WI Western Isles