GGNHSB PHPU NEWSLETTER

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Summer eating

In the summer months, the number of food-poisoning cases rises so whether you're having a barbecue, picnic or summer buffet, it's important to take care when preparing and cooking food. Please note the following food-safety tips.

Barbecues

- Always keep raw food separate from any ready-to-eat foods
- Make sure the charcoal is hot enough before you start to cook
- Always cook meat dishes until they are piping hot all the way through and the juices run clear
- Don't assume that if meat is charred on the outside it's cooked inside
- Always wash your hands after handling raw meat
- Use separate utensils for raw and cooked foods
- Keep food covered to prevent insects getting to it
- Consider pre-cooking poultry, burgers and sausages in the oven and finishing them off on the barbecue when cooking for a large number of people
- Remember that left-over marinade has been in contact with raw meat and therefore must not be used as a sauce

Picnics

- Use a cool-bag with ice packs to keep food cool during the journey
- Don't take food from the 'fridge until the last moment
- Wash your hands or use antiseptic wipes before eating
- Wash fruit and vegetables thoroughly before eating
- If taking pets or visiting a farm etc. make sure that you keep them away from the food and wash your hands or use antiseptic wipes after petting animals
- Make sure your 'fridge is at the right temperature i.e. below 5° C. It's advisable to purchase a 'fridge-thermometer from your local supermarket

If you would like more information on this or other food-safety matters, please contact your local environmental health department.

Hib vaccine – don't mix

The PHPU has recently been advised that some package-inserts of *Hiberix* could be misleading as they do not take account of current Scottish Executive recommendations.

Please remember that the *Hiberix* (Glaxo SmithKline) vaccine ***should not be mixed*** with either DT or DTaP even though the package-insert might advise mixing with Glaxo SmithKline's own brand *Infanrix* (DTaP). Please note that children whose parents request primary immunisation with the non-recommended acellular pertussis can be given *Hiberix* and I*nfanrix* at the same time but separately, one in each limb.

Children receiving the recommended whole-cell pertussis vaccine are immunised with both vaccines using the mixed ACT Hib/DTwP combination pack.

Vaccine refrigerators

This year the winter vaccination programme for people over 65 years will include *Pneumovax* in addition to the 'flu vaccine. Refrigerators in GP practices are already being used to store extra stocks of vaccine required for the childhood Hib programme. In view of this, GPs are reminded to keep vaccine-orders for child programmes as small as possible and to consult Leverndale pharmacy whenever necessary to ensure that levels of stock in practices allow the correct storage of all vaccines. To ensure optimum storage conditions, GP practices are reminded to regularly record refrigerator temperatures when storing medications/vaccines.

For advice on storage of vaccines contact Margaret Johnston at the PHPU (Monday (pm) and Friday (am) only) on 201 4824 or Leverndale pharmacy on 211 6674/6673.

'MMR and Autism' – new book

In his book, *MMR and Autism,* Michael Fitzpatrick, a GP in Hackney and parent of an autistic child, explains why he believes the anti-MMR campaign is misguided. This book aims to reassure parents of children facing vaccination, to relieve the anxieties of parents of autistic children and to provide health care professionals with an overview of a contemporary health issue. Published by Routledge, it can be ordered by phone (01264 343071) or e-mail info.health@routledge.co.uk

Decontamination of surgical instruments

A recent audit undertaken by the Primary Care Prevention & Infection Control Team (P&ICT) has shown that there continues to be a significant amount of reprocessing of surgical instruments at local level within primary care settings as opposed to central sterile-services departments.

Whilst there are examples of good practice, in some cases *practice is unacceptably poor.* These findings have implications for the prevention & control of healthcare-acquired infections including vCJD.

The effectiveness of decontamination can be reduced by the wrong choice of decontamination method and/or poor technique. Details of procedure guidance for the sterilization of medical devices can be obtained from the Health Technical Memorandum (HTM 2010 and 2030) and the Medical Devices Agency Bulletin, *Benchtop Steam Sterilisers, Guidance on Purchase, Operation and Maintenance* (MDA DB 2002 (06) October 2002).

A protocol for the reprocessing of surgical instruments is currently being developed by the P&CIT and will be available shortly. In the meantime, consideration should be given to the following points:

- risk assessment should be undertaken when choosing the correct method of decontamination

  3 options are;

  - use a central sterile-services facility
  - use single-use disposable items
  - use a bench-top steam steriliser
- staff should be trained in decontamination and sterilization processes
- instruments should be visually inspected for signs of rust and deterioration
- instruments should be re-inspected after the decontamination process for dryness and cleanliness
- accurate records of each cycle and pressure-holding time should be kept (i.e. maintain an audit trail)
- sterilisers should be maintained in line with current guidelines with a planned preventative maintenance programme in place
- mechanical cleaning should be carried out wherever possible
- the area used for manual cleaning should be dedicated solely for that purpose and not used for other activities
- clean and dirty decontamination areas should be separated
- staff should wear protective clothing throughout the decontamination process
- the manufacturer's instructions on how to use the steriliser should be followed

Further advice can be obtained by contacting the P&CIT on 211 3568.

Recent studies on prevalence and brain overgrowth in autism

A study[1] recently published in the journal Archives of Diseases in Childhood reported that in a population of children born between 1979 and 1998 in 5 districts in north east London, the prevalence of autistic spectrum disorder (ASD) levelled off between 1992 and 1996.

The authors identified a total of 567 children with a diagnosis of ASD born 1979-98. Reported autism, excluding 94 cases of Asperger's syndrome, increased every year until 1992, since when prevalence has plateaued. This flattening off persisted after allowing for expected delay in diagnosis in more recent birth cohorts. The age of diagnosis of ASD was estimated to have decreased per five-year period since 1983 by 8.7% for childhood autism and by 11% for atypical autism. There was also some evidence that MMR was more likely to be mentioned as a trigger after August 1997 than before.

Another study[2] in JAMA last month suggested that the clinical onset of autism was preceded by 2 phases of brain-growth abnormality; a reduced head size at birth and a sudden and excessive increase in head size between 1 and 2 months and again between 6 and 14 months of age. The authors concluded that abnormally accelerated rate of growth may serve as an early warning signal of risk for autism.

The study originated from the observation that autism most commonly appears by 2 to 3 years of life at which time the brain is already abnormally large. The authors explored the possibility that brain overgrowth might begin much earlier, perhaps before the onset of clinical behavioural signs.

Head circumference (HC), body length, and body weight measurements in the first year of life were obtained from the medical records of 48 children with ASD aged 2 to 5 years who had participated in magnetic resonance imaging studies. Of these children, 15 (longitudinal group) had measurements at 4 periods during infancy; birth, 1 to 2 months, 3 to 5 months, and 6 to 14 months; and 33 (partial HC data group) had HC measurements either at birth only, or at birth and at 6 to 14 months.

The authors compared the ASD data with normative data of healthy infants and found that birth HC in infants with ASD was significantly smaller; after birth, HC increased 1.67 standard deviations with mean HC at the 84th percentile by 6 to 14months. Within the ASD group, every child with autistic disorder had a greater increase in HC between birth and 6 to 14 months than infants with pervasive developmental disorder - not otherwise specified. Only 6% of the individual healthy infants in the longitudinal group showed accelerated HC growth trajectories from birth to 14 months whilst 59% of autistic children showed these accelerated growth trajectories.

[1]Arch Dis Child 2003;88;666-70
[2]JAMA,July 16,2003,Vol 290,No 3