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GGNHSB PHPU NEWSLETTER

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Scabies in care homes

Scabies is an itchy skin condition caused by a tiny mite (*Sarcoptes scabiei*) that buries itself beneath the skin. The symptoms, caused by an allergic reaction to the mite's faeces, can take up to 6 weeks after contact with an affected person to manifest. The mite is transferred by close direct skin contact of several minutes duration, e.g. holding hands with or washing an affected resident, so infection can spread quickly throughout a care home.

If a resident has an itchy rash, staff should consider whether it might be scabies. Diagnosis can sometimes be difficult and it is advisable that GPs seek specialist dermatological confirmation and advice when considering treatment for a number of staff and residents in a care home. Where a case does present, GPs should advise senior staff to look for any new cases by inspecting residents' skin and report any rashes in care staff. The PHPU should be contacted in the first instance for management advice (201 4917).

Where there is a confirmed outbreak of scabies, all residents and care staff, irrespective of whether they have symptoms or not, should be treated with an acaricide, preferably in unison or within 24 hours of the first case being treated. Only symptomatic staff should have their immediate family treated. Two applications with an acaricide such as Lyclear or Malathion (Derbac M) cream are required for cases and one application for asymptomatic contacts. Those with encrusted scabies who are extremely highly infested due to their immunocompromised state may require multiple treatments.

Hydrocortisone creams help reduce the itch which can persist for up to a week after acaricidal treatment. Compliance with treatment is essential if an outbreak is to be brought under control; this means impressing upon all staff the need to follow carefully the instructions on skin application of acaricide and to leave the treatment on the skin for the recommended time before washing off.

Infanrix/IPV – important note

The PHPU was recently made aware of two incidents where babies received a dose of Infanrix/IPV instead of Pediacel for primary immunisation. Please note that Infanrix/IPV is not to be used for primary immunisation instead of Paediacel. It is for pre-school boosting only and is an alternative to Repevax. The name **Infanrix/IPV** does not mean it is for **infants!**

Td vaccine for travel

In April 2005, Dr Syed Ahmed wrote to all GPs, practice nurses and community pharmacists recommending the use of Revaxis for travel purposes in adolescents and adults.

The Department of Health has now advised immunisation co-ordinators that Sanofi Pasteur MSD is temporarily unable to supply Revaxis (Td/IPV). To manage current stocks of the Revaxis, the DOH is recommending that the stocks of Revaxis held by Farillon be reserved for teenage boosting as part of the routine childhood programme and not for other indications such as travel immunisation. The Department recommends that low-dose diphtheria/tetanus (Diftavax) be used for adult and travel purposes where indicated.

The National Travel Health Network's advice on polio immunisation is that all travellers must be up-to-date with the UK immunisation schedule i.e., the traveller should complete a primary course prior to travel or should have received a dose of polio vaccine as an adult.

This problem with supplies will have an impact on practices over the summer months. The requirement for polio immunisation will need to be established by the GP or practice nurse and will depend on the individual case and travel destination. Where travellers *urgently* require polio, staff should contact Leverndale pharmacy (211 6675) for information about available Revaxis as there is also a shortage of single-antigen IPV. **Diftavax should not be used in these cases.**

Recommendations for travel to the different WHO regions are detailed below:

Polio-free regions

WHO European
WHO Western Pacific
WHO American

Recommendation: Polio booster no longer recommended for travel to countries within these regions unless the traveller has not completed a primary course or has not received a dose of polio as an adult. In these cases, complete primary course or give an adult boost.

Non polio-free regions

WHO African
WHO South East Asia
WHO Eastern Mediterranean

Recommendation: A booster dose of polio recommended for those who have not received a dose within 10 years

Guidelines for asplenic patients

Severe, potentially life-threatening infection is a major long-term risk after splenectomy and in those who have functional hyposplenism. Most serious infections are caused by pathogenic encapsulated bacteria especially *Streptococcus pneumoniae* (pneumococcus), as well as *Haemophilus influenzae* type B and *Neisseria meningitidis* (meningococcus).

