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CURRENT NOTES

Legionnaires' disease outbreak in Calpe, Spain

46/0601 On 6 February, the European Centre for Disease Prevention and Control (ECDC) issued a rapid risk assessment (at http://ecdc.europa.eu/en/publications/Publications/Forms/ECDC_DispForm.aspx?ID=810) concerning the cluster of travel-associated Legionnaires' disease which has occurred over a two-month period in a hotel in Calpe, Spain.

Since 16 December 2011, 13 cases of travel-associated Legionnaires' disease (TALD) including three deaths have been notified to the ELDSNet Surveillance Network. All cases are associated with one hotel in the town of Calpe, in the province of Valencia, Spain, between 25 November 2011 (first arrival) and 31 January 2012 (last departure). In addition, three hotel staff have presented with Legionnaires' disease.

The TALD cases are mainly residents from the United Kingdom (12 cases), and Spain (one case). The average age of the cases is 74 years (min 44-max 89) and the gender distribution is seven males / six females. The hotel was closed on 2 February. Guests from the UK who stayed in the hotel prior to its closure have been informed about the symptoms of Legionnaires' disease, and an alert has been issued to clinicians in the UK asking them to consider Legionnaires' disease in cases of pneumonia with recent travel to this area. Local hospitals and general practitioners in the area have also been alerted to support case-finding.

Legionnaires' disease is a potentially fatal infectious disease which tends to be under-diagnosed and under-reported. Early treatment of patients is important and health care providers should be reminded to consider this disease when ascertaining patients presenting with pneumonia, to enquire about recent travel, and to notify the relevant public health authorities of their country. [Source: ECDC News Release, 6 February 2012. <http://ecdc.europa.eu/en/press/news/Pages/News.aspx>]

Outbreak of Salmonella Newport

46/0602 HPS is investigating five cases of *Salmonella* Newport infection in Scotland as part of the investigation of a UK-wide outbreak. HPS is coordinating investigations with the Food Standards Agency and Health Protection Agency, which has seen an additional 30 cases across the rest of the UK since December 2011. Cases of *Salmonella* Newport infection caused by the same strain have also been found in the Republic of Ireland and Germany.

Infection with *Salmonella* Newport causes a similar illness to other forms of *Salmonella* infection and symptoms include diarrhoea, vomiting, abdominal pain and fever. As with other strains, most cases resolve within four to seven days.

Four of the five cases in Scotland were in patients aged under six years old, with the fifth case occurring in an adult. None of the Scottish cases have reported needing hospital treatment. No new cases have been reported in Scotland since the first week in January. Investigations into the source of the infections are continuing. [Source: HPS News Release, 2 February 2012. <http://www.documents.hps.scot.nhs.uk/news/salmonella-newport-2010-02-02.pdf>]

Although the cause of infection has not been conclusively identified, a potential link to watermelons has been identified.

One person, who also had serious underlying health complications, has died in the outbreak. The outbreak was first detected in early December 2011 and the most recently reported illness was at the end of that month. [Source: FSA Press Release, 2 February 2012. <http://www.food.gov.uk/news/newsarchive/2012/feb/salnew>]

Current situation with immunoglobulin products (Scotland)

46/0603 The Scottish National Blood Transfusion Service (SNBTS) has informed HPS that there are current issues with the supply of certain immunoglobulins from Bio Products Laboratory (BPL):

