

# GGNHSB PHPU NEWSLETTER

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## 'Green Book' update

The PHPU deals with queries regarding vaccines on a daily basis and like most primary care staff our first reference point is the Department of Health's, Immunisation against Infectious Diseases ('Green Book'). However, we would like to draw the attention of all who administer vaccines to the electronic updated version of the 1996 book which is available on the DoH website.

<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/GreenBook/fs/en>

Some chapters have recently been extensively revised including those on influenza, pneumococcal, meningococcal and varicella vaccination. Changes include new guidance on influenza vaccine in pregnancy, MenC conjugate vaccine, and varicella vaccination of health care workers.

These replacement chapters represent current JCVI recommendations and should be followed *in place* of the 1996 version of the Green Book.

The editor's note on the website suggests that eventually these chapters will be published as a complete volume however, until then, the electronic version should be followed.

## MMR-vaccine requests

The number of MMR-vaccine requests per month in GGNHSB has risen significantly since August 2004. This is due to the ongoing immunisation-drive aimed at 13-25-year-olds. Comparative figures for years 2002 and 2003 are detailed in the table below.

Month	2002	2003	2004
January	-	2400	1500
February	-	1800	4000
March	-	800	3000
April	1000	2000	2600
May	2000	1300	1700
June	2000	1500	1000
July	2000	700	1300
August	840	1300	1800
September	1600	1400	3100
October	1000	1600	3400
November	3000	1100	3000
<b>Total</b>	-	<b>15900</b>	<b>26400</b>

## Influenza update for Scotland

Reports from the fluspotter scheme show a slight rise in activity for week 48 (week ending 28/11/04). Consultations for influenza-like illness (ILI) increased from a rate of 16 per 100,000 during week 47 (week ending 21/11/04) to 21 per 100,000 during week 48. Although an increase in activity, this consultation rate still remains well within the baseline range of 0 - 50 per 100,000 population.

No outbreaks of respiratory illness have been reported to Health Protection Scotland (formerly SCIEH) from any of the NHS Board areas during weeks 47 and 48.

### Fluspotter threshold levels

0 - 50	Baseline
50 - 600	Normal seasonal
600 - 1000	Higher than expected
>1000	Exceptional

The Scottish Enhanced Respiratory Virus Infection Surveillance (SERVIS) gives additional epidemiological information on consultations for ILI in addition to all respiratory infections (ARI) and links this with virological testing in a small sample of presenting cases.

The highest consultation rate for ILI during week 48 was in the 5 - 19 year age group (19.5 per 100,000 population) with lowest rates occurring in the 0-4 years and 75-years-and-over groups (0 per 100,000). However, these rates are currently based on very small figures and are subject to fluctuations from week to week. In contrast ARI (all respiratory infections) rates are based on larger numbers and show a more consistent pattern. ARI rates continue to be highest in the 0-4 years age group. This variation in age distribution of morbidity for ARI is probably due to other circulating viruses such as RSV and rhinovirus.

## Tetanus in the over-40s

GPs and primary care staff are reminded to check the tetanus-immunisation status of people, especially women, born before 1961 when the tetanus vaccine was introduced into the primary immunisation schedule. Men who served in the armed services from 1938 could have been vaccinated during their service. This advice follows on from a case of tetanus in an unvaccinated Glasgow woman (>60yrs) who developed a wound infection after routine excision of a skin lesion.

## Chlamydia testing in Glasgow

In April 2001, GGNHSB launched a local strategy for management of genital *Chlamydia trachomatis* infection. Monitoring of testing-activity across Glasgow has been conducted at regular intervals since then. This report provides an update on pan-Glasgow chlamydia testing-activity and outcomes over the 4-year period from shortly before the strategy was launched, to June 2004 inclusive

Overall, chlamydia testing-activity increased substantially during the review period (trend +2170 patients tested per year). Testing-activity increased in all settings, but was greatest in family planning clinics (trend +800 patients tested per year). The number of tests per 6-month period increased from 10766 (Jul-Dec00) to 20290 (Jan-Jun04) (88.5% increase) with the number of positive tests in the same periods increasing from 780 to 1684 (116% increase).

When opportunistic testing was recommended in 2001, it was expected that the target age-group for testing should be sexually active women younger than 25 years and women aged 25 years and over with two or more sexual partners or a change of sexual partner in the last year.

