

- Wound botulism in IDUs
- Flu vaccine
- Nurse prescribers and PGDs
- Mumps/MMR leaflets
- Meningococcal leaflets
- Syphilis increasing in Glasgow

# GGNHSB PHPU NEWSLETTER

www.show.scot.nhs.uk/ggnhsb/Depts/public\_health/phpu/pubs+reps (Tel 201 4917)

Volume 3 Issue 11

November 2004

## Wound botulism in IDUs

The PHPU was recently been made aware of a South Glasgow case of wound botulism associated with injecting drug use. A second letter (21st October) was sent to all relevant agencies and followed the first alert sent on the 8<sup>th</sup> October highlighting two cases in the North of the city. The first reported case remained well with a localised abscess; typing of the organism proved difficult although tests so far suggest *Clostridium botulinum*. The second case had a clinical diagnosis of botulism and is making a slow but steady recovery. No organism has yet been isolated though some results are still awaited. We suspect that these cases have resulted from injecting directly into muscle or subcutaneous tissue (muscle popping). The most recent case is seriously ill in the Southern General Hospital with clinical signs of botulism including neurological signs and symptoms.

It is thought that these cases are caused by a batch of drugs contaminated with *Clostridium botulinum*. Reports of such cases have been a relatively new phenomenon, no cases being recorded before 1999 in the UK. The increase in Scotland is mirroring the increase in England.

The key clinical signs and symptoms are as follows:

- febrile, descending, flaccid paralysis
- double or blurred vision, drooping eyelids, slurred speech, difficulty in swallowing and muscle weakness
- paralysis may progress to the arms, legs, trunk and respiratory muscles (in untreated cases)
- if rapid onset, there may be no symptoms before sudden respiratory paralysis occurs, which may be fatal
- autonomic signs include dry mouth, fixed or dilated pupils, as well as cardiovascular, gastrointestinal and urinary dysfunction
- surviving patients may take months to recover

*C.botulinum* is sensitive to benzyl penicillin and metronidazole. In wound infections, surgical debridement may reduce the organism load and therefore toxin production, but circulating toxin can only be neutralised by administration of antitoxin. **Please note that *C. Botulinum* antitoxin is held at the Pharmacy Department, Glasgow Royal Infirmary.**

## Flu vaccine

### Vaccine supplies

Most GP practices received the first quantity of replacement flu vaccine following the delivery of 166,000 doses (10,000 more than originally envisaged) to pharmaceutical wholesalers in Scotland at the end of the week commencing 18th October and approximately 200,000 doses were delivered in the week commencing 1st November 2004.

The third and final delivery to all Scottish wholesalers is planned for the week commencing 8th November.

The wholesalers will be contacting all of their community pharmacy colleagues by phone with the date and quantity of vaccine to be delivered to them.

Monitoring so far shows low flu activity, this gives practices an opportunity to target all those who have not been vaccinated because of the vaccine supply problem.

### Ramadan

The PHPU has recently been informed that some GP practices have had considerable difficulty persuading a large proportion of their Muslim patients to have flu vaccination during Ramadan due to concerns that it would break the rules of fasting. Interestingly, a clinical review published in the BMJ in early October discussed the changes that Muslims make to their drug regimes during Ramadan (BMJ 2004; 329: 778-82). The review refers to a 1997 conference arranged by the International Organisation for Medical Sciences in Morocco, where both medical practitioners and religious experts discussed 'substances and actions that nullify fasting'. The conference unanimously concluded that injections through skin, muscle, joints or veins are acceptable during the month of Ramadan. The only type of injection not considered acceptable was intravenous feeding.

Although individuals will vary in their beliefs regarding the acceptability of immunisation during Ramadan, this BMJ review article provides a useful discussion point for Muslim patients and their GPs.

<http://bmj.bmjournals.com/cgi/content/full/329/7469/-d>

## Nurse prescribers and PGDs

Extended Nurse Prescribers (ENPs) can prescribe from a limited formulary, which includes most vaccines, found in Part 8C of the Scottish Drug Tariff. However, as a result of the introduction of the new vaccines, which include inactivated polio vaccine, there are now some prescribing anomalies for ENPs. Currently the only form of polio in the ENP formulary is the live oral polio vaccine (OPV) which is no longer available. ENPs therefore **cannot** prescribe any of the new childhood vaccines or the Revaxis for individuals over the age of 10 years.

