

NHSGG and CLYDE NEWSLETTER

Public Health Protection Unit www.nhsggc.org.uk/phpu

INSIDE THIS ISSUE

- Flu vaccines and children
- Flu vaccination and egg allergy
- Measles in UK and France
- Vaccine pharmacy technician
- Invasive meningococcal disease
- Flu info for GPs on website
- HIV risk ?Be in time for PEP
- PGDs and HCAs

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Flu vaccines and children

Febrile convulsions: Immunisation staff are reminded that flu vaccines marketed by Pfizer (formerly Wyeth) should not be given to children under 5yrs due to the possibility of febrile convulsions. This includes CSL Biotherapeutics generic vaccine and Enzira. Although there is no evidence that other seasonal flu vaccines carry this risk the MHRA has asked practitioners to promptly report every case of febrile convulsion in children occurring within 72 hours of receiving the seasonal flu vaccine. See link below for more details on reporting.

www.mhra.gov.uk/Publications/Safetyguidance/DrugSafetyUpdate/CON096841

Paediatric dose: There have been queries about the appropriate dose of flu vaccine for children 6 to 36 months. The PGD recommends that staff refer to the Summary of Product Characteristics (SPC) for the brand of vaccine being used. However, the SPCs give only general information stating a potential dose range of 0.25 to 0.5ml.

For clinically at-risk children who are also immunocompromised (for whatever reason) use the higher 0.5ml dose, as this patient group does not respond well to the lower dose.

For clinically at-risk children who are not immunocompromised, use 0.25ml. However, if the child is heavier and at the older end of the age range 0.5ml may be used.

If in doubt and for individual case advice please contact PHPU on 0141 201 4917.

Please also note that Fluvirin® is *not licensed* for use in children aged under 4 years.

Flu vaccination and egg allergy

Please note that children with confirmed severe egg allergy can receive flu vaccine under supervision at the RHSC. There is increasing evidence that it is safe and the paediatric team is hoping to publish the results after this season's cohort. Immunisation staff are therefore encouraged to refer such children to Dr Rosie Hague at the RHSC.

Individuals who *eat egg freely* can receive the standard dose of influenza vaccine regardless of past history of egg allergy or evidence of sensitization to egg on skin testing or specific IgE. Individuals with more severe egg allergy should be individually assessed to determine whether the benefits of influenza vaccination outweigh the risks. The British Society for Allergy and Clinical Immunology has recently updated egg allergy guidelines which are accessible at www.bsaci.org.

Measles in UK and France

Travelling Community in UK

In August there was a small outbreak of measles in Scotland among members of the travelling community, also during the summer there was an outbreak of measles among members of the travelling community in England.

The latest report is of two probable cases of measles among members of the travelling community in Scotland. The last date of onset of the rash was approximately 16th October. The family involved has stayed in at least three NHS Board areas (Lothian, Tayside and A&A).

Primary care staff should be aware that measles is still present in the travelling community in Scotland and should promote appropriate diagnostic testing and increase index of suspicion in this population group. As always, opportunistic MMR vaccination of the unprotected should not be missed.

Ongoing outbreak in France

There has been a measles epidemic raging in France since 2008 that has involved more than 5000 cases.

The National Institute of Health Surveillance recorded that measles virus circulation intensified in early 2010; over 3000 cases between January and August with a peak incidence in April. In the 1st 8 months of 2010, the proportion of hospitalized cases, among reported cases, was 34 percent.

Since the epidemic began, 4 people have died of measles complications. The circulation of the virus is affecting the entire metropolitan area of France. The regions most affected are the Midi-Pyrenees, (Poitou-Charente, Limousin, Central, Languedoc-Roussillon, Pays de Loire, Paca and Ile-de-France). This situation has resulted from inadequate vaccination (90% overall in 2007, but very heterogeneous across regions).

Staff should bear this outbreak in mind and take every opportunity to ensure that those travelling to the affected areas in France are fully immunised with two doses of MMR vaccine.

Vaccine pharmacy technician post

The PHPU welcomes Karen Pawelcyk who takes up her new year-long post, Vaccine Pharmacy Technician, on 22nd November.

Please note that from that date all vaccine-storage and cold-chain incidents should be reported to Karen, who will be based in the Public Health Pharmacy unit at Board headquarters, on **0141 201 4424**.

