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GGNHSB PHPU NEWSLETTER

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MMR & autism - no link (again)

A study of more than 30,000 children in Japan should put to rest the claim that the MMR vaccine is responsible for the apparent rise in autism in recent years.

The study, led by Hideo Honda, shows that in the Japanese city of Yokohama the number of children with autism continued to rise after the MMR vaccine was replaced with single vaccines. In the UK, parents panicked and vaccination rates plummeted after gastroenterologist Andrew Wakefield claimed in a 1998 study that MMR might trigger autism despite the study being based on just 12 children and later retracted by most of its co-authors. In some parts of the UK, the proportion of children receiving both doses of the MMR vaccine has dropped to 60 per cent. This has led to measles outbreaks and fears of an epidemic despite the fact that **not one epidemiological study has revealed a link between the vaccine and autism**. Until now studies have concentrated on what happened **after introduction** of the MMR vaccine. Honda's is the first to look at the autism rate **after withdrawal** of the vaccine. Japan withdrew it in April 1993 following reports that the anti-mumps component was causing meningitis (it plans to introduce another version).

With his colleagues Yasuo Shimizu and Michael Rutter of the Institute of Psychiatry in London, Honda looked at the records of 31,426 children born in one district of Yokohama between 1988 and 1996. The team counted children diagnosed as autistic by the age of 7. They found the cases continued to multiply after the vaccine withdrawal, ranging from 48 to 86 cases per 10,000 children before withdrawal to 97 to 161 per 10,000 afterwards. The same pattern was seen with a particular form of autism in which children appear to develop normally and then suddenly regress - the form linked to MMR by Wakefield.

Important note: Infanrix-IPV

Please note that due to declining stocks of Repevax, supplies of Infanrix-IPV for pre-school boosting will be made available from around 15th March. Infanrix-IPV is interchangeable with Repevax and to balance central stocks, supplies of these vaccines may alternate in future.

The PGD for Infanrix-IPV is available from lead nurses and should be accessible on-line (by mid-March) at:

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

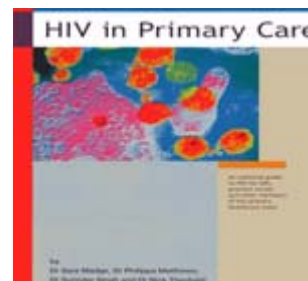
HIV in primary care

'HIV in Primary Care', described as an essential guide to HIV for GPs, practice nurses and other members of the primary healthcare team, is a new publication from the Medical Foundation for AIDS and Sexual Health.

HIV prevalence continues to rise in the UK. It's estimated that up to 14,000 people are living with undiagnosed HIV infection and many of them will approach their GP with problems that might be HIV-related. GPs can play a vital role in diagnosis thus enabling their patients to access potentially life-saving specialist care and antiretroviral therapy. Many people diagnosed with HIV can lead full and healthy lives.

The booklet aims to help primary care staff recognise the signs and symptoms of HIV infection, offer HIV testing when needed, and provide information on routine health care for people living with HIV. It is free, on request, to GPs and primary health care teams and can be downloaded as a pdf from the website www.medfash.org.uk. Tel: 020 7383 6345 or email to enquires@medfash.bma.org.uk

In Glasgow, the Brownlee Centre provides specialist treatment and care to HIV-positive adults. Staff are available to give advice and offer support with any HIV-related queries, including testing, and can be contacted on **211 1089/1075**. HIV testing is also available at the Sandyford Initiative. Tests are included as part of the standard Sandyford Sexual Health Screen, but can also be requested separately. Tel: 211 8600.



School BCG programme

The PHPU reminds all GPs and practice staff that school BCG programmes occur yearly and that any pupil who misses BCG will be automatically called the following year. However, school leavers who miss it should be referred to the TB liaison nurse who covers the pupil's area of residence. Please note that any pupil who has been vaccinated previously does not require skin testing or further BCG.

Drug-resistant HIV in NYC

A highly resistant strain of rapidly progressive human immunodeficiency virus (HIV) has been diagnosed for the 1st time in a New York City resident who had not previously undergone antiviral drug treatment, according to New York's Department of Health and Mental Hygiene (DOHMH).