ENPs providing travel advice and vaccines are reminded that typhoid and Hep A vaccines are in the formulary and can be prescribed as individual vaccines. The combination vaccine however is marked with a triangle indicating that it is centrally supplied and therefore will not be paid on a GP10 (N). The prescription must therefore be on a GP10.

Some practices are reporting they have stocks of the German Pneumovax. Please be advised that this is "unlicensed" as all the labelling is written in German. As such it cannot be administered under a PGD but only with a "patient specific direction." The patient specific direction can be a list of patients assessed by the doctor as requiring vaccination with the pneumococcal vaccine. Nurses are advised to document in the patient record the type of direction under which they are administering vaccines i.e. a patient specific or group direction. PGDs developed for use in Greater Glasgow are available on the Primary Care website at:

<http://www.show.scot.nhs.uk/ggpct/staff/pgd.htm>

## Mumps leaflet and poster

Please note that Mumps/MMR posters and leaflets for the 13-25-year-olds who are most at risk during this current mumps outbreak are now available. Copies will be sent to GP practices, health visitors and lead nurses. Schools and colleges can obtain stocks from GGNHSB Health Promotion on 201 4915.



## New meningococcal leaflets

The Meningitis Research Foundation (MRF) has produced a new information leaflet for the public, *Race Against Time*, as well as a booklet for junior doctors. This booklet, written as a learning and teaching tool, follows on from an MRF-funded study by the Imperial College School of Medicine and Royal College of Paediatrics and Child Health. The study showed that a few clinical errors repeatedly led to delayed or inadequate treatment of cases of meningitis and septicaemia, often with devastating consequences. To obtain copies of these publications contact the MRF by phone on 0131 228 3322 or on-line: [www.meningitis.org](http://www.meningitis.org).

## Syphilis increasing in Glasgow

There has been a further increase in the number of syphilis cases reported to GGNHSB in recent months. Since the beginning of 2004, 57 cases have been confirmed. This is an acute rise above the increased numbers of 43 in 2003 and 26 in 2002. This compares with the normal background incidence of 1-2 cases per annum.

This local increase in syphilis, which began in 2001, is part of a national increase and is largely confined to men who have sex with men. However, there has been a small number of cases amongst heterosexuals, mainly, but not exclusively, in those returning from abroad.

Syphilis is a sexually transmitted infection caused by the bacterium (spirochaete) *Treponema pallidum*. Previously, the number of cases had fallen to a level where most clinicians would rarely see a case, in view of this, practitioners may find the following summary of signs and symptoms helpful.

An infected person might have no symptoms but still transmit the infection without knowing. Many symptoms are non-specific but the primary stage is characterised by one or more painless ulcers (chancre) at the site of infection, which can include genital areas, mouth and anus. These sores clear up spontaneously in two to six weeks. There is usually accompanying local lymphadenopathy (large, rubbery, typically painless nodes). However, many affected individuals have no memory of a chancre.

Left untreated, secondary symptoms may develop 6 weeks to 6 months from initial infection. These symptoms are highly variable but can include a diffuse rash, usually on the trunk and also on the palms and soles. Wart-like lesions known as condylomata lata appear like genital warts but are in fact teeming with infectious spirochaetes. General symptoms include fever, malaise, pharyngitis, laryngitis, anorexia arthralgia and generalised lymphadenopathy. Late syphilis occurs four or more years after an untreated primary infection and can be fatal.

Any individual in whom syphilis is a differential diagnosis should have syphilis serology checked. Direct examination of the ulcer material by dark-ground microscopy should be done to give an immediate diagnosis in case of suspected primary syphilis. Treatment is usually with penicillin.

Syphilis testing can be obtained through the Sandyford Sexual Health Service. In addition to scheduled appointments a walk-in service is available every weekday morning from 8.00 a.m. Gay and bisexual men may also access The Steve Retson Project, 3 evenings a week (details at [www.sandyford.org/srp](http://www.sandyford.org/srp)). There is also a syphilis Fast Track service running until the 18<sup>th</sup> December at various venues around the city, see [www.sandyford.org/srp/fasttrack](http://www.sandyford.org/srp/fasttrack) for details. In the event of a positive syphilis result some thought should be given to partner notification. Support for this process is available through the Sexual Health Advisors at Sandyford on 211 8639.