GGNHSB PHPU NEWSLETTER

www.nhsgg.org.uk/phpu (TEL: 0141 201 4917/FAX:0141 201 4950)

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Lymphogranuloma venereum

Lymphogranuloma venereum (LGV) is a sexually transmitted bacterial infection caused by specific strains of *Chlamydia trachomatis* (serovars L1, L2 and L3). Until recently, it has been uncommon in Western Europe, but in 2004 an outbreak amongst men who have sex with men (MSM) was described in the Netherlands and since then clusters of cases have been reported from several western European cities. Enhanced surveillance began in England in October 2004 and has now been extended to include Scotland. Since November 2004 there have been three confirmed cases - two in Edinburgh and one in Glasgow.

Initial results indicate that the same strain, L2, is circulating in the UK and the same population sub-group, MSM, is affected. Many of the cases are co-infected with other sexually transmitted infections, in particular, HIV. LGV infection has been associated with recent unprotected receptive anal intercourse or other unprotected anal penetration. Further descriptions of the three Scottish cases can be found at: http://www.show.scot.nhs.uk/scieh/PDF/pdf2005/0506.pdf.

Symptoms of LGV can be confused with other conditions and therefore referral to non-genitourinary medicine departments is probable.

Cases may typically present with:

- painful defecation with or without rectal bleeding
- inguinal lymphadenopathy which may be fluctuant (bubo) and mistaken for other sepsis

By the time of presentation any genito/anal ulceration will have resolved and many patients will not recollect ulceration. Untreated LGV can progress to rectal strictures and sinus formation which may raise suspicion of bowel cancer. Biopsy material can also be confused with Crohn's disease.

Diagnosis of LGV is made on detection of *Chlamydia trachomatis* DNA by nucleic acid amplification from rectal swab, urethral swab or lymph node aspirate.

Any man with the above history and presenting with these symptoms should be referred to GUM (Sandyford Initiative) or the Steve Retson Project to exclude LGV and rectal gonorrhoea. GUM has a walk-in morning clinic from 8.30am each weekday (no appointment necessary). For further advice please call the Sandyford Initiative professional helpline on (0141) 211 8646 or page the on-call GUM doctor through Gartnavel General Hospital switchboard on (0141) 211 3000 or 211 8634.

Tetanus infection in IDUs

In the UK in recent months there has been a number of cases of tetanus infection in injecting drug users (IDUs). The primary immunisation schedule provides a minimum of 5 doses of the vaccine (3 doses in the infant primary schedule, 1 dose at pre-school and 1 dose before school leaving). In addition, it is recommended that a further dose should be given to travellers to areas where medical attention for a tetanus-prone wound is not easily accessible and whose last dose of tetanus was more than 10 years previously, even if they have received 5 doses in the past.

Every opportunity should be taken to ensure that drug injectors are fully protected against tetanus. If there is any doubt about immunisation status, a booster dose should be given. Revaxis®, (Td/IPV) is currently the vaccine being used for school-leaving boosting, traveller boosting, and in adults with no evidence of primary immunisation, (3 doses a month apart, a 4th dose 5 years later and a 5th dose 10 years after that). Concerns about additional doses producing unacceptable rates of reactions are unfounded. (Ramsay et al, 1997, CDR Review 5, 65-6)
www.hpa.org.uk/cdr/archives/CDRreview/1997/cdrr0597.

New MRSA leaflets

NHS Greater Glasgow has recently produced three information leaflets for patients with MRSA who are:

- in hospital
- being discharged from hospital
- in the primary-care setting

A fourth leaflet, a MRSA fact sheet, is for anyone who is about to use a health service or who wants some general information about MRSA.

Small numbers of these can be obtained from the PHPU 201 4917. Depending on demand, bulk supplies may be made available at a later date.

BCGs and childhood vaccines

Staff are reminded that no gap is required between BCG and the new childhood vaccines (Paediacel®, Repevax®, Revaxis®). However, if not given simultaneously, an interval of not less than 4 weeks is advised between MMR and BCG because these are two live vaccines. It's important to note that no further vaccinations should be

given for at least 3 months in the arm used for BCG vaccination because of the risk of regional lymphadenitis.

