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CURRENT NOTES

Group A streptococcal infection – NHS Lothian

44/0801 A man who was being treated in NHS Lothian for a Group A streptococcal infection has died. The 82-year-old developed the infection in Liberton Hospital over two weeks ago. He had received antibiotics for the illness, but went on to suffer further complications.

It is the second death associated with Group A Streptococci (*Streptococcus pyogenes*), a bacterium usually found living harmlessly on the skin, nose or throat. Most Group A Strep infections are relatively mild. The infection can result in a sore throat or skin infection such as impetigo and can also cause respiratory infections. On rare occasions, the bacteria can cause serious illness. These are known as invasive infections and are usually caused when the organism enters the system through an open wound or skin lesion. The incidence of these more serious infections is very low, with around one to four cases per 100,000 population in Scotland. The invasive infection is most common in the elderly population, especially those aged 75 and over.

An 86-year-old woman who developed the infection at the same time died a fortnight ago. Both had been inpatients in Ward 4 in Liberton Hospital and, as a precaution, infection control procedures were reinforced and still remain in place. The ward is not accepting new patients.

Screening for staff and patients is also being undertaken to reduce the possibility of repeat infection.

Two other patients have since been diagnosed with the infection in their blood and are both well following antibiotic treatment. One other patient had a skin infection which has responded to treatment. Four patients were found to be colonised which means the infection was living on their skin, nose or throat without causing any harm. They are all well and also being treated with antibiotics.

Another patient who was recently admitted into the RIE was also found to have the Group A Strep infection, but has no connection with Ward 4 at Liberton.

Tests are underway to establish the source and strains of the infection to determine if there is any link between all of the cases. All patients in Ward 4 in Liberton and their relatives have been informed, and the nature of the infection and the actions taken fully explained to them. [Source: NHS Lothian News Release, 19 February 2010. http://www.nhslothian.scot.nhs.uk/news/mediaroom/news_release/10_02_19_strepa.asp]

Introduction of 13-strain pneumococcal vaccine - update

44/0802 On 19 February, the Scottish Chief Medical Officer (CMO) issued a letter providing information about the Scottish Government's plans to replace the pneumococcal conjugate vaccine Prevenar® (which contains antigens against seven pneumococcal strains) with Prevenar 13® (which contains antigens against thirteen strains).

Healthcare providers should now familiarise themselves with the information that is available about Prevenar 13®. An attached annex provides some background, and a new chapter of the 'Green Book' has also been produced by the UK Department of Health. This can be accessed online at http://www.dh.gov.uk/en/PublicHealth/HealthProtection/Immunisation/Greenbook/dh_4097254.

Healthcare providers should be preparing local patient group directions (PGDs) for the new vaccine. A model PGD has been prepared and is available on the Health Protection Scotland website at: <http://www.hps.scot.nhs.uk/immvax/publicationsdetail.aspx?id=43950>.

The CMO's letter is available at [http://www.sehd.scot.nhs.uk/cmo/CMO\(2010\)05.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2010)05.pdf).

One new case, one further death in ongoing anthrax outbreak

44/0803 A further case of anthrax has been confirmed in a heroin user in Scotland, bringing the total number of cases in Scotland to 24. This case occurred in the NHS Dumfries & Galloway board

area and the individual is currently receiving hospital treatment. This is the first case in NHS Dumfries & Galloway, indicating that the outbreak is continuing to spread in Scotland.

In addition, one patient in the NHS Fife area who was previously confirmed as having anthrax has now died, bringing the total number of deaths in Scotland among confirmed anthrax cases in this outbreak to 10. A further two cases have been confirmed in England linked to the use of heroin, one in London and one fatal case in Blackpool. This makes the total number of cases in the UK 26 with 11 deaths.

The spread of the outbreak to another new area of Scotland appears to confirm the continued circulation of contaminated heroin and underlines the need for heroin users to understand the risks of continued use of heroin.

The distribution of confirmed cases by NHS board area (total: 24) (deaths) is: NHS Ayrshire and Arran - 1 (0), NHS Dumfries & Galloway: 1 (0), NHS Fife: 2 (1), NHS Forth Valley: 1 (1), NHS Greater Glasgow & Clyde: 12 (6), NHS Lanarkshire: 4 (0), NHS Tayside: 3 (2).

The outbreak began with the identification of cases in NHS Greater Glasgow & Clyde in December, with cases now having been identified in seven NHS board areas across the country. Two cases have also been identified in England. Another fatal case in a drug user in Germany in December also appears to be linked to the current outbreak. The outbreak represents the first known outbreak of anthrax to have occurred in conjunction with drug use. Advice and information continues to be issued to drug workers and vulnerable groups and will continue to be highlighted. Information for drug users, drug workers and members of the public is also available on <http://www.hps.scot.nhs.uk/anthrax>. All those who may have contact with drug users, including their families and friends, are reminded to familiarise themselves with this information and to share it with drug users themselves. [Source: HPS News Release, 22 February 2010. <http://www.hps.scot.nhs.uk/news/spdetail.aspx?id=340>]

H1N1 update

44/0804 The latest figures from Health Protection Scotland on the incidence of influenza A (H1N1) in Scotland were published on 18 February are:

- A rate of GP consultations for flu-like illness - not necessarily H1N1 - across Scotland of 76.6 per 100,000, a decrease on last week's figure of 79.6.
- No samples tested positive for H1N1 in those people consulting their GPs through the sentinel scheme as compared to last week's figure of 3.2 per cent of samples testing positive.
- The proportion of cold and flu related calls to NHS 24 decreased from 2.5 per cent to 2.2 per cent.
- As of February 15, 1,539 people with influenza A (H1N1) have been hospitalised since the start of the outbreak. In the last week nobody required hospital admission.
- The estimated uptake rate of the vaccine so far for people under 65 years in a clinical at-risk group is 53.8 per cent, among individuals aged 65 years and over in a clinical at-risk group is 54.5 per cent. Overall this equates to a vaccination rate of 54.1 per cent - up from 53.4 per cent the previous week.
- As of January 8, the uptake rate in front line health and social care staff is 51.5 per cent and 32.4 per cent respectively.
- As of February 15, there have been 68 deaths linked to influenza A (H1N1) since the start of the outbreak.

After taking expert advice from the Joint Committee for Vaccination and Immunisation, the Scottish Government has agreed to continue the offer of H1N1 vaccination to the initial phase one priority groups over the summer. For most people the H1N1 virus has mild symptoms but some, especially those who have been defined as a priority, can suffer severe complications. These initial priority groups - such as those with long term conditions and pregnant women - are still urged to come forward for and accept the vaccination to ensure they are protected against the low levels of H1N1 still circulating in our communities.

The method of reporting weekly rates has changed due to the continuing decrease in H1N1 levels. The estimated breakdown of GP consultation rates per NHS board and the estimated number of people contracting the virus will no longer be reported. This is because the smaller figures involved in the returns would result in unreliable estimates. [Source: Scottish Government News Release, 18 February 2010. <http://www.scotland.gov.uk/News/Releases/2010/02/18144058>. The full HPS situation report can be accessed at <http://www.hps.scot.nhs.uk/resp/publicationsdetail.aspx?id=43975>]

WHO influenza vaccine recommendations - 2010-11 influenza season

44/0805 On 18 February, the World Health Organization (WHO) published recommendations for the composition of influenza virus vaccines for the forthcoming season in the northern hemisphere (November 2010 to April 2011). They foresee a trivalent vaccine including also a 2009 pandemic influenza A(H1N1) strain:

- an A/California/7/2009 (H1N1)-like virus;
- an A/Perth/16/2009 (H3N2)-like virus*;
- a B/Brisbane/60/2008-like virus.

* A/Wisconsin/15/2009 is an A/Perth/16/2009 (H3N2)-like virus and is a 2010 southern hemisphere vaccine virus.

Each year, representatives of the WHO Collaborating Centres on Influenza meet to analyse the data and make recommendations for the following year's vaccine strains. The recommendations are used by pharmaceutical manufacturers to update the composition of the vaccine, so that vaccine strains are matched to circulating strains the following year. WHO also provides the manufacturers with prototype strains for the seasonal vaccine.

Further details on the basis for these recommendations are available at http://www.who.int/csr/disease/influenza/recommendations2010_11north/en/index.html.

Global initiative on tuberculosis control

44/0806 The European Centre for Disease Prevention and Control (ECDC) is currently hosting the first meeting of the Stop TB Partnership subgroup on Introducing New Approaches and Tools (INAT) for Tuberculosis (23 and 24 February 2010).

Recognising the urgent need for new tools to control tuberculosis (TB) both in the European Union and globally, ECDC is an active member of the INAT-subgroup. Other international and national members in the working group include the US Agency for International Development, the Foundation for Innovative New Diagnostics (FIND), and the Global Alliance for TB Drug Development.

