

NHSGG and CLYDE NEWSLETTER

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Public Health Protection Unit (PHPU) 0141 201 4917 www.nhsggc.org.uk/phpu

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Measles now endemic in UK

Fourteen years after the local transmission of measles was halted in the United Kingdom (UK), the disease has once again become endemic, according to the Health Protection Agency (HPA), the public health body of England and Wales. In an update on measles cases in its weekly bulletin in July, the agency stated that, as a result of almost a decade of low mumps-measles-rubella (MMR) vaccination coverage across the UK, 'the number of children susceptible to measles is now sufficient to support the continuous spread of measles'.

In an earlier update, the HPA reported that all recent indigenously-acquired cases with a genotype in England and Wales had been found to have the same D4 sequence (MVs/Enfield.GBR/14.07), a genotype 1st identified in April 2007 and which is now endemic in the UK [2].

In May [2008], a 17-year-old with underlying congenital immunodeficiency died of acute measles infection, the first such fatality in the UK since 2006. The strain was also MVs/Enfield.GBR/14.07, genotype D4 [more accurately clade D4; see below].

The total number of confirmed measles cases in England and Wales so far this year [2008] is 461. In Scotland, there have been 68 cases of measles reported in 2008, of which 51 have been laboratory-confirmed [3]. All of the cases in Scotland were either not immunised or of unknown immunisation status. Only 2 of the cases were imported from abroad, both from Pakistan.

The HPA has recommended that health services exploit 'all possible opportunities' to offer MMR vaccine to children who have not received 2 doses. The agency also stressed the necessity for all healthcare workers in contact with vulnerable patients to have documented immunity to measles.

Europe is facing a measles epidemic, with large ongoing outbreaks for instance in Switzerland, Austria and Italy.

Auto-injectors and babies

Please note that paediatricians do not advise using adrenaline auto-injectors in babies and small children as the needle is likely to come out the other side or end up intra osseous. These should only be used in children whose weight is over 15 kg.

New Hep C service contract

In March this year NHSGGC board issued a tender seeking an organisation, or partnership of organisations, that could provide services to address the prevention, care and support needs of people at risk of, or infected with, hepatitis C. A comprehensive range of services was sought, including interventions addressing prevention; promotion of testing; care and support; awareness raising and the education and training of staff.

The PHPU is pleased to announce that after a rigorous selection process, **C-Level** has been awarded the contract to provide these services for the next 30 months to 31st March 2011. The new expanded service will commence on 1st October 2008. C-Level is currently funded to provide prevention services mainly to IDUs (injecting drug users) through peer education.

Hepatitis C is a major public health problem in Scotland and particularly in Greater Glasgow and Clyde, where over 40% of the total number of cases has been diagnosed, the highest of any health board in Scotland. In addition there are many more individuals who are unaware of their infection.

NHSGGC has always been committed to tackling this issue and Phase II of the National Action Plan, launched on the 19th of May, presents a framework for action and the resources to facilitate local delivery of these actions.

C-Level is a key partner in this next phase of the campaign to tackle hepatitis C and the PHPU looks forward to working with it.

C-Level is currently based at 268 Bath Street, Glasgow, G2 4JR. 0141 332 2520.
www.c-level.org.uk

Copies of the Hepatitis C Action Plan for Scotland: Phase II, can be found at:
www.scotland.gov.uk/Resource/Doc/222750/0059978.pdf

'New-to-immunisation' seminar

Due to demand, an additional seminar for staff new to childhood immunisation had been arranged for Monday 6th October 2008 in Dalian House (1.30 - 4pm).

Unfortunately, it's now fully booked !

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Chlamydia testing in 2007

Since 2001, NHS Greater Glasgow has undertaken continuous monitoring of chlamydia testing activity across the Board area and provided regular feedback to clinicians, with the aim of ensuring that testing was optimally targeted towards population subgroups at highest risk of infection. Following the assimilation of Clyde into the new NHS Greater Glasgow & Clyde (NHSGGC) Board area in April 2006 and harmonisation of data collection systems between Clyde laboratories, it has become possible to monitor chlamydia testing activity across the entire NHSGG&C Board area.