Invasive meningococcal disease

Influenza notifications usually rise in winter with an associated rise in reports of invasive meningococcal disease (IMD). The highest incidence of IMD occurs in infancy with a smaller peak in young adults.

If a GP has clinical suspicion of IMD, parenteral benzylpenicillin should be administered before arrangements for rapid emergency admission to hospital. If there is a history of immediate allergic reaction after previous administration of penicillin, a third generation cephalosporin may be used.

Dosage of IV/IM benzylpenicillin for suspected IMD

Adults and children aged 10 years and over	1.2 grams
Children 1-9 years	600 mg
Children under one year	300 mg

Antibiotic chemoprophylaxis for close contacts

Close contacts are generally defined as people who live in the same household as the case, have stayed overnight in the same household as the case during the 7 days before onset of illness, or who are intimate kissing contacts such as sexual partners. It is only if there are linked cases (e.g. university outbreak) that wider use of antibiotic prophylaxis may be recommended.

The aims of chemoprophylaxis for close contacts are:

- eradicating carriage from established carriers who pose a risk of infection to others
- eradicating carriage from those who have newly acquired the invasive strain and who may themselves be at risk of invasive disease.

It is important to remember that chemoprophylaxis is not always effective, so information should also be given to close contacts on the signs and symptoms of IMD.

Rifampicin is the only licensed antibiotic for chemoprophylaxis for close contacts and is thus by far the most commonly used antibiotic. Ciprofloxacin (for adults and children aged 2 and over) and IV/IM ceftriaxone are both effective for eliminating carriage of meningococci, but less commonly used (see BNF for information on dosage regimes).

Rifampicin dosage regime (twice daily for 2 days)

Adults and children over 12 years	600mg
Children 1-12 years	10mg/kg body weight
Infants under 12 months	5mg/kg body weight

The most up-to-date national management guidelines can be obtained at:

http://www.hpa.org.uk/infections/topics_az/meningo/meningococcalguidelines.pdf

Find information at:

www.meningitis.org/health-professionals/primary-care/gps
www.meningitis.org/about-us/resource-centre/

Flu info for GPs on website

GPs should note that the presentations used in September's flu seminars and other seasonal flu information can be found on the PHPU website. Click on link below.

www.nhs.gov.uk/content/default.asp?page=s1543_2_1

HIV risk? Be in time for PEP

Gay Men's Health, a Scottish voluntary organisation, in consultation with NHS Greater Glasgow and Clyde, has launched an HIV prevention social marketing campaign for gay and bisexual men that aims to raise awareness of post exposure prophylaxis for sexual exposure (PEPSE).

Despite being one of the groups at highest risk of HIV infection in Scotland, gay and bisexual men have low levels of awareness of this potentially life-saving treatment.

The campaign has a range of printed and on-line resources and will be supported by trained peer-educators delivering one-to-one interventions on the commercial gay scene in both Edinburgh and Glasgow.

The campaign materials and full information on PEP can be accessed at the dedicated campaign website: www.pepscotland.com

There might be an increase in enquires about PEP and where to access it in NHSGGC as the campaign progresses, therefore staff should re-acquaint themselves with the Board's policy for the 'Management of occupational and non-occupational exposures to bloodborne viruses (including needlestick injuries and sexual exposures)' which can be found at www.nhs.gov.uk/phpu

Training opportunities around BBVs is available within GGC. All training is free and further details of courses and how to book can be found at:

www.sandyford.org/practitioners/training.aspx

PGDs and health care assistants

There are two commonly asked questions about vaccination procedure under a PGD.

Q. Can a Health Care Assistant (HCA) work under a PGD?

A. No, Only designated healthcare professionals may work under a PGD. Details of this group can be found on the MHRA website at www.mhra.gov.uk. Only nurses, midwives and pharmacists can work under PGDs in NHSGGC. An appropriately trained HCA may only administer a vaccine or any other medicine under a Patient Specific Direction, that is to say at the direction of an independent prescriber.

Q. The vaccine PGD states that the patient record must be signed as part of the documentation and audit trail. How is that done in a 'paper free' surgery?

A. If the healthcare professional administering the vaccine is directly recording the vaccination onto the electronic patient record the electronic signature which results as part of the system's audit trail is acceptable. However, if a record of vaccination is being made by, for example, an administration assistant after the clinic, then it will be necessary to have a written signature. In this case it is acceptable for the healthcare professional to sign the SIRS list and retain the duplicate sheet.

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