New tools (drugs, vaccines and diagnostic methods) are crucial in assuring the progress towards the global elimination of TB and the ultimate aim of the INAT-subgroup is to increase the implementation of these tools for TB control at a global level. The subgroup will concentrate on the urgent need for timely information and technical assistance that will ensure the rapid evaluation and implementation of new tools, policies and approaches for TB control and prevention. The focus will be on a number of new diagnostic methods which are under development and, in several cases, already in advanced stages. [Source: ECDC News Release, 23 February 2010. <http://ecdc.europa.eu/en/press/news/Pages/News.aspx>]

ANSWER

(AIDS News Supplement to the Weekly Report)

HIV infection and AIDS: Quarterly report to 31 December 2009

Note to readers: From mid-2009, data produced by Health Protection Scotland (HPS) must conform to guidelines laid down by National Services Scotland (NSS) governing confidentiality and the suppression of small numbers which may result in disclosure. To this end, HPS is now in the process of reviewing and redeveloping the current routine publication strategy for HIV/AIDS data. It is hoped that the new strategy will be introduced in mid 2010. In order to continue providing stakeholders with up to date information, HPS has prepared a limited set of data, presented herein, which highlights reporting from January to December 2009 along with cumulative figures.

HIV reports: 6247	AIDS cases: 1552	Total deaths: 1626	AIDS deaths: 999
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In 2009, NHS Scotland laboratories reported positive HIV-antibody test results for 417 individuals not previously recorded as HIV-positive. The cumulative total of known HIV-positive individuals in Scotland is now 6247, of whom 4521 (72%) are male and 1726 (28%) are female (Table 1). At least 1626 (26%) are known to have died. Of the 417 recently reported HIV-positive individuals, 291 (70%) are male, and 286 (69%) are aged between 25 and 44 years (Table 2). The probable route of transmission was men who have sex with men (MSM) in 137 cases (including a small number who were also injecting drug users), heterosexual intercourse in 196 cases, and injecting drug use in 15 cases. Of the heterosexual cases, 109 probably acquired their infection abroad. For 60 cases, the transmission category is, as yet, undetermined. Greater Glasgow & Clyde accounted for 190 cases, 79 were from Lothian, 33 from Grampian, 26 from Lanarkshire and 24 from Tayside (Table 3).

Continuing investigation into previously reported cases has resulted in the enhancement of several records with additional epidemiological information. See Table 5 for detailed updates to totals in transmission categories, NHS boards, and other figures.

Of the 417 cases reported during 2009, 205 (49%) and 2445 (39%) of the 6247 total reports are presumed to have acquired their infection outwith Scotland (Table 4).

In 2009, 64 cases of AIDS were reported by clinicians, 30 of which were diagnosed in 2009 with 34 diagnosed in previous years. The cumulative number of AIDS cases is now 1552, of whom 1227 (79%) are male, while 999 (65%) are known to have died. Of the newly reported AIDS cases, 24 were from Lothian, 29 were from Greater Glasgow & Clyde, and 47 were

male. (Data not featured in tables). During the period 1 October 2008 to 30 September 2009, 3040 persons had at least one CD4 count performed. At the time of their most recent attendance, 254 (9%) had a count <200 cells/mm³, 545 (18%) a count of between 201 and 350, 802 (26%) a count of between 351 and 500, and 1418 (47%) a count of > 500 (Table 6). The majority of cases were from the Lothian (1045, 34%) and Greater Glasgow & Clyde (971, 32%) areas (Table 7). Across Scotland, 76% of cases attending for CD4 monitoring are receiving triple therapy or higher.

Of the 383 cases who entered monitoring for the first time between 1 October 2008 and 30 September 2009, 92 (24%) had a count <200, 75 (20%) a count between 201 and 350, 74 (19%) a count of between 351 and 500, and 138 (36%) a count of > 500. (Data not featured in tables).

In the 12 months prior to 30 September 2009, 2795 persons had at least one viral load test performed, 2211 (79%) had evidence of reasonable viral control indicated by a viral load measure of <400 copies/ml. Of the 311 cases that entered monitoring for the first time in the same period, 164 (54%) had a viral load <400 (Table 8). Of those cases who were receiving ART at triple therapy level or higher, 96% have evidence of reasonable viral control (Table 9).

To reduce the effects of reporting delay, the data presented in Tables 6 to 9 are three months in arrears.

More detailed information and cumulative information is included in the following tables. The HIV-positive and AIDS databases are under continual review and modification as additional information becomes available. This may result in apparent discrepancies when current and previously published tables are compared.

NB Small numbers. Suppressed data in Tables 1-9 are represented by asterisks (*)

TABLE 1: HIV-1 infected persons, Scotland, by exposure category and date reported; to 31 December 2009

How person probably acquired the virus	January 2009 to December 2009			Cumulative to 31 December 2009			
	Male	Female	Total	Male	Female	Total	% of Total
Men who have sex with men (MSM)	135	0	135	2283	0	2283	36.5%
Sexual intercourse between men and women							
<i>'high risk' partner</i> ¹	0	2	2	48	180	228	3.6%
<i>exposure in Africa</i> ²	38	58	96	500	656	1156	18.5%
<i>exposure abroad (excl. Africa)</i> ³	11	2	13	176	96	272	4.4%
<i>exposure UK</i>	19	15	34	204	226	430	6.9%
<i>under investigation</i>	24	27	51	29	32	61	1.0%
<i>no further information available</i>	0	0	0	22	30	52	0.8%
Heterosexual sub-total	92	104	196	979	1220	2199	35.2%
Injecting drug use (IDU)	12	3	15	952	409	1361	21.8%
IDU and MSM	2	0	2	53	0	53	0.8%
Blood factor (e.g. Haemophiliac)⁴	0	0	0	88	0	88	1.4%
Blood/Tissue transfer (e.g. Transfusion)⁴	0	1	1	30	22	52	0.8%
Mother to Child	3	2	5	43	41	84	1.3%
Other	1	2	3	9	7	16	0.3%
Undetermined	46	14	60	84	27	111	1.8%
Total	291	126	417	4521	1726	6247	100.0%

1. Men and women who had sex with injecting drug users, or with those infected through blood factor treatment or blood transfusion, or women who had sex with bisexual men.

2. Persons without other identified risks but who have had sexual intercourse in Africa.

3. Persons without other identified risks but who have had sexual intercourse abroad excluding African countries.

4. Includes persons infected in the UK prior to 1985 and persons who acquired their infection abroad.

TABLE 2: HIV-1 infected persons, Scotland, by age group and date reported; to 31 December 2009

Age (Years)	January 2009 to December 2009			Cumulative to 31 December 2009		
	Male	Female	Total	Male	Female	Total
0 - 14	*	*	*	72	41	113
15 - 24	21	12	33	806	456	1262
25 - 34	78	44	122	1698	774	2472
35 - 44	115	49	164	1275	332	1607
45 +	74	20	94	647	120	767
NK	*	*	*	23	3	26
Total	291	126	417	4521	1726	6247

TABLE 3: HIV-1 infected persons, Scotland, by NHS board¹ and date reported; to 31 December 2009

NHS board	January to December 2009	Cumulative to 31 December 2009				
	Total	MSM	S.I. between men & women	Injecting drug use	Other/Undetermined	Total
Ayrshire & Arran	12	60	42	8	24	134
Borders	6	25	15	10	8	58
Dumfries & Galloway	5	32	29	20	7	88
Fife	15	75	103	35	27	240
Forth Valley	13	68	54	21	14	157
Grampian	33	143	230	41	29	443
Greater Glasgow & Clyde	190	769	719	199	89	1776
Highland	12	51	60	13	14	138
Lanarkshire	26	121	126	26	20	293
Lothian	79	881	608	684	85	2258
Shetland	*	*	*	*	*	9
Tayside	24	110	205	304	28	647
Western Isles	*	*	*	*	*	6
Total	417	2336	2199	1361	351	6247

1. NHS board of residence or, where this is not known, NHS board of source of specimen.

TABLE 4: HIV-1 infected persons presumed to have been infected outwith Scotland by presumed geographical area of exposure, exposure category, and date reported; to 31 December 2009

Geographical area of exposure	January to December 2009	Cumulative to 31 December 2009				
	Total	MSM	S.I. between men & women	Injecting drug use	Other/Undetermined	Total
Other UK & Ireland	37	331	81	48	23	483
Africa (incl. Sub-Saharan Africa, North Africa & Middle East, and Africa NOS)	105	30	1167	*	61	1260
Asia (incl. South & South East Asia, East Asia, and Asia NOS)	13	31	137	*	12	183
Eastern Europe & Central Asia	14	22	22	15	*	63
Western Europe (incl Europe NOS)	22	99	73	41	11	224
Americas (incl. North America, Latin America, and Caribbean)	10	113	24	10	6	153
Oceania	*	42	6	*	*	50
NK	*	5	19	*	5	29
Total	205	673	1529	120	123	2445

