breed earlier. This may have lead to an early increase in the bank vole population and probably also to a higher hantavirus prevalence. Moreover, humans may have been more exposed to rodent droppings due to increased outdoor activities (recreational and occupational) in forests and gardens resulting in higher case numbers during the winter season 2006/07. It is unclear, however, why the hantavirus infections among humans so far appear to be restricted to the endemic area in Baden-Wuerttemberg.

To specifically address questions about risk factors in humans, population size and Puumala virus prevalence in bank voles, Public Health authorities in Baden-Wuerttemberg have started further investigations in collaboration with the Robert Koch Institute. If the actual hantavirus continuous to be mainly restricted to Baden-Wuerttemberg it will be interesting to identify factors responsible for this phenomenon. A case-control study has been initiated to identify risk factors for human infection, and bank vole trapping will give insight in the currently circulating Puumala virus subtypes in the rodent population and a rough overview of the population size. A press release was issued in April 2007 to inform the public about the situation and to give recommendations for the prevention of exposure to hantavirus [9]. For a better understanding of the bank vole population dynamics as well as epidemiologic patterns and risk factors of human hantavirus infections in Germany, monitoring of the reservoir and further epidemiologic studies among humans will be necessary.

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Vibrio cholerae O1 strains with decreased susceptibility to fluoroquinolones in travellers returning from India (Rajasthan) to France, April 2007

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Two returning French travellers were hospitalised in late March 2007 for cholera caused by *Vibrio cholerae* serogroup O1 serotype Ogawa. In a separate event, a third case was hospitalised in early April 2007. All three travellers had returned from a trip to India (Rajasthan). They all required urgent specialised care in an intensive care unit and were treated by intravenous rehydration therapy and antibiotics. The *V. cholerae* O1 strains isolated during the first cluster of two cases and the third unrelated case were tested for antibiotic susceptibility. These tests showed resistance to nalidixic acid with decreased susceptibility to ofloxacine and ciprofloxacin. The three isolates were sensitive to tetracycline and doxycycline, and one of them was sensitive to trimethoprim-sulfamethoxazole.

The vast majority of cholera cases worldwide are treated by oral rehydration therapy (ORT) which, when administered in a timely and sufficient manner, has transformed the prognosis of cholera since the early 1960s and remains the mainstay of cholera treatment [1]. A total of 129 imported cases of confirmed cholera were diagnosed in France between 1973 and 2005, with a median of three diagnosed cases per year [2]. An additional two cases were diagnosed in 2006. Although many may go undetected, the number of diagnosed cases is on the decrease. Imported cholera cases, however, are diagnosed increasingly in infants or elderly persons who may not well tolerate massive fluids loss [2,3]. Antibiotics may be a useful adjunct [1] as they have been shown to reduce the duration of diarrhoea [1,4-8], the volume of diarrhoea [5,6,8], the volume of fluids required for rehydration [9,10], the duration of hospital stay [9] and the duration of excretion of *V. cholerae* [4-8]. Although emergence of multiple antibiotic resistance during cholera epidemic outbreaks has been documented over the past 30 years [11,12], there is little data on the prognosis of cholera in patients infected with resistant strains. Available data points to longer-lasting and more severe cholera in patients treated with inappropriate antibiotics [1]. In industrialised countries, treating with inappropriate antibiotics may be associated with increased morbidity in patients and higher costs to the community [1].

In a 2004 publication [13], the World Health Organization (WHO) examined the possible antibiotic regimen indicated when needed in outbreak or highly endemic situations. The WHO recommends single-dose doxycycline or tetracycline qid per three days or erythromycin in young children qid per four days. Although fluoroquinolones are not recommended by the WHO for treating suspected cholera, they are widely used in the first-line treatment of diarrhoea caused by infections acquired in developing countries. *V. cholerae* O1 strains resistant to fluoroquinolones have emerged in India [14] and Bangladesh [15,16] over the past years for a number of reasons. Quite logically, it was only a matter of time before resistant strains were imported to Europe. The impact of emerging antibioresistant cholera strains is greatest on patients in endemic countries but also affects imported cases. Community- or hospital-based clinicians considering antibiotic therapy for cholera in returning travellers before susceptibility testing should bear in mind that at least three cases imported to France from Rajasthan in 2007 showed decreased susceptibility to fluoroquinolones.

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A large outbreak of cryptosporidiosis in western Ireland linked to public water supply: a preliminary report

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In mid-February 2007, there was a small rise in the number of laboratory-notified cases of cryptosporidiosis in the city and county of Galway, Ireland in comparison to February 2006. The notification of cryptosporidiosis by laboratories has been a statutory obligation in Ireland since January 2004. A further increase in cases was observed in early March 2007 (Figure). An investigation was established, with a case defined as 'an individual with laboratory-confirmed cryptosporidiosis from 1 January 2007 onwards who lived in County Galway'.

Figure. Cases of cryptosporidiosis in Galway, Ireland, by week of notification from January 1 2007