GGNHSB PHPU NEWSLETTER

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Vaginal specula incident

The inadequate sterilisation of reusable vaginal specula in a Lanarkshire medical practice between April 2000 and November 2003, highlights the need for efficient decontamination of all reusable equipment which is re-processed outwith a central sterile services department (CSSD). It is the duty of the contractor to ensure that correct decontamination methods and techniques are employed to ensure safe practice. Contractors should also be aware that the efficacy of decontamination may be hindered at any stage of the process by a poor choice of method or technique.

Details of procedure guidance for sterilization of medical devices can be obtained from the Health Technical Memorandum (HTM) 2010 and 2030 and the Medical Devices Agency Bulletin, Benchtop Steam Sterilizers - Guidance on Purchase, Operation and Maintenance, MDA DB 2002 (06) October 2002 available from the MDA/MHRA website : http://www.medical-devices.gov.uk/

It is important that staff involved in the decontamination of reusable devices are aware of the relevant guidance and take steps to ensure that this guidance is being followed at a local level.

A suitable method of reprocessing re-usable devices outwith a CSSD needs to be considered very carefully, and staff should ensure that infection-control practices are robust. Everyone should be aware of their responsibilities in relation to the decontamination process and the possible consequences for both patients and staff of practices that do not conform.

The following are key recommendations for the re-processing of re-usable equipment at a local level.

Recommendations

- where single-use items are available this is the preferred option
- a risk assessment should be undertaken when choosing the correct method of decontamination
- staff should be trained in decontamination and sterilisation processes
- instruments must 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 according to current guidelines and a planned preventative maintenance programme should be in place
- wherever possible, mechanical cleaning should be carried out
- the area used for manual cleaning should be dedicated for that purpose (i.e. 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 for use of the steriliser should be followed at all times

Advice can be obtained by contacting the PCT Prevention & Control of Infection Team on 211 3568

Further reading:

Infection Control Guidance for General Practice ISBN 0-9541962-0-57, January 2003; Infection Control Nurses Association & Royal College of General Practitioners. Copies can be obtained by telephoning Fitwise: 01506 811077 (£10 per copy)

BCG clinics-new arrangements

Please note that new arrangements have been made for BCG vaccination of babies and young children identified as 'at risk'. **From the 1st April**, health visitors are asked to contact the PHPU to arrange appointments for the new twice-monthly BCG clinics. Children will be allocated to either William Street (north) or Govanhill (south) depending on their postcode. To arrange an appointment for the PHPU clinic please call **201 4598**.

Health visitors are also reminded that there is a monthly BCG clinic at the Princess Royal Maternity therefore, before contacting the PHPU, please check that 'at risk' babies born at the PRM have not already been vaccinated or awaiting appointment for the PRM clinic.

Immunisation seminars

Due to circumstances beyond our control, the immunisation seminars organised for late March and April have had to be postponed. We will inform you of the new dates and venues as soon as these are confirmed.

Hib booster uptake-rates

At the 1st March, the GGNHSB Hib booster uptake-rate for children born between April 1999 and April 2003 was 81.3% compared to the Scottish average of 79.87%.

The table below gives the uptake numbers and rates for all health board areas in Scotland.

Children born between 2nd Apr 99 and 3rd Apr 03			
HB area	**no. in cohort**	**no. with 4th Hib**	**% uptake**
A&A	14786	11188	75.7
A&C	16756	13433	80.2
Borders	4452	3556	79.9
D&G	5517	4840	87.7
Fife	14874	10397	69.9
Forth V	12005	9684	80.7
Glasgow	**36568**	**29724**	**81.3**
Grampian	22539	16963	75.3
Highland	8637	5745	66.5
Lanarkshire	25011	21891	87.5
Lothian	32201	27356	85.0
Orkney	708	539	76.1
Shetland	1020	490	48.0
Tayside	15724	12869	81.8
West Isles	1021	507	49.7
Scotland	**211819**	**169182**	**79.87**

Mumps in Glasgow – still rising

The number of reported and confirmed cases of mumps continues to increase in the GGNHSB area.

At 1st March, the total number of cases reported to the PHPU was 298 of which 70 have been laboratory-confirmed.

Confirmed mumps in GGNHSB area 01/12/2003 - 01/03/2004		
Age range	**Confirmed cases**	**Reported**
<16 yrs	6	61
16-24 yrs	57	196
25-34 yrs	5	18
35-50 yrs	2	20
>50 yrs	0	3
Total	**70**	**298**

Mumps, a potentially fatal disease, can cause meningitis and male infertility. Where the opportunity arises, GPs in the GGNHSB area are being urged to offer MMR to those in the 16-24-year-old age group who are not already vaccinated. Please note that the vaccination regime is two MMR vaccinations, not less than 3 months apart. The PHPU would also ask primary care staff to continue to encourage parents to present unvaccinated children for MMR. In the GGNHSB area, the uptake of triple vaccine has declined to 85% in 2003 from 87% the previous year.

MMR – the latest

Brian Deer, the Sunday Times journalist, recently disclosed Dr Andrew Wakefield's conflict of interest in relation to his controversial research published in the *Lancet* in 1998[1]. This has been followed by the 'retraction of an interpretation'[2] by 10 of the 12 original authors published the latest edition of the *Lancet*.

The 10 co-authors have made it clear that no causal link was established between MMR and autism and recognise that their raising the possibility of such a link has had major implications for public health. In view of this, they have retracted the 'interpretation' placed upon their findings.

On the same subject, an epidemiological study using the UK GPRD shows that the medical and drug histories of boys diagnosed with autism were very similar to those of boys not so diagnosed. Perhaps even more usefully, the study shows that the rise in diagnosis of autism was accompanied by a similar decline in the diagnosis of other developmental disorders.

One of the factors that has fuelled the controversy over the alleged association between MMR vaccination and autism is the rise in diagnosis of autism during the 1990s. Previous studies showed that there was no direct association between the two, but there have been arguments over whether changes in diagnosis could account sufficiently for the increase. This case-control evaluation used data from over 250 UK general practices. It showed that there were no significant differences between autistic and non-autistic boys in medical or drug (including vaccine) history, or in the medical or drug histories of the mothers during pregnancy. It did show, however, that during the early 1990s boys with diagnosed developmental disorders were unlikely to be diagnosed as autistic whereas in the late 1990s the diagnosis was likely to be autism. The authors conclude that their data does show that changes in diagnostic practice probably has been a major explanation for the rise in diagnosed cases of autism.

[1] Wakefield AJ et al *Lancet* 1998; **351**:637-41

[2] Murch S et al *Lancet* 2004; **363**: 749

Avian influenza in humans

Since mid-December 2003, eight Asian countries have confirmed outbreaks of highly pathogenic avian influenza in domestic fowl and other birds caused by the H5N1 strain. Over the past two months, more than 100 million birds have either died of the disease or been culled in Asia. There has been a limited number of human H5N1 infections, with high mortality, reported in two countries. The table below gives the numbers of confirmed human cases and deaths at 1st March 2004.

Confirmed human cases of A(H5N1)		
Country	**Confirmed cases**	**Deaths**
Thailand	10	7
Vietnam	23	15
Total	**33**	**22**