Note: 'NOS': not otherwise specified

TABLE 5: Trends in HIV and AIDS, Scotland¹ by year of report / death and selected category; to 31 December 2009

Year of report/monitoring/ death	HIV reporting by risk and presumed geographical area of exposure														Monitoring and Progression		Deaths ²	
	All risks ³				Men who have sex with men (MSM)				Sexual intercourse between men and women				IDU	Age group ⁵ 15-24	Individuals undergoing CD4 count monitoring ⁶	AIDS cases diagnosed ⁶	All HIV infected cases	AIDS only
	Presumed area of exposure ⁴				Presumed area of exposure ⁴				Presumed area of exposure ⁴									
	Total ⁷	within Scotland	outwith Scotland	outwith UK	Total ⁷	within Scotland	outwith Scotland	outwith UK	Total ⁷	within Scotland	outwith Scotland	outwith UK						
1997	182	106	68	39	79	53	26	10	58	26	26	22	39	27	1059	70	74	47
1998	168	95	63	44	76	49	27	12	55	20	30	29	26	15	1130	40	59	27
1999	156	92	63	52	64	49	15	7	63	20	43	41	19	14	1216	54	46	23
2000	154	87	66	56	65	51	14	6	67	22	45	43	15	18	1306	46	47	30
2001	171	79	89	69	68	43	25	8	76	21	52	50	19	22	1390	37	47	20
2002	250	104	140	113	92	58	34	16	131	31	97	89	13	26	1526	59	59	31
2003	258	105	148	125	101	63	38	20	135	33	101	98	11	39	1683	44	56	28
2004	363	141	219	192	140	100	40	19	200	28	170	165	15	52	1929	43	25	6
2005	406	158	248	204	173	109	64	35	198	31	167	159	27	48	2208	40	43	15
2006	345	127	216	177	150	91	59	30	166	22	142	135	22	36	2407	33	34	12
2007	452	162	285	226	209	124	85	37	224	35	187	177	10	64	2668	40	33	9
2008	411	158	239	198	159	98	60	29	210	42	167	160	19	32	2870	33	33	15
2009	417	130	176	153	137	89	48	31	196	32	113	107	15	33	2961	30	31	9

Year of report	HIV Reporting by NHS board				HIV Reporting by selected presumed geographical region of exposure			
	Lothian	Greater Glasgow & Clyde	Tayside	Grampian	AFRICA			
					MSM	Hetero	IDU	Other ⁸
1997	70	39	23	18	*	16	0	*
1998	58	43	21	16	*	17	0	*
1999	52	39	7	14	*	25	0	*
2000	60	34	10	14	0	33	0	0
2001	54	47	18	20	*	36	*	*
2002	76	86	18	15	0	76	0	7
2003	83	98	14	24	0	80	0	5
2004	111	124	26	25	5	139	0	*
2005	131	136	18	33	*	132	0	6
2006	98	109	26	23	6	110	*	*
2007	118	153	32	47	*	148	0	5
2008	119	140	26	46	*	130	0	7
2009	79	190	24	33	*	97	0	5

- Due to active follow-up, data on the Scottish AIDS/HIV Register is constantly changing. Figures presented in this table may differ slightly from those previously published.
- Death figures are for those persons known to be HIV infected, or who have been diagnosed with AIDS. In some cases the actual cause of death may have been unrelated to the person's infection status. Death data is subject to reporting delay.
- 'Presumed Location Exposure' is based on information provided by the patient at the time of test or during subsequent follow-up. A case is presumed to have been infected in Scotland

- if, after investigation, no evidence exists to the contrary. 'Outwith UK' is a subset of 'outwith Scotland'. Cases under investigation are excluded from all categories except the total.
- Includes persons outwith three main risk groups.
- Age at time of first positive specimen.
- Subject to reporting delay.
- Paediatric, blood/blood product recipients, and persons whose risk is unknown/undetermined.
- Includes cases currently under investigation.
- Excludes cases currently under investigation.

TABLE 6: CD4 Monitoring, Scotland. HIV infected persons alive as at 30 September 2009 who have undergone CD4 count monitoring within the previous 12 months by exposure category and most recent CD4 count

NHS board	Most recent CD4 count						Total
	<50	51-200	201-350	351-500	>500	Not Known	
Men who have sex with men (MSM)	9	60	181	360	636	7	1253
Sexual intercourse between men and women	18	88	258	349	602	10	1325
Injecting drug use	9	51	89	78	129	2	358
Other/Undetermined	2	17	17	15	51	2	104
Total	38	216	545	802	1418	21	3040

TABLE 7: CD4 Monitoring, Scotland. HIV infected persons alive as at 30 September 2009 who have undergone CD4 count monitoring: numbers by most recent CD4 count and percentage on ART (in this analysis triple therapy level or higher) within the previous 12 months, by NHS board¹

NHS board ¹	Most recent CD4 count												
	<50		51-200		201-350		351-500		>500		Not Known	Total	
	Cases	(% ART)	Cases	(% ART)	Cases	(% ART)	Cases	(% ART)	Cases	(% ART)		Cases	(% ART)
Ayrshire & Arran	0		3		6		7		23		0	39	
Borders	0		5		2		9		14		0	30	
Dumfries & Galloway	0		6		9		16		16		0	47	
Fife	0	(0%)	6	(100%)	25	(72%)	44	(86%)	58	(81%)	1	134	(81%)
Forth Valley	1		3		14		20		46		2	86	
Grampian	5	(80%)	13	(100%)	47	(96%)	54	(74%)	111	(69%)	0	230	(78%)
Greater Glasgow & Clyde	10	(30%)	77	(78%)	145	(74%)	255	(69%)	476	(75%)	8	971	(73%)
Highland	0		6		12		13		26		0	57	
Lanarkshire	1	(0%)	11	(55%)	24	(83%)	37	(68%)	93	(74%)	0	166	(72%)
Lothian	15	(47%)	67	(79%)	223	(85%)	294	(76%)	437	(84%)	9	1045	(80%)
Shetland	0		2		0		3		2		0	7	
Tayside	5	(20%)	16	(69%)	38	(76%)	50	(68%)	115	(84%)	1	225	(76%)
Western Isles	1		1		0		0		1		0	3	
Excl NHS Boards with 100+ Cases	2	(100%)	26	(69%)	43	(79%)	68	(65%)	128	(77%)	0	267	(74%)
Total	38	(45%)	216	(77%)	545	(81%)	802	(72%)	1418	(78%)	21	3040	(76%)

1. NHS board of residence or, where this is not known, NHS board of source of specimen. Treatment data are presented only for those NHS boards with 100+ cases currently undergoing monitoring.

TABLE 8: HIV infected persons undergoing viral load monitoring by most recent viral load group and level of ART treatment as at 30 September 2009

More recent VL group	All cases attending in previous 12 months					Cases attending for the first time in the previous 12 months				
	Triple or more	Mono/Dual	Naïve	Stopped	Total	Triple or more	Mono/Dual	Naïve	Stopped	Total
< 400	2072	58	37	44	2211	145	2	13	4	164
400-999	35	1	29	9	74	7	0	11	1	19
1k-10k	26	3	115	68	212	3	0	44	0	47
> 10k	29	2	184	83	298	6	1	74	0	81
Total¹	2162	64	365	204	2795	161	3	142	5	311

TABLE 9: HIV infected persons who had undergone viral load monitoring and who had received antiretroviral treatment at triple therapy (or higher) level to 30 September 2009; numbers by treatment profile and with viral load <400 copies per ml^{1,2}

Treatment profile ²	Total treated		VL <400	
	N	%	N	% of total in class
2 NRTI + NNRTI	398	18%	392	98%
2 NRTI + PI	239	11%	231	97%
2 NRTI + NNRTI + PI	49	2%	45	92%
NRTI/NtRTI + NNRTI	731	34%	715	98%
NRTI/NtRTI + PI	393	18%	362	92%
Triple NRTI	34	2%	33	97%
Other	318	15%	294	92%
Total	2162	100%	2072	96%

1. Less than 400 copies/ml is a level indicative of reasonable viral control

2. Excludes several cases for whom results of most recent attendance are still pending

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Focus: HIV prevalence among non-injecting drug using heterosexuals, injecting drug users (IDUs), and men who have sex with men (MSM) who undergo attributable HIV testing in Scotland: 2008 update

