

GGNHSB PHPU NEWSLETTER

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www.nhsgg.org.uk (TEL: 0141 201 4917/FAX:0141 201 4950)

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SARS

On the 12th March 2003, the World Health Organisation (WHO) issued a global alert following reports of over 150 cases of severe acute respiratory syndrome (SARS). It is a severe respiratory infection which typically starts with flu-like symptoms, progressing to an atypical pneumonia and sometime respiratory distress syndrome.

The first cases, recorded in Vietnam and southern China, including Hong Kong, were followed by reports in Indonesia, Phillipines, Singapore, Thailand, England, Germany and Canada. As of 7th April, a cumulative total of 2601 probable cases of SARS, with 98 deaths, have been reported to the WHO from 17 countries.

Case-definition: WHO defines a *suspected case* as an illness occurring in a person presenting *after 1st February 2003* with ;

- 1) history of high fever ($>100.4^{\circ}\text{F} / 38^{\circ}\text{C}$)
- 2) one or more respiratory symptoms including cough, sore throat, shortness of breath and difficulty breathing
- 3) close contact, within 10 days of onset of symptoms, with a person in whom SARS has been diagnosed and/or onset of symptoms within 10 days of travel to an area with reported foci of SARS transmission.

A *probable case* is defined as a suspected case with;

- 1) chest radiograph findings of pneumonia or respiratory distress syndrome (RDS) **or**
- 2) unexplained respiratory illness resulting in death, with autopsy examination demonstrating pathology of RDS but no identifiable cause

Aetiology: Although the identity of the aetiological agent has not been confirmed, laboratory data indicate that a new coronavirus may be the possible cause. Coronaviruses can survive on environmental surfaces for up to 3 hours and are possibly transmitted from person to person by droplets, hand contamination, fomites and small-particle aerosols

Transmission: Transmission has been reported in Guangdong, Hong Kong, Singapore, Hanoi and Canada and appears to be limited to a well-defined population of health-care workers (HCW) and close contacts. Most transmissions have been the result of direct transmission from a symptomatic case.

Clinical management: Individuals who have returned from an area of known SARS transmission and present to their GP or local A&E dept. with respiratory symptoms but *who do not have* a pyrexia $> 38^{\circ}\text{C}$, should be asked to carry out regular temperature checks for 7-10 days with advice to contact their GP should fever develop.

Suspected cases of SARS in the community should be managed *at home* by the GP unless the patient's clinical condition warrants hospital admission. For most of these patients, hospital admission *will not be necessary*. A surgical mask should be worn by symptomatic patients attending, and being transported to and from, general practice, hospital or other health-care facility.

GPs are asked to liaise with their local hospital laboratory and ensure that acute and convalescent (10 to 14 days later) serum samples (at least 20mls in a plain glass tube) are taken and sent to the local laboratory with a clear indication as to the illness suspected (SARS) and a travel history. Specimens should be sent for *all* cases even for patients with very mild illness.

Suspected cases should be admitted to hospital if their clinical condition indicates it **or** if they have chest x-ray changes. Such patients should be nursed in a single room with full respiratory precautions.

Clinicians evaluating suspected cases at home or in hospital should refer to the up-to-date guidance for professionals on the SCIEH website below (WHO and Centre for Disease Control sites are also listed)

www.show.scot.nhs.uk/scieh/infectious/respiratory/influenzasurveillance/SARS.htm

www.who.int/csr/sars/en/.

www.cdc.gov/ncidod/sars/

Case reporting: Suspected or probable cases being cared for in hospital or the community should be reported immediately to the Consultant(s) in Public Health Medicine (201 4917). A customised reporting form is available at : [www.phls.org.uk/topics az/SARS/sarsform.pdf](http://www.phls.org.uk/topics_az/SARS/sarsform.pdf)

Travel advice: The UK public is strongly advised **not** to travel to the Guangdong Province and Hong Kong areas. This advice is being reviewed daily and this travel warning may be extended to other countries later. Travellers to other areas where SARS has previously been reported, (Hanoi, Singapore, Beijing and Shanxi in China and Taiwan), should be aware of the symptoms of the disease and should seek medical advice if they develop them.

'Crypto' season

We are approaching the 'crypto' season (last week Apr/1st week May) when the lambs are born and there is a chance of some of them becoming infected with *Cryptosporidium* from their asymptomatic carrier mothers during suckling. However, much work has been carried out by Scottish Water and its predecessor (West of Scotland Water) to minimise the risk of the *Cryptosporidium* oocyst getting into our public water supply (Milngavie Treatment Works processing Loch Katrine water). This includes removing the sheep Scottish Water owns at Loch Katrine, implementing a range of measures to minimise ingress of farm effluent into the aqueducts and building a contingency system that enables diversion of unpolluted water at short notice into the affected mains. We believe that the risk of another *Cryptosporidium* oocyst incident or outbreak of cryptosporidiosis has been substantially lowered by this range of measures.