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- Human Tetanus Immunoglobulin (250iu/vial). Neither SNBTS nor BPL have any specific tetanus immunoglobulin (TIG) in stock so Human Normal Immunoglobulin (HNIG) for sub-cutaneous use (Subgam) should be used as an alternative. BPL are hopeful that TIG will be available within a fortnight:
 - Subgam may be administered for prophylaxis in an individual with a tetanus prone wound. This is a licensed product, although not specifically licensed for this indication. The volume of Subgam required to achieve the recommended dose of 250iu will be approximately 5mls.
 - HNIG for intravenous use (Vigam) may be used as an alternative to TIG for treatment of clinical tetanus. The volume of Vigam required to achieve the recommended treatment dose of 5,000-10,000 iu will be approximately 250 to 500mls. This product is held by Gartnavel General Blood Bank.
- Human Hepatitis B immunoglobulin (500iu/vial). SNBTS and BPL have product available but it expires at the end of February 2012. BPL is working with the Medicines and Healthcare Regulatory Agency (MHRA) to put an extension of six months on this batch as they do not have another batch near completion at the moment. The extension will only apply to stock which is held at BPL. This stock will be re-labelled and sent out once agreed with the MHRA.
- Human Anti-D immunoglobulin (D-Gam 250iu). BPL will have none of this product available until the beginning of April 2012. SNBTS currently have three months supply so this should not cause any problems.
- Human Anti-D immunoglobulin (D-Gam 500iu). BPL is currently out of stock but has a batch being released next week. Currently SNBTS has one months supply of this product and will replenish when the BPL stock is released (returning to three months supply).

EFSA work on Schmallenberg virus

46/0604 Further to *Current note* 46/0103 (at <http://www.hps.scot.nhs.uk/ewr/redirect.aspx?id=50158>) the European Food Safety Authority (EFSA) has been asked by the European Commission to provide urgent scientific and technical assistance concerning possible risks resulting from the ‘Schmallenberg’ virus.

The Schmallenberg virus that affects mainly sheep but also cattle and goats can result in birth defects. Named after the German town where it was first identified, the Schmallenberg virus, which belongs to a vector-transmitted group of viruses, was found in Europe in the second half of 2011, and to date has infected animals in Belgium, France, Germany, the Netherlands and the United Kingdom.

In the short-term, EFSA will provide the European Commission and member states with likely scenarios on how the virus could manifest itself in animals in the coming months. EFSA will also work together with member states to ensure that the epidemiological data can be used to maximum effect through the provision of guidance. Periodical reports will be shared on the status and analysis of the data collected. Once the data have been collected, EFSA will provide an overall assessment of the impact of the Schmallenberg virus infection on animal health, animal production and animal welfare together with a state-of-the-art review on what is known about the virus.

In December 2011 the European Centre for Disease Prevention and Control (ECDC) carried out a preliminary assessment on the possible animal to human transmission risks of the new virus which concluded that ‘it is unlikely that this virus can cause disease in humans, but it cannot be completely excluded at this stage’. In light of these findings, EFSA is liaising closely with ECDC and will address areas of concern for human health, should these arise. [Source: EFSA News Story, 31 January. <http://www.efsa.europa.eu/en/press/news/120131.htm>]

Defra’s Animal Health and Veterinary Laboratories Agency (AHVLA) has announced the completion of testing of the latest samples received as a result of heightened vigilance for this new disease. Schmallenberg virus has now been identified in 11 submissions across the counties of Norfolk, Suffolk, Essex, Kent and East Sussex. These counties are in the area already identified as potentially at risk from infected midges being blown across the Channel from affected areas in Europe. The agency therefore suspects this to be the most likely cause of transmission.

As surveillance continues and the lambing season progresses, further cases are to be expected. [Source: AHVLA News Release, 31 January 2012. <http://www.defra.gov.uk/ahvla/news/>]

UK Climate Change Risk Assessment

46/0605 On 26 January, Defra published the *Climate Change Risk Assessment (CCRA)* which highlights the top 100 challenges to the UK of a changing climate and provides compelling evidence of the need to increase resilience.

In order to provide a reliable baseline for decisions by the UK and devolved governments, local authorities and businesses’ the research does not take into account any future policies or plans. However, a Government report published alongside the CCRA does highlight the many current and future policies already in place and gives details of plans which will address some of the risks identified.