Prepared by: Beth Cullen, Lesley Wallace, Glenn Codere, and David Goldberg

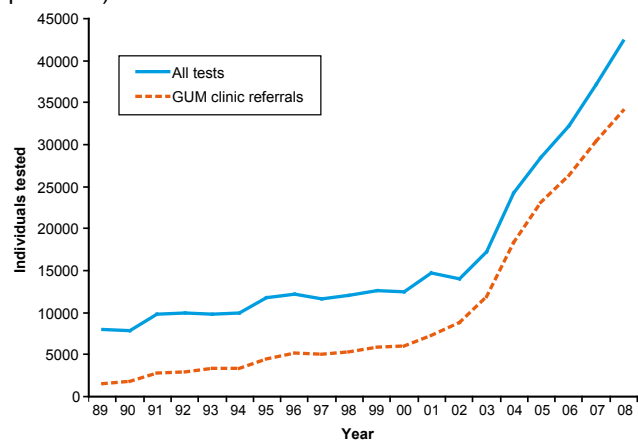
Since 1989, HPS, in association with HIV testing laboratories throughout Scotland, has collected data on persons who have undergone attributable HIV testing. Data for 2008 and recent previous annual data are presented in this report. In 2008, 43726 individuals from Grampian, Greater Glasgow & Clyde, Lothian and Tayside had at least one named HIV test (Table 1), 366 (0.84%) of which were antibody positive. It should be noted that the total tests figure excludes repeat tests within a calendar year and tests undertaken in the context of screening programmes; that is, tests on blood donors, those attending for a travel screen and antenatal clinic attendees. The 43726 figure compares with those of 37083, 32239, and 28510 for 2007, 2006, and 2005, respectively, and indicates a two and a half fold rise in testing since 2003 (17266). Note that the majority of testing (80%, 34023/42395) is performed in the genitourinary medicine (GUM) clinic setting (Figure 1). The corresponding numbers of persons tested in the GUM clinics for 2007, 2006, and 2005 are 30426, 26286, and 23122, respectively. Thus, between 2004 and 2008, an 85% increase in the numbers of persons undergoing an HIV test in GUM clinics was observed.

TABLE 1: HIV prevalence among adults (aged 15yrs+) by selected NHS board*, 2008

NHS board	Individuals tested	Positive	% positive
Grampian	5904	45	0.8%
Greater Glasgow & Clyde	18225	169	0.9%
Lothian	14081	122	0.9%
Tayside	5516	30	0.5%

* NHS board of source of specimen

FIGURE 1: Diagnostic HIV-antibody testing, 1989-2008
Individuals Tested (excluding screens, repeat tests, and known positives)



This upward trend reflects Scottish Government Health Department policy promoting i) the routine HIV testing of all persons attending GUM clinics with a new sexually transmitted infection problem,¹ and ii) testing and diagnosis in non-HIV specialities (including primary care).² The importance of expanding HIV testing to a wider range of settings is underlined in UK guidelines.³ The drive for testing has been given further

impetus in Scotland in 2009 following the publication of the HIV Action Plan in Scotland (2009-2014).⁴

(In line with the National Services Scotland Statistical Disclosure Control Protocol, certain data in this report are not disclosed due to the small numbers of reports.⁵)

Non-IDU heterosexual men and women

In 2008, 30398 persons from Grampian, Greater Glasgow & Clyde, Lothian and Tayside, identified as non-IDU heterosexuals, underwent attributable HIV testing; 127 (0.4%) of these were antibody positive (Table 2). The corresponding rates for 2007 and 2006 were 0.5% (139/25805), and 0.4% (82/22836), respectively. Between 2006 and 2008, a 33% increase in testing was observed; most of which reflects increased testing in those individuals whose likely exposure risk occurred in the UK.

There has been a decrease in overall prevalence among non-IDU heterosexuals from the previous high level of 0.7% (116/16633) reported in 2004. The overall decline from 0.7% to 0.4% between 2004 and 2008 may be explained in part by the continuing increase in the numbers of individuals, for whom sexual risk behaviour was confined to the UK, undergoing attributable testing (25125 in 2008 compared with 18506 in 2006). This group comprised 83% of all testing in non-IDU heterosexual men and women.

When the data are analysed by geographical region of exposure, it is clear that the highest prevalence in both men and women is observed among those whose likely exposure risk occurred in sub-Saharan Africa. In 2008, an overall prevalence of 7.3% (77/1053) was observed in this group; which represents a decrease on the prevalence observed in 2007 (10.5%, 94/894) and an increase on that observed in 2006 (5.9%, 48/816). Decreases in prevalence between 2007 and 2008 were also noted in men whose likely exposure risk occurred in North Africa/Middle East, Central/South America, and Australasia, and in women whose sexual contacts were in Western and Eastern Europe. In addition, there were increases in the prevalence among men whose sexual contacts were in Eastern Europe and among both women and men whose likely exposure risk occurred in the Far East/other parts of Asia and in the Indian Sub-Continent.

HIV infection in the non-IDU heterosexual population living in Scotland remains, for the most part, imported as a result of individuals moving to Scotland from countries where there is a high prevalence of HIV, notably sub-Saharan Africa.

Injecting drug users (IDUs)

In 2008, 2381 IDUs throughout Scotland had an attributable HIV test and, of these, 13 (0.5%) were antibody positive (648 female and 1733 male IDUs); the corresponding proportions for 2007, 2006, and 2005 being 0.3%, 0.8%, and 0.9%, respectively (Table 3). In several NHS boards where diagnoses have been made in recent years, an increase in prevalence was noted in

Greater Glasgow & Clyde and Lothian, while a reduction in prevalence was observed in Grampian and Lanarkshire. In Lanarkshire, no HIV positives were detected for the first time in three years. Of the 13 antibody positive IDUs, 12 were aged between 30 and 44. Active follow-up suggests that at least six of the 13 probably acquired their infection outside Scotland.

While these observations suggest that HIV transmission among IDUs in Scotland is uncommon, behavioural data indicate that there is the potential for the acquisition of HIV through injecting drug use practices. In 2007/2008, 19% of current injectors reporting to the Information Services Division's Scottish Drug Misuse Database indicated that they had shared needles/syringes in the previous month; this is highest among those aged less than 20 (29%).⁶ In addition, 32% of injectors reported having shared spoons/water/filters/solutions in the previous month. It should be noted, however, that the overall proportion of needle/syringe sharing among IDUs has decreased from the peak level of 35% reported in 2001 to 21% in 2006/2007 and to 19% in 2007/2008.⁶

Men who have sex with men (MSM)

In 2008, 3868 MSM had an attributable HIV test and, of these, 121 (3.1%) were antibody positive (Table 3). The corresponding proportions for 2007, 2006, and 2005 were 4.4%, 3.1%, and 3.9%, respectively. While an overall 7% increase in testing among this population between 2007 and 2008 should be noted (3619 to 3868), a decrease in prevalence in all eleven NHS boards reporting cases was noted. In six NHS boards (Fife, Grampian, Greater Glasgow & Clyde, Lanarkshire, Lothian and Tayside) where a relatively high number (>100) of MSM had an attributable HIV test during 2008, notable decreases in prevalence were evident.

HIV prevalence among this population has remained between 3-4% in the past four years. There is some evidence that HIV transmission in Scotland is occurring among this group; among those undergoing a repeat attributable HIV test in a calendar year, eight seroconversions (a negative test result followed by a positive one) were recorded in 2005, 10 in 2006, 11 in 2007, and 15 in 2008.⁷ This finding is consistent with i) infection and

behavioural data collected in the Medical Research Council (MRC) Gay Men's Sexual Health Survey which indicates high-risk behaviour (e.g. unprotected anal intercourse) among this population, and ii) surveillance data indicating no sign of a decrease in the incidence of infectious syphilis and sustained high levels of rectal gonorrhoea infection in this group.^{8,9}

It is also worth noting that although there has been an 83% increase in the number of MSM undergoing HIV testing since 2003 when the opt-out testing policy was introduced, the MRC cross-sectional community sexual health surveys, undertaken since 1996, indicate that testing levels remain low and that small numbers of MSM undergo regular and repeat testing.⁹ As HIV testing of MSM is considered to be one of the most important measures in effecting a reduction in HIV transmission in this population, efforts to encourage testing must continue.