Period	Tests <25s	Tests ≥25s	*Total tests	Total +ve tests (% rate)
Jul/Dec 00	3568	7011	10766	780 (7.25 %)
Jan/Jun 01	5883	10061	16165	1114 (6.89%)
Jul/Dec 01	5678	10592	16517	1177 (7.13%)
Jan/Jun 02	6856	11204	18280	1193 (6.53%)
Jul/Dec02	6898	10862	17913	1281 (7.15%)
Jan/Jun 03	7732	10924	18900	1399 (7.4%)
Jul/Dec 03	8226	11497	19840	1480 (7.46%)
Jan/Jun 04	9156	10981	20290	1684 (8.3%)

\* includes test samples where age was not specified.

Although there is some evidence of a slow but progressive improvement in the targeting of testing towards younger women, nevertheless 8,513 (42.0%) of the 20,290 tests performed in Jan-Jun 04 were in women **above** the upper limit of the target age-group (>25s). Of these, 3518 (41.3%) were in general practice, 882 (10.4%) in GUM, 2354 (27.7%) in family planning clinics and 1759 (20.7%) in 'other' settings. The respective detection rates were 4.2%, 5.7%, 3.3% and 2.5%.

In conclusion, current chlamydia testing-activity within Glasgow appears **insufficiently** targeted towards the population at greatest risk of infection (<20 years age-group).

### Recommendations:

- More innovative and appropriate methods of providing feedback to GPs, sexual health specialists, gynaecologists, urologists and microbiologists in GGNHSB area should be explored.
- Testing for *Chlamydia trachomatis* infection should be performed in all patients presenting with symptoms and signs which may be attributable to chlamydial infection
- Opportunistic testing of sexually active men and women should focus specifically on targeting the appropriate age-group (<25 yrs)
- An audit project addressing the factors underlying chlamydia testing in older women should be considered

To obtain a copy of the full review please contact [anne.scoular@gghb.scot.nhs.uk](mailto:anne.scoular@gghb.scot.nhs.uk)

## Legionnaires' disease

In autumn 2002, there was much press interest in the outbreak of legionellosis originating from an air conditioning plant at a council-run arts centre in Barrow-in-Furness affecting about 200 people (121 confirmed cases and 5 deaths).

Recently, Fife NHS Board has been investigating a possible cluster of legionnaires' disease in West Fife. Of the 7 people affected, 5 have recovered, 1 is in hospital and 1 person has died.

All those affected were aged between 40 and 70 years. At the time they became ill, 5 were in West Fife, 1 in Central Fife and 1 in Forth Valley.

Investigations to date have not revealed any common factors in the 7 cases other than a possible association with living or working in the Inverkeithing and Rosyth areas of Fife. It is still not possible to say at this stage whether this has arisen from chance or whether there is an underlying common source of infection.

Meanwhile, this unit has recently been notified of 2, apparently unrelated, cases of legionnaires' disease which remain under investigation.

Legionnaires' disease is caused by a bacterium, *Legionella pneumophila*, and often presents as an atypical pneumonia. Most cases are single cases, but when outbreaks occur they are most common in the summer and early autumn. The fatality rate is around 10%.

Infection occurs by breathing mists from water sources contaminated by legionella bacteria. These bacteria reproduce in high numbers in warm, stagnant water (90-105°F) and are generally propagated from cooling towers, evaporation condensers of large air-conditioning systems and whirlpool spas etc. All ages can be affected, but it mainly affects people over 50 years. Person-to-person spread does not occur.

In Glasgow, on average, 10 cases are reported every year and most are travel-related. The incubation period ranges from 2 to 10 days and symptoms include fever, chills, cough, muscle aches, headache, tiredness, and sometimes diarrhoea and confusion. In more serious cases, multi-organ failure and death may occur.

The PHPU, in collaboration with environmental health departments, attempts to detect the source of infection when cases occur. Investigation of locally-acquired disease, (i.e. not travel-related), includes inspection of facilities with high-risk water-vapourising systems. Good design and maintenance of such facilities is the mainstay of legionellosis prevention.

Laboratory diagnosis includes detection of antigen in urine, culture from sputum and rising titres of antibody in blood samples 3 to 6 weeks apart. Erythromycin is the drug of choice in treating legionellosis.

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