

# GGNHSB PHPU NEWSLETTER

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## Wound botulism in IDUs

There have been two cases of suspected wound botulism in injecting drug users (IDUs) reported in Glasgow this month. The PHPU sent letters to all GPs and other front-line services on 8<sup>th</sup> October to raise awareness of this potential wound infection in IDUs presenting with abscess at injecting sites.

These recent Scottish cases follow 27 suspected cases of wound botulism in injecting drug users (IDUs) reported to the Health Protection Agency, England, between 1<sup>st</sup> January and 25<sup>th</sup> August 2004. Two suspected cases occurred in Scotland and twenty-five in England; 6 of the English cases were laboratory-confirmed. Three confirmed cases occurred in the London region during January and February, and the remaining 3 in Yorkshire and Humberside during June and July.

Wound botulism occurs when spores of *C. botulinum* contaminate a wound, germinate and produce botulinum neurotoxin in vivo. All of the wound botulism cases detected so far in the UK have been among illegal injecting drugs users (IDUs). The symptoms of botulism are caused by the neurotoxin which blocks the release of acetylcholine at the neuromuscular junction resulting in a descending flaccid paralysis. Patients with botulism may present with blurred vision, drooping eyelids, slurred speech, difficulty swallowing, dry mouth, and muscle weakness. There is usually no fever, no loss of sensation and no loss of awareness. If untreated, paralysis may progress to the arms, legs, trunk, and respiratory muscles. Clinicians should suspect botulism in any patient with an afebrile, descending, flaccid paralysis.

Botulinum antitoxin is effective in reducing the severity of symptoms if administered early in the course of the disease for all forms of botulism and should not be delayed for the results of microbiological testing. In cases of wound botulism, antimicrobial therapy and surgical debridement are important to reduce the organism load and avoid relapse after antitoxin treatment. *C. botulinum* is sensitive to benzyl penicillin and metronidazole.

Information on the supply of botulinum antitoxin is available from the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC) duty doctor on 0208 200 6868 (24 hours).

## Chiron 'flu vaccine supplies

GPs will be aware that Chiron has had its influenza vaccine manufacturer's licence suspended for three months by MHRA.

This **does not** affect any 'flu vaccine already issued to practices nor does it affect Agrippal, Begrivac or Fluad.

Departments of Health in the UK have obtained contingency supplies from other manufacturers but these are not expected to be available *before* 25<sup>th</sup> October 2004.

The mechanism for distribution of contingencies is being worked out so practices are asked not to appoint people for 'flu vaccination until further notice from the PHPU.

There is no significant influenza infection in the UK at present.

## Mumps on the increase again

The number of suspected mumps cases reported to the PHPU has risen significantly in the last few weeks (see table below). GPs are again reminded to offer opportunistic MMR vaccination to the 13-25-year-old group. Ideally, to ensure maximum immunity, 2 doses of MMR are recommended (3 months apart) although 1 dose, conferring ~90% protection, is considered sufficient in this situation. School children who are currently scheduled for BCG should, if possible, receive BCG prior to the MMR (minimum 1 month gap and in different arms if less than 3 months between injections). If the MMR is given first, there must be at least a 4-week gap before the Heaf test can be done.

Reported cases of mumps in GGNHSB  
01/08/04 - 01/10/04

Week no (month)	Suspected	Confirmed
33 Aug	15	1
34 Aug	21	4
35 Aug	19	3
36 Aug/Sep	11	3
37 Sep	10	2
38 Sep	21	6
39 Sep	31	5
40 Sep/Oct	18	-
41 Oct	51	-
<b>Total 2004</b>	<b>1101</b>	<b>218</b>

## Latest hepatitis C figures

The Scottish Centre for Infection and Environmental Health (SCIEH) has recently produced updated figures for hepatitis C infection. Cumulatively, until the end of December 2003, there were 18,109 cases of laboratory - diagnosed HCV in Scotland. It's estimated that the actual number of cases is much higher - approximately 40-50,000 - but over half of those infected remain undiagnosed. The majority of diagnosed cases in Scotland contracted the infection through injecting drug use (58%) and are male (67%), aged between 15-44 years at the time of diagnosis - the age range to which most IDUs belong. Only 2% of those diagnosed acquired their infection from blood products.