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NB Small numbers. Suppressed data in Tables 2-3 are represented by asterisks (*)

TABLE 2: Prevalence of HIV among adults (age 15+) having a named HIV antibody test, Scotland¹ 2006- 2008: non-IDU heterosexuals by geographical region of exposure and gender

Region of exposure	Year	Male			Female		
		No	+ve	Prev	No	+ve	Prev
UK	2006	9282	6	0.1%	9224	10	0.1%
	2007	10541	10	0.1%	10703	15	0.1%
	2008	12296	13	0.1%	12829	14	0.1%
Sub-Saharan Africa	2006	369	18	4.9%	447	30	6.7%
	2007	424	38	9.0%	470	56	11.9%
	2008	467	25	5.4%	586	52	8.9%
North Africa-Middle East	2006	*	*	2.4%	143	0	0.0%
	2007	*	*	1.1%	130	0	0.0%
	2008	*	*	0.9%	162	0	0.0%
Indian Sub-continent	2006	*	*	1.7%	*	*	2.0%
	2007	54	0	0.0%	57	0	0.0%
	2008	*	*	3.4%	*	*	3.5%
Far East-Other Asia	2006	*	*	0.7%	98	0	0.0%
	2007	*	*	1.1%	*	*	1.1%
	2008	468	6	1.3%	105	5	4.8%
North America	2006	232	0	0.0%	152	0	0.0%
	2007	205	0	0.0%	185	0	0.0%
	2008	262	0	0.0%	204	0	0.0%
Central South America	2006	70	0	0.0%	78	0	0.0%
	2007	*	*	1.0%	91	0	0.0%
	2008	103	0	0.0%	85	0	0.0%
Caribbean	2006	16	0	0.0%	33	0	0.0%
	2007	17	0	0.0%	32	0	0.0%
	2008	19	0	0.0%	41	0	0.0%
Western Europe	2006	569	0	0.0%	503	0	0.0%
	2007	*	*	0.2%	*	*	0.9%
	2008	*	*	0.2%	523	0	0.0%
Eastern Europe	2006	*	*	0.4%	*	*	0.6%
	2007	259	0	0.0%	*	*	0.6%
	2008	*	*	0.8%	239	0	0.0%
Australia	2006	153	0	0.0%	195	0	0.0%
	2007	*	*	0.8%	129	0	0.0%
	2008	135	0	0.0%	175	0	0.0%
Not Known	2006	*	*	2.3%	171	6	3.5%
	2007	*	*	0.7%	*	*	1.8%
	2008	*	*	0.4%	*	*	1.1%
Total	2006	11587	34	0.3%	11249	48	0.4%
	2007	13072	58	0.4%	12733	81	0.6%
	2008	15216	52	0.3%	15182	75	0.5%

¹ Grampian, Greater Glasgow & Clyde, Lothian and Tayside NHS Boards only

HPS use the following criteria in order to extract data for presentation.

Numbers tested: individuals tested. Excludes repeat tests carried out in individuals within the indicated calendar year, screening tests, and known positives who had previously presented in Scotland.

Positives: includes persons newly diagnosed HIV-positive (regardless of origin of infection), and persons known to be positive who are presenting in Scotland for the first time.

Excludes known positives who had previously presented in Scotland.

NHS board: NHS board of residence or, where this is not known, NHS board source of specimen.

TABLE 3: Prevalence of HIV among adults (age 15+) having a named HIV antibody test, Scotland 2006- 2008 by NHS board, selected exposure category, and year of test

NHS board	Year	Injecting drug users			MSM		
		Tested	Positive	% Positive	Tested	Positive	% Positive
Ayrshire & Arran	2006	70	0	0.0%	*	*	2.7%
	2007	23	0	0.0%	*	*	3.1%
	2008	17	0	0.0%	*	*	1.3%
Borders	2006	*	*	3.6%	*	*	3.6%
	2007	53	0	0.0%	*	*	5.7%
	2008	*	*	2.4%	22	0	0.0%
Dumfries & Galloway	2006	*	*	0.7%	33	0	0.0%
	2007	121	0	0.0%	*	*	11.5%
	2008	*	*	1.0%	44	0	0.0%
Fife	2006	86	0	0.0%	*	*	0.9%
	2007	114	0	0.0%	*	*	2.4%
	2008	47	0	0.0%	*	*	1.9%
Forth Valley	2006	15	0	0.0%	*	*	1.9%
	2007	22	0	0.0%	*	*	2.4%
	2008	9	0	0.0%	*	*	1.8%
Grampian	2006	*	*	0.4%	303	7	2.3%
	2007	*	*	0.8%	281	15	5.3%
	2008	*	*	0.5%	298	7	2.3%
Greater Glasgow & Clyde	2006	*	*	0.6%	1337	39	2.9%
	2007	*	*	0.2%	1373	45	3.3%
	2008	*	*	0.7%	1591	46	2.9%
Highland	2006	78	0	0.0%	*	*	3.8%
	2007	84	0	0.0%	*	*	2.9%
	2008	119	0	0.0%	91	0	0.0%
Lanarkshire	2006	*	*	0.8%	147	9	6.1%
	2007	*	*	0.4%	169	12	7.1%
	2008	192	0	0.0%	153	5	3.3%
Lothian	2006	*	*	0.7%	1349	49	3.6%
	2007	*	*	0.3%	1120	61	5.4%
	2008	*	*	0.4%	1227	54	4.4%
Orkney	2006	0	0	0.0%	0	0	0.0%
	2007	*	*	0.0%	0	0	0.0%
	2008	*	*	0.0%	*	*	0.0%
Shetland	2006	14	0	0.0%	*	*	0.0%
	2007	11	0	0.0%	*	*	0.0%
	2008	9	0	0.0%	*	*	0.0%
Tayside	2006	137	5	3.6%	*	*	0.7%
	2007	*	*	0.9%	199	9	4.5%
	2008	*	*	1.0%	195	5	2.6%
Western Isles	2006	0	0	0.0%	*	*	0.0%
	2007	*	*	0.0%	0	0	0.0%
	2008	*	*	0.0%	*	*	0.0%
Scotland	2006	2142	17	0.8%	3744	115	3.1%
	2007	2160	7	0.3%	3619	158	4.4%
	2008	2381	13	0.5%	3868	121	3.1%

Focus: Unlinked anonymous HIV testing of genitourinary medicine clinic attendees in Glasgow: 2008

Prepared by: Beth Cullen, Lesley Wallace, Glenn Codere, and David Goldberg

Anonymous HIV prevalence data among attendees of the genitourinary medicine (GUM) clinic in Glasgow during 2008 (January-June) are presented in Tables 1-3. Prior to 2005, similar data on GUM clinic attendees elsewhere in Scotland were available; however, due to the majority of GUM clinic attendees undergoing attributable HIV testing — as a consequence of the Sexual Health Strategy policy to offer all attendees with a sexually transmitted infection (STI) problem an HIV test¹ — anonymous HIV testing was discontinued in all centres except in Glasgow. Since some attendees still declined to have an attributable HIV test, it was considered important to continue the anonymous HIV testing initiative in one major site. Note that only GUM clinic attendees who i) attend the clinic with concerns about an STI problem for the first time within a calendar quarter, ii) have a blood sample taken for syphilis serology and, iii) do not object to a residual sample of their blood being tested anonymously for HIV, are eligible for entry into the survey. (In line with the National Services Scotland Statistical Disclosure Control Protocol, data in some cells are not disclosed due to the small numbers of reports.²)

Men who have sex with men (MSM)

During 2008 (Jan-June), HIV prevalence among MSM, including those previously diagnosed as HIV positive, was 4.4%; a prevalence higher than that reported in 2007 (3.9%), but lower than those reported in 2006, 2005, and 2004 (4.9%, 4.7%, and 4.9%, respectively). When those previously diagnosed positive are excluded, the prevalence in 2008 was 2.4%, compared with 2.3% and 3.0% in 2007 and 2006, respectively. In the absence of data on new or incident infection, serial prevalence data which exclude those previously diagnosed positive provide some insight into the incidence of HIV. Between 2004 and 2005, HIV prevalence among MSM (excluding those previously diagnosed positive) increased from 3.0% to 3.6%, a trend consistent with i) an increasing incidence of HIV among MSM, ii) increasing numbers of MSM at higher risk of HIV attending the GUM clinic, or iii) a combination of i) and ii). The subsequent decline in prevalence, however, observed between 2005 and 2007 (from 3.6% in 2005, to 3.0% in 2006, to 2.3% in 2007) was encouraging as it suggested that this trend had been reversed. The 2008 data indicate that the prevalence may have stabilised (2.4%).

Between 2004 and 2007, the proportion of HIV-positive MSM who were undiagnosed prior to their clinic visit and remained unaware of their infection following attendance decreased (from 49% in 2004 to 8% in 2007). This was a very encouraging sign which reflected the increase in test uptake as a result of the screening policy change to opt-out testing. During 2008, however, this downward trend has not been sustained. Seven of 17 (41%) HIV-positive MSM who were undiagnosed prior to the clinic visit, remained unaware of their infection following attendance. These data indicate the need for continued efforts to improve further HIV test uptake, particularly among high-risk MSM who attend GUM clinics, to reduce the prevalence of undiagnosed infection, one of the main aims of the HIV Action Plan in Scotland (2009-2014).³

Non-IDU heterosexual men and women

HIV prevalences among heterosexual men and women in 2008 were 0.2% and 0.3%, respectively, which remained the same on exclusion of any individuals who had been previously diagnosed HIV positive. The comparison of prevalences over time indicates little change, with the exception of an increase in prevalence among men between 2006 and 2007 (0.2% to 0.4%, respectively).