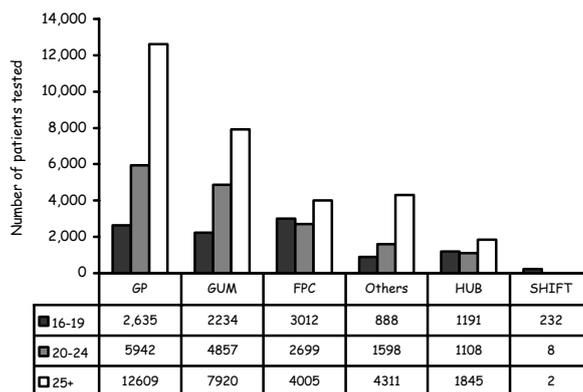
In the calendar year 2007, there were 56,932 patients tested for genital chlamydial infection in the entire NHSGGC area, of whom 43,587 (77%) were female and 13,345 (23%) male. The proportion of adult CH(C)P residents tested for chlamydial infection varied from 17% in South Lanarkshire to 62% in Glasgow City. 12.4% (1652 of 13,345) male patients tested positive, compared with 6.6% (2856 of 43,587) females. Full unit postcodes (allowing classification by SIMD) were available on just over half of the cohort; analysis of this subgroup suggested a significant social gradient in the proportion of tests with positive results, from a relatively high proportion in SIMD quintile 1 (most deprived) to a relatively low level in SIMD quintile 5 (least deprived). This social gradient was statistically significant in both sexes, but the effect was steeper in men. The proportion of tests that were reported as positive varied across 6.8% in South East CHCP residents to 9.3% in those of Inverclyde CHP. This is likely to mainly reflect the differential rates of testing by age and gender; 23,067 women over the age of 25 years were tested for *Chlamydia trachomatis*, accounting for over half (53%) of all female testing activity. This substantial effort generated 647 positive tests (23% of all positive tests in female patients). Conversely, 8,353 young women aged 16-19 were tested; this accounted for only 19% of all female-testing activity, but 38% of all positive results were in this age group.

There is considerable geographic variation in targeting of chlamydia testing towards subpopulations at greatest risk, with commensurate variations in the proportion of tests that are reported as positive. Primary care represents a very substantial component of current activity, where there is the greatest gain to be achieved from improving the potential health gains derived from chlamydia testing by appropriate enhanced service contracting with primary care providers to encourage appropriate testing.

Recommendations:

- Clinicians should continue to target the age-groups at greatest risk and those with symptoms
- The review should be conducted annually to optimise health gains from the GGNHSB Chlamydia Strategy
- Improvements in completeness of data on residential postcodes collection should be sought to investigate further potential health inequalities in testing
- Feedback to CH(C)Ps, GPs and other service providers should be provided in a range of innovative ways

Age distribution of patients tested, by setting, 07



HPV programme - update

The HPV programme in Scotland is will commence on 1st September and on the 8th September in the NHSGG&C area. The programme is school-nurse led and school-based with all girls between the ages of 12 and 18 years being targeted.

Repevax supply problem

Immunisation staff had previously been advised to use Repevax (+ Hib/MenC) for pre-school boosting as national restrictions on supplies of Pediacel (5-in-1 vaccine) meant it was to be used only for primary vaccination. The PHPU has recently been informed by NHS NSS National Procurement that there is now a restricted supply of Repevax. However, it is anticipated that supplies of Infanrix IPV/Hib (5-in-1 vaccine) for pre-school booster will be available from mid-September.

It is recommended that, until the 5-in-1 vaccine becomes available, **only children called by SIRS should be immunised**. Children should not be immunised opportunistically or from the 'queue print' until supplies of pre-school booster are replenished.

The local vaccine holding centres will endeavour to supply practices with Repevax for the next 4-6 weeks. Where supplies of Repevax are insufficient, appointed children should be given MMR, and Hib/Men C if required*, and the child will be automatically re-called by SIRS for the appropriate pre-school booster.

* Hib is required for any pre school child who has not received 1 dose of Hib over the age of 12 months

Malaria in UK travellers

UK travellers to Africa or South Asia are advised to take appropriate malarial prophylaxis. A recent study published in the BMJ¹ shows that those UK travellers born in malaria-endemic countries rely on a prevailing myth that they have natural immunity to malaria. As an increasing proportion of cases reported are caused by *Plasmodium falciparum*, the species more likely to be fatal, it is important that travellers to endemic countries take prophylaxis.

¹Smith AD et al BMJ 2008;337:a120doi:10.1136/bmj.a120