

- Live oral polio vaccine
- Immunisation-guideline
- Hib catch-up campaign
- Hand-hygiene awareness
- Pneumococcal campaign
- Antenatal HIV testing
- SARS resurgence
- SARS masks
- MMR and porcine material

# GGNHSB PHPU

# NEWSLETTER

[www.show.scot.nhs.uk/ggnhsb/Depts/public-health](http://www.show.scot.nhs.uk/ggnhsb/Depts/public-health) (TEL: 0141 201 4917/FAX:0141 201 4950)

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## Live oral polio vaccine

Live oral polio vaccine (OPV) is routinely used for immunisation in the UK and recommended for infants over two months of age.

OPV may contain trace amounts of penicillin, neomycin, polymyxin and streptomycin but these do not contraindicate its use except where there is a history of *extreme hypersensitivity* to these particular antibiotics. In such cases inactivated polio vaccine (IPV) can be obtained on a named-patient basis.

## Immunisation-guideline launch

The Primary Care Trust (PCT) recently organised 4 half-day seminars to launch updated immunisation guidelines for use in conjunction with the 1996 Immunisation against Infectious Diseases ('Green Book'). The PHPU team's presentation covered general immunisation issues, the planned Hib catch-up campaign for all children aged from 6 months to 4 years, and the pneumococcal immunisation programme (see opposite) planned for Autumn and aimed at those over 65 years. Seminars were well attended by the range of health professionals involved in immunisation.

## Hib catch-up campaign

From 2<sup>nd</sup> June 2003, all children aged from 6 months to 4 years on 1<sup>st</sup> April 2003 (i.e. born between 2<sup>nd</sup> April 1999 and 1st October 2002) will be offered an extra dose of Hib vaccine. This is part of a UK-wide programme recommended by the UK Joint Committee on Vaccination and Immunisation (JCVI) to address a small but significant rise in Hib infections over the last two years.

Please note that it is quite safe to administer Hib vaccine at the same time as MMR and other vaccines and that there is no requirement for any time interval between the administration of Hib and other vaccines if not given simultaneously. The Hib vaccine (Hiberix) used in this campaign is a single antigen vaccine containing a capsular polysaccharide of *Haemophilus influenzae* type b conjugated to a tetanus toxoid (protein carrier); it does not contain a tetanus vaccine nor does it contain Thiomersal.

## Hand-hygiene awareness

Hand hygiene is the single most important method of minimising healthcare associated infection. The PCT's Infection Control Team (ICT) provides practical training in hand-hygiene techniques using an ultra-violet cabinet which makes contaminated areas of skin visible. To highlight the importance of hand hygiene in primary care settings, the ICT is prepared to visit your department/practice and provide on-site instruction and advice. If interested, contact the PCT's Infection Control Team on **211 3568**

The Infection Control Audit Tool for GP Practice is now ready for distribution. Contact Sarah Caulfield (ICN) on **211 3815** to obtain a copy indicating your preference e.g., paper, e-mail, or disk copy (please note that for a disk copy, a disk must be sent to the ICN department).

## Pneumococcal campaign

The pneumococcal immunisation campaign for people over 65 years is scheduled to start in September. We remind GPs that an item-of-service fee (IOS) is currently being negotiated, however practices should place their orders *now* in the same way as the 'flu vaccine (through community pharmacies).

## Antenatal HIV testing

The routine HIV screening of pregnant women will commence on 1<sup>st</sup> July 2003. The HIV test will become one of the standard blood tests offered to pregnant women during antenatal care and, as with any blood test, a woman may choose not to be tested.

The move is part of a national drive to reduce the number of babies born with the virus and follows the recent publication of annual figures for HIV infection in Scotland in 2002, where heterosexuals formed the largest group of new diagnoses.

Babies can become infected with HIV during pregnancy, delivery or breastfeeding and infection is often more severe than in adults.

If positive mothers are offered appropriate treatment the chances of the baby being born with HIV are reduced from one in six to one in a hundred.

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

## SARS – resurgence in Toronto

On 26<sup>th</sup> May, WHO added Toronto (Canada) to the list of areas with recent local transmission of SARS. This was in response to the reporting of 8 new *probable* and 26 *suspected* cases of SARS, including three deaths, all linked to four hospitals in Greater Toronto.

