

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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Novel Influenza A (H1N1)

The PHPU uses a number of local and national data sources to carry out flu surveillance.

Virology

Although diagnosis is now made primarily on a clinical basis, a small number of swabs are still being taken, predominantly by GP flu-spotter practices and in hospitalised patients. In the period 30/07/09 to 02/08/09 only 17 out of 149 (11%) swabs tested positive for H1N1, suggesting that other viruses are in circulation.

Antiviral prescribing

GP antiviral prescribing remains stable; only around 400 prescriptions for Tamiflu or Relenza were issued by practices in the week 27/07/09 to 02/08/09 (although this excludes prescriptions issued in the out-of-hours period). Over the weekend of 01/08/09 to 02/08/09 the out-of-hours service received 266 calls from patients with flu-like symptoms, however following assessment only 15% required antivirals.

Consultation rates

The consultation rate for flu-like illness based on data from NHSGGC's 10 flu-spotter practices is 25.8 per 100 000 which is lower than the national average of 55.0 per 100 000.

Inpatient data

As of 04/08/09 only 1 patient is hospitalised due to H1N1 within NHS GGC.

Summary

All indicators suggest that the flu situation is currently stable within NHSGGClyde. Surveillance is ongoing to ensure that any changes to this trend are detected quickly.

Vaccines at 12 and 13 months

The routine childhood schedule states that children should receive Hib/Men C vaccine at 12 months of age, and MMR and pneumococcal vaccines at 13 months.

This month the JCVI (Joint Committee on Vaccination and Immunisation) concluded that it is acceptable to give MMR, PCV and Hib/Men C vaccines at the same time (this is based on evidence from a clinical study that showed no additional adverse reactions). This new advice, which will be reflected in the Green Book in due course, introduces flexibility to the childhood schedule. *The routine childhood schedule remains unchanged.* Immunisation staff may give all three vaccines at 12 months or at 13 months, or keep to the routine schedule.

Flu Friends

Patients with suspected influenza A (H1N1) should not attend the community pharmacy or any other centre to collect antiviral medicines. Instead, a Flu Friend should be nominated.

Pharmaceutical Public Health has received reports that patients diagnosed with influenza A (H1N1) are attending community pharmacies for uplift of antiviral medicine. Often they browse the pharmacy, select other items and wait for several minutes at the counter before giving any indication to staff that they have symptoms. In some areas this is happening in up to 50% of cases and poses an increased risk of exposure to staff and other customers of whom some will be mothers with their young children.

All GPs and Healthcare Practitioners prescribing antiviral therapy for influenza A (H1N1) infection are reminded to reiterate the Flu Friend message when issuing a prescription to a patient.

It is appreciated that some patients might have difficulty finding someone to go to the pharmacy for them. If a Flu Friend cannot be found, and as a last resort, patients should be advised to phone the pharmacy in advance so that staff can organise the safest way of dispensing the medicine.

New seasonal influenza vaccine

Sanofi Pasteur MSD is highlighting the launch of a new vaccine for seasonal influenza called Intanza[®]. It comes in 2 strengths, 9mcg/strain for adults aged 18 to 59 years and 15mcg/strain for those over 60 years. (The usual strength for influenza vaccine is 15mcg/strain).

It differs from other flu vaccines in that administration is by intradermal rather than intramuscular injection. The Intanza[®]/IDflu[®] patented device allows a straightforward perpendicular injection technique to the deltoid area

However, GPs should note:-

- this is a new product and although it contains this season's recommended viral strains, Sanofi MSD has recently indicated that **IT WILL NOT BE READY FOR 2009/10**
- the vaccine might address the issue of immunosenescence (the reduced response of the immune system in ageing), but not the problem of inducing an immune response in those individuals with immunosuppression (for whatever reason)

For further information contact the Public Health Pharmacist (Health Protection) on 201 4502

Campylobacter rates rising

In recent weeks there has been a general increase of 19% in Scotland in laboratory-confirmed cases of campylobacter compared to the same period in 2008. In NHSGG&C the increase was 34.3% (see table below). It is not known if this is a genuine increase or is due to improved laboratory ascertainment or sampling bias (more specimens being taken than usual). Investigations are underway by Health Protection Scotland to try to shed some light on the factors that determine these numbers.