Revaxis® for travellers

Please note that single antigen polio vaccine (IPV) is no longer routinely available. The PHPU therefore recommends that Td/IPV be used where protection against tetanus **or** diphtheria **or** polio is required. This provides comprehensive long-term protection against all three diseases.

In the last few months the PHPU has received calls from staff looking for single antigen IPV where Td (Diftavax®) has already been administered. Although some Td is still in circulation, there are no plans to obtain further supplies when current stocks are exhausted. For this reason, **only Td/IPV should be used for travel vaccination.**

Primary immunisation rates '04

Primary immunisation uptake-rates for all Scottish Health Boards have recently become available. The tables below detail the percentage uptake-rates for children at age 1 year and again at age 2 years in the GGNHSB area and in Scotland as a whole.

Primary immunisation uptake-rates 2004 (at 1yr of age)

Area	Cohort number	D (%)	T (%)	P (%)	Polio (%)	Hib (%)	MenC (%)
GG	9210	94.9	94.9	94.6	94.9	94.5	94.6
Scotland	52474	95.4	95.4	95.2	95.4	95.1	94.4

Primary immunisation uptake-rates 2004 (at 2yrs of age)

Area	Cohort number	D (%)	T (%)	P (%)	Polio (%)	Hib (%)	MenC (%)
GG	8945	97	97	96.9	97	96	96.6
Scotland	51573	97.6	97.6	97.3	97.6	96.9	96.4

MMR uptake-rates 2004 (at 2yrs of age)

Area	MMR (%)
GG	87.1
Scotland	88.3

Cryptosporidiosis season

The cryptosporidiosis season will start soon (4th week April/1st week May) and therefore cryptosporidiosis should be considered in anyone presenting with watery, non-bloody diarrhoea, colic, nausea/vomiting and possibly fever (NB stool specimens should be requested from patients with these symptoms).

Clinicians responsible for patients with the conditions listed below are reminded of the DoH's standing advice that such high-risk patients should boil water.

- HIV/AIDS
- Severe Combined Immune Deficiency (SCID)
- Specific T cell deficiencies e.g., CD40 ligand deficiency

Children and mobile phones

The National Radiological Protection Board's report on mobile phones was launched earlier this year. Although there was no evidence to support the view that mobile phones are hazardous to health, the NRPB's chairman, Sir William Stewart, admitted that he was more concerned by the evidence presented to the panel this time. Previous work had been published in 2000 by the UK Independent Expert Group on Mobile Phones (BMJ 2000; 320:1358).

The group acknowledged that members of the public were worried about the effects of exposure to radiation from phones and masts. They also acknowledged that some laboratory-based studies suggested prolonged exposure may affect cognitive functioning, increase susceptibility to cancer and damage to DNA, although epidemiological evidence supporting a link between ill health or disease and exposure to the electromagnetic frequency (EMF) associated with mobile phone technology (microwave) is tenuous. It is important to remember that the intensity of EMF experienced in the vicinity of most base stations (usually attached to a mast, concealed in a church steeple or tree, or miniaturised in a microcell/picocell) is many hundreds of times less intense than that experienced at the skull of a user who applies the phone to their head or at the abdomen of the user who carries the phone in their pocket or on their belt.

The report urges particular vigilance relating to more vulnerable groups such as younger children. Sir William does not believe that children under 10 years of age should use a mobile phone and that older children should, ideally, only have 'pay-as-u-go' in order to limit use to important calls and text messages. Parents should not have contracts that provide free evening calls allowing children to chat on mobile phones for hours each evening.

The full report is available on-line at:
www.iegmp.org.uk

Pandemic influenza plan

The UK Health Departments' Flu Pandemic Plan has been updated and is available on the Scottish Executive and Department of Health websites. A leaflet entitled 'Pandemic Flu – Important information for you and your family' is also on the SE website and a 'Frequently Asked Questions on Pandemic Flu' is on the Health Protection Scotland (formerly SCIEH) site.

These documents are available at:
www.dh.gov.uk/PublicationsAndStatistics/Publications
www.scotland.gov.uk/library5/health/pfle-00.asp
www.show.scot.nhs.uk/scieh/

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