GGNHSB PHPU NEWSLETTER

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Thiomersal in vaccines

After the series of scare-stories about thiomersal-containing vaccines in early-January editions of The Scotsman, Jackie Kemp's balanced and reasoned article in The Herald (15th Jan 03) brought some relief to public health clinicians forced yet again to respond to misleading and fear-inducing articles about childhood vaccines.

She points out that initial scare stories arose from an NHS-sponsored web site, *UKMI*, where a FAQs article aimed at GPs stated that the very low thiomersal concentrations *'may be toxic in utero and during the first six months of life'*. This was a direct quotation from an article by a Dutch dermatologist, v'ant Veen, published in the journal *Drugs, 2001, vol. 61, no.5*.

When contacted by the Herald staff, Veen explained that his paper looked at the effect of thiomersal (contained in cleaning agents, some skin care products, contact lens solutions) *on the skin* and that although he commented in his article that thiomersal 'may be toxic' for babies in the womb, this was based on an American study which reported toxic effects in Iraqi children who had eaten food accidentally contaminated with very high doses of organic mercury. He added that the dose of thiomersal in vaccines was, however, very low and, furthermore, he was not aware of any evidence to link thiomersal and autism.

Thiomersal, which contains *ethylmercury*, an organic form of mercury, is effective in killing bacteria and has been used since the 1930s to prevent bacterial contamination in vaccines. *Ethylmercury* is rapidly removed from the body after vaccination and should be distinguished from *methylmercury*, the most common form of organic mercury which is present in the environment and particularly in deep-sea predatory fish. It has a longer (40-50 days) half-life in breast-feeding infants.

Recent reviews investigating the issue of thiomersal in vaccines all agree that with the possible exception of minor skin reactions, there is no evidence of any significant risk associated with the amount of thiomersal present in vaccines. Nevertheless, it has been agreed on a European-wide basis that even though there is no evidence of toxicity, purely as a precautionary measure, thiomersal–containing vaccines should be phased out over time as soon as equally safe and effective alternatives are available.

Glasgow - HIV doubled in 02

The latest figures from the Scottish Centre for Infection and Environmental Health (SCIEH) show that there has been a dramatic increase in the numbers of new HIV cases recorded in Greater Glasgow NHS Board. In 2002, the total number of new cases was **82** compared with **41** in 2001. For the first time since testing began in 1985, GGNHSB has more new diagnoses than any other NHS Board in Scotland, including Lothian.

Over half of these new cases – **45** of the 82 - were among heterosexual men and women. Although the majority of these (35) were contracted outside the UK, a small but significant number (10) were contracted in the UK. There was also an increase in the numbers of HIV cases reported among men who have sex with men (MSM), rising from **16** in 2001 to **27** in 2002. However, there were no new cases of HIV amongst injecting drug users (IDUs) in 2002. Given this alarming increase in HIV, colleagues in the community are asked to take every opportunity to reinforce safe-sex messages, particularly among young people.

The Glasgow figures for these routes of transmission reflect the Scottish situation, where a 67% increase in the numbers of heterosexual cases has been reported nationally with the majority of cases acquired abroad. However, HIV subtype data, which is available for the first time, indicates that nationally, approximately one third of the heterosexual cases, presumed to have been infected within the UK, had a non-B subtype. Non-B subtypes are usually associated with infection acquired in resource-poor countries. This is a worrying statistic, because it may indicate that non-B subtypes are beginning to spread among the indigenous heterosexual population (see full SCIEH report for more details).

The numbers of new AIDS diagnoses in Scotland rose from **46** in 2001 to **73** in 2002, the highest number since the introduction of Highly Active Anti-Retroviral Therapy (HAART) in 1996. The rise in AIDS cases is mainly due to the large numbers of people – many from abroad – receiving a late diagnosis of both HIV and AIDS. This reinforces the necessity for earlier detection and an increase in the awareness and uptake of testing

The full SCIEH report can be found at:
http://www.show.scot.nhs.uk/scieh/PDF/pdf2003/0303.pdf

HIV, STIs and insurers

The British Medical Association and Association of British Insurers have recently issued new guidance on what information GPs can provide to insurers about HIV and sexually transmitted infections (STIs).