The Government has also today announced a National Adaptation Programme that will prepare the UK for the effects of climate change, including the risks set out in the CCRA. People are encouraged to give their views through a new website on the action

needed to tackle the implications of climate change where they live and work. [Source: Defra News Release, 26 January 2012. <http://www.defra.gov.uk/news/2012/01/26/climate-change-risk-assessment/>]

The type, magnitude and urgency of climate change risks vary across the UK. As much policy relevant to adaptation is devolved, the devolved governments are developing their own adaptation strategies (a process to which HPS is contributing). The Climate Change (Scotland) Act 2009 puts in place parallel arrangements to those set out in the UK Climate Change Act. Specifically, the Scottish Act requires a Scottish Adaptation Programme to be developed to address the risks identified in the CCRA for Scotland.

This will be the first Scottish Adaptation Programme covering a period of five years (2013-2018) and a new Programme will be developed every five years, following each new CCRA.

MHRA alert on butterbur herbal products

46/0606 Medicines and Healthcare products Regulatory Agency (MHRA) is aware that herbal products containing butterbur (*Petasites hybridus*) are being marketed in the UK and has issued a letter to the UK herbal industry asking them to remove these products from sale. Anyone using the product is advised to stop immediately and, if concerned, to consult their GP or pharmacist.

Butterbur is most commonly used to treat migraine and hayfever and contains pyrrolizidine alkaloids (PAs) which studies have shown can result in serious liver damage and organ failure.

There are no products containing butterbur licensed for use in the UK under the Traditional Herbal Registration scheme and the sale of butterbur is prohibited or restricted in a number of other European countries. There have been no adverse drug reactions reported in the UK but cases of liver toxicity have been linked with these products in Europe.

Products with a traditional herbal registration can be identified by a THR number on their label. A product with a THR has been assessed by the MHRA so that consumers can be confident that its quality can be assured and that it is accompanied by the necessary information about how to use the product safely. [Source: MHRA Press Release, 1 February 2011. <http://www.mhra.gov.uk/NewsCentre/Pressreleases/CON143514>]

Mercury in skin lightening products

46/0607 The WHO has recently issued an information sheet drawing attention to the fact that mercury is still a common ingredient in skin lightening soaps and creams. It is also found in other cosmetics, such as eye makeup cleansing products and mascara. Skin lightening soaps and creams are commonly used in certain African and Asian nations. They are also used among dark-skinned populations in Europe and North America. Mercury salts inhibit the formation of melanin, resulting in a lighter skin tone.

Mercury in cosmetics exists in two forms: inorganic and organic. Inorganic mercury (e.g. ammoniated mercury) is used in skin lightening soaps and creams. Organic mercury compounds (thiomersal [ethyl mercury] and phenyl mercuric salts) are used as cosmetic preservatives in eye makeup cleansing products and mascara.

The WHO is stressing the following points:

- mercury-containing skin lightening products are hazardous to health and as a result have been banned in many countries. However, there are reports of such products still being available to consumers, and they are advertised on the Internet. The Texas Department of State Health Services reported the availability of a mercury-containing beauty cream on 1 September 2011.
- public awareness needs to be raised regarding the types of products and the specific products that contain mercury and the risks associated with mercury exposure.
- a 2011 survey found that ‘Consumers gravitated to known mercury-free choices in countries that had government seals and/or regulation about mercury content.’
- information on alternatives must also be provided, because skin lightening products that do not contain mercury may contain other hazardous substances.

Further WHO information on mercury is available at http://www.who.int/ipcs/assessment/public_health/mercury/en/index.html.

Surveillance of known hepatitis C antibody positive cases in Scotland: Results to 30 September 2011

Prepared by: Allan McLeod, Sharon Hutchinson and David Goldberg

In Scotland

During July to September 2011, 514 new cases of hepatitis C antibody-positivity were diagnosed.

