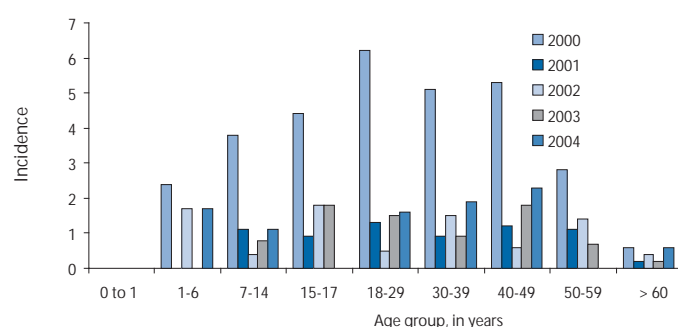


FIGURE 3

Incidence of trichinellosis per 100 000 population, by age group, 2000-2004



In the past four years (2001-2004), between one and three outbreaks have been identified each year, involving between 2 and 20 people. In each outbreak, the epidemiological investigation has shown that the infections were due to eating infected pork.

TABLE 1

Outbreaks of trichinellosis in Latvia, 2000-2004

Year	Total number of cases	Outbreaks	Total number of patients in all outbreaks
2000	91	4	77
2001	20	1	2
2002	20	3	13
2003	22	2	20
2004	24	3	13

TABLE 2

Epizootic situation of trichinellosis in Latvia, 1999-2004

Year	Pigs		Wild pigs		lynx		Beaver		Foxes	
	Number of checked animals	Positive cases	Number of checked animals	Positive cases	Number of checked animals	Positive cases	Number of checked animals	Positive cases	Number of checked animals	Positive cases
1999	368 610	-	120	3	-	-	-	-	-	-
2000	328 546	3	238	5	2	2	5	-	-	-
2001	322 723	2	567	7	-	-	14	-	-	-
2002	446 408	-	583	9	-	-	8	-	150	36
2003	429 171	-	313	13	2	2	8	-	-	-
2004	419 105	-	1022	12	-	-	14	-	-	-

UPDATE ON THE EUROPEAN LYMPHOGNULOMA VENEREUM EPIDEMIC AMONG MEN WHO HAVE SEX WITH MEN

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Trichinellosis situation in animals

The FVS is responsible for surveillance, reporting and control of zoonoses in the animal population and the food chain. It has produced guidelines for slaughter houses for the veterinary examination of cows, sheep, goats and horses.

Diagnosis in the FVS slaughter house laboratory is by:

- Trichinoscopy and compression or
- Recovery of larvae after mechanical digestion of a sample.

All pig and horse carcasses are tested for trichinella larvae. If there are any positive results, the affected slaughterhouse is investigated and placed under restrictions while legally prescribed remedial measures are instituted. When animals are slaughtered at home, or hunted for personal consumption, the owner or hunter is responsible for ensuring the carcass is tested before it is consumed. (Table 2)

In the period 1999-2004, trichinellosis was identified in 3 pigs on one farm in 2000 and in 2 pigs on one farm in 2001. In each case the pigs were slaughtered at home without veterinary supervision. Every year, trichinellosis is found in large numbers of wild pigs.

To control trichinellosis outbreaks, the FVS organises unannounced checks on food producers that have been associated with trichinellosis outbreaks. In the first quarter of 2005, the FVS tested 58 samples from various retail grocery products (fresh pork, 17 samples; smoked pork and bacon, 33; salted bacon, 8) for *Trichinella* larvae. *Trichinella* larvae were not found in any of these samples.

References

1. Commission decision of 19 March 2002 laying down case definitions for reporting communicable diseases to the Community network under Decision No 2119/98/EC of the European Parliament and of the Council (notified under document number C(2002) 1043). (2002/253/EC). Official Journal of the European Communities 2002; L 86/44: 3 April 2002. (http://europa.eu.int/eur-lex/pr1/en/oj/dat/2002/L_086/L_08620020403en00440062.pdf).

The Europe-wide epidemic of lymphogranuloma venereum (LGV), caused by *Chlamydia trachomatis* serovar L2, is continuing. It is affecting men who have sex with men (MSM), many of whom are HIV positive. Outbreaks and various case reports have been described in several European countries and, more recently, in the United States and Canada. The outbreak is of public health importance, since LGV facilitates transmission of HIV and other blood-borne infections.

Overview of the LGV situation in Europe (March 2005)

In the Netherlands, 144 confirmed cases of LGV had been reported by March 2005, the majority in Amsterdam: 65 cases in 2002/3 were identified retrospectively. In France, 142 cases of LGV have been confirmed, mainly in Paris and Bordeaux, of which 21 in 2002/3 were identified retrospectively. In the United Kingdom

(UK), 34 confirmed cases have been reported since October 2004, the majority in London, with others reported in cities across the UK: 8 were identified retrospectively. Concurrent incident infections with hepatitis C were diagnosed in the Netherlands and the UK. Only small clusters of cases have been reported from other European countries: 8 cases in Belgium, 20 cases in Germany, three cases in Sweden and one in Spain.