For some time, the disclosure of information to third parties, particularly insurance firms, has been seen as a deterrent to people seeking advice and testing for HIV and other STIs. The new guidance states that there is no reason to disclose '*information about an isolated incident of an STI that has no long-term health implications, or even multiple episodes of non-serious STIs*'. Similarly, *"insurance companies should not ask whether an applicant has taken an HIV, Hepatitis B or Hepatitis C test, had counselling in connection with such a test, or received a negative test result. Doctors should not reveal this information when writing reports and insurance companies will not expect this information to be provided*". **Insurers may ask only whether someone has had a *positive* test result, or *receiving treatment* for HIV/AIDS or Hepatitis B or C.**

In the HIV article in December's issue of the newsletter, we stated that '*pre-test counselling* [for HIV] *is no longer thought necessary*'. We were keen to stress that HIV testing should be normalised and its diagnosis considered a task for *all* medical practitioners. The insurance guidance above should help with this. However, practitioners *must* obtain informed consent to testing. The GMC guidance on serious communicable disease advises that pre-test discussion/counselling be a prerequisite to ensure the patient is given appropriate information about the implications of the test and adequate time to consider and discuss them.

Paragraph 4 of the GMC guidance states that the pre-test information must be appropriate to the circumstances and the nature of the condition being tested. Receiving an HIV diagnosis can be devastating, and it is important to recognise that some patients considering an HIV test may request or require more in-depth discussion or counselling. As a minimum, someone carrying out an HIV test should arrange a clear date and time to give the result and should feel able to give a positive result. Health Advisors at the Sandyford Initiative (211 8634) and counsellors from the CAST team at the Brownlee Centre (211 1074) are always available to offer advice or services to professionals undertaking such tests.
www.bma.org.uk/ap.nsf/Content/MedicalInfoInsurance
www.gmc-uk.org/standards/serious.htm.

Pneumococcal vaccine(≥65yrs)

The Joint Committee on Vaccination and Immunisation (JCVI), which provides advice to all UK health departments on immunisation and vaccination issues, has recently recommended the routine vaccination of people aged 65 years and over to protect against pneumococcal disease. The Scottish Minister has accepted this recommendation and has set up a group to look at the practicalities of this being implemented in Sept/Oct 03.

Lab-diagnosis of measles

The PHPU has not recorded any laboratory-confirmed cases of measles infection in the past few years. However, in order to verify clinical diagnosis and for general surveillance purposes, we would advise GPs to ask us for a saliva-testing kit for diagnostic confirmation when notifying the department of clinical cases.

Salivary testing is an accurate and non-invasive way of measuring specific antibody levels to measles (IgM and IgG). Swabs are easy to take and can be done by health-care personnel, the parent/carer(s) of a child or an adult case themselves.

A definite case is the detection of measles IgM in saliva **or** a four-fold rise in IgG **in conjunction** with a negative history of measles vaccination in the 6-weeks prior to the onset of symptoms. A probable case is defined as a case with a rash occurring within 4 weeks of contact with a definite case.

The sample should be taken between 1 and 4 weeks after the onset of the first symptom and sent to the *Public Health Laboratory Service, London. The results will be posted to the GP usually within 3 weeks. Please note that a negative result will not affect the payment of the notification fee.

*An instruction sheet, pre-paid plastic envelope and relevant forms are all in the kit which can be obtained from the PHPU (201 4917).

Low-dose diphtheria

In January's newsletter we advised that due to the lack of low-dose diphtheria vaccine, the combined Td vaccine could be administered, with appropriate advice, even if the patient had had a recent tetanus injection. However, we've recently been informed that low-dose diphtheria vaccine is now available and can be ordered through the usual route.

Combined hepA/hepB vaccine

In May 2002, the PHPU wrote to all GPs and relevant health care professionals advising the use of the combined hep A and hep B vaccine (Twinrix) for patients with a present or past history of intravenous drug use and patients with chronic hepatitis C infection. This vaccine offers protection against both hepatitis A and B virus. Please note that the combined vaccine is to be used for **all new patients** presenting for vaccination; those already started on a course of hep B vaccination should continue with the single vaccine.

The original PHPU letter of May 2002 can be found on the web site below. (PHPU letters to GPs/Trusts/HVs dating back to Jan 02 are now available on our web site)
www.show.scot.nhs.uk/ggnhsb/Depts/public_health/phpu/letters

If you would like to comment on any aspect of this newsletter then contact Dr Marie Laurie on 201 4933