- This figure compares with 544 and 584 for the third quarter of 2009 and 2010, respectively.
- 37% (188) resided in the Greater Glasgow and Clyde NHS Board area.
- 65% (336) were male and 33% (171) female.
- 51% (262) are known to have injected drugs, representing 93% of those with a known risk factor.
- At the time of diagnosis, 21% (108) were aged 20-29 years, 38% (195) were aged 30-39 years, 26% (135) were aged 40-49 years, 9% (44) were aged 50-59 years and 5% (24) were aged over 60 years.
- 20% (100) were known to have been diagnosed in specialist drug services, where dry blood spot testing for hepatitis C was introduced in 2009*.
- 21% (108) were diagnosed by general practitioners, while 19% (97) were diagnosed in the hospital setting (including infectious disease and gastroenterology units). Source of referral was not known in 30% (152) of cases.

A total of 30934 cases of hepatitis C antibody-positivity had been diagnosed as at 30 September 2011.

- 67% (20768) are male and 32% (9848) female; gender was not known in 1% (318) of cases.
- 57% (17733) are known to have injected drugs, representing 90% of those with a known risk factor, while 1% (361) of all cases were associated with the receipt of blood factor.** For the 5% (1662) who were placed in the 'Other' category, risk information such as 'blood transfusion', 'sexual intercourse' and 'tattoo' were indicated.
- At the time of diagnosis, 34% (10645) were aged 20-29 years, 36% (11061) were aged 30-39 years, 17% (5163) were aged 40-49 years, 6% (1729) were aged 50-59 years and 3% (1013) were aged over 60 years. Age was not known in 1% (344) of cases.
- 41% (12567) of cases resided in the Greater Glasgow and Clyde NHS Board area, 14% (4330) in Lothian, 11% (3377) in Grampian, 8% (2362) in Tayside, 7% (2104) in Lanarkshire, 6% (1944) in Ayrshire & Arran and 6% (1397) in Forth Valley.
- Source of referral was known in 78% (24218) of cases. Of these, 35% (8376) were diagnosed in the hospital setting (including infectious disease and gastroenterology units), 29% (6977) by general practitioners, 8% (1848) in prisons, and 8% (1814) in genito-urinary medicine clinics.
- 33% (10246) were known to have had a genotype test for hepatitis C. Of these, 49% (5046) were genotype 1, 5% (504) were genotype 2, 45% (4619) were genotype 3, and less than 1% were genotype 4 (69) and genotype 5 (8).

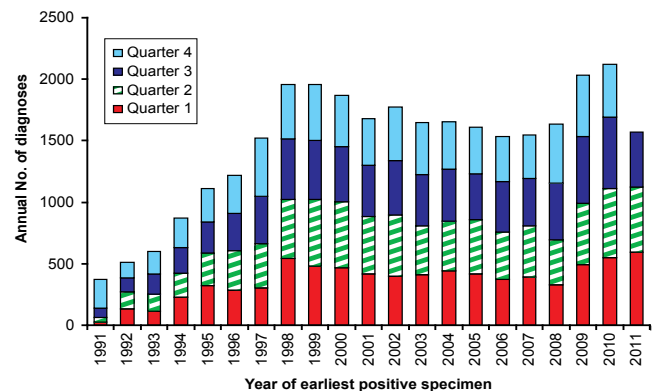
- 14% (4196) of cases were known to have died, as at 31 December 2010.
- Of the 26738 cases not known to have died, 8% (2156) were aged 20-29 years, 35% (9265) were aged 30-39 years, 35% (9346) were aged 40-49 years, 13% (3584) were aged 50-59 years and 5% (1332) were aged over 60 years as at 30 September 2011. Age was not known in 1% (344) of cases.

As at 30 September 2011, approximately 0.8% (25726/3163498) of Scotland's population aged 15-59 years had been diagnosed hepatitis C antibody-positive.

* Diagnoses made on dry blood spot samples were confirmed at NHS testing laboratories.

** Persons who acquired their hepatitis C infection in Scotland through blood factor will have become infected prior to the time, in the mid 1980s, when heat treatment was introduced to prevent bloodborne infection (see tables 2 and 3).

