Bovine spongiform encephalopathy

Bovine spongiform encephalopathy is a disease of cattle which was first diagnosed in the British Isles in 1986. So far, over 14 000 cattle have been diagnosed as suffering from this disease. Approximately 300 new cases are reported each week with no sign of a downturn in numbers. The disease is thought to be caused by a virus or a protein particle from a protein cattle feed containing brain tissue of sheep suffering from scrapie. The incubation period of the disease is five to seven years. There are no diagnostic tests for the disease in cattle and symptoms occur only shortly before death. Similar diseases have been described in humans, sheep, mink, zoo herbivores and cats.

Certain control measures have been implemented and these include the slaughter of cattle diagnosed as suffering from the disease with the destruction of the carcass so that animals known to be infected do not enter the food chain; a ban on the use of certain bovine offals for human consumption, where the animal is less than six months old; a ban on the use of milk from an infected animal for human consumption, but this milk can be used for an infected cow's calf.

(J F)

Influenza

As in 1989 this year has seen an outbreak of influenza B following the annual winter epidemic of influenza A. Figure 1 shows how virus laboratory reports in Scotland have reflected this situation.

It seems that influenza B causes illnesses that are not so easily recognized as the traditional 'flu like illness'. It may present as 'gastric flu' where vomiting is a marked feature and also with a persistent and progressively severe headache associated with fever that can raise suspicions of meningitis. A painful cough owing to tracheitis is less common in influenza B than A, although bronchitis or pneumonia, especially in smokers and the elderly, are frequently reported as complications.

(E W)

Hand, foot and mouth disease

Strictly speaking hand, foot and mouth disease is a syndrome rather than a diagnosis of a specific infection. It is usually caused by coxsackie A16 but may also be caused by other enteroviruses. These agents are highly infectious, probably spreading by faeco-oral transmission, though respiratory secretions may also play a role. The syndrome appears throughout the year with a summer peak in the number of cases. Children under the age of 10 years are most commonly affected, but adults may present as sporadic cases and family clusters can occur. Although cases are regularly reported, an increase in numbers occurs every four years or so.

After an incubation period of between two days and two weeks (usually three to five days) there is a one to two day prodromal period with a sore mouth and pyrexia during which mucosal vesicles with a similar distribution to those of herpetic gingivostomatitis develop. At least 75% of cases develop peripherally distributed cutaneous lesions. These may involve either the extensor or flexor surfaces of the hands and feet (or less commonly just the hands) and take the form of papules and subepidermal vesicles with a surrounding area of erythema (often purplish). When both the peripherally distributed exanthem and the enanthem are fully developed diagnosis is straightforward. Herpangina may sometimes be accompanied by a similar (non-vesicular) exanthem but its enanthem tends to lie more posteriorly. Herpetic gingivostomatitis is usually associated with greater systemic disturbance and lesions owing to secondary inoculation in the skin are distinctive in their distribution. The disseminated rash may occur in individuals with pre-existing eczema.

Older patients may run a relapsing course over several weeks before eventual resolution. Apart from an occasional reluctance to eat there are few other problems. The patients are usually at their most effective in the first few days of symptoms. Clinical diagnosis is usually adequate, but if confirmation is desired (for example in an adult, or where there is concern that the illness is due to Stevens-Johnson syndrome associated with drug toxicity) isolation of virus from stool or vesicle fluid is the usual method. Early in the course of infection throat swabs may be usefully cultured. Serological tests are not routinely available. It should be remembered that patients who have had the syndrome are only protected against the specific enterovirus of infection and thus further episodes may occur.

(P W)

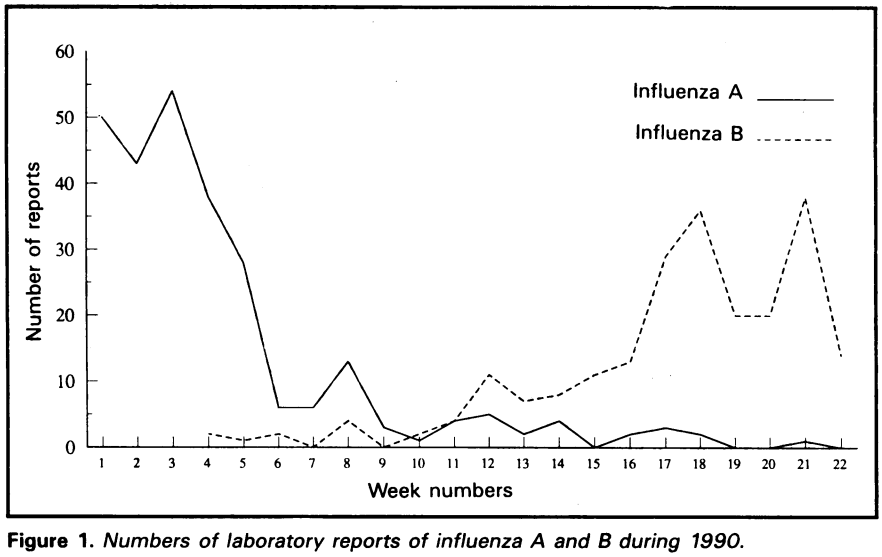

Figure 1. *Numbers of laboratory reports of influenza A and B during 1990.*

Meningococcal vaccination certificates for Saudia Arabia

This year, vaccination certificates are required by the Saudi authorities for all pilgrims to Mecca but not for those travelling to other parts of the country. The certificates must confirm that vaccination against meningococcal infection has been performed no more than two years and not less than 10 days before arrival. Vaccine manufactured by Smith Kline and French or Merieux UK is available on prescription.

(E W)

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