Preliminary results of active surveillance systems in The Netherlands, France, the UK and the US, describe broadly similar trends and responses to the epidemics. The current outbreak of LGV is occurring in MSM only and is characterised by severe anorectal infections with long-lasting symptoms including rectal pain, tenesmus, rectal discharge and constipation. The majority of LGV patients are HIV positive. All reported a variety of sexual risk behaviours, including unprotected anal sex, with numerous anonymous partners. Epidemiological investigations of transmission risk factors are underway.

Recognition of cases

At first, rapid recognition of the outbreaks was hindered, because doctors and patients were not familiar with the signs and symptoms of the disease. There is a lack of licensed chlamydia polymerase chain reaction (PCR) tests for rectal specimens and genotyping facilities. Reporting LGV is not mandatory in many countries and new cases have often not been reported in a timely way.

Notification through ESSTI ALERT (European Surveillance of Sexually Transmitted Infections early warning and alert system), informed epidemiologists in Europe of early LGV cases with international links, and prompted the investigation of possible LGV cases in the Netherlands and France. Active surveillance for LGV was implemented in the Netherlands in January 2004, in France in March 2004 and in the UK in October 2004. Retrospective evaluation of possible cases in The Netherlands and France has confirmed that MSM with LGV were presenting to medical services as early as 2002.

Microbiological and clinical issues of LGV

The laboratory diagnosis of LGV ideally uses direct detection of *Chlamydia trachomatis* specific DNA in rectal specimens followed by amplification of the *omp1* gene using nested PCR and restriction endonuclease digestion to identify LGV specific serovars (L1, L2 or L3). However, *C. trachomatis* nucleic acid amplification tests (NAATs) are not licensed for use on rectal or pharyngeal specimens. Most commercial platforms perform well for rectal specimens but currently only reference laboratories and major centres with rectal specimen testing experience have validated these tests for use. Using unlicensed tests and the complexity of the confirmatory tests may have hindered the identification of LGV cases. Real-time PCR is needed that will identify L2 serovars directly from the specimen to allow timely and sensitive detection.

Preliminary results from ongoing clinical studies demonstrate that LGV-2 infections occur also in patients with no signs or symptoms. The first case of urethritis caused by LGV-2 in France was found in a male patient with no other genital or anorectal complaints. Wider screening of MSM is needed but this requires a validated real-time PCR. Such tests are currently being validated by a number of laboratories, including one in Amsterdam and the United States Centers for Disease Prevention and Control.

Serology has been widely used to diagnose LGV but this is not specific enough. However, direct detection may not always be possible and serology may have a role if the rectal specimen is negative, inhibitory, or it is not possible to amplify the *omp1* gene. A high antibody titre in patients with proctitis is highly suspicious of LGV, whereas a low antibody titre with evidence of symptoms cannot confirm or exclude LGV.

Sequence diversity within the *omp1* gene has been used to further identify strain variation. In the Amsterdam outbreak, a single strain known as AMSTLGV2b was found, which has also been identified in France. Variants have been detected in Germany and the United Kingdom. Confirmation of sequence variants is necessary to define the limits of the outbreaks in the future.

Information needs to be disseminated on confirmation of LGV strains (by genotyping), evaluation of serology, international validation of the real-time PCR and confirmation of sequence variants. Information on reference laboratories should become available soon on the ESSTI website (<http://www.essti.org/>).

International information exchange and collaboration results in recommendations to diagnose and control outbreak.

ESSTI has facilitated international information exchange and collaboration since cases were first detected. In April 2005, a scientific conference was organised by ESSTI and RIVM, the Netherlands. The meeting provided the opportunity to formulate the following recommendations to improve LGV prevention and control efforts across Europe:

- Clinical recognition still needs to be improved by increasing awareness of sexually transmitted infections among general physicians.
- Updated clinical information and guidance for investigation (including standardised questionnaires), diagnosis and management should be placed on the ESSTI website.
- International comparison of strains is required. More information sharing among European microbiologists would be beneficial.
- A Europe-wide accepted case definition and international recommendations for standard diagnostic methods are needed as quickly as possible.
- ESSTI should publish a list of reference laboratories competent at confirming LGV diagnosis.
- International internet-based anonymous reporting of LGV cases (real-time surveillance) should be considered.
- A multi-centre study on epidemic characteristics and clinical features of LGV proctitis among MSM should be considered.
- There is a continuing need for targeted interventions to improve the sexual health of MSM.

Since European countries are not equally affected by the LGV epidemics, it was recommended that:

- In countries with no or few reported cases at present, more awareness of LGV is needed in the MSM community. Clinicians need information about the clinical features of LGV, diagnostics and methods of reporting. These countries should begin to identify laboratory diagnostic facilities and reference centres.
- In countries with a number of reported cases, active surveillance should be implemented and the transmission risk factors and clinical features need to be investigated thoroughly. International collaboration should increase the power of descriptive and analytic investigations.

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LARGE OUTBREAK OF HEPATITIS A IN TOURISTS STAYING AT A HOTEL IN HURGHADA, EGYPT, 2004 - ORANGE JUICE IMPLICATED

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In August and September 2004, a large outbreak of hepatitis A occurred involving tourists staying at a specific hotel (hotel X) in the Egyptian resort of Hurghada. A total of 351 cases associated with this outbreak were came to the attention of the Robert Koch-Institut (RKI): 271 primary and 7 secondary infections reported in Germany, and 60 primary and 13 secondary infections which were reported via the national public health institutes of eight other European countries.