FIGURE 1: Persons in Scotland reported to be hepatitis C antibody positive by year and quarter of earliest positive specimen; to 30 September 2011



Methods

For details of methods see *SCIEH Weekly Report* vol.33 no.99/29. (<http://www.documents.hps.scot.nhs.uk/ewr/pdf1999/9929.pdf>).

In collaboration with the Scottish National Blood Transfusion Service (SNBTS), records of hepatitis C antibody positive cases diagnosed through their screening programme have been added to the national surveillance database.

Principal Investigators

The following are the principal investigators:

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Co-workers

We are very grateful to the following staff who have put an enormous amount of effort into collecting and collating the data:

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5. Lanarkshire HIV/AIDS and Hepatitis Centre, Monklands District General Hospital, NHS Lanarkshire
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Support

The work is supported by the Scottish Government Health and Wellbeing Directorate.

TABLE 1: Persons in Scotland reported to be hepatitis C antibody positive; Number and rate/100000 population¹ by NHS board and year of earliest positive specimen to 30 September 2011.

NHS board		2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 (to 30 Sept)	Total ²
Ayrshire & Arran	Number	101	133	146	124	105	131	99	129	145	182	106	1944
	Rate/100000	27.4	36.2	39.8	33.7	28.5	35.7	27.0	35.3	39.5	49.6		
Borders	Number	11	11	11	12	10	16	17	19	17	16	24	255
	Rate/100000	10.3	10.2	10.2	11.0	9.1	14.5	15.3	17.1	15.1	14.2		
Dumfries & Galloway	Number	78	50	49	51	66	48	44	54	53	58	22	768
	Rate/100000	52.8	33.9	33.3	34.5	44.4	32.4	29.8	36.5	35.7	39.1		
Fife	Number	56	40	26	65	64	49	83	47	52	47	24	876
	Rate/100000	16.0	11.4	7.4	18.3	17.9	13.7	23.0	13.0	14.4	12.9		
Forth Valley	Number	75	73	66	77	67	83	84	69	111	111	103	1397
	Rate/100000	26.9	26.1	23.6	27.3	23.6	29.0	29.2	23.8	38.3	37.8		
Grampian	Number	240	190	196	162	175	186	144	175	206	170	175	3377
	Rate/100000	45.6	36.3	37.4	30.9	33.3	35.1	27.0	32.6	38.2	30.9		
Greater Glasgow & Clyde	Number	735	794	733	656	598	560	604	617	848	853	545	12567
	Rate/100000	61.4	66.5	61.5	55.1	50.2	47.0	50.7	51.8	71.0	70.9		
Highland	Number	51	57	50	34	26	41	33	57	74	50	45	869
	Rate/100000	17.0	19.1	16.6	11.2	8.5	13.4	10.7	18.4	23.9	16.1		
Lanarkshire	Number	89	146	135	134	158	102	94	116	147	142	129	2104
	Rate/100000	16.1	26.4	24.4	24.1	28.3	18.3	16.8	20.7	26.2	25.2		
Lothian	Number	150	167	150	242	240	208	220	206	196	271	240	4330
	Rate/100000	19.3	21.4	19.2	30.7	30.2	26.0	27.2	25.2	24.0	32.4		
Tayside	Number	92	105	81	97	100	104	127	127	179	223	206	2362
	Rate/100000	23.7	27.1	21.0	25.0	25.7	26.6	32.3	32.1	45.1	55.4		
Total³	Number	1683	1773	1645	1657	1612	1531	1553	1623	2032	2125	1631	30934
	Rate/100000	33.2	35.1	32.5	32.6	31.6	29.9	30.2	31.5	39.1	40.7		

¹ Based on population at 30 June of indicated year

² Includes persons diagnosed prior to 2001

³ Includes persons diagnosed in Island Boards (NHS Orkney, NHS Shetland and NHS Western Isles)

"NHS board" refers to the persons NHS board of residence, or where this is not known, the NHS board of source of referral