The strain of 3-class anti-retroviral-resistant HIV (or 3-DCR HIV) does not respond to 3 classes of anti-retroviral medication and also appears to greatly shorten the interval between HIV infection and the onset of AIDS. The origin of this unique variant of HIV is unexpected as it appears to have been recovered from a single patient who had not received treatment with anti-retroviral drugs. Either this patient has had the misfortune to be infected with a spontaneous HIV mutant resistant to all 3 classes of anti-retroviral drugs, or the extensive use of anti-retroviral drugs in the community may have selected this unwelcome triple drug-resistant variant, and an outbreak of HIV infection and AIDS not amenable to treatment with currently available drugs is in the offing. It remains to be established whether the use of crystal methamphetamine has played any role in the appearance of this variant strain.

Bird 'flu - true rate higher?

A Vietnamese boy who died of encephalitis of unknown origin in February 2004 has now been diagnosed as having had H5N1 avian 'flu. Specimens of cerebrospinal fluid, faeces and blood have all tested positive for the H5N1 virus. Diagnosis was not made at the time because he had not developed severe respiratory symptoms. His 9-year-old sister died of a similar illness two weeks before him although unfortunately there were no samples from her available for testing. Encephalitis is endemic in Vietnam and the World Health Organisation (WHO) has expressed concern that cases of encephalitis may be masking bird 'flu. Furthermore, cases occurring in the countryside may not even reach hospital for a formal diagnosis. So, the prevalence of avian 'flu may have been underestimated.

Neither child had been in contact with sick chickens but the family had fighting cocks which, although asymptomatic, were culled. However, asymptomatic ducks in the area could have been the source of the virus. This is more likely as water-based birds adapt more easily to new strains of influenza than do land-based birds and, although asymptomatic, infected ducks can shed a large amount of infectious material. As surveillance for H5N1 relies on the seeking out of sick birds, the threat from ducks may have been overlooked.

In response to this, the WHO has sent experts to Vietnam to work on surveillance and epidemiology. Chief veterinary officers, expert scientists, and representatives of the UN and donor organisations recently met, at the request of the Vietnamese government, to look at formulating a long-term strategy to eliminate the virus in poultry and co-ordinating international aid.

Hep B regimes & risk groups

In 1992, the WHO recommended that all countries consider adding hepatitis B immunisation to the infant immunisation schedule by 1997. Although most countries have complied, the UK targets only people in high-risk groups. Enquiries to the PHPU indicate that there is some confusion about the different time intervals between doses and the reasons for the different regimes.

The standard immunisation regime consists of 3 doses. The first dose is given at an elected date, the second a month later, and a third dose six months after the first.

Where more rapid immunisation is required, an accelerated schedule may be used. An example would be in the prevention of perinatal transmission from an infected mother to her child. In this instance, a dose at birth, 1 month, 2 months and a booster at 12 months are recommended. A similar regime might be used with a high-risk needle-stick injury in an unimmunised person. Babies of mothers in Glasgow with high-risk behaviour such as drug injecting, usually receive 3 doses, at birth, 2 months and 4 months, mainly for pragmatic reasons and to fit into the primary immunisation programme. No booster is normally required with these babies, as the aim is environmental protection rather than prevention of transmission at birth. See tables 1 and 2 below for summary of regimes and recommendations for different risk groups.

Table 1 Hep B regimes

Hep B regime	Dose 1	Dose 2	Dose 3	Booster
Standard 1	0	1mnth	6nths	-
Standard 2	0	2mnths	4mnths	-
Accelerated 1	0	1mnth	2mnths	12mnths
Accelerated 2	0	1wk	3wks	12mnths

Table 2 Hep B regimes and risk groups

Risk group	Hep B regime
^a Babies of Hep B+ve mothers	Accelerated 1
Babies of mothers at risk	Standard 2
Traveller (adults & children)	*Standard 1/Accelerated 1 or 2
^a HCWs	**Standard 1/Accelerated 1 or 2
^a High-risk needle-stick injury	Accelerated 1 or 2

* depends on time available before departure

** depends on exposure-prone activities

^a antibody testing recommended

Please note that antibody testing following vaccination is only recommended for the HCWs, babies born to Hep B- positive mothers, and high-risk needle-stick injury groups.

If you would like to comment on any aspect of this newsletter please contact Marie Laurie on 201 4933 or by e-mail at marie.laurie@gghb.scot.nhs.uk