EPI-NEWS

NATIONAL SURVEILLANCE OF COMMUNICABLE DISEASES

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As from 1 May 2010, only the electronic version of EPI-NYT (the Danish version of EPI-NEWS) will be published. The reasons for this change include the considerable postage expenses and the general trend towards electronic communication. We hope readers will continue subscribing to EPI-NYT, which will continue to be available free of charge via E-mail. To subscribe, please visit www.ssi.dk/epi-nyt.
(Department of Epidemiology)

PHONE GUIDANCE ON VACCINATION AND MALARIA PROPHYLAXIS IN CONNECTION WITH FOREIGN TRAVEL

As from 6 April 2010, the health staff guidance service on vaccination and malaria prophylaxis in connection with foreign travel will be open on working days 8.30-11.00 AM and 2-3 PM. Phone: +45 32 68 30 38.
The services are now managed jointly with the other guidance services provided by the Department of Epidemiology. Also feel free to contact the service via E-mail: epiinfo@ssi.dk.
Before submitting your request, we recommend that you see "Rejser og smitsomme sygdomme" (in Danish language) at www.ssi.dk/rejser and/or the latest issue of EPI-NEWS containing vaccination recommendations for foreign travel, EPI-NEWS 26 a+b/09.
(Department of Epidemiology)

ERROR ON FORM 1515

The Department of Epidemiology has become aware of an error on the reverse of the National Board of Health form 1515 which is used for individual notification of infectious diseases. Specifically, the error is found on forms labelled with no. 80232311 from October 2007.
On the reverse of the form, the name of the disease, notification criteria and microbiological agent/serological markers are stated. In the section describing "purulent meningitis", the subsection on microbiological agent/serological markers states "Neisseria meningitidis". The correct text is "Detected microorganisms". All cases of purulent meningitis are notifiable, not just meningitis caused by Neisseria meningitidis, cf. executive order no. 277 of 14 April 2000 with subsequent amendmends published by the National Board of Health. We regret this error which will be corrected in future reprints of the form.
(Department of Epidemiology)

CLARIFICATION OF NEED FOR HIV TESTING AFTER RISK SITUATIONS

EPI-NEWS 46/09 comments on the National Board of Health's new strategy on health staff's duty to actively offer HIV testing to anyone at special risk of infection. For persons actively requesting an HIV test, it was stated that testing should take place immediately in connection with the request and not, as previously, at a certain interval after the risk situation occurred, the so-called window phase. Persons requesting a test may be informed that the majority of those infected test positive very quickly and that a negative result in the now widely used combitest is reliable already four weeks after exposure; the corresponding period for modern antibody tests is eight weeks. It should be stressed that unless a patient presents with symptoms of acute HIV infection, the National Board of Health does NOT recommend a re-test after an additional two months, provided the blood sample is HIV-negative one month after an unequivocal risk exposure situation.
(Danish National Board of Health)

HOLLAND: Q-FEVER OUTBREAK

Q-fever is a zoonosis caused by the Coxiella burnetii bacterium, EPI-NEWS 46/06 and 03/09. The bacterium is primarily found in cattle, sheep and goats, and may provoke abortion. In infected animals, the bacteria accumulate frequently in large quantities in the placenta, but they are also to some degree excreted in urine, milk and faeces. The route of human infection is primarily airborne via aerosoles or dust from infected material. The incubation period for humans varies from two days to three weeks. Human-to-human infection with Q-fever does not occur; however, the placenta of infected pregnant women is highly infectious.

Outbreaks in Holland

In Holland, the number of patients recorded with Q-fever has increased drastically in recent years from 17 annual cases in the 1978-2006 period to 168 in 2007, 1,000 in 2008, 2,357 in 2009 and 225 by March 2010. Most patients are residents of Noord Brabant, a region with intensive goat farming. Approx. 30% of the goat farms test positive and the outbreak is attributed to an unusual combination of high population density, intensive goat farming, and, possibly, also a more virulent subtype of C. burnetii than the types prevalent in e.g. cattle.

Control measures

The Dutch authorities have implemented a number of measures to control the outbreak. In goat farms with more than 50 milk-producing sheep or goats, the following measures are in place: mandatory vaccination of all animals, Q-fever tests performed routinely on tank milk samples, and breeding restrictions. In December 2009, all pregnant milk-producing goats were destroyed in such farms where tank milk samples tested positive. Manure from such farms shall be covered and stored for a period of 90 days prior to field manuring.

Q-fever occurrence in neighbouring countries

As C. burnetii may spread from 500 to 5,000 metres from an infected farm, there is a risk that the Dutch outbreak may spread to other regions. Consequently, exporting live goats from Holland is prohibited by law. 2008 saw an increase in the number of human Q-fever cases in Germany. This increase located in Southern Germany is compatible with regular fluctuations in the incidence of Q fever in Germany. In Belgium, which also borders on Germany, no increase in Q-fever has been observed in humans or animals.