TABLE 2: Persons in Scotland reported to be hepatitis C antibody positive by NHS board and risk group; to 30 September 2011

NHS board	IDU	Blood Factor	Other	Not Known	Total
Ayrshire & Arran	775	29	67	1073	1944
Borders	102	6	14	133	255
Dumfries & Galloway	500	5	27	236	768
Fife	443	11	34	388	876
Forth Valley	586	15	46	750	1397
Grampian	2171	25	131	1050	3377
Greater Glasgow & Clyde	7932	105	722	3808	12567
Highland	363	19	60	427	869
Lanarkshire	1095	32	93	884	2104
Lothian	2461	76	314	1479	4330
Tayside	1269	32	144	917	2362
All Islands	36	6	10	33	85
Scotland	17733	361	1662	11178	30934

Notes: 'Other' includes sexual contact, tattoo/body piercing, needlestick, bite, blood spillage, blood transfusion, or perinatal risk

Persons who acquired their hepatitis C infection in Scotland through blood factor will have become infected prior to the time, in the mid 1980's, when heat treatment was introduced to prevent blood borne infection

'NHS board' refers to the persons NHS board of residence, or where this is not known, the NHS board of source of referral

All Islands refers to NHS Orkney, NHS Shetland and NHS Western Isles

TABLE 3: Persons in Scotland reported to be hepatitis C antibody positive by risk group and earliest positive specimen; to 30 September 2011

Risk Group	Prior to 2001	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 (to 30 Sept)	Total
IDU	7364	1143	1149	1028	960	928	786	824	745	936	1055	815	17733
Other	1022	71	95	93	82	107	128	96	110	89	85	45	2023
Not known	3683	469	529	524	615	577	617	633	768	1007	985	771	11178
Total	12069	1683	1773	1645	1657	1612	1531	1553	1623	2032	2125	1631	30934

'Other' includes sexual contact, tattoo/body piercing, needlestick, bite, blood spillage, blood products, blood transfusion, or perinatal risk

Persons who acquired their hepatitis C infection in Scotland through blood factor will have become infected prior to the time, in the mid 1980's, when heat treatment was introduced to prevent blood borne infection

TABLE 4: Persons in Scotland reported to be hepatitis C antibody positive, by age group at time of earliest positive specimen and year of earliest positive specimen; to 30 Sept 2011

Age Group at diagnosis	Prior to 2001	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 (to 30 Sept)	Total ¹
Under 20	550	74	64	51	35	36	28	32	30	27	28	24	979
20-29	4937	644	645	621	572	546	434	427	458	509	475	377	10645
30-39	4202	597	638	587	586	566	560	552	546	765	863	599	11061
40-49	1368	223	244	234	315	293	326	360	371	503	509	417	5163
50-59	354	66	94	89	102	117	136	129	146	161	187	148	1729
60+	434	49	51	56	43	47	42	51	60	60	57	63	1013
Total¹	12069	1683	1773	1645	1657	1612	1531	1553	1623	2032	2125	1631	30934

1. Includes those for whom age at diagnosis is not known

Earliest positive specimens with specimen dates prior to 1991 were identified through retrospective testing of stored sera

Children aged under 2 years at the time of diagnosis were included if they had two consecutive PCR positive tests

TABLE 5: Persons in Scotland reported to be hepatitis C antibody positive by source of referral and year of earliest positive specimen; to 30 September 2011.

Source of referral	Prior to 2001	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 (to 30 Sept)	Total
GP	2409	412	509	420	429	401	405	439	417	417	375	344	6977
Hospital Patients	3856	431	478	457	437	405	348	396	413	404	406	319	8350
GUM Clinic	743	99	79	85	102	114	89	90	113	133	105	62	1814
Prison	953	132	117	95	61	60	35	73	58	92	96	76	1848
Other	2321	285	299	253	247	194	159	152	153	291	505	344	5203
Not Known	1787	324	291	335	381	438	495	403	469	695	638	486	6742
Total	12069	1683	1773	1645	1657	1612	1531	1553	1623	2032	2125	1631	30934

'Other' includes those diagnosed in Specialist Drug Services, Counselling Clinics, Renal Units, Haemophilic Clinics, Occupational Health and Scottish National Blood Transfusion Service donor screening.