Approximately 36% of the diagnosed cases (6484) reside within the Greater Glasgow NHS Board area. 65% of the Glasgow cases acquired infection through injecting drug use and show an age and gender profile similar to the Scottish group as a whole.

In April 2004, the Royal College of Physicians of Edinburgh held a consensus conference on hepatitis C. The key messages to emerge from this were:

- The hepatitis C epidemic is a public health crisis
- Services are already struggling to cope with the burden of infection and liver disease
- Significant resources must urgently be directed at prevention of disease and delivery of care
- High priority for case-finding should be given to former injecting drug users
- Community-based and specialist nurse-led services should be provided
- The requirement for liver biopsy to determine selection of patients for therapy is no longer essential for all patients
- Access to treatment should be broadened to all those who might benefit.

Greater Glasgow NHS Board is working within their current planning structures to try and address those areas that they can influence.

Practitioners are reminded that testing is a complex area for many patients, particularly if they have ongoing substance misuse problems, and therefore adequate support for the patient should be sought. Testing can be carried out at the Brownlee Centre, where pre and post test counselling is available. In addition, C-level is a voluntary organisation based in Glasgow that offers advice, information and support to people affected by hepatitis C. An outreach testing-clinic also operates from the C-Level premises. Patients can also seek information from the National Hepatitis C Resource Centre and the Information Line.

**BBV Counselling and Testing Team.** Brownlee Centre (211 1089/1075)

**C-Level (332 2520)** [www.c-level.org.uk](http://www.c-level.org.uk)

**National Hepatitis C Resource Centre (353 6969)**  
[www.hepccentre.org.uk/](http://www.hepccentre.org.uk/)

**UK Hepatitis C Information Line (0870 242 2467)**  
(10am-4pm)

## Meningococcal disease

Traditionally, higher numbers of meningococcal disease are reported in the autumn and winter seasons. Early treatment of suspected cases with benzylpenicillin *before admission to hospital* is recommended to reduce case-fatality rates. This recommendation is based on the rapid clinical deterioration that can occur in the course of meningococcal disease.

Case numbers of meningococcal meningitis and septicaemia have fallen in the last few years following the introduction of the meningococcal C vaccine. Unfortunately, however, the number of deaths rose by 17% last year, which brought the total close to the number of deaths occurring before the introduction of the men C vaccine.

Specialists are convinced that one reason for the number of deaths is the mistaken belief that the men C vaccine protects against all strains of the bacteria. The Meningitis Research Foundation's survey of students found that approximately half of them thought they could not get meningococcal disease as they had been vaccinated with men C. Mothers of young children who contacted the Foundation helpline commonly expressed the same beliefs. This false sense of security makes the requirement to raise awareness to the dangers of meningococcal disease all the more necessary.

Meningococcal disease can present initially as a flu-like condition with later development of high fever. Severe headaches and photophobia as well as a stiff neck, back and joint pains are other prominent features. Sleepiness, vomiting and confusion are also very common. Babies with meningococcal disease can be difficult to rouse, have a staring expression and a fever. Vomiting and refusal to feed are also common.

Meningococcal septicaemia is characterised by a rash that appears under the skin. It begins as a cluster of tiny blood spots, occurring anywhere on the body, which look like pin-pricks. These can progress to bigger blotches resembling bruising under the skin. The rash, characteristically, does not blanch when pressed (tumbler test).

## Babies at risk of hepatitis B

Babies born to **hep B-positive mothers** have, until now, received hep B vaccine at birth, 2 months, 3 months and 12 months (booster). Please note that this regime has changed and it is recommended that they be vaccinated at **birth, 1 month, 2 months and 12 months (booster)**. Antibody testing should be done at Yorkhill hospital 3 months after the booster dose. Health visitors can arrange appointments for testing by telephoning Dr Rosie Hague's secretary on 201 0598. Please note that these changes are clearly outlined in the letter now being sent from the PHPU to health visitors of newly born at-risk babies.

If you would like to comment on any aspect of this newsletter, please contact Marie Laurie on 201 4933 or at [marie.laurie@gqhb.scot.nhs.uk](mailto:marie.laurie@gqhb.scot.nhs.uk)