Among UK nationals (including those previously diagnosed HIV positive), prevalences remained low among men and women at 0.2% and 0.0%, respectively, which have been constant for many years. Among persons declaring African nationality, however, the prevalence among women (9.7%) was greater than that among men (6.6%). In comparison to previous years, this differential has decreased; however, for the last two years in succession, the prevalences among both male and female African nationals have increased following an approximate 50% decrease between 2004 and 2006. This observation may be partly explained by changes in the risk profile of African nationals who attend the Glasgow GUM clinics. For Africans at high risk of being HIV infected, more appear to be attending the GUM clinic setting for a test and fewer appear to be attending other clinical settings such as their general practitioner. (Please note the data in the accompanying Focus report indicate an 18% increase in testing amongst this population in all settings between 2007 and 2008, building on a 10% increase observed between 2006 and 2007.)

Of non-UK, non-African nationals, 0.2% were identified as having HIV infection during 2007/2008. Furthermore, a respective 25% and 0% of HIV-infected heterosexual men and women who were not aware of their infection prior to their GUM clinic visit, remained unaware of their status following attendance in 2008. These proportions are considerably less than those observed among men and women during 2007 (56% and 67%, respectively), though these data should be interpreted with caution as the absolute numbers are low over the six-month period of testing.

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TABLE 1: HIV prevalence among non-IDU GUM clinic attendees in Glasgow by sexual orientation and year of specimen 2005-2008 (1 Jan-30 Jun)

		Tests	All Pos	Prevalence	Previously Unk Pos	Prevalence
MSM	2005	554	26	4.7%	19	3.6%
	2006	698	34	4.9%	20	3.0%
	2007	593	23	3.9%	13	2.3%
	2008	746	33	4.4%	17	2.4%
Het M	2005	*	*	0.2%	*	0.1%
	2006	*	*	0.2%	*	0.2%
	2007	2074	9	0.4%	9	0.4%
	2008	*	*	0.2%	*	0.2%
Het F	2005	*	*	0.2%	*	0.2%
	2006	*	*	0.3%	*	0.2%
	2007	*	*	0.3%	*	0.2%
	2008	2387	6	0.3%	6	0.3%

TABLE 2: HIV prevalence among GUM clinic attendees in Glasgow by exposure category and nationality, 2007 & 2008¹ (combined)

Nationality	Heterosexual Males			Heterosexual Females			All Exposure Categories		
	Tested	Positive	Prevalence	Tested	Positive	Prevalence	Tested	Positive	Prevalence
UK	4261	7	0.2%	3856	0	0.0%	9591	57	0.6%
Rest of Europe	123	0	0.0%	155	0	0.0%	*	*	0.9%
Americas	*	*	4.8%	40	0	0.0%	*	*	2.8%
Africa	106	7	6.6%	113	11	9.7%	235	18	7.7%
Asia	67	0	0.0%	28	0	0.0%	*	*	0.9%
Oceania	17	0	0.0%	12	0	0.0%	*	*	2.9%
Total	4595	15	0.3%	4204	11	0.3%	10379	82	0.8%

¹ Excludes with nationality not known

TABLE 3: HIV infections among non-IDU GUM clinic attendees by diagnosis status; 2005 to 2008 (1 Jan-30 June)

		% previously diagnosed ¹		% diagnosed at that visit ²		% undiagnosed after clinic visit ³	
		%	N	%	N	%	N
MSM	2005	27	(7/26)	79	(15/19)	21	*
	2006	41	(14/34)	70	(14/20)	30	(6/20)
	2007	44	(10/23)	92	(12/13)	8	*
	2008	48	(16/33)	59	(10/17)	41	(7/17)
Het M	2005	50	(2/4)	50	*	50	*
	2006	25	(1/5)	50	*	50	*
	2007	0	(0/9)	44	*	56	(5/9)
	2008	67	*	75	*	25	*
Het F	2005	0	*	100	*	0	*
	2006	40	*	67	*	33	*
	2007	40	*	33	*	67	*
	2008	0	(0/6)	100	(6/6)	0	(0/6)

¹ % = Number previously diagnosed/total HIV positive

² % = Number diagnosed at visit (total HIV positive - previously diagnosed)

³ % = Number remaining undiagnosed after clinic visit (previously undiagnosed - number diagnosed at that visit)

Focus: HIV in Scotland, 2009: Review

Prepared by: Beth Cullen, Lesley Wallace, Glenn Codere, and David Goldberg

In 2009, a total of 417 newly identified cases of HIV were reported to Health Protection Scotland – a similar number to that reported in 2008 (411). This compares with annual reports of between 150 and 180 diagnoses during the 1990s, between 160 and 250 from 1998 to 2002, and between 250 and 450 from 2003 to 2007. The steady increase in HIV diagnoses observed in recent years may, in part, be attributable to the Scottish Government policy to offer and recommend an HIV test to all genitourinary medicine (GUM) clinic attendees suspected of having a sexually transmitted infection.¹ Notably, a 36% increase was observed in the number of newly identified infections in the Greater Glasgow & Clyde NHS Board area, while percentage decreases of 34% and 28% were recorded in Lothian and Grampian NHS Boards, respectively. In 2009, as in the preceding seven years, most new cases were diagnosed in the Greater Glasgow & Clyde NHS Board area (190).

FIGURE 1a: HIV reports, Scotland by year of report and NHS board; to 31 December 2009

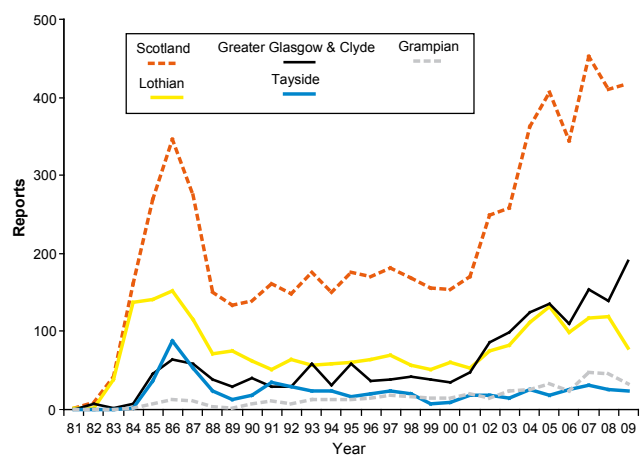
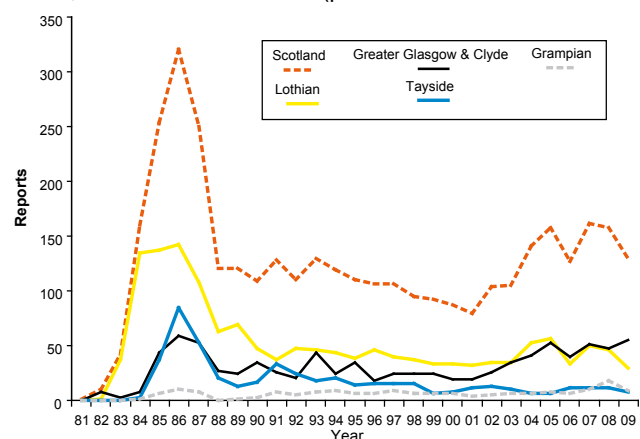


FIGURE 1b: HIV reports, Scotland by year of report and NHS board; to 31 December 2009 (presumed infected in Scotland)



At a risk group level, as in all years since 2000, the number of cases in the heterosexual risk category (196) exceeds those in men who have sex with men (MSM) (137). This may, however, change as new information becomes available for the 111 cases (51 of which have been initially reported as heterosexual) still under investigation and for whom transmission category information is incomplete. Following an increase in the number of new cases reported among injecting drug users (IDUs) from 10 in 2007 to 19 in 2008, the number decreased in 2009 to 15,

suggesting that HIV transmission among IDUs in Scotland remains uncommon.

Further analysis indicates that over 40% of the newly reported cases, for whom geographical area of exposure is known, were presumed to have acquired their infection outside Scotland (176). Over the last five years, the proportion of non-IDU heterosexuals who were presumed infected in Scotland has remained stable at around 16% (31/198 in 2005 and 32/196 in 2009) with the exception of 2008 when 20% (42/210) of individuals in this group were presumed infected in Scotland. These recent annual figures represent a reduction from pre-2003 figures when annual proportions fluctuated between 24% and 32%. However, for some cases the data are incomplete at the time of publication. Of the 130 individuals presumed to have acquired their infection in Scotland, 68% (89/130) were MSM, representing 65% (89/137) of the new MSM cases recorded during 2009.