TABLE 6: Persons in Scotland reported to be hepatitis C antibody positive and not known to be dead by NHS board and current age group; to 30 Sept 2011

NHS board		20-29	30-39	40-49	50-59	60+	Total ¹
Ayrshire & Arran	Number	211	738	499	194	59	1737
	%	12.1%	42.5%	28.7%	11.2%	3.4%	
Borders	Number	23	68	69	32	23	222
	%	10.4%	30.6%	31.1%	14.4%	10.4%	
Dumfries & Galloway	Number	109	311	139	83	37	709
	%	15.4%	43.9%	19.6%	11.7%	5.2%	
Fife	Number	99	321	190	117	43	772
	%	12.8%	41.6%	24.6%	15.2%	5.6%	
Forth Valley	Number	155	478	380	166	55	1259
	%	12.3%	38.0%	30.2%	13.2%	4.4%	
Grampian	Number	346	1434	792	324	126	3053
	%	11.3%	47.0%	25.9%	10.6%	4.1%	
Greater Glasgow & Clyde	Number	567	3719	4568	1246	419	10725
	%	5.3%	34.7%	42.6%	11.6%	3.9%	
Highland	Number	60	225	249	173	65	781
	%	7.7%	28.8%	31.9%	22.2%	8.3%	
Lanarkshire	Number	143	719	603	222	104	1818
	%	7.9%	39.5%	33.2%	12.2%	5.7%	
Lothian	Number	278	883	1326	764	304	3591
	%	7.7%	24.6%	36.9%	21.3%	8.5%	
Tayside	Number	298	578	686	293	116	1998
	%	14.9%	28.9%	34.3%	14.7%	5.8%	
All Islands	Number	*	17	18	21	12	73
	%	*	23.3%	24.7%	28.8%	16.4%	
Scotland	Number	2156	9265	9346	3584	1332	26738
	%	8.1%	34.7%	35.0%	13.4%	5.0%	

1. Includes those under the age of 20 and those for whom age was not known

'NHS board' refers to the persons NHS board of residence, or where this is not known, the NHS board of source of referral

All Islands refers to NHS Orkney, NHS Shetland and NHS Western Isles

* Values less than 5 are denoted with an asterisk due to issues of confidentiality but are included in totals

The last Hepatitis C Surveillance Report was in Issue 11/43
The next Hepatitis C Surveillance Report will be in Issue 12/18

Notifiable diseases

Part 2 (Notifiable Diseases, Organisms and Health Risk States) of the Public Health etc.(Scotland) Act came into effect on 1 January 2010 and sets out new duties for registered medical practitioners, NHS boards and directors of diagnostic laboratories. GP practices should familiarise themselves with the Scottish Government guidance on the new notification requirements at: <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/publicact/Implementation/Timetable3333>.

Registered medical practitioners report notifiable diseases based on ‘clinical suspicion’. As such, notifications may not be subject to laboratory report confirmation. The published figures will record therefore how many diseases have been clinically suspected.

Patient notifications can, however, be reclassified. When, for example, a suspected (and notified) tuberculosis case is subsequently reported as negative by a laboratory (and found not to be a health protection risk) it would subsequently be removed from the disease totals.

Diseases to be notified by registered medical practitioners with effect from 1 January 2010:

Notifiable Diseases which come into effect on 1 January 2010

*Anthrax	*Meningococcal disease	*Severe Acute Respiratory Syndrome (SARS)
*Botulism	Mumps	*Smallpox
Brucellosis	*Necrotising fasciitis	Tetanus
*Cholera	*Paratyphoid	Tuberculosis (respiratory or non-respiratory) (see Note 2)
*Clinical syndrome due to <i>E. coli</i> O157 infection (see note 1)	*Pertussis (Whooping Cough)	*Tularemia
*Diphtheria	*Plague	*Typhoid
*Haemolytic Uraemic Syndrome (HUS)	*Poliomyelitis	*Viral haemorrhagic fevers
*Haemophilus influenzae Type b (Hib)	*Rabies	*West Nile fever
*Measles	Rubella	Yellow Fever

It is recommended that those diseases above marked with an * require urgent notification, i.e. within the same working day.