Commentary

It is essential to keep Q-fever in mind when considering differential diagnoses in persons presenting with symptoms consistent with Q-fever, who have visited Holland. It is particularly important if such persons have stayed in Noord Brabant. Q-fever may present in the form of influenza-like symptoms, pneumonia, hepatitis or endocarditis in those who have a predisposition. Q-fever can cause abortion in pregnant women. Particular attention should be given to persons with an increased risk of developing a chronic infection during the aftermath of the acute infection, e.g. immunosuppressed patients, persons with structural cardiovascular malformations (cardiac valve conditions, vascular prostheses) and pregnant women, EPI-NEWS 46/06 and 51/07.
(S. Bacci, P. Valentiner-Branth, K. Mølbak, Dept. of Epidemiology, S. Villumsen, Dept. of Microbiol. Surv. & Research)

Individually notifiable diseases

Number of notifications received in the Department of Epidemiology, SSI (2009 figures are preliminary)

Table 1	Week 10 2010	Cum. 2010 [1]	Cum. 2009 [1]
AIDS	0	14	6
Cholera	0	0	0
Creutzfeldt-Jakob	0	5	1
Food-borne diseases	3	48	82
of these, infected abroad	0	15	12
Gonorrhoea	8	124	119
Hepatitis A	1	9	7
of these, infected abroad	1	2	5
Hepatitis B (acute)	0	8	5
Hepatitis B (chronic)	10	43	36
Hepatitis C (acute)	0	0	2
Hepatitis C (chronic)	16	84	62
HIV	6	43	60
Legionella pneumonia	2	25	22
of these, infected abroad	0	4	0
Leptospirosis	0	0	0
Measles	0	1	8
Meningococcal disease	1	18	25
of these, group B	0	1	8
of these, group C	1	5	3
of these, unspec. + other	0	0	0
Mumps	0	2	2
Neuroborreliosis	1	5	3
Ornithosis	0	0	0
Pertussis (children < 2 years)	5	19	22
Pneum. disease, invasive (IPD) [2]	4	37	35
Purulent meningitis			
Haemophilus influenzae	0	0	2
Listeria monocytogenes	0	2	2
Other aethiology	0	3	2
Unknown aethiology	0	0	1
Under registration	0	0	0
Rubella (during pregnancy)	0	0	0
Rubella (congenital)	0	0	0
Shigellosis	4	23	20
of these, infected abroad	3	18	20
Syphilis	20	76	55
Tetanus	0	0	0
Tuberculosis	4	66	88
Typhoid/paratyphoid fever	1	12	3
of these, infected abroad	1	10	0
VTEC/HUS	2	27	24
of these, infected abroad	0	6	5

Table 1, comments

In 2010, none of the following have been reported: Anthrax, botulism, cholera, diphtheria, haemorrhagic ffever, leprosy, plague, polio, rabies, typhus exanthematicus

[1] Cumulative no. 2010 and corresponding period 2009

[2] Meningitis, all age groups, invasive pneumococcal disease

Selected laboratory diagnosed infections

Number of specimens, isolates, and/or notifications received at Statens Serum Institut

Table 2	Week 10 2010	Cum. 2010 [2]	Cum. 2009 [2]
Bordetella pertussis (all ages)	0	30	29
Gonococci	14	107	77
of these, females	2	27	16
of these, males	12	80	61
Listeria monocytogenes	0	7	13
Mycoplasma pneumoniae			
Resp. specimens *4)*	1	27	21
Serum specimens *4)*	8	64	36
Streptococci *5)*			
Group A streptococci	5	44	49
Group B streptococci	3	22	18
Group C streptococci	1	8	6
Group G streptococci	2	30	34
S. pneumoniae	27	276	343

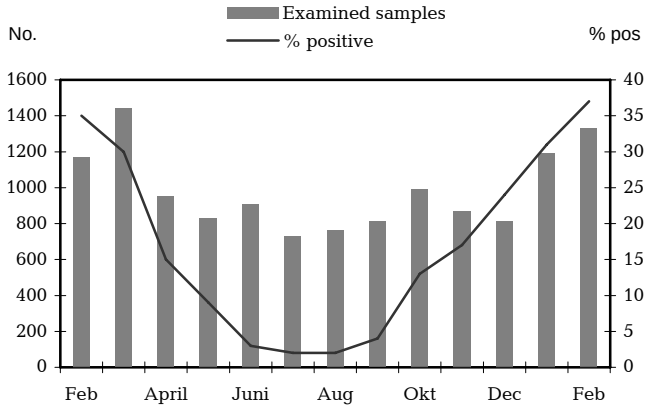
Table 3	Week 8 2010	Cum. 2009 [2]	Cum. 2008 [2]
MRSA	12	93	114
Pathogenic int. bacteria *7)*			
Campylobacter	32	315	214
S. Enteritidis	6	46	35
S. Typhimurium	4	51	158
Other zoon. salmonella	6	84	97
Yersinia enterocolitica	1	22	28
Verocytotoxin-prod. E.coli	3	19	18
Enteropathogenic E. coli	3	27	22
Enterotoxigenic E. coli	10	88	26

Tables 2 & 3, comments

3) Cumulative no. 2010 and corresponding period 2009
4) Respiratory specimens with positive PCR
5) Serum specimens with pos. complement fixation test
6) Isolated in blood or spinal fluid
7) See also www.germ.dk

Norovirus 2009-2010

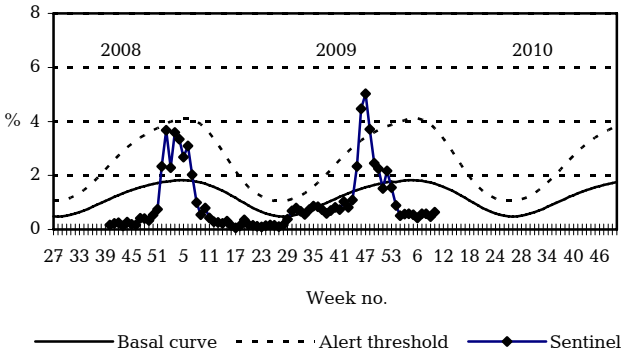
Examined samples and percent positive, Feb 09 - Feb 10



Samples from clinical microbiology departments at Odense University Hospital, Copenhagen University Hospital, and the Department of Virology, SSI

Sentinel surveillance of the influenza activity

Weekly percentage of consultations, 2008/2009/2010



Sentinel:	Influenza consultations (as percentage of total consultations)
Basal curve:	Expected frequency of consultations under non-epidemic conditions
Alert threshold:	Possible incipient epidemic

17 March 2010