Most infections occur within the first 2 years in those who have undergone splenectomy, however an elevated risk of serious infection remains lifelong. Asplenic children under 5 years of age are at even higher risk than adults, and those with sickle cell anaemia are at especially high risk of overwhelming infection.

Lifelong prophylactic antibiotics should be offered to all asplenic, irrespective of age, especially in the 2 years after splenectomy. Phenoxymethylpenicillin or amoxycillin is generally recommended, with erythromycin being the drug of choice in those who are penicillin allergic.

Vaccines recommended

Pneumococcal vaccines

Pneumovax: 23-valent unconjugated polysaccharide vaccine for people aged over 2 years.

Single dose at least 2 weeks before elective splenectomy and as soon as possible after traumatic splenectomy

Repeat doses every 5 years due to likelihood of antibody decline in this specific group.

Prevenar: 7-valent polysaccharide conjugated vaccine for children under 5 years of age

Infants under 6 months: 3 doses one month apart and a 4th dose after 1st birthday

Infants 7-11 months: 2 doses one month apart and a 3rd dose after 1st birthday

Children 1-5 years: 2 doses, 2 months apart

(All children should also receive *Pneumovax* after their 2nd birthday and at least 2 months after their 2nd dose of *Prevenar*).

Haemophilus influenzae type B (Hib) vaccine

Infants under 6 months: 3 doses, one month apart

Infants 7-11 months: 2 doses, one month apart

Over 1 year of age: 1 dose

At least 2 weeks before elective splenectomy and as soon as possible after traumatic splenectomy

Meningococcal C vaccine

Infants under 6 months: 3 doses, one month apart.

Infants 7-11 months: 2 doses, one month apart

Over 1 year of age: 1 dose.

At least 2 weeks before elective splenectomy and as soon as possible after traumatic splenectomy

Influenza vaccine

Required annually

Malaria prophylaxis

Malaria poses a particular threat to those who are asplenic or those with a dysfunctional spleen. Anti-malarial prophylaxis and precautions against mosquito bites should be high priority for those travelling to malarial areas.

The end of school BCGs

Changes to the BCG vaccination programme were announced by the Department of Health in England and the Scottish Executive Health Department on 6th July.

Following advice from the Joint Committee on Vaccination and Immunisation (JCVI), the current universal BCG vaccination programme delivered through schools will be replaced with a targeted programme aimed at providing earlier vaccination for those individuals who are in greatest need.

In almost all cases, a child becomes infected with TB via a close family member or household contact. The new programme will identify and vaccinate babies, and other individuals, at most risk of TB infection and includes those living in areas of high prevalence and those whose parents or grandparents live or have lived in a high prevalence country for TB.

Scombrototoxin poisoning

The Health Protection Agency (HPA) has confirmed sporadic cases of scombrototoxin poisoning (histamine poisoning) from several parts of the country. Usually associated with the Scombridae family of fish, such as tuna or mackerel, scombrototoxin forms in food when spoilage bacteria, time and temperature permitting growth, produces a complex mixture of compounds. Symptoms include flushing of the face and neck, tingling of the tongue, vomiting and/or diarrhoea.

The toxin can be distributed in the food in varying degrees and chemical testing is the only method to confirm its presence. From investigation into these sporadic cases, there are links to the handling of tuna and, in particular, to sandwiches. Although packaging of the tuna was thought to be a problem initially, further investigations revealed that the levels of histamine were excessive *after* packs had been opened, the contents cooked and/or added to mayonnaise for sandwich filling.

Poisoning can be avoided by ensuring that raw fish used as an ingredient is kept as fresh as possible by storing in ice, proper refrigeration or freezing at the normal recommended temperatures. Defrosting of frozen product should be carried out by refrigeration or microwave.

Appointments for BCG clinics

Please note that **health visitors** must contact the PHPU to arrange BCG for 'at risk' babies and young children. Staff should not be advising parents/carers to arrange appointments.

The number to ring for BCG appointments is **201 4518**.

Infection-control policy

The GGNHSB infection-control policy is now on-line at <http://www.nhs.uk/iccmanual>