species and serogroups. Based on the IASR, 28 cases (21%) were diagnosed by culture of the organism, 57 cases (42%) by urinary antigen detection and a similar number of cases by seroconversion. The Legionella urinary antigen test has a sensitivity of 63.8–88.9% and a specificity that approaches 100% (8). Sensitivity can be further improved if the urine is concentrated by ultrafiltration. The urine antigen detection EIA method proved to be rapid and easy to use, and it can detect antigen in the early stage of the disease with high sensitivity and specificity. Therefore, we recommend the urinary antigen assay as the ideal method for the diagnosis of legionellosis. Though it is only possible to obtain in Japan by importation, the test is commonly used in Europe and the United States. Its use for the diagnosis of LD should be considered in Japan.

Clinical issues

During the 16 months since the enforcement of the new IDCL legislation, there have been far more new patients with LD than those reported during the 14 years investigated by the Working Party on Legionellosis in Japan. This reflects the increased awareness of this disease due to the enforcement of the new Law and the increase in cases subjected to confirmatory diagnosis due to the development of simple diagnostic tests. Availability of the urinary antigen detection test, the most rapid and simple diagnostic method for legionellosis, should allow earlier and adequate treatment, leading to a further decrease in the mortality rate.

Screening for LD cannot be effectively without well-developed national screening schemes, designed to provide data in an informative and timely way. The Infectious Disease Surveillance Center (IDSC) is assisting in this process through sharing of information on cases, and providing epidemiological, microbiological and environmental data related to Legionella infection.

References

(in effect since 1987) was abrogated and the Law Concerning the Prevention of Infectious Diseases and Medical Care for Patients of Infections (the Infectious Disease Control Law) was enacted in Japan.

In the new Infectious Disease Control Law, all infectious diseases of new categories I through IV are designated. All category I through III infectious diseases and 33 kinds of category IV diseases require notification of all cases, and 28 of category IV are surveyed on the basis of the reports from sentinel clinics and hospitals. The concept of emerging/re-emerging diseases has been introduced and several of these diseases are categorized in this Law (1).

The data collection, analyzing and dissemination are the responsibility of the Infectious Disease Surveillance Center (IDSC) of the National Institute of Infectious Diseases (NIID). Updated information is disseminated on the home page, IDWR: Infectious Disease Weekly Report, of IDSC with both html and PDF-file forms on a weekly basis (2).

Recently the biannual surveillance data from April 1, 1999 to December 31, 2000 was released officially and the situations of emerging/re-emerging infectious diseases in Japan are shown as follows: Ebola (0/0), Plague (0/0), Cholera (39/58), Diphtheria (2/1), EHEC (3,115/3,638). (Number of cases 1999/2000)

The complete data is available on CD-ROM released by the Ministry of Health, Labor and Welfare, and IDSC/NIID (3).

References