

case was travelling in Australia or for case 7 as this was a clinical diagnosis with a negative culture.

In 2006, the local health authorities have continued to liaise with primary care physicians, respiratory nurses and chest physicians, but no further related cases have been identified.

## Conclusion

This outbreak of nine cases included seven cases with identical microbiological profiles, one case that was diagnosed on clinical grounds and one case that was diagnosed outside the United Kingdom. All nine patients were local residents of white ethnicity (unusual in patients in the UK) who reported a history of drinking in Pub A. Tuberculosis typing allowed one earlier case to be excluded from the outbreak.

In this particular outbreak it has been very difficult to take reliable medical histories due to a combination of poor history telling on the part of the patients and the complex social context in which the outbreak took place. Other authors have previously reported that conventional contact tracing has been insufficient in tuberculosis outbreaks linked to pubs [1]. Without genetic typing it would have been very difficult to establish links between cases in this outbreak. With tuberculosis typing (VNTR method) now routinely available in Wales for all positive cultures, we may see further cases linked to this outbreak in the future.

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## Epidemiological surveillance implemented in southeast France during the 2006 Olympic Winter Games

F Franke<sup>1</sup>, L Coulon<sup>2</sup>, C Renaudat<sup>1,3</sup>, B Euillot<sup>2</sup>, N Kessalis<sup>2</sup>, P Malfait<sup>1</sup> ([Philippe.MALFAIT@sante.gouv.fr](mailto:Philippe.MALFAIT@sante.gouv.fr))

<sup>1</sup>Cellule inter régionale d'épidémiologie Sud, France

<sup>2</sup>Direction départementale des affaires sanitaires et sociales des Hautes-Alpes, France

<sup>3</sup>Programme de formation à l'épidémiologie de terrain PROFET, France

## Background

*Eurosurveillance* recently reported on the surveillance system set up in Italy for the 2006 Olympic Winter Games [1,2]. Some of the competitions of the 2006 Olympic Winter Games in Torino, Piemonte, Italy, were held close to the French-Italian border, near the city of Briançon, in the department of Hautes-Alpes, and an epidemic intelligence mass gathering system [3,4] was set up by the local public health authorities in France (the Direction départementale des affaires sanitaires et sociales (Ddass) des Hautes-Alpes, and the Cellule interrégionale d'épidémiologie Sud (Cire Sud)). The aim was the early detection of any incident that could justify prevention or sanitary control measures, and to guide interventions in the case of an outbreak or of environmental pollution.

## Methods

The system was in place from 30 January to 15 March 2006, and collected the following information:

Mortality was monitored daily through deaths recorded by the town hall in Briançon, and the analysis of the causes reported on the death certificates sent to the Ddass.

Acute gastroenteritis, influenza-like illness, and measles surveillance was carried out through a sentinel network of general practitioners set up especially for this period. The two private and public microbiology laboratories in Briançon provided test result data for stool culture, hepatitis A serology and methemoglobinaemia. Data were collected every week.

Data from the accident and emergency department at the hospital in Briançon, and from the Hautes-Alpes emergency ambulance service (SAMU) were followed up daily.

Surveillance data for mandatorily notifiable diseases [5] and carbon monoxide poisoning were reported daily, as usual, and communication channels for these were reinforced.

Preventive measures were also taken in and around Briançon: monitoring the quality of food and accommodation services, in reference to statutory food hygiene standards, intensification of routine water-quality checks and adjusted reinforced water treatment, public information campaigns about legionnaires' disease and carbon monoxide poisoning, and enhanced controls of quality standards for personal skiing equipment.

Every day, data collected from the various sources were analysed by Cire Sud and Ddass and information was transmitted to the French local authorities every evening. In addition, a weekly report in both French and English was sent every Friday to the data providers, and the Italian regional (Piemonte) and national health authorities, the European Centre for Disease Control and Prevention (ECDC), and the Institut de Veille Sanitaire (French National Institute for Public Health Surveillance, InVS).

## Results

The participation rate of the partners was close to 100%, and all the data transmission deadlines were met. No adverse health event was identified in the area under surveillance. The activities observed in the accident and emergency department of the hospital in Briançon (daily average of 58 cases), and of the SAMU (daily average of 94 cases) were similar to observations made in the previous year.

## Conclusions

The 2006 Olympic Winter Games had a very limited impact on illness and adverse events in the neighbouring French region of Hautes-Alpes.

The special epidemiological surveillance implemented in France during this period was found relevant to the situation, as it met the assigned objectives and the needs of both data providers and decision-makers. All partners had a good understanding of the system, and had no problems working with it.

The temporary enhanced surveillance was set up on the existing routine non-specific surveillance systems using data from hospitals, emergency ambulance services and mortality statistics collected by town halls. Ad hoc surveillance activities involved general practitioners and medical laboratories. The cooperation and responsiveness displayed by the partners have laid the groundwork for a useful and effective network to be used in future sanitary emergency situations such as disease outbreaks and environmental contamination events.

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