FIGURE 2a: HIV reports, Scotland by year of report and transmission category; to 31 December 2009

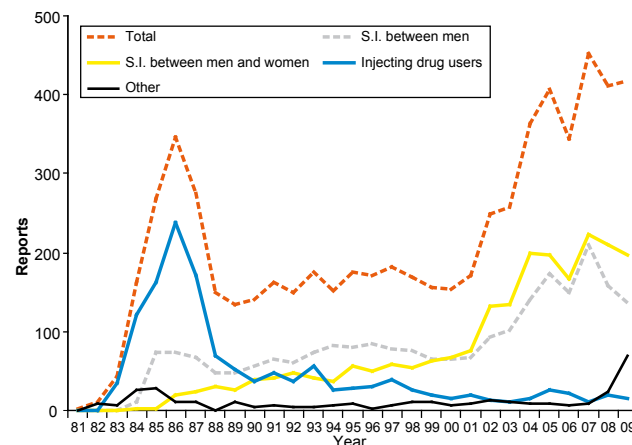
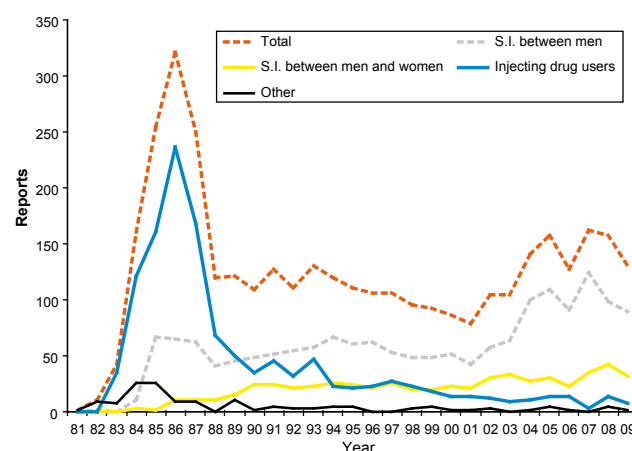


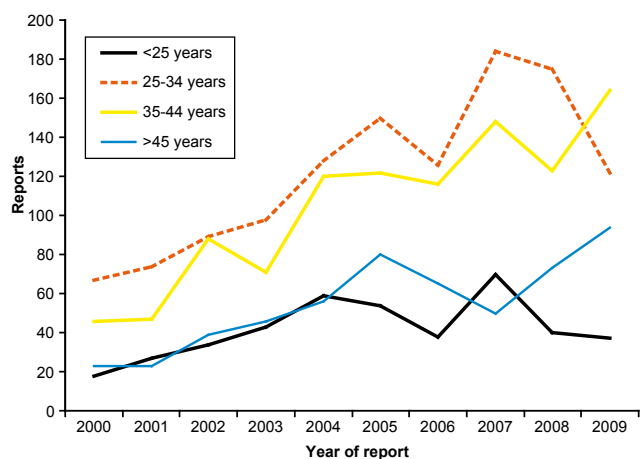
FIGURE 2b: HIV reports, Scotland by year of report and transmission category; to 31 December 2009 (presumed infected in Scotland)



Between 2008 and 2009, decreases of 14% (159 to 137) and 7% (210 to 196) in the number of new diagnoses among MSM and non-IDU heterosexual men and women, respectively, were observed. The former was particularly notable in Lothian NHS Board (61 to 37), and the latter, in Lothian (54 to 32) and Grampian (31 to 18) NHS Boards. There were increases

in Greater Glasgow and Clyde NHS Board among both MSM (47 to 66) and non-IDU heterosexual men and women (76 to 109). Also of note are i) the decrease in the number of cases in 2009 among individuals aged 25 to 34 years (from 175 to 122), the lowest annual number recorded in this age category since 2003, and ii) the increases in cases among individuals aged 35 to 44 years (from 123 to 164), and 45 years and over (from 73 to 94), the highest annual numbers ever recorded in these groups. Cases among those aged less under 25 remained stable. The majority of cases among individuals aged 35 to 44 years and among those aged 45 and over were identified in Greater Glasgow & Clyde (71 and 35, respectively) and Lothian (35 and 15, respectively) NHS Boards. Of the 164 cases aged 35 to 44 years, half occurred among non-IDU heterosexual men and women (83) and a further 30% (50) among MSM. This is similar to the observation among individuals aged 45 and over - 44% of cases occurring among non-IDU heterosexual men and women (41), and a further 29% occurring among MSM (27). The median ages of non-IDU heterosexuals and MSM newly diagnosed in 2009 were 37 years and 35 years, respectively. Over the past five years, the median age at diagnosis has remained relatively stable among MSM, while among non-IDU heterosexuals, a rise has been observed from 33 years in 2007 to 34 years in 2008, to 37 years in 2009.

FIGURE 3: HIV reports, Scotland by year of report and age at diagnosis to 31 December 2009



HIV infection among men who have sex with men

The decline in newly identified cases of HIV among MSM observed between 2007 and 2008 (from 208 to 159) was sustained in 2009 (137); the lowest annual figure recorded since 2003, though one that is expected to rise as active follow-up is completed on currently unclassified cases. This finding may reflect a change in the incidence of infection among this group, following a peak in 2005, particularly given that, across Scotland, HIV prevalence, in MSM undergoing attributable HIV testing, also decreased in 2008 (3.1%; 121/3868), having increased from 3.1% (115/3744) in 2006 to 4.4% (158/3619) in 2007. Further data, however, generated through the attributable HIV testing of MSM, suggest such a change is unlikely: of those undergoing a repeat attributable HIV test in a calendar year, eight seroconversions (a negative test result followed by a positive one) were recorded in 2005, but increases have been noted year on year since then with 10 recorded in 2006, 11 in 2007, and 15 in 2008. Data generated through the unlinked anonymous HIV testing of syphilis

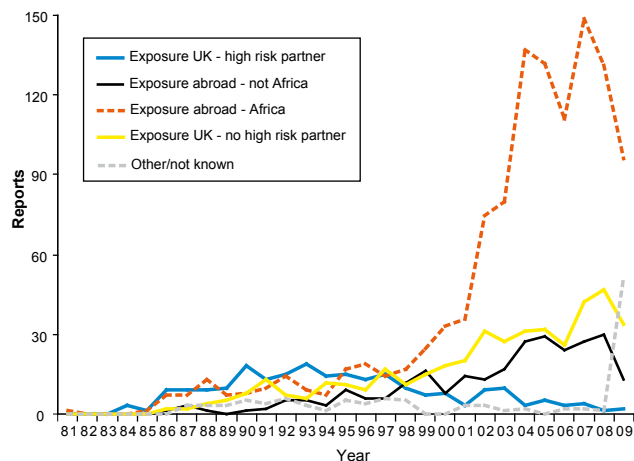
specimens from MSM attending Glasgow GUM clinics, and the attributable HIV testing of MSM also suggest no change - HIV prevalence among attendees who had not been previously diagnosed HIV positive remained stable between 2007 and 2008 (2.3% and 2.4%, respectively). Furthermore, the incidence of infectious syphilis among MSM over the past few years seems to show no sign of decreasing despite considerable health promotion efforts to increase awareness and access to testing (data for 2009 are not yet available), while data from enhanced surveillance consistently reveal that one fifth of MSM diagnosed with infectious syphilis are co-infected with HIV. In addition, although the overall number of episodes of gonorrhoea infection in MSM has decreased in the past two years, the incidence of rectal gonorrhoea, an indicator of unprotected anal intercourse, which increased among MSM in 2007 to the same level as that reported in 2003, remained stable in 2008, accounting for almost one third of all gonorrhoea diagnoses among MSM (data for 2009 are not yet available). Information from both infection data and behavioural studies indicates that unprotected sexual intercourse continues to occur, and thus the risk of HIV acquisition among MSM is evident despite initiatives to raise awareness and levels of knowledge.^{2,3} Such behaviour continues to pose a considerable public health challenge.

HIV infection among non-IDU heterosexuals

The observed decrease in newly identified cases among non-IDU heterosexual men and women appears to be principally due to a decrease in the number of detections among infected men and women who probably acquired their infection in African countries (from 130 in 2008 to 96 in 2009). There was a corresponding reduction in the proportion of heterosexually acquired cases belonging to this group from 62% in 2008 to 49% in 2009, though this may change as a result of further information on transmission risk becoming available for a number of cases. From the data currently available, it appears that the peak year for cases with an African connection was 2007 (148/224). The decline in total numbers between 2008 and 2009 may reflect i) a decline in the number of migrants from African countries coming to Scotland, ii) a decline in the prevalence of HIV among such African migrants, or more likely iii) a combination of i) and ii). HIV prevalence among persons with risk exposure in sub-Saharan Africa decreased from 10.5% (94/894) in 2007 to 7.3% (77/1053) in 2008. Prevalence data for 2009 are not yet available.