Nevertheless, until the Milngavie Treatment Works is upgraded (which will include the provision of the microfilter that is required to remove microscopic oocysts of *Cryptosporidium*), there remains an unquantifiable risk of such parasites entering the water. If they do so in large numbers, for instance after a flood coinciding with the lambing or calving season, it is possible for outbreaks of waterborne cryptosporidiosis. GPs and hospital doctors must remain vigilant at this time of year and *remember to send stool specimens from patients suffering from unexplained persistent diarrhoea in the spring.*

Cryptosporidiosis causes 10-14 days of watery non-bloody diarrhoea, colic, nausea (with or without vomiting) and possibly fever, although some people remain asymptomatic during their infection. It is unpleasant but usually not life-threatening and resolves spontaneously in most healthy people. There is no treatment or cure for cryptosporidiosis, other than rehydration. Infection can be severe and life-threatening, however, in patients who are seriously immunocompromised including HIV/AIDS patients, children with Severe Combined Immune Deficiency and those with specific T cell deficiencies such as CD40 ligand deficiency (Hyper IgM Syndrome). These high-risk groups should be reminded of standing advice to boil all drinking water. Any other patient who is seriously immunocompromised is encouraged to discuss with their doctor whether they also want to take the precaution of boiling their drinking water, although the scientific evidence justifying this action is scanty.

Revised immunisation guidelines

Please note that the Primary Care Trust (PCT) has organised 4 seminars in May/June to launch the revised immunisation guidelines. Relevant staff will be provided with details in the next few weeks. Speakers include; Dr Syed Ahmed (CPHM), Margaret-Ann Barr (Deputy Risk Manager, PCT), Jane Camp (Clinical Gov/Practice-Dev. Nurse), Margaret Johnston (Principal Pharmacist), Monica Maguire (Public Health Nurse), and Julie Mullen (Deputy Screening Manager, Child Health).

MMR-uptake figures

The latest uptake figures for MMR immunisation in the 3-month period 1st Oct - 31st Dec 02 for children aged 24 months was 84.9%; a fall of 3% since the previous period 1st Jul - 30th Sep 02. In January this year, Glasgow had one confirmed case of adult measles, acquired abroad, and two secondary cases; these were the first cases of confirmed measles in Glasgow for five years.

In the GGNHSB area, 3000 invitations for MMR immunisation are sent out each month. For the past eight months, and in co-operation with the Child Health department, we have arranged for an MMR information leaflet and covering letter for parents/guardians to be enclosed with the appointment. The telephone number of the PHPU is on the letter to provide the opportunity for parents/guardians to discuss any concerns they may have with public health staff.

Nursery-school exclusion

The PHPU regularly receives enquiries about exclusion of nursery-school children with confirmed food poisoning or unexplained diarrhoea. We adhere to national exclusion guidelines, however, in some circumstances an individual risk assessment is required. This takes account of risk factors such as the child's age, the nursery facilities, staffing levels and hygienic practice skills etc.

As a general rule, **children with diarrhoeal illness should be excluded from nursery whilst they have diarrhoea and for 48 hours after it ceases**; the rationale being to prevent transmission of infective disease to other children. *Formal exclusion* by the PHPU is carried out only when an *asymptomatic* child continues to excrete *Salmonella*, *E. coli O157*, *Shigella* or *Typhoid*; a symptomatic child would be excluded routinely. When a child is to be formally excluded, a standard exclusion letter is sent by the PHPU to the child's parent/guardian and copied to the nursery, the child's GP and environmental health officer(s) allocated to the case. Formal exclusion applies until clearance criteria have been met whereupon a letter rescinding the instruction is sent and copied as before.

Some infections will require demonstration of 2 negative stool specimens, 48 hours apart, prior to the child's return to nursery. Since some young children continue to excrete organisms such as *Salmonella* or *E. coli O157* for several weeks after symptoms cease, the PHPU will advise on the course of action, taking into account the risk factors mentioned above. In the case of *E. coli O157*, screening of high-risk contacts is also undertaken. Outbreaks of illness caused by *Salmonella* or *E. coli O157* in a nursery would automatically generate a response from the PHPU in the form of an Outbreak Control Team.

Children with *Campylobacter* or viral infection do not require *formal exclusion* but the standard 2-day diarrhoea-free period is advised before the child returns to the nursery.

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