Public health authorities have established an epidemiological link between one individual in this new cluster and the original outbreak in Toronto. Actions being taken by authorities in Greater Toronto include immediate isolation of all cases, heightened infection control, intensive contact tracing, and voluntary home quarantine of contacts.

### Early identification and management

The key to successfully containing SARS is the early recognition and rapid isolation of cases. Colleagues are reminded that cases in the UK are most likely a result of people returning from affected areas and they should be alert therefore to the possibility of SARS in anyone who develops a febrile respiratory illness **within 10 days** of leaving an area with recent local transmission. Affected areas now include Toronto in addition to the Chinese provinces of Beijing, Guangdong, Hebei, Hubei, Inner Mongolia, Jilin, Jiangsu, Shanxi, Shaanxi, Tianjin, Hong Kong Special Administrative Region of China, Taiwan, China and Singapore.

[www.who.int/csr/sars/areas/2003\\_05\\_26/en/](http://www.who.int/csr/sars/areas/2003_05_26/en/)

Please note that guidance on the management of suspected or probable SARS cases can be found at:

<http://www.show.scot.nhs.uk/scieh/>

### Health-care staff returning from affected areas

Health-care staff recruited to the NHS from a SARS affected country (or who have worked in a healthcare setting there) might pose a risk to patients and other staff because of their higher risk of exposure to SARS. Such staff (including students) should not commence work in the NHS **until 14 days after leaving** a SARS affected country. If during that time they develop symptoms compatible with SARS, they should have clearance from a local public health consultant before starting or returning to work. NHS staff who have recently visited an affected area for personal or professional reasons, should also be excluded from work if showing any symptoms suggestive of SARS.

<http://www.show.scot.nhs.uk/scieh/>

### Travel advice

WHO is not recommending any restrictions on travel to Toronto but travellers should be aware that cases are being reported from Toronto and should take this into account when making their travel plans. More information is available at : <http://www.show.scot.nhs.uk/scieh/>

## SARS masks for health staff

During the next few weeks, 45,000 respirator-type masks (complying with European standard FFP3) will be issued to NHS Boards (PHPUs), hospitals and GP practices. A further 5000 masks will be stored centrally as a strategic reserve.

Initially purchased for use in the event of a smallpox outbreak, and exceeding the filtration specification indicated for protection against SARS (EN149: 2001FFP2), these masks are to be made available to healthcare workers (HCW) should they encounter a person with suspected or probable SARS. Please note that these masks are **not** for patient use.

Respirator-type masks are intended to help reduce the wearer's exposure to airborne particles and are made to defined national standards. Although there is a range of respirator devices available, it has been recommended that only devices meeting the European standard EN149: 2001FFP2 or USA standard N95, or higher filtration, be used.

Respiratory devices are one way of preventing the spread of SARS but other infection-control precautions must be taken, including the use of personal protective equipment e.g., goggles/visor, gown/apron and gloves.

<http://www.show.scot.nhs.uk/scieh/>

## MMR and porcine material

On 30<sup>th</sup> May, it was brought to the attention of the PHPU that MMR vaccine currently used in Glasgow might contain material of porcine origin. The PHPU immediately wrote to GPs and other primary care team members alerting them to this fact<sup>1</sup>.

Following further investigation, it would appear that the **MMRII** vaccine produced by Aventis Pasteur contains porcine material in its end product. However, although porcine material is used in the early manufacturing of the **Priorix** vaccine, produced by GSK, the vaccine subsequently undergoes stringent purification procedures and dilution steps which renders the amount of porcine material remaining in the final product, if any, to be negligible.

The PHPU has since sought further clarification and guidance from the religious leaders of the Muslim and Jewish communities. As these vaccines are not ingested, Jewish leaders do not consider it a religious issue and therefore both vaccines, MMR II and Priorix, should be acceptable to the Jewish community. We have received similar reassurances from Muslim leaders, however, they felt that parents should be given the choice between the two vaccines and that **Priorix** should be the preferred vaccine for Muslim children. We have therefore alerted Leverndale Pharmacy to make both of these vaccines available to the primary care teams.

<http://www.show.scot.nhs.uk/gqhsb/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