Among non-IDU heterosexual men and women who probably acquired their HIV in Scotland, 27 cases of HIV were identified in 2008. Although this figure is lower than those recorded in the previous two years, it may increase if new data become available. In the previous five years, the average number of cases per year was 30. As indicated by data from unlinked anonymous HIV testing studies, HIV prevalence among non-IDU heterosexuals in Scotland who are unlikely to have had any risk exposure in sub-Saharan African countries remains low. In 2008, the prevalences among non-IDU heterosexual men and women of UK nationality attending Glasgow GUM clinics were 0.2% and 0.0%, respectively; which have been constant for many years and are consistent with the prevalence in those men and women undergoing attributable testing across Scotland (0.1% and 0.1%, respectively).

FIGURE 4: HIV reports, Scotland heterosexual transmissions by year of report and heterosexual sub-category; to 31 December 2009



In 2008, an approximate twenty-fold lower prevalence of HIV among pregnant women, born in the UK receiving antenatal care in Scotland (0.03%, 8/27474), compared to that among pregnant women born outside the UK (0.6%, 18/3257), was observed. These findings represent a decrease in HIV prevalence among UK born pregnant women, but an increase among non-UK born pregnant women compared to 2007 (0.05%, 12/26339 and 0.48%, 10/2068, respectively); resulting in a larger differential compared to previous years. Universal antenatal testing continues to detect HIV infection among pregnant women. Of 13 infected women undiagnosed prior to pregnancy who gave birth during the first six months of 2008, 10 (77%) were diagnosed antenatally. While reductions in the proportions of HIV-infected women remaining undiagnosed during pregnancy have been observed over the last five years, the proportion recorded in 2008 (23%) was the highest since 2003 (45%).

HIV infection among IDUs

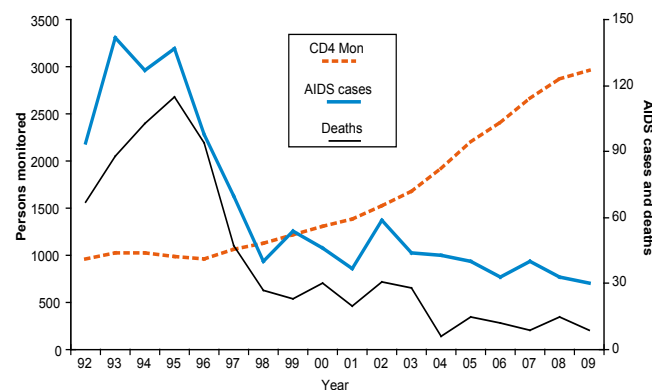
Between 2008 and 2009, the number of newly identified cases of HIV reported among IDUs decreased (from 19 to 15). The annual totals have remained low over the last three years with 10 and 19 diagnoses recorded in 2007 and 2008, respectively. Of the 15, seven were probably infected in Scotland. All were aged between 33 and 54 years. Encouragingly, the prevalence of HIV among IDUs undergoing attributable HIV testing in Scotland has remained relatively stable between 2007 and 2008 (0.3% and 0.5% respectively) and remains lower than in previous years (0.9% in 2005 and 0.8% in 2006), indicating that HIV transmission among this population is uncommon. Data from the Scottish Drugs Misuse Database highlight a reduction in needle/syringe sharing among IDUs in Scotland between 2006/2007 and 2007/2008.⁴ The 2006/2007 survey indicated that 29% of current IDUs had 'used a needle or syringe that someone else has used' in the previous month, but this proportion reduced to 27% in 2007/2008. This finding is similar to that reported for 2005/2006 when 27% of current IDUs reporting that they had 'lent/borrowed/shared' a needle or syringe in the previous month and indicates a considerable reduction from the peak level of 35% reported in 2001.⁴ Due to

revision of the question on sharing in April 2006, however, pre- and post-2006 data are not directly comparable. The 2008/2009 data will be available shortly (<http://www.drugmisuse.isdscotland.org/publications/abstracts/isdbull.htm>).

HIV treatment and care

The number of HIV infected individuals in specialist care (as indicated by the number of persons having a CD4 cell count test to monitor their immune function) has risen continuously over the last decade, more than doubling since 2000 (1360 to 3040), a figure which is expected to increase further as reports for the last quarter of 2009 are collated by HPS (in the first quarter of 2010). Approximately 76% of those in care were on triple therapy or higher in the twelve months prior to September 2009 (latest data available). Of these individuals, 96% had evidence of reasonable viral control (indicated by a viral load of <400 copies/ml) (see Table 9 in ANSWER report). The initial downward trend in AIDS diagnoses and AIDS-related deaths observed since the introduction of antiretroviral therapy in 1996 has remained stable in more recent years with 30 (the lowest number ever recorded) and nine, respectively, in 2009. Thus, there are more people living with HIV infection in Scotland than ever before. Data indicate that, of 299 individuals who were diagnosed for the first time in Scotland (and were not known elsewhere), and who attended for CD4 monitoring, between 1 October 2008 and 30 September 2009, almost one fifth (19%, 56/299) were diagnosed late (indicated by a CD4 count of <200 within 30 days of their earliest positive diagnosis). Thus, with the continuing high numbers of HIV diagnoses and the increase in the numbers of persons in specialist care and on therapy in 2009, one of Scotland's most pressing HIV challenges is to ensure that all infected persons needing treatment and care receive it.

FIGURE 5: AIDS cases (and known deaths) and persons undergoing CD4 count monitoring, Scotland to 31 December 2009*



* CD4 count monitoring data for 2009 only available up to 30 September.

References

1. Scottish Government. Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health. Edinburgh: Scottish Government, 2005. Available at: <http://www.scotland.gov.uk/Publications/2005/01/20603/51182>.
2. Williamson LM, Hart GJ. High prevalence and undiagnosed infection among a community sample of gay men in Scotland. *J Acquir Immune Defic Syndr* 2007; **45**(2): 224-230.
3. Williamson L, Flowers P, Knussen C, Hart GJ. HIV testing trends among gay men in Scotland, UK (1996-2005): Implications for HIV testing policies and prevention. *Sex Transm Infect* 2009; **85**: 550-554.
4. Information Services Division, NHS National Services Scotland. Drug Misuse Statistics Scotland 2008. Edinburgh: Information Services Division, 2008. Available from: <http://www.drugmisuse.isdscotland.org/publications/08dmss/08dmss.pdf>

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?subjectid=18>.

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 (by age)
Week ended 12 February 2010

A National Statistics release

Infectious Disease	Age Group																			
	All ages		Under 1		1 - 4		5 - 14		15 - 24		25 - 34		35 - 44		45 - 64		65 & over		Not known	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Anthrax	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Botulism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Brucellosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cholera	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Syndrome <i>E.coli</i> 0157	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Diphtheria	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Haemolytic Uraemic Syndrome (HUS)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Haemophilus Influenzae Type B (Hib)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Measles	2	-	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Meningococcal infection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mumps	7	9	-	-	1	-	1	1	2	6	1	1	1	1	1	-	-	-	-	-
Necrotizing Fasciitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Paratyphoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Pertussis	-	1	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-
Plague	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Poliomyelitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rabies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rubella	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Severe Acute Respiratory Syndrome (SARS)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Smallpox	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tetanus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuberculosis : respiratory	5	1	-	-	-	-	-	-	1	-	1	-	1	-	3	-	-	-	-	-
Tuberculosis : non-respiratory	2	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	-
Tularemia	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Typhoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Viral haemorrhagic fevers	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
West Nile Fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Yellow Fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	16	11	0	0	3	0	1	1	2	7	2	1	2	1	5	1	0	0	1	0

Statutory Notification of Infectious Diseases (by NHS board)
Week ended 12 February 2010

Infectious Disease	NHS BOARD AREA														Current week	Previous week	Current week last year	Total from 1st week of year			
	AA	BR	DG	FF	FV	GR	GG	HG	LN	LO	OR	SH	TY	WI				2009	2010		
Anthrax	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	23		
Botulism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
Brucellosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
Cholera	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-		
Clinical Syndrome <i>E.coli</i> O 157	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1		
Diphtheria	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-		
Haemolytic Uraemic Syndrome (HUS)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
Haemophilus Influenzae Type B (Hib)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
Measles	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	2	-	5	27	9
Meningococcal infection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4	2	39	8
Mumps	1	-	-	1	1	3	3	-	2	1	-	-	4	-	-	-	16	22	10	59	83
Necrotizing Fasciitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Paratyphoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	1	1
Pertussis	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	2	4	11	4
Plague	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Poliomyelitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rabies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rubella	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	13	7
Severe Acute Respiratory Syndrome (SARS)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Smallpox	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tetanus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuberculosis: respiratory	-	-	-	-	-	-	6	-	-	-	-	-	-	-	-	-	6	7	5	27	41
Tuberculosis: non-respiratory	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-	-	2	12	7	19	30
Tularemia	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Typhoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Viral haemorrhagic fevers	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
West Nile Fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Yellow Fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	1	0	0	1	1	3	11	1	3	2	0	0	4	0	27	48	35	198	208		

Amendments: add 1 Mumps (1 x LO wk 5).

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