Note 1: *Escherichia coli* O157

Clinical suspicion should be aroused by (i) likely infectious bloody diarrhoea or (ii) acute onset non-bloody diarrhoea with a biologically plausible exposure and no alternative explanation. Examples of biologically plausible exposures include:

- contact with farm animals, their faeces or environment;
- drinking privately supplied or raw water;
- eating foods such as undercooked burgers or unpasteurised dairy products;
- contact with a confirmed or suspected case of VTEC infection.

Further guidance is available at: <http://www.hps.scot.nhs.uk/giz/e.coli0157.aspx>.

Where a case is notified as HUS (Haemolytic Uraemic Syndrome) it should NOT also be notified as ‘Clinical syndrome due to *E. coli* O157 infection’.

Note 2: Tuberculosis

For the purposes of notification, respiratory TB or non-respiratory TB should be taken to have the same meanings as the World Health Organisation definitions of **pulmonary TB** and **non-pulmonary TB** respectively:

Pulmonary TB is tuberculosis of the lung parenchyma and/or the tracheobronchial tree.

Non-pulmonary TB is tuberculosis of any other site.

Where tuberculosis is clinically diagnosed in both pulmonary and non-pulmonary sites, this should be treated as pulmonary TB.

Registered medical practitioners have been advised to contact their local NHS Board Health Protection Team for advice should they have any doubts about the diagnosis of suspected cases.

Non-notifiable diseases

Registered medical practitioners are no longer required to notify the diseases listed below.

- Bacillary dysentery
- Chickenpox
- Food poisoning
- Scarlet fever
- Viral hepatitis

These diseases are now covered by a list of notifiable organisms details of which will be reported by laboratories to health protection teams.

Statutory Notification of Infectious Diseases

Week ended 27 January 2012

A National Statistics release

Infectious Disease	Current week	Previous week	Current week last year	Total from first week of year	
				2011	2012
Anthrax	-	-	-	-	-
Botulism	-	-	-	-	-
Brucellosis	-	-	-	-	-
Cholera	-	-	-	-	-
Clinical Syndrome <i>E. coli</i> O157	-	-	-	-	-
Diphtheria	-	-	-	-	-
Haemolytic Uraemic Syndrome (HUS)	-	-	-	-	-
Haemophilus Influenzae Type B (Hib)	-	-	-	-	1
Measles	-	2	-	3	5
Meningococcal Infection	-	2	2	22	8
Mumps	4	9	36	152	26
Necrotizing Fasciitis	-	-	1	1	-
Paratyphoid Fever	-	-	-	-	-
Pertussis	2	2	1	1	11
Plague	-	-	-	-	-
Poliomyelitis	-	-	-	-	-
Rabies	-	-	-	-	-
Rubella	-	2	1	4	2
Severe Acute Respiratory Syndrome (SARS)	-	-	-	-	-
Smallpox	-	-	-	-	-
Tetanus	-	-	-	-	-
Tuberculosis: Respiratory	7	3	13	23	20
Tuberculosis: Non-respiratory	1	4	10	13	8
Tularemia	-	-	-	-	-
Typhoid Fever	-	-	1	1	-
Viral Haemorrhagic Fevers	-	-	-	-	-
West Nile Fever	-	-	-	-	-
Yellow Fever	-	-	-	-	-
TOTAL	14	24	65	220	81

Amendments: Add 1 Meningococcal infection (1 x wk 3)

Source: Health Protection Scotland, NHS National Services Scotland

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