NHSGGC Campylobacter cases Wks 1-28 08 & 09

Wks 1-28	2008	2009	Increase	% Increase
Total	487	654	167	34.3

Campylobacter is the most common cause of bacterial food poisoning in the UK. In NHSGG&C the total number of laboratory-confirmed cases reported in 2008 was 1100 (in Scotland just under 5000). This is a gross underestimate of the total burden of campylobacter infection as most human cases are not brought to the attention of GPs.

The reservoir of campylobacter is the gastrointestinal tract of birds (particularly poultry), cattle and other animals including domestic pets. It is from these sources that food and water may be contaminated. Campylobacter can be found in many raw chickens sold in shops and supermarkets. It is important that these raw products are cooked properly and that no blood is visible in the centre of the meat. Carcasses can also contaminate other foodstuffs such as bread. The infectious dose is relatively low, however since campylobacter doesn't multiply in food, and person-to-person spread is unusual, outbreaks are uncommon.

The symptoms of campylobacter infection include abdominal pain, profuse diarrhoea (sometimes bloody), nausea, headache, fever and, less commonly, vomiting. The incubation period is usually 2-5 days after exposure to contaminated food or drink, most commonly undercooked meat (especially poultry), unpasteurised milk and untreated water. Symptoms last for 4-7 days in most cases and if infection is especially severe or prolonged, antibiotics can be used as a treatment. Campylobacter is not usually a threat to pregnant women, however, sufferers should be advised to drink large amounts of fluids to avoid the effects of de-hydration.

Infection-control advice includes washing hands diligently at key times, cooking meat properly (especially at barbecues), practising safe food preparation to prevent cross-contamination, avoiding unpasteurised dairy products and untreated water.

Formal exclusion from work, school or nursery is not necessary. However, those affected should not return to work/school/nursery until they have been diarrhoea-free for at least 48 hours.

New genital ulcer test

Genital ulceration is an uncommon but important clinical presentation. Sexually transmitted infections (STIs) account for a small, but clinically important proportion of cases. In these cases, it is vital to identify the underlying pathogen, to ensure appropriate management of patients and their sexual partners. Laboratory diagnosis of infective genital ulceration has, until recently, been clinically and technically complex. However, from 17th August 2009, innovative application of technology at the West of Scotland Specialist Virology Centre means that the existing test for herpes viruses will **also** incorporate a nucleic acid amplification test (NAAT) for syphilis.

What is the change?

Existing assay: detects *Herpes simplex* (HSV)1/HSV2 /*Varicella zoster* (VZV)

New assay: detects HSV1/HSV2/*Treponema pallidum* (syphilis)

When will the change be implemented?

17th August 2009

What is the reason for the change?

There are two main reasons. Firstly, syphilis diagnoses have been rising steeply in Scotland in recent years; the incidence of infection is at its highest in 50 years. Syphilis is a serious systemic disease, with potential for permanent health sequelae. Secondly, laboratory testing is essential in clarifying the cause of genital ulcers, because clinical appearances are very misleading; around 30% of primary syphilis presentations are with multiple painful ulcers, indistinguishable from 'textbook' genital herpes. Thus, laboratory confirmation is essential to guide clinical management.

Practical points

The sample must be transported to the lab in the standard virus PCR sample solution, VPSS (a thin orange labeled clear tube)

- Any swab can be used to take a sample - **but do not leave the swab in the tube**
- A yellow STI request form should be completed
- GPs who strongly suspect a clinical diagnosis of syphilis should continue to refer patients urgently to the local GUM service

Queries ?

- For technical queries about the test or result, contact the lab on 0141 211 0080
- For clinical queries, contact the Sandyford Professional Helpline on 0141 211 8646

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